Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review

for

East Riding of Yorkshire

CCG

Urgent Care:
Outline Case for Change

August 2016

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Yorkshire and the Humber Clinical Senate
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Version Control

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Version 0.1	9th August 2016		Joanne Poole
Version 0.2	19th August 2016	Document formatted	Steph Beal
Version 0.3	30th August 2016	Additional comment from council incorporated	Joanne Poole
Final Version	31st August 2016		Joanne Poole

1. Chair's Foreword

1.1 The Senate welcomes the opportunity to work with East Riding of Yorkshire Clinical Commissioning Group (CCG) on the development of their proposals for urgent care. We were asked to consider the robustness of the Case for Change and whether it provides a clear clinical evidence base to support the need for change. We have therefore focused on this issue and not considered the potential models for urgent care which the CCG will need to develop in the next stage of work.

1.2 I would like to take this opportunity to thank the small panel of Council members and lay members who assisted with this review.

2. Summary of Key Recommendations

2.1 The Senate agrees that the case for change does demonstrate a clear clinical evidence base. The Senate is in agreement that the current model of Minor Injuries Units (MIU) is unsustainable. The primary reason for this is the inability of the CCG to recruit clinicians with the required skills and competencies to maintain a consistent level of service.

2.2 The Senate recommendations to further strengthen the Case for Change document are summarised below.

i. The Senate recommends that the Case for Change would be strengthened by further information on the community beds provision and how these will be used to support the shift of care to the out of hospital setting
ii. The CCG needs to demonstrate their consideration of the wider integrated urgent care system more effectively within the Case for Change
iii. An effective engagement campaign with the public is key and commissioners are advised to focus on ensuring the public understand the services being offered to them, otherwise the shift from attendance at A&E will not be achieved
iv. Engagement with primary care will be key to enabling the whole system change required and this should be acknowledged within the Case for Change
v. Commissioners will need to engage with the Local Workforce Action Group within the Sustainability and Transformation Plan (STP) to address the issues of workforce supply and transformation
vi. The Senate recommends that the Case for Change could make clearer the relationship with the out of hours services and the management of patients with long term conditions. Mental health issues also require more consideration

2.3 The Senate considered how the CCG can strengthen their clinical leadership in the absence of a dedicated urgent care lead but advises commissioners that this post is crucial in achieving the level of collaboration required across organisations. The CCG needs to consider differing ways to recruit to this position, with greater reliance on the clinical positions within the Urgent Care Network in the interim.

3. Background

Clinical Area

3.1 East Riding of Yorkshire Clinical Commissioning Group (ERYCCG) has, in 2016, published its revised Urgent Care Strategy. In line with the revised strategy and their commissioning intentions, the CCG are now reviewing their current provision of Minor Injuries Units and community beds across their geography with a view to changing how these services are provided. The

purpose of the outline Case for Change document, which the Senate has been asked to review, is for commissioners to articulate the issues and challenges being faced by the current configuration of Minor Injuries Services and community beds and present an argument of why this service needs to change.

3.2 In addition, the CCG presently does not have a dedicated clinical lead for Urgent Care and are concerned that this may impact on the assessment of the evidence base.

Role of the Senate

3.3 The CCG approached the Senate to seek advice on the strength of the clinical evidence base within the Case for Change. The specific question the Senate was asked to consider is:

Does the Case for Change demonstrate a clear clinical evidence base and is it robust enough to inform the development of the service options for public consultation.

How can the CCG strengthen their clinical leadership in the absence of a dedicated urgent care lead?

3.4 The Senate has been asked to provide early advice to feed into the planned stage 2 assurance process. The commissioners are meeting with NHS England in August where they will present the clinical Case for Change as part of their pre-consultation business case. The CCG have therefore requested the advice from the Senate as part of these discussions and both to inform the development of the consultation document and pre-consultation business case.

Process of the Review

3.5 The Senate received the request from commissioners, with the supporting evidence, on the 21st June 2016. The formal Terms of Reference for the review were agreed on the 8th July 2016. Panel members were appointed in early July and sent the evidence on their appointment. Commissioners were invited to the Senate Council meeting in July but unfortunately were unable to attend. The Council discussed the evidence at this meeting and a teleconference was held on the 18th July to provide opportunity for a discussion between commissioners and panel members. The commissioners are conducting further work on travel distances and the relationship with deprivation and the Senate requested sight of this to support the evidence, which we have received. This work was not available within the timescale and therefore could not be considered in our response.

3.6 The draft report was submitted to commissioners on the 12th August. Commissioners confirmed that they were content with the accuracy of the report and the report was subsequently ratified by the Senate Council by email discussion at the end of August 2016. The report will shortly be published on the Senate website.

4. Evidence Base

4.1 The Case for Change document sets out the national strategic context and the national developments within the Urgent and Emergency Care Review. The national drivers are also clearly articulated within the East Riding of Yorkshire CCG Urgent Care Strategy 2015 – 2020. Both documents draw upon the work undertaken by their Urgent and Emergency Care Network

4.2 The underlying evidence base regarding the effectiveness of primary, community and intermediate care is still only emerging. The Senate has referred to the National Institute for Health Research report[1] to identify the evidence base which reflects mixed evidence about the impact of community-based initiatives on rates of hospital admission.

4.3 Due to the lack of specific clinical guidance, the clinicians involved in this review worked to achieve a consensus based on experience and judgement.

5. Recommendations

5.1 The Senate agrees that the Case for Change does demonstrate a clear clinical evidence base and is robust enough to inform the development of the service options.

5.2 The recommendations are detailed below:

The Current Model of Minor Injuries Units

5.3 The Senate is in agreement that the Case for Change clearly demonstrates that maintaining six Minor Injuries Units (MIUs) is not sustainable in the longer term. The primary reason for this is the inability of the CCG to recruit clinicians with the required skills and competencies to maintain a consistent level of service. This is compounded by the low level of usage by the public, as low as 5 – 10 patients per day in the coastal units, which does not allow staff to maintain their range of skills and competencies.

5.4 The current provision offers a confusing service to patients due to the variation in the type of service, the variation in the availability of diagnostic testing and their differing hours of opening.

5.5 The Senate supports the commissioner intentions to re-design this service to achieve an improved quality of service, which meets national standards, consistently delivered and fully integrated into an urgent care model.

[1] Insights from the Clinical Assurance of Service Reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed method study. National Institute for Health Research.

The Community Beds Provision

5.6 The Senate recognises the variability in the current provision of community beds and the current lack of emphasis on active rehabilitation and re-ablement to progress patients back to their own home. The Senate supports the commissioner vision to move towards increased community based rehabilitation services supporting patients to go home with appropriate wrap around community support. The Senate recognises the community beds may not always be the best way of supporting patients back to independence but recommends that this Case for Change would benefit from more information about the services offered by these beds, the utilisation of these beds, and what community bed base there will be to support the shift of care to the out of hospital setting.

5.7 Commissioners will also note that appropriate community support includes the assessment and support of carers and the supply of equipment to enable home care. Close working with the local authority is essential to achieve progress on this care close to home model.

The Wider Context of the Integrated Urgent Care System

5.8 The Case for Change focuses on the review and the re-design of the six Minor Injuries Units and the community beds across the East Riding to develop a model for delivering a service to a national specification and standards. Initially, the Senate had difficulty in contextualising this smaller part of the urgent care system and understanding its fit within a wider strategy under the umbrella of the Sustainability and Transformation Plan (STP).

5.9 The Case for Change would benefit from greater reference as to how the MIUs and community beds link into the rest of an integrated urgent care system. It would benefit from greater recognition of other structures within the system, the clinical hubs and the alignment with 111 for example, with discussion on how to signpost patients effectively and efficiently through the whole system.

5.10 The Senate was more assured of the clarity of this wider work through the provision of the CCG Urgent Care Strategy. The strategy sets out how all parts of the local urgent and emergency care system need to work in a more joined up way as part of a single system. The CCG acknowledges that this can only be achieved with closer collaborative working with Hull CCG and Hull and East Yorkshire Hospitals NHS Trust to look at how the urgent care pathway can be simplified, coordinated and integrated around populations.

5.11 The Senate emphasises the importance of not losing sight of this wider context as the options develop for the MIU and community bed provision.

Engagement with the Public

5.12 In discussion with the Senate, commissioners reflected on the work they have undertaken with the public to improve the use of the MIUs, including their diverse marketing campaigns. Commissioners confirmed that consultation with patients

suggest that they still do not know that the MIUs are there or what service they offer or are simply favouring attendance at Accident and Emergency.

5.13 The Senate recommends that commissioners focus their communications and engagement plan on persuading the public of the benefits of attending the service that will replace the MIUs. It should not be assumed that patients will attend an Urgent Care Centre (UCC) when they did not attend the MIU. It will take a large cultural shift to persuade the public of the benefits of the UCC and the anticipated benefits to the urgent care system will not be achieved unless the CCG are able to ensure that the public understand what service is being offered to them and what symptoms they take to which service.

5.14 There are options which commissioners will need to consider in the next stages of their work in how patients can be most effectively triaged across the range of services to refer patients to their most appropriate service.

5.15 The Senate recognises the rurality of much of the CCG geography with some areas only served by minor and single track roads with poor public transport links. It is an issue which needs debate with the public as the provision of a quality and consistent service needs to be supported by the patients' ability to access this. The lack of travel information did not enable the Senate to fully understand this issue. There is also no reference within the documentation of the seasonal increase in population, especially in the summer months.

5.16 In the next stages of work, CCGs are advised to consider the equality and health inequalities and agree:

- What action will you take to address the identified equality and health inequalities priorities?
- How will you know what progress you are making in addressing equality and health inequalities?
- What are the key risks/opportunities for achieving your equality and health inequalities priorities?
- What evidence is there of improved outcomes and how will you record this?

Engagement with Primary Care

5.17 The Senate recommends that commissioners undertake further work with primary care to better understand how GP practices link in with other parts of the existing urgent care service, particularly as there is no acute hospital within the CCG geography. The strong relationship with primary care is essential in enabling the whole system and achieving the integration of urgent care and this should be acknowledged within the Case for Change. The Local Medical Committee may be a body that can help achieve this.

5.18 The Senate also recommends that commissioners engage with the Local Workforce Action Group within the Sustainability and Transformation Plan (STP) to address the issues of workforce supply and transformation.

Improving the Management of Patients with Long Term Conditions and Mental Health Issues

5.19 The Senate recommends that the Case for Change could make clearer the relationship with the out of hours services and the management of patients with long term conditions. The Case for Change would benefit from more consideration to the elderly, frail patients and those with co-morbidities and the relationship with community services to manage those patients.

5.20 It was noted that there was also little mention of mental health issues and the Senate recommends that this requires more consideration. It is also not clear what out of hours social care is available.

The Need for Clinical Leadership

5.21 The CCG's Urgent Care Strategy clearly states that achieving a coherent urgent care service for the local population will require significant leadership and collaboration across all organisations involved in commissioning and delivering urgent and emergency care across the Humber and North Yorkshire sub-region.

5.22 The CCG therefore recognises the need for strong clinical leadership but has unfortunately failed to appoint to the position of a dedicated urgent care lead. The Senate was asked how the CCG can strengthen their clinical leadership in the absence of this role. Our advice to the CCG is that this is a role that they cannot effectively function without. The CCG may wish to consider trying to appoint a clinician to this role from outside their area and to utilise the network of clinicians within the Urgent and Emergency Care Networks and the Senates to advertise this opportunity.

5.23 Without a lead position, commissioners will need to be more reliant on their Urgent Care Network and the clinical positions within this to influence their CCG members. The commissioners are also recommended to work closely with their locality (formerly known as cogs) and forge stronger links with the urgent care leads in Hull.

5.24 Commissioners may also want to reflect on why they have failed to appoint and consider ways in which they can explain the role and inspire clinicians to apply for this crucial position.

Other Comments

5.25 Commissioners may wish to consider strengthening the information in their Urgent Care Strategy regarding where 111 or the ambulance service can direct patients "in hours" as the focus seems to be on out of hours.

5.26 The slides used within the Case for Change document on pages 29 – 32 are difficult to read.

6. Summary and Conclusions

6.1 The Senate agrees that the Case for Change does demonstrate a clear clinical evidence base and is robust enough to inform the development of the service options. The Senate is in agreement that the current model of Minor Injuries Units is unsustainable but that the information on community beds could be further strengthened. The Senate also recommends a number of areas within the body of this report where the Case for Change could be improved.

6.2 The Senate considered how the CCG can strengthen their clinical leadership in the absence of a dedicated urgent care lead but advises commissioners that this post is crucial in achieving the level of collaboration required across organisations. The CCG needs to consider differing ways to recruit to this position with greater reliance on the clinical positions within the Urgent Care Network in the interim.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Chris Welsh, Senate Chair, NHS England – North (Yorkshire and the Humber)

Rebecca Bentley, Nursing Professional Lead & Non-Medical Prescribing Lead, Bradford District Care Trust

Dr Steve Ollerton, Clinical Leader, Greater Huddersfield Clinical Commissioning Group

Catherine Wright, Allied Health Professionals Lead, Bradford District Care Trust

Dr Andrew Phillips, GP & Deputy Chief Clinical Officer, Vale of York Clinical Commissioning Group

Jean Gallagher, Public Representative

Peter Allen, Public Representative

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict
Dr Andrew Phillips	GP & Deputy Chief Clinical Officer	Vale of York CCG	1.7.16	Clinical Lead for Urgent and Emergency Care Network and therefore involved in the wider integrated urgent care strategy for this geography	6.7.16	This was not considered to be a significant conflict of interest You are able to provide an independent perspective of the strength of the case for change document and bring a wide understanding of that grography. It was agreed that you can participate in this work on behalf of the Senate.

Appendix 3

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Review of the Urgent Care Developing Case for Change for East Riding of Yorkshire Clinical Commissioning Group

Sponsoring Organisation: East Riding of Yorkshire CCG

Terms of reference agreed by: Joanne Poole, Senate Manager and Tracey Craggs, Assistant Director of Operational Delivery

Date: 8th July 2016

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Chris Welsh, Senate Chair

Citizen Representative: Peter Allen and Jean Gallagher

Clinical Senate Review Team Members:

Steve Ollerton	Clinical Leader	Greater Huddersfield CCG
Rebecca Bentley	Nursing Professional Lead & Non Medical Prescribing Lead	Bradford District Care Foundation NHS Trust
Andrew Phillips	Deputy Chief Clinical Officer	Vale of York CCG
Cathy Wright	AHP Lead	Bradford District Care Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: Does the case for change demonstrate a clear clinical evidence base and is it robust enough to inform the development of the service options for public consultation?

How can the CCG strengthen their clinical leadership in the absence of a dedicated urgent care lead?

Objectives of the clinical review (from the information provided by the commissioning sponsor): To obtain independent clinical advice on whether the case for change is robust enough to support stage 2 assurance prior to going out to public consultation on the future options for the service.

Scope of the review: To consider the case for change only, the CCG have not as yet developed options for the future service

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 21st June 2016

Agree the Terms of Reference: 8th July 2016

Receive the evidence and distribute to review team: evidence received 21st June. Panel members appointed early July and sent evidence on their appointment

Teleconferences: 18th July

Draft report submitted to commissioners: 12th August

Commissioner Comments Received: 22nd August

Senate Council ratification; by email before the end of August 2016

Final report agreed: by end of August 2016

Publication of the report on the website: mid-September 2016

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

Urgent Care: Developing Case for Change by NHS East Riding of Yorkshire CCG. Version 2.0 dated 19th May 2016

The review team will review the evidence within this document and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

Clinical Senate Council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate Council will:

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix 4

BACKGROUND INFORMATION

The evidence received for this review is listed below:

Urgent Care: Developing Case for Change Version 2.0, 19th May 2016. NHS East Riding of Yorkshire Clinical Commissioning Group

Urgent Care Strategy 2015 – 2020, approved by Governing Body on 15th March 2016