# IMPROVING YOUR HEALTH SERVICES AT SOLIHULL HOSPITAL

NHS
Solihull
Clinical Commissioning Group

## A Case for Improvement

**Solihull Urgent Care**
**Business Case**

**December 2013**

## Version Control

| Revision | Date | Originator | Checker | Approver | Description |
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| **V 0.1** | 22nd November 2013 | Jo Hodgkiss | Karen Middlemas | Dr Patrick Brooke | Project team first draft. |
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# Foreword

**Dr Patrick Brooke**

**Chief Officer – Solihull CCG**

For several years there have been discussions amongst local clinicians about how we can improve urgent care services for the people of Solihull. The development of clinical commissioning in which clinical leaders came together to lead service redesign has helped us to move forward this important piece of work to the point that we can now propose real improvements to local urgent care services for the people of Solihull built on existing well regarded services joining together under one roof, with one front door and one reception desk.

NHS Solihull Clinical Commissioning Group (CCG) has set out to engage around future services in what is often a politically controversial area; this business case was built by a process of Co-Production between Patient and Clinical Experts with CCG officers and current service providers. We started by agreeing with the Solihull Health and Wellbeing Board a series of principles that we would work to, then through a series of meetings with clinicians and patients we applied those principles to our understanding of the system, tested this against national evidence as well as regional and national best practice. The result is an 'Elegant Solution' in that it proposes not only a way to maintain existing urgent care services but also how we can improve local access, safety, quality and efficiency of the care provided.

One issue that arises from this report is that our patient and clinical experts tell us that the name of the unit should better represent what it does. Whilst they propose the name needs to change, the service will be improved with a safer, better quality, more effective service for Solihull that is sustainable long term this will enable us to shape Solihull Hospital to be the vibrant Hospital in our community that we all aspire for it to be.

I commend this review as it has been built through a process of extensive engagement with our public, local clinicians, patient representatives as well as regional and national experts – it sets out changes that will improve the quality of urgent care services for the people of Solihull whilst ensuring longer term sustainability of acute medical services in Solihull Hospital. I would like to personally thank the many people who have engaged with us in building this case for improvement, I hope like them, that you too will see there's a lot more to this than a name.

# Executive Summary

As part of its commitment to securing a sustainable health future for Solihull patients and residents, Solihull Clinical Commissioning Group (CCG) have been undertaking a review of the urgent care health services currently available across the borough.

The review included an in depth study of the urgent care services currently provided on the Solihull Hospital site, particularly looking at how those can be strengthened and streamlined to ensure that urgent care facilities are fit for purpose.

Typically, reviews of this type happen when an urgent care system has become overwhelmed. While this is not necessarily the case in Solihull it is prudent to examine the national drivers in detail, apply them to the Solihull Hospital site and attempt to improve the service provision with a view to future-proofing it against known and expected issues.

There were a number other factors contributing to the decision to undertake a review of urgent care services on the Solihull Hospital site. These included:

- Solihull Accident and Emergency department has seen a reduction in its ability to meet the required levels of performance due to increased pressures, particularly in winter.
- There was a wider review of all Walk In Centres in the Birmingham area.
- The contracts for service provision of both walk in and out of hours services on the Solihull Hospital site are both due to expire in 2014. This means that the time is ripe to undertake a review of the provision of all urgent care services on the Solihull Hospital site.
- The building lease for the Walk In Centre building is due for renewal in 2014.

Currently Solihull Hospital is signposted as an Accident and Emergency department, and given historical political reluctance to deviate away from the name Accident and Emergency, the review has been undertaken from the outset with a view to being scrutinised in this way.

This business case has taken into account these sensitivities and can provide assurance that the review has been carried out as thoroughly as possible. Solihull CCG is committed to ensuring that it carries out its business in an open and transparent way. Furthermore it recognises the enormous effort that has been put into this review by a wide range of stakeholders including the invaluable input from our patient experts, who are referenced as the Patient Reference Group.

The urgent care review has established that the service provision and delivery at Solihull Hospital can be improved by redesigning the current layout, to help signpost those needing urgent care and make it simpler.

- Bringing together our urgent care services under one roof, with one front door and one reception where all services are joined together to work around the needs of the individual.

- Ensure urgent care services which are currently available will continue to be available.

- Continue to maintain a walk in service.

Given that our clinical and patient experts believe there is only one viable option in respect of the redesign, we seek to engage with our patient and residents and communicate with them and suggest this could be entitled 'Engaging Solihull in urgent care'. Timing is crucial and given the concerns of out patient and clinical experts with regard to their perception that there is a risk that the name 'Accident and Emergency' could be seen as a misrepresentation of its actual function, we seek to start implementation of our engagement and consultation exercise early in January 2014 allowing a full twelve weeks for the communication and engagement activities. This is the equivalent timescale required for formal consultation.

We appreciate that the Healthier Communities Scrutiny Board will want to be able to offer further guidance and confirm that we will offer a transparent and auditable engagement strategy to ensure that this is met. We will work alongside Healthwatch to agree our approach and help steer us through the review of urgent care.

# 1. Introduction and Background

*This section outlines: the purpose of this document; the role of the Solihull Urgent Care Review project; its supporting governance and assurance processes; and the stakeholder engagement undertaken in relation to this work.*

## 1.1 Introduction

**1.1.1** The aim of this document is to make the case to commence a public consultation and engagement exercise entitled **'**Engaging Solihull in urgent care'. This exercise will present a future state to improve the safety, quality and access for urgent care on the Solihull Hospital site and will explain the issues with the current state.

**1.1.2** This business case does not propose specific service changes but outlines how services currently available on the site can make improvements by working differently in an integrated, streamlined way to ensure services are sustainable for the future and less confusing for those accessing the services.

**1.1.3** The business case seeks to demonstrate compliance with the Secretary of State for Health 'four tests' which are:

- Support from GP commissioners;
- Strengthened public and patient engagement;
- Clarity on the clinical evidence base; and
- Consistency with current and prospective patient choice.

A separate document which undertakes a self assessment against the four tests is available at Appendix 1**.**

## 1.2 Background

**1.2.1** The NHS was created to ensure that people receive healthcare based on need and not ability to pay. Its challenge now, both nationally and locally, is to continue to improve quality and efficiency.

**1.2.2** Solihull is a metropolitan borough bounded by Birmingham to the west, Coventry to the east and Warwickshire to the north east and south. Solihull CCG is almost coterminous with Solihull Metropolitan Borough Council and has a mix of urban and rural communities, mostly white British, with very diverse heath needs. The more deprived communities (some amongst the most deprived in the country) are located in the wards in the north of the borough; there are also pockets of deprivation seen in the south and west.

**1.2.3** Solihull CCG is clinically led and covers 32 practices with a total registered population of approximately 235,000. The CCG, like CCGs across the country, was formed according to the Government White Paper *Equity and excellence*: Liberating the NHS (July 2010) and the subsequent Health and Social Care Bill, which set out the vision for transforming the way NHS services are commissioned. In April 2013 the CCG took over the commissioning of NHS services, a role previously undertaken by Solihull Primary Care Trust, and has been fully authorised by the Department of Health. This means that as an accountable public body, the CCG is responsible for buying and managing the majority of healthcare services for the people of Solihull within a budget of £267.7m.

1.2.4 Hospital services are run by Heart of England NHS Foundation Trust (HEFT), which is made up of Good Hope Hospital, Heartlands Hospital, Solihull Hospital and Birmingham Chest Clinic. Community health services for the Solihull locality are provided by Solihull Hospital.

1.2.5 A GP run walk-in centre is also available on the Solihull Hospital site and GP Out of Hours services are operated from rooms adjacent to the Solihull Accident and Emergency Department.

## 1.3 Why change?

1.3.1 It is widely accepted that health services in Solihull need to develop and change to ensure patients are offered services that are accessible, high quality and sustainable for the future. This is because health outcomes need to continually improve; the Solihull population is changing and there are financial pressures facing the whole of the NHS.

1.3.2 In 1962 Enoch Powell, then minister of health, published the *Hospital Plan for England and Wales*.The plan served as a framework for the development of hospital services in the decades that followed, leading to the building of many new hospitals and the refurbishment of others. At the heart of this framework was the district general hospital, designed to provide a comprehensive range of inpatient and outpatient services to populations of 100 000 to 150 000. District general hospitals have formed the backbone of NHS hospital care ever since.

1.3.3 Today, many of these hospitals face an uncertain future. The uncertainty has arisen as a result of advances in healthcare technology enabling more specialist services to be provided outside the hospital, changes in the workforce (particularly a reduction in the hours worked by doctors in training), evidence that some services are better concentrated in fewer centres able to achieve superior outcomes, and government policies designed to increase patient choice and stimulate greater efficiency in the use of resources.

1.3.4 Solihull Hospital has a relatively small catchment population and is within close proximity to other larger centres such as Heartlands Hospital. There are have been changes to service delivery on the Solihull site over the last two decades which all impact on the ability to deliver a full Accident and Emergency department.These changes include:

- In 1993/1994 - In line with Independent District General Hospital policy– Paediatric inpatient care was moved to Birmingham Heartlands Hospital.
- In 1994 a purpose built hospital named as Solihull District General Hospital, opened, ensuring care was provided for the whole community from one site.
- In 1995/96- Acute surgery moved to Birmingham Heartlands Hospital.
- In 1996, Solihull Hospital and Birmingham Heartlands Hospital merged to form Birmingham Heartlands and Solihull NHS Trust this was later changed to Heart of England NHS Foundation Trust (HEFT).
- In April 2007 Heart of England NHS Foundation Trust was joined by Good Hope Hospital, Sutton Coldfield, to create the very first merger of its kind.
- In 2010 Solihull replaced their full maternity service with a midwife led birthing unit for low risk births and continued to offer antenatal, post natal and other associated maternity clinics.
- In 2012, in line with national best practice, a review of Stroke Services was carried out across the Heart of England NHS Foundation Trust. The review recommended that Hyper Acute Stroke Services are centralised to Heartlands Hospital with Solihull Hospital becoming an Acute Stroke Unit for subsequent rehabilitation.

**1.3.5** Nationally, the NHS is facing the challenge of creating a sustainable model for the small and medium sized District General Hospital. The proposed changes within this document give Solihull Hospital a much more sustainable and effective 'front door.' It brings together all the fragmented walk in and out of hours services into one place and cements the hospitals position as being at the heart of the community for the people of Solihull.

**1.3.6** In order to reduce the number of people who need a hospital admission and enable more care to be delivered outside of the hospital, work is being undertaken to develop integrated services in Solihull. Solihull CCG have built a unique partnership with Solihull Metropolitan Borough Council, Birmingham and Solihull Mental Health Foundation Trust and Heart of England NHS Foundation Trust (the main provider of acute and community NHS health care in the borough) to enable this to happen.

**1.3.7** There is both national and international evidence on the benefits that can be derived from developing integrated care systems. Examples of successful integrated systems can be taken from the United States, where the Veterans Health Administration reduced bed days by 50% by introducing regional integrated service networks. In the UK, Torbay Care Trust are a great example of how individuals and organisations can work together to create joined-up, integrated care that is centred around patients' needs. Care is provided by multidisciplinary health and social care teams, with care coordinators who work in geographical 'zones' aligned to general practices to provide a range of services that meet the specific needs of older people after they are discharged from hospital. More recently, the South Devon and Torbay clinical commissioning group have introduced proactive case management of at-risk older people, using predictive risk tools. This has provided an added capability to intervene before hospitalisation occurs. These teams also provide ongoing care and support in the home environment.

**1.3.8** We have a duty in the NHS to ensure that services provided are clear and navigable. In relation to urgent care services, there are currently four different ways members of the public can access urgent care on the Solihull Hospital site, each with their own access point. This leads to confusion for patients and duplication in both the care provided and administration. The drivers for the review stem from the desire to ensure access to safe services is clear for patients and sustainable.

**1.3.9** There is a need to respond better to the way healthcare is changing, such as; the development of ambulatory care models, better diagnostics, homecare, better links to the community and technological advances. Health economies need to grasp these advances and understand the impact they will have on other services.

**1.3.10** "The reasons for the growing pressures our A&E departments are experiencing have been well rehearsed. Two things in particular are often cited. Firstly, an ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care. Secondly, we know that many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E.[1]

**1.3.11** Millions of patients every year seek or receive help for their urgent care needs in hospital who could have been helped much closer to home. The opportunities for bringing about a shift from hospital to home are enormous. For example, we know that 40% of patients attending A&E are discharged requiring no treatment at all; there were over 1 million avoidable emergency hospital admissions last year; and up to 50 per cent of 999 calls requiring an ambulance to be dispatched could be managed at

[1] Transforming urgent and emergency services in England – End of Phase 1 Report

the scene. To seize the opportunities these numbers present, we will need to greatly enhance urgent care services provided outside of hospital."[1]

## 1.4 Solihull Urgent Care Review

1.4.1 In order to respond to these challenges, Solihull CCG believes that there are significant opportunities to improve the quality of care it provides to it residents and visitors in Solihull through reviewing the urgent care services available on the Solihull Hospital site.

1.4.2 A review of urgent care services on the Solihull Hospital site received sign off and permission to proceed by the Solihull Health and Wellbeing Board in January 2013. The review seeks to:

- Understand how the urgent care system is used through data analysis and engagement with patients and other stakeholders.
- Understand and agree with partners the services which need to be delivered.
- Research and audit in order to determine models to deliver agreed service.
- Create an options appraisal including a quality and financial business case.
- Identify the preferred model and commission the service.

1.4.3 The Solihull urgent care review seeks to demonstrate compliance with the Department of Health 'four tests' used to assess major service reconfiguration. The details of the 'four tests' used to assess major service change are shown below in Table 1.1.

### Table 1.1: Four tests of reconfiguration

| Test | Requirement |
|---|---|
| **Support from GP commissioners** | **Commissioners will need to consider the engagement / involvement that may need to take place with practices whose patients will be significantly affected by the case for change, inviting views and facilitating a full dialogue where necessary. Local commissioners will need to demonstrate the nature of the discussion with consortia or with other appropriate bodies as a proxy. For example, the commissioner could obtain written sign off from relevant local consortia representative.** |
| **Strengthened public and patient engagement** | **The National Health Service Act 2006 requires local health organisations to make arrangements in respect of health services, to ensure that users of those services such as the public, patients and staff are involved in the planning, development, consultation and decision- making in respect of the proposals. Local commissioners should engage Healthwatch and Health Overview and Scrutiny Committees to seek their views.** |
| **Clarity on the clinical evidence base** | **It is recommended that clinicians should lead in gathering this evidence, considering current services and how they fit with the latest developments in clinical practice, and current and future needs of patients.** |
| **Consistency with current and prospective patient choice** | **Local commissioners will need to consider how the proposed service reconfiguration affects choice of provider, setting and intervention; and the choice this presents the patient compared with the current model of provision. Commissioners will need to ensure this consideration is part of any dialogue with local clinicians, Healthwatch and Scrutiny Committees.** |

| | |
|---|---|
| | **In meeting the choice test, commissioners will want to make a strong case for the quality of proposed services and improvements in the patient experience.** |

1.4.4 The key milestones for the Solihull urgent care review are outlined in Table 1.2.

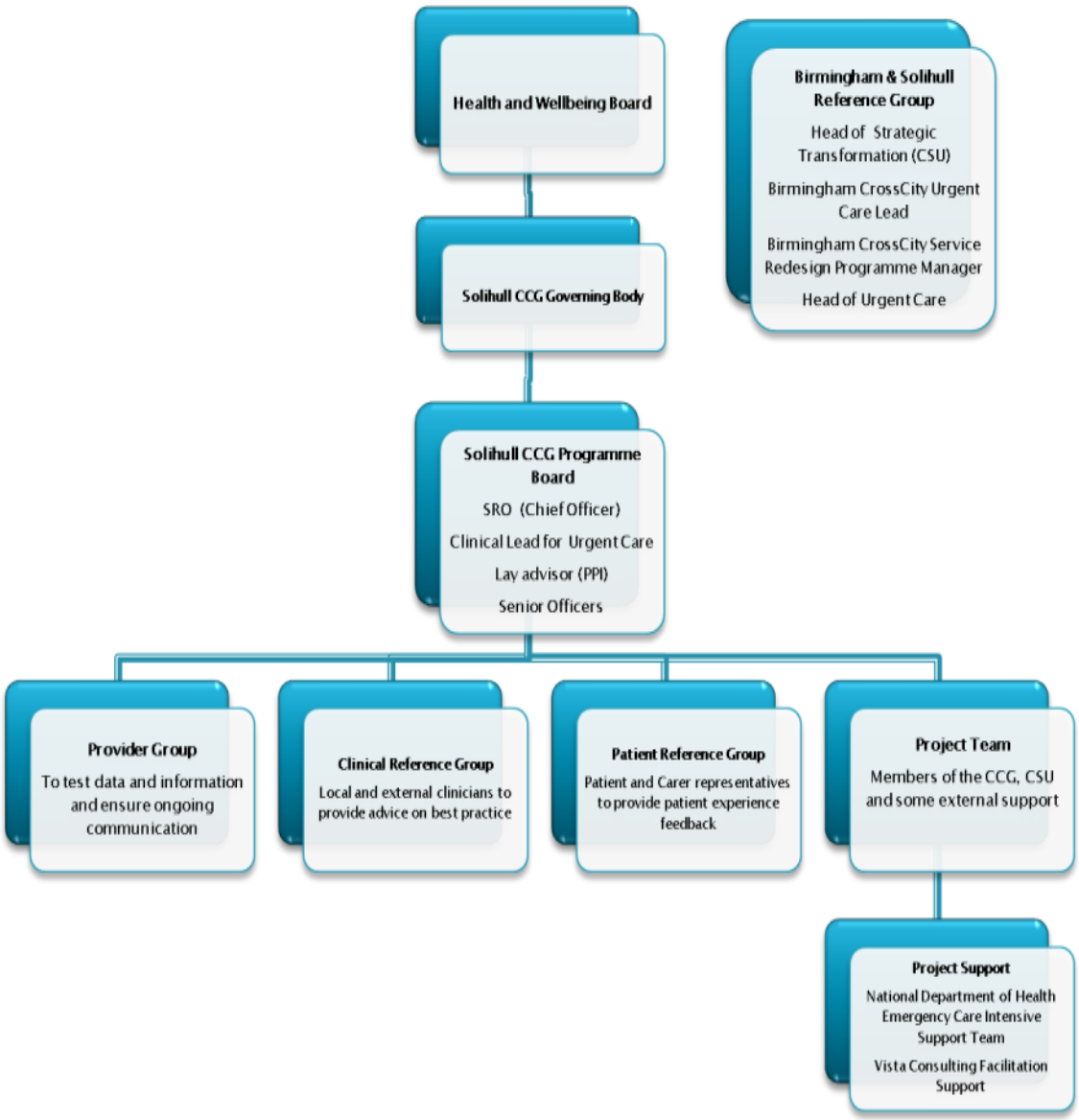
**Table 1.2: Key Milestones**

| Date | Key Milestone |
|---|---|
| **January 2013** | Health and Wellbeing Board agree to sponsor the review |
| **Jan- March 2013** | Pre programme planning |
| **April 2013** | Review officially launched at Stakeholder Event |
| **April – May 2013** | Information gathering and governance agreed |
| **May - September 2013** | Clinically led option and patient reference generation and appraisal |
| **October 2013** | Patient reference option generation and appraisal |
| **November 2013** | Modelling and Analysis<br>Business case and engagement plan drafted |
| **Mid December 2013** | Draft Business Case drafted and submitted to Programme Board for approval |
| **End December 2013** | Business Case submitted to Health and Wellbeing Board, Healthier Communities Scrutiny Board and CCG Governing Body for approval to proceed |
| **Beginning of January 2014** | Approval to proceed at the January 2014 meetings of the Healthier Communities Scrutiny Board and CCG Governing Body |
| **15th January 2014** | Aim to commence public engagement process |

## 1.5 Governance and Assurance

**1.5.1** Accountability for the delivery of the review rests with the CCG Governing Body and as such the Senior Responsible Officer for the review is the Chief Officer at Solihull CCG. However, the successful delivery requires the leadership and input of a range of individuals from a variety of organisations. The governance structure, agreed in April 2013, and outlined in Figure 1.1 reflects this dynamic.

**Figure 1.1: Solihull urgent care review governance structure**



### 1.5.2 Solihull CCG Urgent Care Programme Board

**1.5.2.1** An urgent care programme board has been set up to oversee the work of the review. The purpose of this board is to receive assurance of the delivery of the Urgent Care Review in Solihull and to make recommendations to the CCG Governing Body and the Health and Wellbeing Board of a preferred option.

**1.5.2.2** The Solihull CCG Urgent Care Programme Board is accountable to the Health and Wellbeing Board as review sponsor and the CCG Governing Body for decision making.

**1.5.2.3** Membership of the board is at a senior level, and includes representatives from a range of organisations as shown in Table 1.3.

**Table 1.3: Solihull Urgent Care Programme Board Representation**

| Name | Role | Organisation |
|---|---|---|
| Dr Patrick Brooke | Chief Officer and SRO | Solihull CCG |
| Dr John Davenport | GP Lead Urgent Care | Solihull CCG |
| Karen Middlemas | Chief of Redesign | Solihull CCG |
| Joanna Hodgkiss | Programme Manager | HEFT |
| Carol Herity | Head of Urgent Care | Birmingham Cross City CCG |
| Helen King | Redesign Project Manager | Birmingham Cross City CCG |
| Julia Lyle | Lay Advisor to Governing Body | Lay Advisor |
| Doug Middleton | Chief of Operations | Solihull CCG |
| Sue Nicholls | Chief Nurse and Quality Officer | Solihull CCG |
| Katy Stewart | Commissioning Manager | Solihull CCG |
| Jon Garrett | Data Analyst | Solihull CCG |
| Claire Austin | Communications Expert | Independent |

### 1.5.3 Clinical Reference Group

**1.5.3.1** A clinical reference task and finish group has been set up as part of the review. The purpose of the group is to understand how the current urgent care system in Solihull operates, including its strengths and weaknesses, agreeing a clinical case for change and ultimately produce options for a simplified clinical model that improves patient outcomes. The options should focus on the clinical viability of any proposed new models and not on the contracting issues associated with any changes to service. Terms of Reference for this group can be found at Appendix 2.

**1.5.3.2** The meetings of the clinical reference group have been externally facilitated by Nigel Edwards (Senior Fellow - Kings Fund) and have been attended by:

- Sirius representation
- Solis representation
- CCG Governing Body representation
- Heart of England FT representation
- Walk in Centre representation

- Out of Hours representation
- Solihull Community Services representation
- Mental Health representation
- West Midlands Ambulance Service representation
- Lead Commissioner for Urgent Care: Birmingham and Solihull
- Social Care representation
- Patient representation

### 1.5.4 Patient Reference Group

**1.5.4.1** A patient reference group has been set up as part of the review. The purpose of the group is to ensure that the patient voice is heard and taken into account in any redesign of services on the Solihull Hospital site. The Group has been set up to feed views and experience from a patient/resident perspective and to participate alongside the Clinical Reference Group in agreeing options for change.

**1.5.4.2** The patient reference group has been independently chaired by Sharon Woodcock, who is the 'Making it Real' lead at Solihull Metropolitan Borough Council. The patient reference group has been recruited to and ran using the 'Local Experts by Experience' model. The recruitment exercise resulted in 12 members being recruited to the group. The sessions have been extremely useful and positive and attended by a representative cross section of Solihull Residents. Professor Matthew Cooke and Dr John Davenport sit on this Group as Clinical Advisors. Terms of Reference for this group can be found at Appendix 2.

### 1.5.5 Provider Group

**1.5.5.1** A provider group has been set up as part of the review. The purpose of the group is to ensure that all current providers of services on the Solihull Hospital site are kept up to date with the review process and have an opportunity to ensure that data/information being used is accurate. Terms of Reference for this group can be found at Appendix 2.

### 1.5.6 Project Team

**1.5.6.1** The purpose of the project team is to ensure that the project is managed in a timely and efficient manner. The team have been responsible for organising events, pulling together best practice evidence, arranging visits to other sites to learn lessons, producing data packs to enable the two reference groups to understand the current state and producing and ensuring a communications and engagement plan is drafted and actioned. The team has been made up of CCG managers and support from the Commissioning Support Unit (CSU) for communications and modelling expertise.

### 1.5.7 External Assurance

#### 1.5.7.1 Office of Government Commerce (OGC)

Conversations have been held with the OGC who have been positive regarding the review process. If this document gains approval to proceed, the OGC would be happy to undertake a gateway review early 2014 to review the plan for implementation.

#### 1.5.7.2 National Clinical Advisory Team (NCAT)

Early conversations have been held with NCAT and they will be asked to undertake a review of the clinical specifications of the proposed model if appropriate.

#### 1.5.7.3 NHS England

Advice from the Strategic Reconfiguration Lead for NHS England has been that the review of urgent care on the Solihull Hospital site is in the 'low risk' category and described it as a "solid bit of redesign work". Recommendations to meet with the Local Area Team and the local Clinical Senate were all actioned.

#### 1.5.7.4 West Midlands Clinical Senate

The West Midlands Clinical Senate has been supportive of the proposed changes outlined in this document. The level of clinical change is thought to be very small and the senate have not felt that they could add any further clinical scrutiny to the review than has already been undertaken.

#### 1.5.7.5 Legal Advice

From the outset of this review, the CCG have sought legal advice from Mills & Reeve LLP. They have reviewed all documents pertaining to the review, such as the governance structures and all terms of reference for all groups. Comments were incorporated into the final versions. Their legal opinion from the outcome of the review is that the proposed model does not restrict access and therefore is not a significant change and would not require public consultation. However, due to the name change of A&E it was felt that it would be beneficial to undertake a wide public engagement piece of work.

## 1.6 Stakeholder engagement

1.6.1 A range of stakeholders have been involved in the development of the proposed changes outlined in this document. Representatives from a range of clinical, user and professional backgrounds have attended workshops, meetings and public events to discuss and develop models of care. In addition, many have provided written and verbal input to the information contained within this document.

1.6.2 Clinicians have been fundamental to the development of the proposed changes.

1.6.3 All organisations understand that it is important to inform and involve people in the process of developing new models for healthcare provision so that changes are made in ways that take account of the views and experience of those affected.

### 1.6.4 Policy Drivers

1.6.4.1 The National Health Service Act 2006 requires local health organisations to make arrangements in respect of health services to ensure that users of those services such as the public, patients and staff are involved in the planning, development, consultation and decision-making in respect of the proposals.

1.6.4.2 The project mandate that the Health and Wellbeing Board agreed to officially sponsor in January 2013 contained the following recommendations:

- Engagement and communication with a broad range of stakeholders will be crucial at every stage of the review.
- We want to work with our residents, clinicians and partners to design a service that will better serve our patients and thousand others like them when they need it.
- We are committed to engaging with a broad range of stakeholders including patients, Solihull residents, elected representatives, providers and commissioners, throughout this process.

1.6.4.3 These recommendations support the principle that patient involvement should begin during the developing phase and not at the end of the process.

### 1.6.5 Pre-review engagement activity

1.6.5.1 Pre-review engagement activities were undertaken with Solihull LINk, Solihull Metropolitan Borough Council Healthier Communities Scrutiny Board, primary care colleagues, the main local providers and other stakeholders. The CCG Chair and Chief Officer have also met with MPs and Councillors.

1.6.5.2 To ensure that this level of engagement continued throughout the review it was proposed that the urgent care review should extend beyond just health and be delivered in partnership with Solihull Metropolitan Borough Council, through the Solihull Shadow Health and Wellbeing Board. This was agreed and the now Solihull Health and Wellbeing Board act as the sponsor for the review and receive regular updates on progress.

1.6.5.3 The review was officially launched at a Stakeholder event at the end of April 2013. The event which was attended by more than 80 people, allowed residents, patients, doctors, healthcare providers, councillors and third sector colleagues to work together to discuss how urgent care services in Solihull should develop in the future. The event was very positive and the attendees agreed a set of

statements (Figure 1.2) to be used as principles in the development of urgent care services. These principles have helped to shape the proposed changes within this document.

### Figure 1.2: Urgent Care Design Principles

| Design principle | What this means for patients and Solihull residents |
|---|---|
| **Safe and high quality care** | Patients feel confident that they are in 'safe hands' should any of them fall ill and they are confident that the service is of a high quality. |
| **Common universal IT system for Solihull** | An integrated IT system, used across all of Solihull would ensure personal and medical information is held in one place but available to clinicians if they need it. |
| **Quick access to the same level of advice and treatment at all times** | Patients can be confident that they can use urgent care services whenever they need them and receive timely and consistent treatment on any day and at any time. |
| **A single point of access to urgent care service** | Patients can contact a single number or attend just one centre to get the care they need. |
| **Increased access to primary care** | Patients can access most of their care from their local surgery when they have a crisis. |
| **Patient centred care** | Every Solihull resident feels that the health care they receive is based around their individual needs and they are treated with dignity and respect. |
| **System that empowers patients to stay well** | Our patients should be able to access services that promote their health and wellbeing, enabling them to live a more fulfilling independent life at home. |
| **Linked community services** | We need to ensure our health and care services communicate together to ensure our patients receive a simpler but better service designed to meet their individual needs. |
| **An equitable and fair system** | Our patients are able to access the same level of care regardless of their needs. |
| **Experienced, flexible and motivated staff** | Our patients feel reassured and confident that their needs will be met if the staff treating them are experienced, flexible to meeting their needs and motivated to help them. |
| **Integrated with Mental Health** | When our residents have to access urgent care services we need to ensure that all that needs are assessed, including their mental health needs. |
| **Case Management** | Our patients have their own care plan which helps to identify and manage risks to keep them stay as healthy and safe as possible. |
| **Using technological advances** | By utilising the latest technology we can make urgent care services more accessible. |
| **Positive political and media support** | We need to ensure that the media and elected representatives fully understand our process so they can help to communicate the facts. |
| **Single Advice Point** | Our residents are able to access advice quickly and easily. |
| **Affordability and reducing wastage** | To provide the very best health services we need to ensure that when our patients need care they get the right treatment, first time. |
| **New approach to incentives** | The staff looking after our patients are motivated to provide the best care they can for them. |
| **Diagnostics in primary care** | Patients should be able to have tests and receive results in a timely manner without needing to be admitted to hospital. |

### 1.6.6 Option development activity

**1.6.6.1** In June 2013 a clinical reference group was established to look at what options were available from a clinical perspective to ensure sustainability of urgent care services on the Solihull Hospital site. The group was facilitated by Nigel Edwards, Senior Fellow from the Kings Fund and Professor Matthew Cooke (previously the National Clinical Director for Urgent and Emergency Care) attended the sessions as an expert in this area. The composition of the group included clinical representation from across the healthcare economy including GP's, secondary care, mental health, social care and the ambulance service. The group also had a patient representation member to feed views from a patient experience perspective.

**1.6.6.2** The clinical reference group met over 3 sessions between July 2013 and August 2013 and they agreed a local clinical case for improvement. Details of this can be found in section 4 of this document.

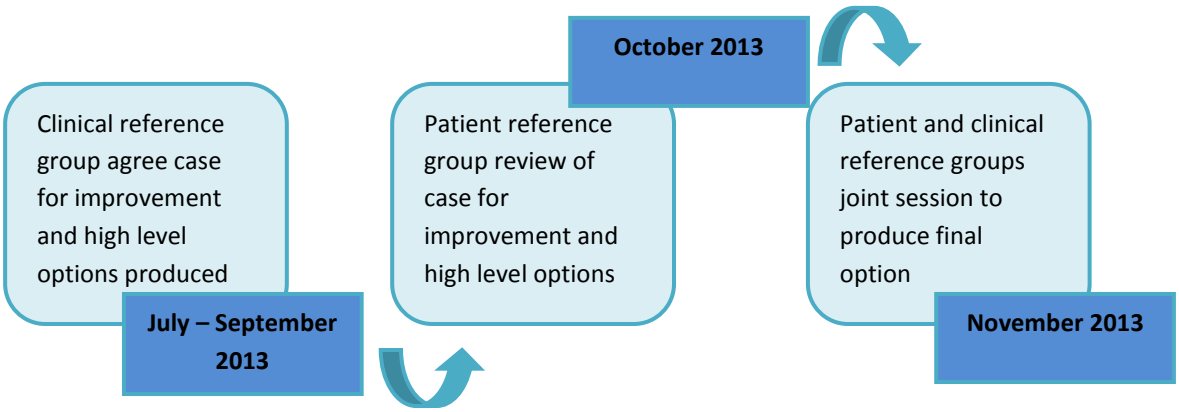
**1.6.6.3** After agreeing a case for improvement, the clinical reference group unilaterally decided on a high level option for urgent care services on the Solihull Hospital site. The clinical reference group then referred their findings to the patient reference group for them to appraise.

**1.6.6.4** A recruitment exercise was undertaken in September 2013 to construct the patient reference group and to ensure that the composition of the group was as representative of the Solihull population as possible.

**1.6.6.5** 12 patients from a variety of health related activity groups were appointed to the patient reference group. The group was independently chaired by Sharon Woodcock, the 'Making it Real' lead at Solihull Metropolitan Borough Council using the 'Local Experts by Experience' model. Professor Matthew Cooke and Dr John Davenport (GP urgent care lead for Solihull) sat on the group as clinical advisors.

**1.6.6.6** The patient reference group met 4 times in October 2013 and quickly agreed with the findings of the clinical reference group. They also shaped some of the elements of the proposed improvements including renaming of the Accident and Emergency department and hours of opening.

**Figure 1.3: Phased Approach**



### 1.6.7 Wider engagement activities

1.6.7.1 Throughout the urgent care review process, Solihull CCG has recognised that there are a significant number of stakeholders and interested parties outside of the working groups and has sought to inform and communicate with these at key points of the review. A stakeholder map has been produced and can be found at Appendix 3.

1.6.7.2 The table below shows the key activities that have been undertaken with key stakeholders and interested parties during the review process:

**Table 1.4: Key stakeholder activities**

| Stakeholder (s) | Activity |
|---|---|
| **Healthier Communities Scrutiny Board** | We have regularly updated members of this Board and have arranged Solihull Hospital site visits for its members. |
| **Health & Wellbeing Board** | As project sponsor, the Health and Wellbeing Board have been kept regularly updated. |
| **Elected Members, PPCs and Councillors** | We have held regular meetings and sent out stakeholders briefings for this group. Site visits have been arranged for this group also. |
| **Healthwatch** | We have engaged with Healthwatch by way of an invitation to sit on the patient reference group and they have also helped us to design and distribute a questionnaire to Solihull residents. |
| **Solihull residents** | With the assistance of Healthwatch we have conducted a survey with local residents to further understand how people use the current services for different conditions. |
| **Local media** | We have engaged with the local media throughout the process. |
| **Patient Groups** | We have engaged with local patient groups and have involved them in the recruitment exercise for the patient reference group. Stakeholder newsletters have also been sent out to these groups to keep them informed and Solihull CCG has attended several PPG meetings to garner their views. |
| **Wider Stakeholders and interested parties** | At the end of April an urgent care stakeholder workshop was held and attended by over 80 people who came together to share their views about how they would like to see the urgent care system in Solihull develop in the future. |
| **Provider Organisations** | All providers of urgent care services on the Solihull Hospital site have been invited to all working groups. Stakeholder newsletters have been issued and meetings for staff to be informed of progress have been undertaken at Solihull Hospital and Solihull CCG. |

| | |
|---|---|
| **Provider Organisations** | With the help of the **E**mergency **C**are **I**ntensive **S**upport **T**eam (ECIST), we have held sessions with the 4 Providers of Urgent Care at Solihull to map their current functions in detail to show if there are any areas of duplication or concern. |
| **Solihull GPs** | Local GPs have been invited to Stakeholder events and kept updated through stakeholder bulletins and newsletters and meetings of their Boards. |
| **Clinical reference group** | We have arranged visits to other sites which have alternative models of providing urgent care to enable shared learning and glean information which is useful to the review in Solihull. |
| **Patient reference group** | The patient reference group are fully engaged with the review and as such co-presented the findings of the review at a Healthier Communities Scrutiny Board meeting in November 2013. |
| **Neighboring CCGs** | To ensure congruence with a wider Birmingham review of services, local CCGs have been invited to join our Programme Board and members of Solihull CCG have updated on progress at joint CCG meetings. |

### 1.6.8 Key learnings from activities to date

1.6.8.1 The work undertaken during the review has highlighted a number of issues. A consensus on the best way forward for urgent care services on the Solihull Hospital site emerged very quickly. Section 5 of this document describes in detail the proposed changes on the Solihull Hospital site. In summary, key learning to date has been:

- There is no nationally recognised comprehensive best practice model for urgent care. Different areas excel in different parts of the urgent care system and it is within our gift to learn from these and create a best practice model of care that is best for the people of Solihull.

- It has become clear during the review that many elements of the urgent care services on the Solihull Hospital site work well: - Walk in services are very popular with the public and have a role to play in an urgent care system. The selected Medical take through the Medical Assessment Unit (MAU) model is recognised to be a good model of care in a small unit such as Solihull. The Clinical and Patient Reference Groups both recommended that the MAU should remain with expansion of its ambulatory emergency care services.

- Feedback from the review is the name Accident and Emergency is a significant risk as it does not describe what is really available on the site as there is no provision for children to be treated as inpatients and Trauma/Surgical patients and patients with complex needs are automatically transferred to Heartlands or elsewhere. Risks occur when patients present at a location not best suited to their medical needs.

- The signage implies a full Accident and Emergency service and so increases the risk of people attending expecting a full service.

- Physical space is an issue for all current providers of urgent care services on the Solihull Hospital site and current IT systems across providers of urgent care services on the Solihull Hospital site are not compatible with each other.

- We have heard from providers, staff working in the system and patients that the current system is confusing. People do not understand what is offered where, what is not available on the site or how the system links together. This results in the patients seeing multiple clinicians before they see the best person for their needs.

- In-conjunction with Healthwatch we undertook a survey of the local population to assess how easy is it to understand where to go for urgent care in Solihull. An analysis of the results showed:

    - People claim to understand the urgent care system in Solihull but when asked about where they would go with certain "urgent care" conditions they gave a wide variety of answers showing different levels of understanding.
    - People particularly struggled to identify where to go when they had chest pains or breathing problems.
    - People seemed to understand where to go when their GP surgery was open. However when their GP surgery is closed there is much less understanding due to the wide range of different services which can be used.
    - A large number of people (22% in normal business hours and 30% outside those hours) would choose to go to Solihull Accident and Emergency when urgent care was needed for a child despite there being no paediatric service there.

- There is a significant overlap in the services provided by different providers, particularly when they are open at the same times. A review of the opening times for each service shows that at some times of the day, multiple choices are available.

- Nationally, there is a manpower crisis in terms of Emergency Medicine, because Solihull Hospital site is not a full Accident and Emergency service it does not receive training recognition for Emergency Medicine which makes recruitment and staffing more difficult.

- Staffing difficulties in emergency medicine are a nationally recognised problem and are likely to remain critical for the next 4-5 years, resulting in heavy reliance on locum doctors, this introduces increased clinical risk. This argument is not one of efficiency or choice; the clinical element of the service is seen as unsustainable from a manpower point of view, and the clinical risk presented is significant. The ability to be able to be flexible around staffing models is of key importance.

## 1.7 Equality impact assessment

**1.7.1** Consideration has been given, throughout this review, to the impact on Solihull residents and the users of the services on the Solihull Hospital site. In line with equality impact assessment guidelines we have specifically considered potential impacts on residents and users belonging to protected groups.

**1.7.2** An equality impact assessment has been undertaken, full details of this can be at Appendix 4, in summary the conclusions are as follows:

"The clinical case for change for the Solihull site, specifically, is clear. It is designed to improve health outcomes for residents and visitors to Solihull. The intention to rehabilitate facilities, improve access and navigability for patients, to remove unnecessary duplication and significantly enhance patients' experiences of urgent care should offer a positive and beneficial impact for all patients, including the statutorily protected characteristic groups. There is no planned diminution of services."

# 2. Health Need

*This section outlines the health need of the Solihull population and the Commissioning intentions of Solihull CCG in order to address these needs.*

## 2.1 Key demographic information

**2.1.1** Solihull covers an area from Chelmsley Wood in the North to Dorridge in the South and from Shirley in the West to Balsall Common in the East. It is located to the South and East of the city of Birmingham.

**2.1.2** The population residing within the Solihull boundaries that are registered to one of the 32 GP practices located in the area was estimated to be 235,000 in April 2013.

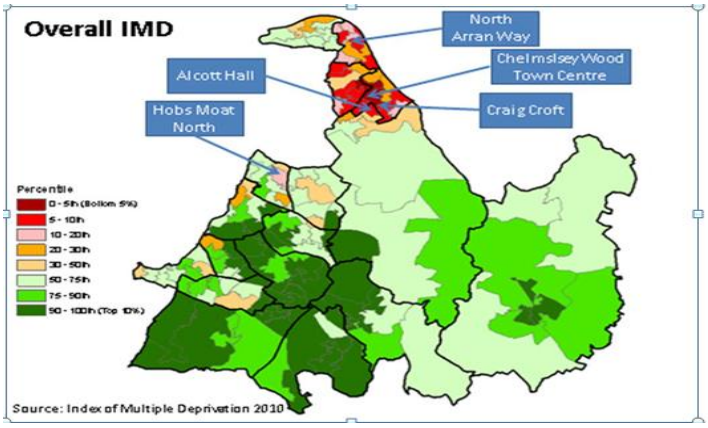
**2.1.3** The size of the population has been fairly stable but is predicted to increase by 7% over the next 10 years. In particular, the age profile of the population is changing. Solihull's population over the age of 65 years of age is predicted to increase by 20% and the population aged over 85 years by 40% over the next 10 years; over half the population will then be older adults and pensioners. The number of people suffering from long term conditions, depression, dementia and mobility problems is expected to increase over the next 10 years and the need for health and social care will consequently increase.

**2.1.4** The key characteristics of the population are outlined below:

- 49% of the population are Male, 51% are Female
- 25% of the population are 60 years old or over
- 86% of the population are White. 7% of the population are Asian or Asian British, 2% are Black or Black British. The remainder are a mix of ethnic groups.

**2.1.5** The borough has two distinctly different social-economic areas. The North of the borough, covering approximately a third of the population, has a high level of health deprivation. The South, West and East of the borough, covering two thirds of the population, consists of more affluent areas with much lower levels of health deprivation (with the exception of one or two small pockets of deprived areas). This is shown in the following diagram:

**Figure 2.1: Index of Multiple Deprivations**



2.1.6 Male life expectancy in Solihull is 79.5 years compared to 78.8 in England and Wales. Female life expectancy in Solihull is 83.5 years compared to 82.8 in England and Wales.

2.1.7 There is an 11 year age gap in life expectancy in men between the most affluent areas of south Solihull and the most deprived areas of the north of the borough, presenting the biggest challenge for Solihull CCG. The gap in life expectancy is mostly explained by higher levels of heart disease, stroke and cancer mortality in the more deprived communities; these diseases are themselves caused by adverse socio-economic factors and unhealthy lifestyles. Tackling these issues is a priority for the CCG.

2.1.8 14% of the population is estimated to smoke. Again this differs significantly between the North and the rest of the borough with an estimated 24% of the North being smokers, compared to 10% for the rest of the borough.

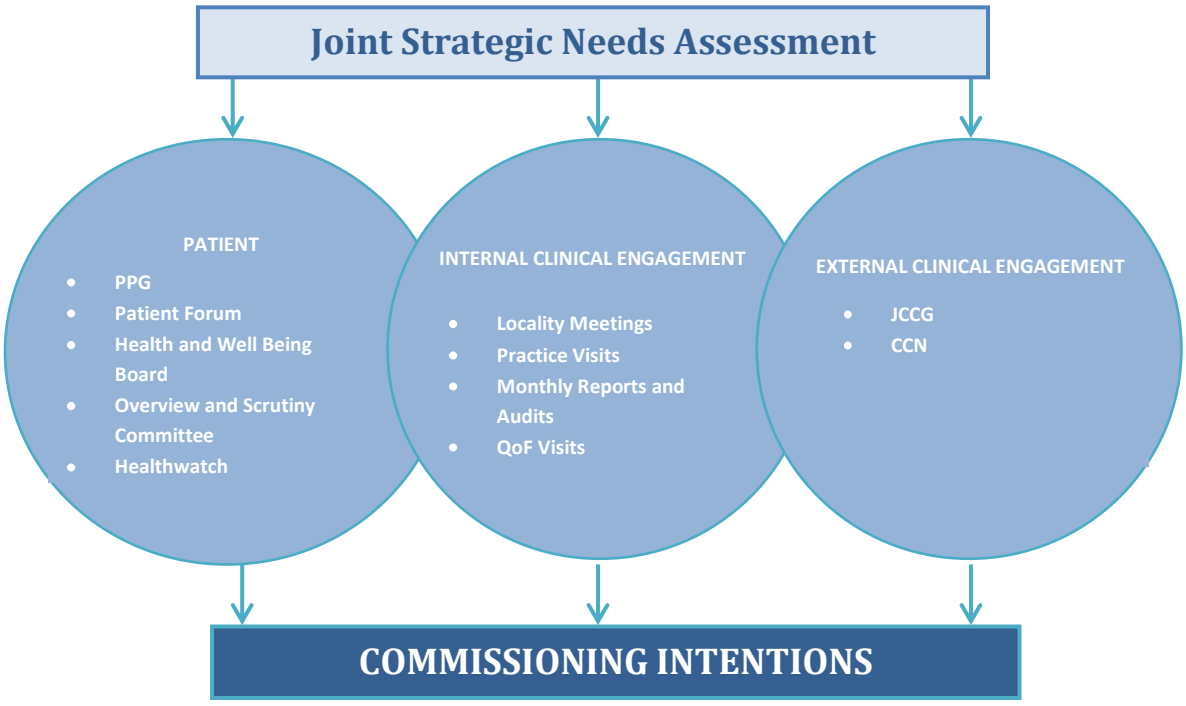
2.1.9 It is estimated that 28% of the population is categorised as obese. Once more the figures differ significantly between the North and the rest of the borough. It is estimated that 35% of the population from the North are Obese, compared to 25% for the rest of the borough.

2.1.10 The three biggest killers for people in Solihull aged less than 75 years are cancer (42%), all circulatory disease (25%) and digestive problems (6%).

## 2.2 Commissioning Intentions

2.2.1 This section outlines Solihull CCG's strategy for 2012-15. It demonstrates that the priorities are driven by the findings of the Joint Strategic Needs Assessment (JSNA) and describes how the strategy has been developed, through engaging with patients and providers. It then outlines the five key programme areas being undertaken by Solihull CCG and lists some of the key issues within each programme area.

**Figure 2.2: Strategy Route Map**



2.2.2 The strategy is informed by engagement with member practices, the Health and Wellbeing Board, involvement from patients and patient groups and aims to the deliver the recommendations made in the Joint Strategic Needs Assessment and support the delivery of the CCG Quality, Innovation, Productivity and Prevention (QIPP) programme and the Joint Health and Well Being Strategy.

2.2.3 Promoting involvement of patients and carers in service design and service monitoring is vital in ensuring that local providers continually improve patient experience through the delivery of high quality services. Our member practices have long embraced the benefits of patient engagement and 26 out of 32 practices have patient participation groups (PPGs). The Chairs of the PPG, supported by PBC/CCG managers, started to meet regularly in 2009 to share good practice and discuss areas of concern or areas for improvement. The then two Practice Based Commissioning Groups in Solihull used this group to share their own commissioning plans to gather patient opinions on services and areas for development and improvement.

2.2.4 Since late 2011 this PPG Chairs meeting has evolved into a Patient Forum that has widened its membership to 2-3 representatives from each practice and is, almost, self sufficient. The Forum invite (request) service providers and commissioners to come to their meetings to provide updates, to explain services and to respond to patient concerns regarding the way services are operating or how they are being developed. The CCG continues to support the Forum but they are now becoming less reliant on CCG support and have become a far more "independent" group and provide invaluable patient insight and feedback for the CCG and also help keep the CCG, and local providers, on their toes. In recent months the Patient Forum have received presentations on the following service areas, from both commissioners and providers:

- Frailty Programme
- Stroke
- Podiatry
- Ambulance Service
- Health Visiting
- Community Services
- Health Trainers (Keeping Healthy)

2.2.5 Solihull CCG Clinical Priorities are built around five key programme areas:

**Table 2.1: Solihull CCG Clinical Priorities**

| Number | Priority | Projects |
|---|---|---|
| 1. | **Preventing Illness and Improving Health** | Cardiovascular Disease (CVD)<br>Cancer<br>Smoking<br>Obesity<br>Children and Families |
| 2. | **Frailty** | Care closer to home<br>Dementia<br>Falls |

| | | |
|---|---|---|
| | | Care Homes / Continuing Health Care<br>End of Life Care |
| 3. | **Mental Health and Learning Disabilities** | Children<br>Transition<br>Adult<br>Rapid Assessment Interface and Discharge (RAID)<br>Alcohol<br>Autism |
| 4. | **Managed Care** | Primary and Community Care<br>Long Term Conditions (Diabetes, COPD, Heart Failure)<br>Planned Care Pathways<br>Medicines and Prescribing |
| 5. | **Care in a Crisis** | Primary care access<br>111/999<br>Urgent care redesign<br>Crisis teams<br>Alternative to admission |

**2.2.6** These programme areas have evolved from CT/PCT, Cluster and PBC programmes, although they have been aligned to the JSNA structure. It is clear therefore that the urgent care redesign project, the concern of this paper, is just one of a wide range of projects focussed on improving patient care and patient health in the Solihull borough.

**2.2.7** In addition to these programme areas there is a range of "operational enabling" projects that are underway, or being planned. The purpose of these projects is to improve the way the systems operate together, to improve information available to patients and clinicians regarding the services available and to maximise opportunities for delivering opportunistic services. Further details of these five programme areas and the projects within each can be found on the Solihull CCG website:www.solihullccg.nhs.uk.

## 2.3 Integrated care

**2.3.1** Solihull CCG is working on a programme to aid integration called ICASS - Integrated Care and Support, Solihull. ICASS is a multi agency programme of work. Key partners include: Solihull CCG, Heart of England NHS Foundation Trust (HEFT), Solihull MBC, Birmingham and Solihull Mental Health Trust, Public Health, Health Watch Solihull, People and Voluntary organisations.

**2.3.2** ICASS is about transforming the way we deliver services; it is not about adding something else on to what we do now. All of the partners have agreed to work together to transform the way we develop and deliver services. The programme is aiming to deliver services that are seamless across health and social care, so that people cannot see where a service ends and another starts. A key aim of the programme is the need to simplify what is offered, to reduce duplication and make services more efficient for patients.

**2.3.3** A key priority for the programme is Frailty and services for older people. 3 key work streams have been identified: Early Intervention and Information; Out of Hospital Care; Hospital Transformation.

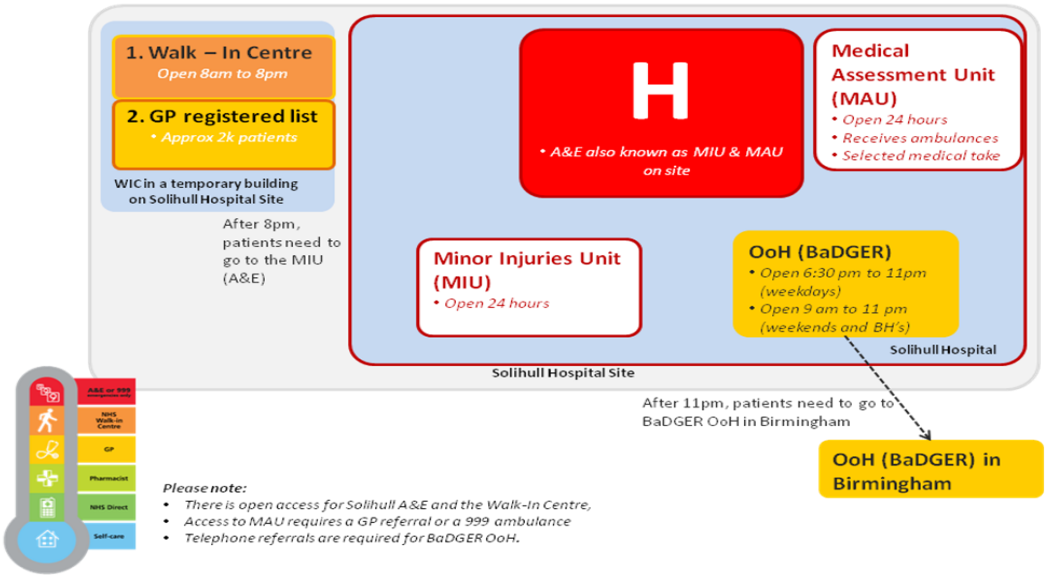
**2.3.4** Senior leaders and Experts by Experience make up the ICASS Board and it is accountable to the Health and Well Being Board.

# 3. Current urgent care service provision

*This section provides a summary of the current services provided from an urgent care perspective on the Solihull Hospital site.*

**3.1** There are currently four services that people access at the Solihull Hospital site if they need urgent or emergency care. These are shown in the figure below:

**Figure 3.1: Current service provision on the Solihull Hospital site**




## 3.2 Secondary Care

**3.2.1** The secondary care urgent care services on the Solihull Hospital site comprise of two elements:

- A Medical Assessment Unit (MAU)
- An Accident and Emergency Department (A&E)

**3.2.2** The medical assessment unit is primarily Consultant led, has a selected medical take and is the receiving area for ambulance arrivals. It is currently adjacent to the A&E. Approximately half of its patients arrive by ambulance and the others through GP referrals or are re-directed from A&E. The ambulance service takes selected cases requiring specialist services directly to Birmingham Heartlands Hospital e.g. acute heart attacks, vascular surgery and children. The unit is open 24 hours per day, 7 days per week.

**3.2.3** The Accident and Emergency Department (A&E) is known locally as a Minor Injuries Unit due to the fact that the following services are not available:

- Children's Inpatient Services
- Maternity Services
- Major Trauma
- Emergency Surgery
- Specialist medical services

Solihull residents have access to these services at Heartlands Hospital, located in Bordesley Green approximately 6 miles from Solihull Hospital. The West Midlands Ambulance Service (WMAS) do not take patients to Solihull Hospital that require access to these services. They drive straight to Heartlands regardless of where the patient is coming from.

A&E is open 24/7, predominately staffed by Emergency Nurse Practitioners, with Middle Grade Doctors. A Consultant is present for limited hours with an on call service at other times. The department primarily sees minor injuries and some acute medical conditions and is signposted internally as a 'Minor Injuries Unit (MIU)'.

## 3.3 Out of hours services

**3.3.1** Housed within the Solihull Hospital building, adjacent to the A&E Department, is an Out of Hours centre. This is run by Badger out of Hours GP service that provides a face to face GP service in the evenings and at weekends.

**3.3.2** On the Solihull site Badger is open from 6.30pm-11pm on weekdays and 9am-11pm at weekends and on bank holidays.

**3.3.3** In addition to on site consultations Badger provides telephone consultations and home visits if required. It does not offer walk in services, all patients contact the Badger call centre beforehand or are referred if their GP surgery is closed.

**3.3.4** If a patient contacts Badger during the night when the Solihull Badger site is closed they are asked to attend the Badger site at Glover Street in the centre of Birmingham.

## 3.4 Primary Care Walk in Services

**3.4.1** The Solihull Healthcare and Walk In centre (Walk In Centre) is located in a temporary building on the grounds of the Solihull Hospital site, approximately 50 yards from the A&E department.

**3.4.2** It is a GP surgery and offers both pre-booked and walk in appointments.

**3.4.3** There is a GP registered list of approximately 2,300 patients.

**3.4.4** As well as offering GP appointments the Walk In Centre offers a Deep Vein Thrombosis (DVT) service for all Solihull residents.

**3.4.5** On occasion the Walk In Centre offers the ability for an ambulance to divert away from the Medical Assessment Unit (MAU) if it is more appropriate for the patient to be seen in a primary care environment.

**3.4.6** The Walk In Centre is open 8 am – 8 pm every day.

## 3.5 Other Primary Care Services in Solihull

3.5.1 The Walk In Centre is one of 32 GP practices covering the Solihull area. There is a GP practice within 50 yards of the Solihull Hospital site (Grove Road run by Bernays and Whitehouse), which also runs the Walk In Centre, and another within half a mile (Yew Tree Medical Centre).

3.5.2 The 32 practices have a combined registered list of approximately 236,000 patients.

3.5.3 Access to GP surgeries is mostly by appointment although some offer open access. They do offer some limited urgent services to non-registered patients.

## 3.6 Summary of Activity on the Solihull site

3.6.1 The following table shows the amount of activity undertaken by each of the services described above. The activity is for one full year, April 2012 – March 2013 unless otherwise stated.

### Table 3.1: Activity

| Service | Activity |
|---|---|
| Medical Assessment Unit | 8,253 ambulance arrivals |
| Accident and Emergency Department | 44,308 attendances |
| Badger Out of Hours | 11,524 attendances |
| Solihull Healthcare and Walk In Centre | 69,195 attendances |

***Notes:***

***The Badger Activity covers all telephone consultation and home visits made by the Solihull Badger site as well as Face to Face contacts.***

***The Solihull Healthcare and Walk In Centre activity is from October 2012 – September 2013. This is because levels of activity are growing (although the building size may now be a limiting factor) and it is felt that it is better to report more recent activity levels.***

3.6.2 The Walk In Centre sees approximately 800 patients per year relating to Deep Vein Thrombosis. These generate approximately 2,000 attendances. (April 2012-March 2013).

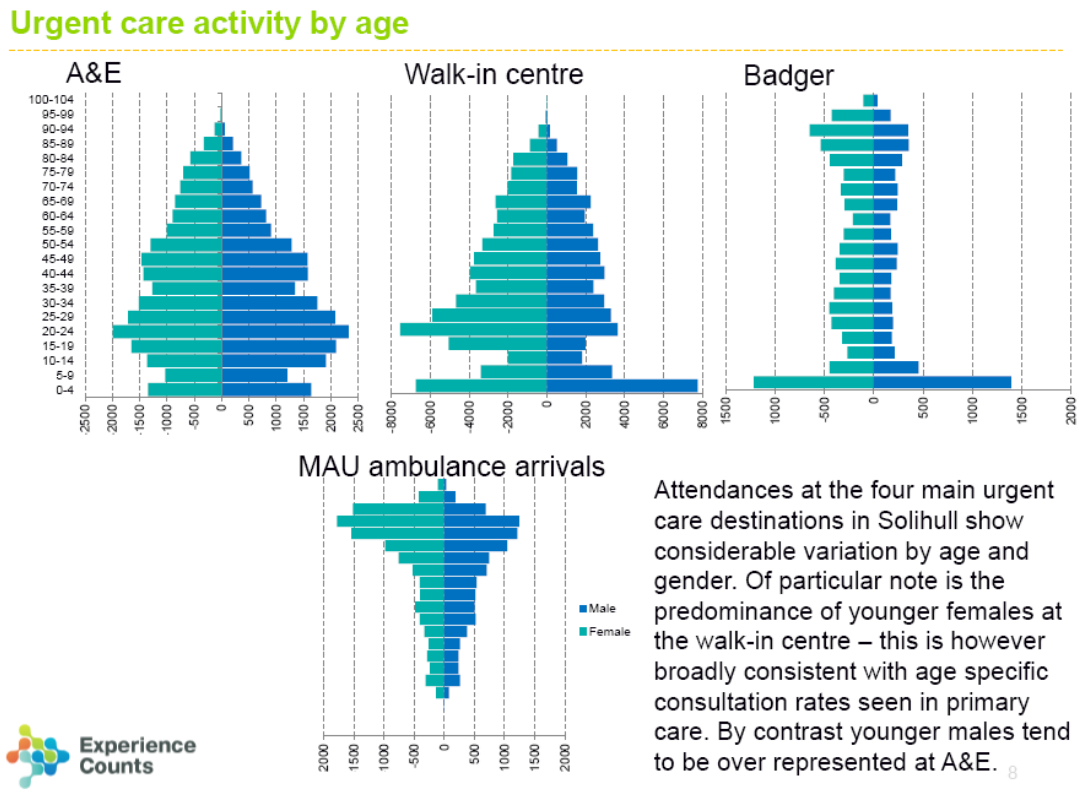
3.6.3 Approximately 250 patients per year arrive by ambulance at the Walk In Centre as part of the ambulance divert service for minor ailments.

3.6.4 Approximately 950 patients per year are transferred from Solihull Hospital A&E department to Heartlands Hospital A&E department.

## 3.7 Age profiles

3.7.1 The following table shows the age profiles of patients attending each of the four services on the Solihull site.

**Figure 3.2: Service age profiles**




3.7.2 The Medical Assessment Unit sees many more elderly patients than any of the other services

3.7.3 A high proportion of the activity that Badger is seeing is within the youngest age range.

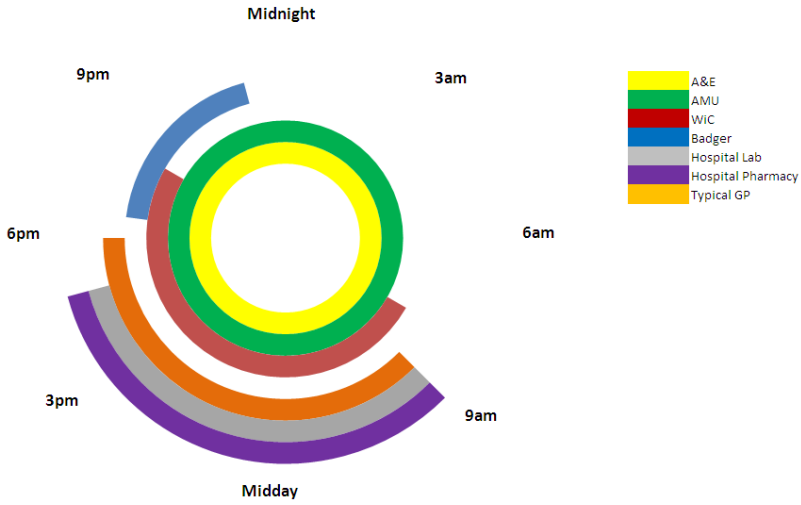
3.7.4 The profile of the patients attending the A&E Department is very similar to the profile of the patients attending the Walk In Centre.

## 3.8 Time of Day

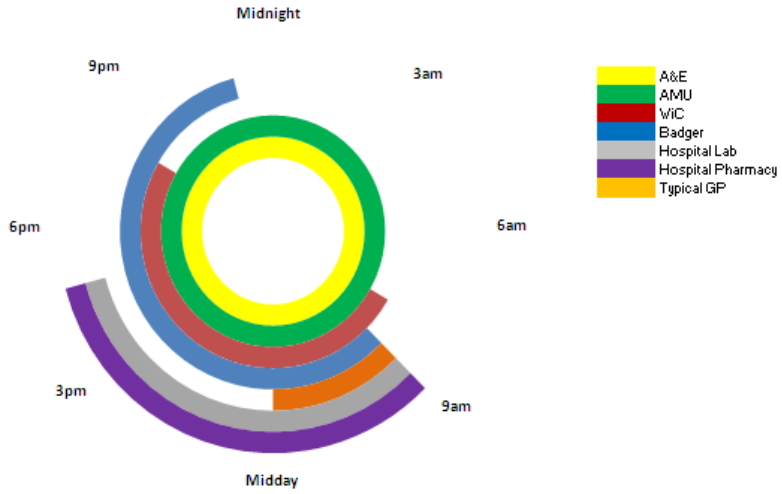
3.8.1 The opening hours for each of the services are:

- MAU and A&E: 24 hours per day, 7 days per week.
- Badger Out of Hours: 6.30pm-11pm on weekdays and 9am-11pm at weekends and on bank holidays
- Solihull Walk In Centre: 8am – 8pm every day.

### Figure 3.3: Opening Hours - Weekday



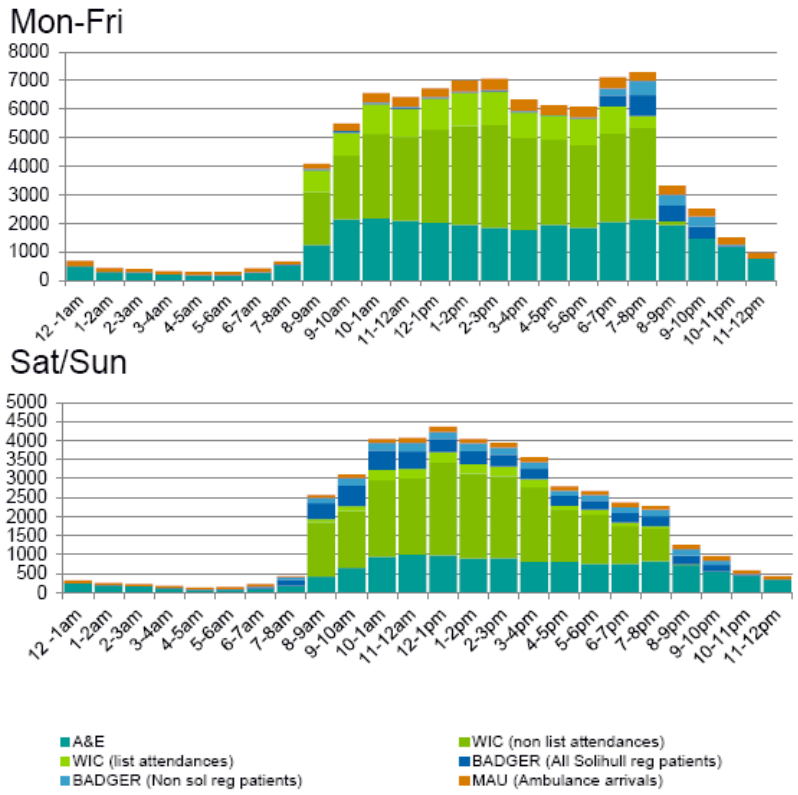

### Figure 3.4: Opening Hours - Weekends




3.8.2 The figures above clearly show an overlap of service provision at some times of the day. Support services are not available at all times.

3.8.3 The following charts show total yearly activity for each service, for each hour of the day.

**Table3.2: Urgent care activity – time of day**




3.8.4 Activity for A&E starts to increase between 8 a.m. – 9 a.m. and is fairly consistent through to 9 p.m. It has been noted that this figure shows activity by arrival time and does not show the number of patients physically in the department at any one time. It is known that the numbers of patients in the department builds up through the day. The figure shows that after 9 p.m. fewer patients arrive. However, the A&E department is still full until the backlog has been cleared, typically around midnight.

3.8.5 The figure also shows that very few patients arrive at Solihull A&E between the hours of midnight and 8 a.m.

3.8.6 Patterns of activity differ at weekends. In particular Walk In Centre activity drops off sharply on weekend afternoons.

3.8.7 Activity at the Badger service peaks between 9 a.m. and midday on weekends whereas for the Walk In Centre the peak times are between midday and 3 p.m.

# 4 The Case for Improvement

*This section describes the case for improving the urgent care services on the Solihull Hospital site, detailing the national and local drivers for this change.*

## 4.1 National Drivers

### 4.1.1 The Keogh review 13 November 2013 - Transforming urgent and emergency care services in England Urgent and Emergency Care Review End of Phase 1 Report[2]

*High quality care for all, now and for future generations*

This long awaited national medical director review of urgent and emergency care services across England reported on the 13 November 2013. The review of urgent care services on the Solihull Hospital site has ensured that it has been consistent with, and informed by the evolving national picture. The review of urgent care services on the Solihull Hospital site is fully in line with the Keogh review and indeed this national review has given us extra support for our model and nomenclature which is fully described in the Keogh paper as follows:

***"..... coordinated Urgent Care Centres.***
*These will be locally specified to meet local need, but should consistently use the "Urgent Care Centre" name, to replace the multitude of confusing terms that are available at present. Urgent Care Centres may provide access to walk-in minor illness and minor injury services, and will be part of the wider community primary care service including out-of–hours GP services. Considering all local facilities in this way will mean that networks will need to examine the extent of duplication or gaps in service offered by all of these facilities currently. Urgent Care Centres may also be advantaged by co-location with Hospital services, particularly in urban areas. Urgent Care Centres would not carry the emergency red sign, nor be considered the right place to go in a medical emergency, but would have protocols in place with the ambulance service if such events occurred."*

### 4.1.2 Regarding current and future NHS activity the Keogh review states that:

"Every year the NHS supports hundreds of millions of contacts from members of the public who need urgent or emergency care. The reasons vary. Some people simply need advice or treatment for relatively minor illnesses, others need help with pre-existing long term health problems which fluctuate or deteriorate. A smaller number need treatment for a serious illness or have a major event or injury which requires swift access to highly-skilled, specialist care to give them the best chance of survival and recovery.

Every year the NHS deals with:

- 438 million visits to a pharmacy in England for health related reasons;
- 340 million GP consultations;
- 24 million calls to NHS urgent and emergency care telephone services;
- 7 million emergency ambulance journeys;
- 21.7 million attendances at A&E departments, minor injury units and urgent care centres;
- 5.2 million emergency admissions to England's hospitals.

[2] Transforming urgent and emergency services in England – End of Phase 1 Report

Importantly, demand for these services has been rising year on year:

- The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008 indicating greater demand and complexity in primary care.
- There were 6.8 million attendances at walk-in centres and minor injury units in 2012/13, and activity at these facilities has increased by around 12 per cent annually since data was first recorded a decade ago.
- Attendances at hospital A&E departments (officially referred to as Type 1 and Type 2 A&E) have increased by more than two million over the last decade to 16 million.
- The number of calls received by the ambulance service over the last decade has risen from 4.9 million to over 9 million.
- Emergency admissions to hospitals in England have increased year on year, rising 31 per cent between 2002/03 to 2012/13.

This growth in demand is set to continue as people live longer with increasingly complex, and often multiple, long-term conditions.

*These facts have led to an overwhelming consensus that our current services are unsustainable."*

**4.1.3** Regarding the changes in healthcare and the way it is delivered the Keogh report states that:

"Advancing science has directed the way we deliver services to achieve the best results, but it also exposes the illusion that all A&Es are equally able to deal with anything that comes through their doors. We now find ourselves in a place where, unwittingly, patients have gained false assurance that all A&E's are equally effective. This is simply not the case."

"A&E departments up and down the country offer very different types and levels of service, yet they all carry the same name. We need to ensure that there is absolute clarity and transparency about what services different facilities offer and direct or convey patients to the service that can best treat their problem. Most importantly, we need to ensure that anywhere that displays a red and white sign is a place that will provide access to the very best care for the most seriously ill and injured patients, 24 hours a day and 7 days a week. A place that can resuscitate, make a diagnosis, start treatment and ensure rapid transfer to the right place if it can't offer the very best care."

**4.1.4** *There is clearly a national focus on ensuring that if a department carries an A&E badge it provides the full range of services that the public traditionally associates with this.*

**4.1.5** Monitor has recently released a preliminary report reviewing the impact and contribution of walk in centres nationally. The key issue highlighted within the report is access to primary care rather than access to A&E services. However, of service users surveyed as part of this national work some 21% did say they would go to A&E if there was no walk in centre service available. As part of the review of urgent care services on the Solihull Hospital site we are seeking to provide a walk in service and this is also described in the Keogh review above. The relevant key recommendations contained within the Monitor preliminary report are as follows: [3]

- *"Assessing patients' needs in the local area and understanding what role the walk-in centre may play in meeting those needs;*

[3] Walk in Centre review: preliminary report Monitor 11 November 2013

- *Deciding what services to procure and from whom where the contract for a walk-in centre is due to expire and the centre is identified as meeting particular needs;*
- *Considering whether services can be delivered in a more integrated way;*
- *Managing conflicts of interest; and*
- *Ensuring transparency in decision making".*

## 4.2 Local Drivers

**4.2.1** From the key learnings highlighted in section 1 (1.6.8) we see the following:

**4.2.2** There is confusion in the system of urgent care services being provided on the Solihull Hospital site. This causes patients to become unclear which service is best for their current needs. Any reorganisation of services should seek to reduce confusion and enable patients to intuitively access the appropriate service easily, at the first time of asking. This is the second key element of future urgent care systems listed in the Keogh report.

*"We're not sure where the best place to go is for urgent care"*

***Patient Reference Group***

**4.2.3** There is an issue with the naming of the A&E department at Solihull Hospital since it currently does not provide all services associated with a full A&E department. This creates the risk that a patient may attend the Solihull A&E department with a condition that cannot be treated there and that the subsequent delay in treatment could have an adverse effect on the outcome for the patient. This is also spelled out in the Keogh report in the section relating to the correct naming of A&E departments depending on the services provided. If we match the services provided by the A&E department at Solihull Hospital to the Keogh report it is clear that the current A&E department would not meet the requirements for a "Major Emergency Centre" or an "Emergency Centre". **The appropriate description for the current A&E department at Solihull Hospital would be "Urgent Care Centre".**

*"The name A&E misrepresents the service that is available on the Solihull Hospital site."*

***Clinical Reference Group***

**4.2.4** One of the original drivers for the review was to look at ensuring the population was receiving the best value for money in the way current services are organised. Although finance is not a key driver we do have a responsibility to ensure that what is provided is as efficient as possible. There is a significant overlap in the services provided by different providers, particularly when they are open at the same times. A review of the opening times for each service shows that at some times of the day, multiple choices are available.

*"At 6 p.m. in the evening there are 4 different places that I could go to on the Solihull Hospital site to meet my urgent care needs."*

***Patient Reference Group***

**4.2.5** The Walk In Centre is currently housed in a temporary building on the Solihull Hospital site. This is not an appropriate long term solution for the provision of walk in services. Therefore, given that walk in services are extremely popular an alternative solution is required. Space

*"There is not enough space to treat patients on the Solihull Hospital site."*

issues have also been highlighted by all providers on the Solihull Hospital site. Design of the front door will need to ensure adequate space is available.

***Provider Group***

4.2.6 In line with the national trend, Solihull has an ageing population with significant growth in the elderly population forecast over the next 10 years. Coupled with the fact that these patients will typically have complex, multiple, long term conditions this means that the demands on urgent care services in Solihull will increase.

*Demand on urgent care services for Solihull will increase.*

4.2.7 Nationally, there is a manpower crisis in terms of Emergency Medicine. The weakness that there is at the Solihull Hospital site in terms of lack of training recognition for Emergency Medicine because it is not a full A&E service makes this even greater. The staffing difficulties, which have been nationally recognised, will, at least in the next 4-5 years, remain critical with heavy locum reliance. This introduces increased clinical risk. The ability to be able to be flexible around staffing models is of key importance.

*"The clinical element of a full A&E service is unsustainable from a manpower point of view, and the clinical risk presented is significant."*

***HEFT ED Consultant***

4.2.8 Since there are currently several providers of urgent care services on the Solihull Hospital site there are multiple IT systems working in isolation and storing patient details and medical records. These are not currently integrated meaning that if a patient presents at more than one of the providers each will be unaware of the results of previous attendances.

*"There is an opportunity to improve patient care by exploring options for a single IT system."*

***Provider Group***

4.2.9 There are issues with access to support services such as Community based services, Mental Health services and in particular diagnostic services on the Solihull site. These can result in delays in patient care. There is an opportunity to improve access to these services as part of a service reorganisation.

*Integration of support services is important.*

***Patient Reference Group***

# 5. Clinical proposals for change

*This section describes the model developed by the Patient and Clinical Reference groups.*

**5.0.1** A series of clinical workshops were held between July and September 2013. The CRG initially considered the following potential options for urgent care service provision on the Solihull Hospital site:

- A 'do-nothing' option
- A reduction of the current A&E service provision
- An increase of the current A&E service provision
- Retention and improvement of all urgent care service provision on the Solihull Hospital site

**5.0.2** A do-nothing option was clinically rejected due to a number of reasons including:

- The clinical risks of the present service related to lack of some core services on site.
- The clinical risks that exist with the current naming of the A&E Department.
- The confusion that exists with the current system.
- The inefficiency of multiple service provision on one site.
- Shortage of space and the ability to meet the long term demand of a growing, ageing population.

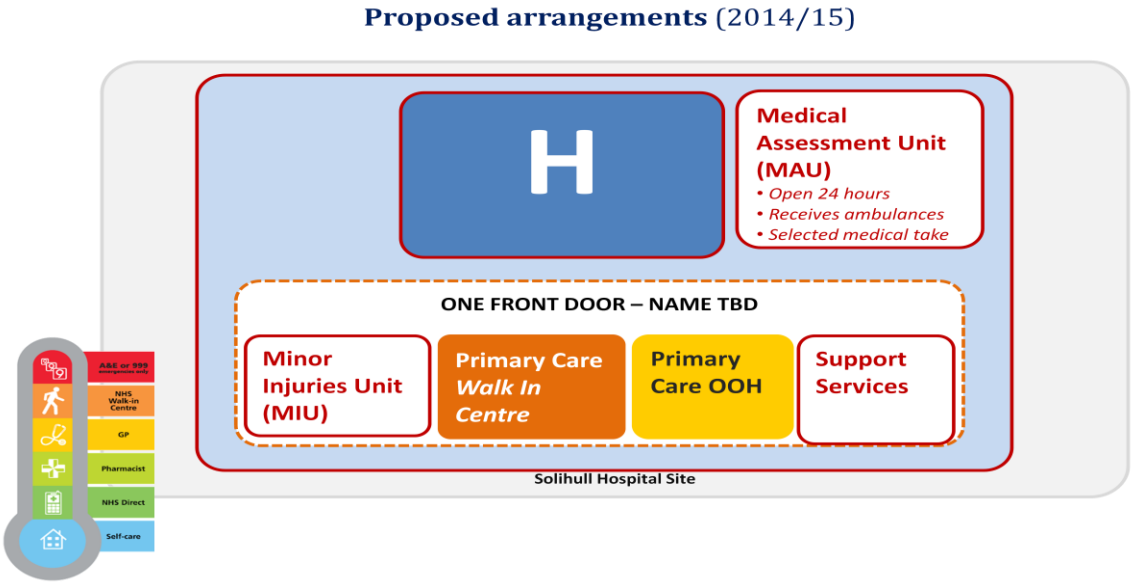
**5.0.3** A reduction of the current A&E service provision was felt to be unviable as neighbouring hospitals would not have the capacity to undertake additional activity. The review was also set up to ensure urgent care services are delivered to Solihull residents as close to home and as quickly as possible where clinically appropriate. It was concluded that the current services provided on the Solihull Hospital site are appropriate to meet the urgent care needs of the catchment population.

**5.0.4** An increase of the current A&E service provision was clinically rejected for four reasons:

- The present services that are not available on site could not be located here as there is evidence that concentrating these services on fewer sites improves clinical outcomes.
- There is a national shortage of A&E doctors and even if we wanted to recruit we would struggle. Over half of the specialist registrar posts in this field are currently vacant in the NHS.
- It is not just about the A&E department, the surrounding hospital (national guidelines) would need to provide adequate support services such as paediatrics and emergency surgery 24 hours a day. At present these services are not available at Solihull.
- The current numbers of patients attending Solihull A&E would not necessitate a fully staffed A&E. For example, between midnight and 8am there are normally only a handful of attendances at the A&E in Solihull. It would be very wasteful to have a full complement of A&E staff and support staff 24/7 when the number of patients does not justify this.

**5.0.5** The Patient and Clinical Reference Groups, supported by available best practice evidence, believe there should be minimal change to the services offered on the Solihull site but the name should change to avoid confusion. The proposal is for a centre which gives access to all the existing services through one 'front door' as described below:

Figure 5.1




## 5.1 Proposed arrangements to address local drivers

**5.1.1** The selected medical take through the Medical Assessment Unit (MAU) model is recognised to be a good model of care in a small unit such as Solihull. The Clinical and Patient Reference Groups recommended the MAU should remain. Work is being undertaken on the site to improve the existing MAU to ensure it continues to meet the growing demand for care particularly for older patients, including increasing the ambulatory emergency care services.

***With appropriate improvements to the existing MAU, the issue of increased demand raised at 4.2.6 can be addressed.***

**5.1.2** The proposal is for the services that currently work in separate locations on the Solihull Hospital site to be co-located in a single physical space. This was backed by the Patient Reference Group who stated that they simply wanted one place to go for their urgent care needs. From a patient perspective the differentiation between primary and secondary care was irrelevant, more important was that the patient feels confident that they will receive the appropriate level of care by a trained professional.

***Co-location results in issues of confusion raised at 4.2.2 and space issues raised at 4.2.5 being addressed.***

**5.1.3** Upon entering the proposed centre the patient will be received by one front desk, there will not be separate reception desks for each service. Both Patient and Clinical Reference Groups have recommended that this front desk fulfil 3 basic requirements:

- Registration
- Initial clinical streaming
- Single information system

The initial clinical streaming process will be designed to ensure that patients are seen by the appropriate professional first time, every time.

***One front desk in a single location also addresses the issue of confusion raised at 4.2.2.***

***A single information system addresses the issue of IT raised at 4.2.8.***

| | | |
|---|---|---|
| 5.1.4 | Principles of integration have been agreed for the delivery of secondary care, primary care walk in and out of hours primary care in the proposed centre. The operational details will form part of the full service specification document to enable the undertaking of a procurement process. | ***An integrated solution that allows flexibility and a cross fertilisation of skills will go some way to addressing manpower issues raised at 4.2.7 and future demand raised at 4.2.6.*** |
| 5.1.5 | For an integrated front door service to be fully effective both Patient and Clinical Reference Groups have recognised and highlighted the need for support services such as mental health, diagnostics, pharmacy, social care and community services. These services currently exist on the Solihull Hospital site but it is anticipated that part of the full service specification will make recommendations for improved ways of working between them and the proposed Urgent Care Centre. | ***Integrated support services forming part of a single front door offer will address the issue relating to access to support services raised at 4.2.9.*** |
| 5.1.6 | The Patient Reference Group expressed a preference for the Urgent Care Centre to be open 24 hours a day, 7 days per week.<br>The service specification document will review current and future demand and will align service provision accordingly. | ***This will ensure that appropriate staff are on site at all times, addressing efficiency issues raised at 4.2.4.*** |
| 5.1.7 | The Patient Reference Group discussed potential names for the proposed 'one front door' and a number of options were put forward. The intention was to test these with a wider public audience. However, since the publication of the Keogh Review (highlighted in section 4 of this document), it has become clear that the proposed service should be described as an 'Urgent Care Centre'. This was one of the proposals of the Patient Reference Group. To ensure consistency with national policy and to aid the public understanding of urgent and emergency care services, we would want to name the service as an Urgent Care Centre. | ***Renaming the service to fully reflect the actual service offering addresses the issue of misrepresentation of service raised at 4.2.3*** |

## 5.2 Conclusion

5.2.1 The proposed Urgent Care Centre on the Solihull Hospital site means that all patients who currently access services will still be able to do so and in many cases the service provided will be improved. The Urgent Care Centre will have the following features:

- One front door
- One front desk
- Access to all services currently available
- Appropriately named
- Available 24/7

# 6. Implications of the proposed model

*This section describes the modelling process, assumptions made and the known impacts in relation to activity and resource that the proposed model will have.*

## 6.1 Modelling process

6.1.1 Following an initial description of activity on the Solihull Hospital site (see section 3), a modelling task and finish group was created to oversee the development of a model to forecast future activity.

6.1.2 The modelling group consisted of service providers and clinicians who work in the system who were responsible for defining the parameters and assumptions to be fed into the model. The group was facilitated by modelling experts from the Commissioning Support Unit (CSU).

6.1.3 In a working meeting the CSU proposed a number of areas for consideration. The modelling group discussed and derived assumptions relating to each, resulting in a set of agreed parameters to be included.

## 6.2 Parameters

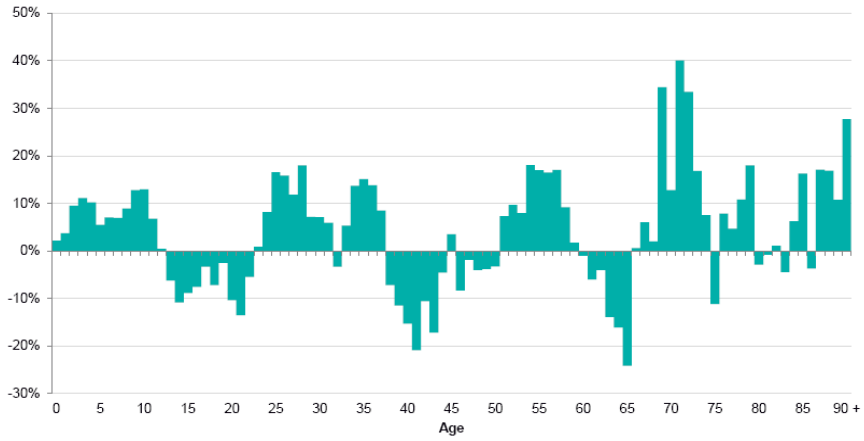
6.2.1 The following areas were considered:

- Demographic changes
- Population health improvements
- Case mix redistribution
- Opening times
- Improved access to general practice
- Duplicate attendances
- Walk In Centre patient flow
- Walk In Centre GP registered list

### 6.2.1.1 Demographic changes

As part of a wider review of urgent care services across Birmingham a forecasted demographic distribution was produced for 2016. This showed an increase in the elderly population in particular from the age of 70 upwards. It is known that the demands for healthcare rise significantly within this age range.

**Figure 6.1 Projected % population change by age between 2012 – 2016**

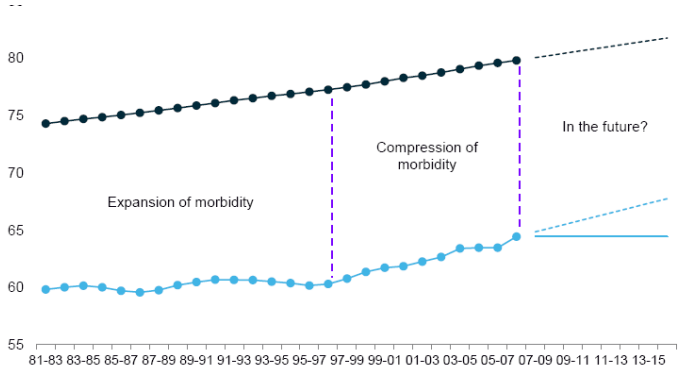



***It was agreed that the model would take into account the projected population changes as shown above.***

### 6.2.1.2 Population health improvements

In addition to demographic changes, it was also recognised that improvements in healthcare are resulting in patients living longer and generally being healthier. The impact of improvements in population health was modelled as shown below:

**Figure 6.2: Trends in life expectancy (LE) and disability free life expectancy (DFLE): England 1982 – 2015**




Projections for life expectancy and disability free life expectancy suggest that in the future for each year that passes, LE will increase by 0.24 years and that DFLE will increase by 0.4 years. It is possible to implement these projections mathematically within the forecasting model.

For example, we would expect a 90 year old in 2018 to have the same level of healthcare utilisation as an 88 year old today.

***These factors were agreed to be built into the forecasting model.***

#### 6.2.1.3 Case mix redistribution

Evidence gathered by the Primary Care Foundation suggests that a proportion of A&E activity could be categorised as primary care. To model the flow of patients after initial assessment and to enable workforce models to be developed it was essential to assess future case mix for the urgent care centre.

To assess future case mix two specific questions were raised and addressed by the modelling group:

1. Can we assume that all current walk in centre and out of hours activity can be managed by primary care?

***The modelling group agreed that it could.***

2. How much activity currently carried out within A&E could be managed by primary care?

The Primary Care Foundation found that between 10 – 30 % of A&E attendances could have been managed in primary care. This set the upper and lower boundaries for consideration by the modelling group.

***With specific input from A&E clinicians it was felt that 20% of current A&E attendances to the Solihull Hospital site could be classed as primary care. It is possible that a higher percentage could be dealt with by general practitioners who have specific training and interest in emergency care.***

#### 6.2.1.4 Opening times

Due to the build up of patients in the Solihull A&E department throughout the day and the fact that the Walk In Centre reaches capacity in the early evening, it was felt prudent to factor in a potential extension of primary care services within the model. The extension used was an extra 2 hours between 8 p.m. and 10 p.m. The following 3 questions were raised and addressed by the modelling group:

1. Would an extension to opening times generate additional demand equivalent to that seen during current Walk In Centre and out of hours opening times?

***The modelling group agreed that it would.***

2. Would some Walk In Centre activity seen in the day move to overnight?

***The modelling group agreed that it wouldn't.***

3. Should all current activity that takes place at Glover Street overnight be repatriated to the Solihull urgent care centre in this model?

***The modelling group agreed that it should***.

### 6.2.1.5 Improved access to general practice

Improving access to general practice such as through extended opening hours, increased numbers of same day appointments, online appointment booking etc. can help to reduce the need to access alternatives such as the Walk In Centre or A&E.

***The modelling group, using local knowledge, felt that improved access to general practice would not have a short term impact on activity in the proposed model but may produce changes over a longer timescale.***

### 6.2.1.6 Duplicate attendances

Wherever there are multiple options for treatment there is likely to be some duplication of activity. For example where someone will attend the Walk In Centre and then subsequently attend A&E. Work carried out in Solihull found that 2.7% of A&E attendances also had a Walk In Centre attendance with 1 day (either side).

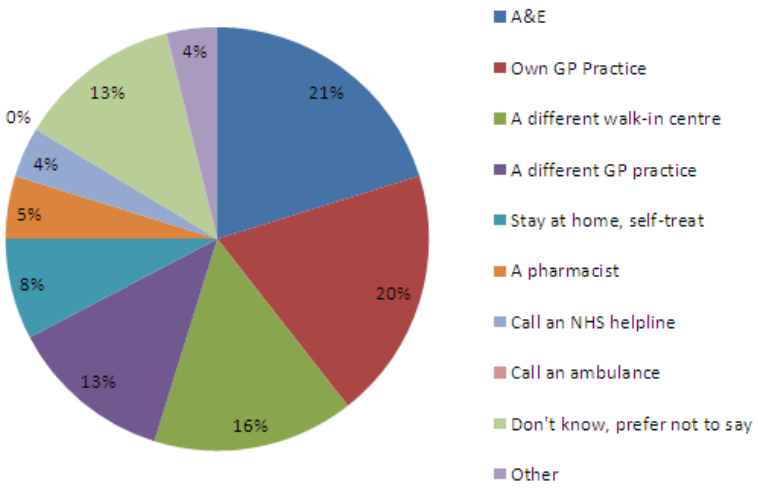
The question put to the modelling group was: Would all duplicate attendances be eliminated in the new model?

***The modelling group felt that there was still potential for duplicate attendances in any model. Refinement of the initial patient assessment process and patient and staff education would reduce this.***

### 6.2.1.7 Walk In Centre patient flow

Due to the physical location of the Walk In Centre moving in the new model, from a temporary building on the Solihull Hospital car park to a co-located facility within the hospital, it was felt prudent to investigate whether patient flows would change. Available evidence from a Walk In Centre Review conducted by Monitor in November 2013 suggested the following:

**Figure 6.3: If the walk-in centre was not available, where would patients have gone instead?**



***The modelling group considered the above evidence and concluded that the model should include an 8% reduction in walk in centre attendances as a result of the changes.***

#### 6.2.1.8 Walk In Centre GP registered list

As part of the Walk In Centre facility on the Solihull Hospital site there is currently a GP registered list which has a list size of approximately 2,300. This equates to approximately 13,000 patient attendances per year. The contract for the GP registered list element of the service is held by NHS England and is not the responsibility of Solihull CCG.

***The modelling group agreed to remove all activity for Walk In Centre registered patients from the model.***

## 6.3 Activity implications of Modelling Factors

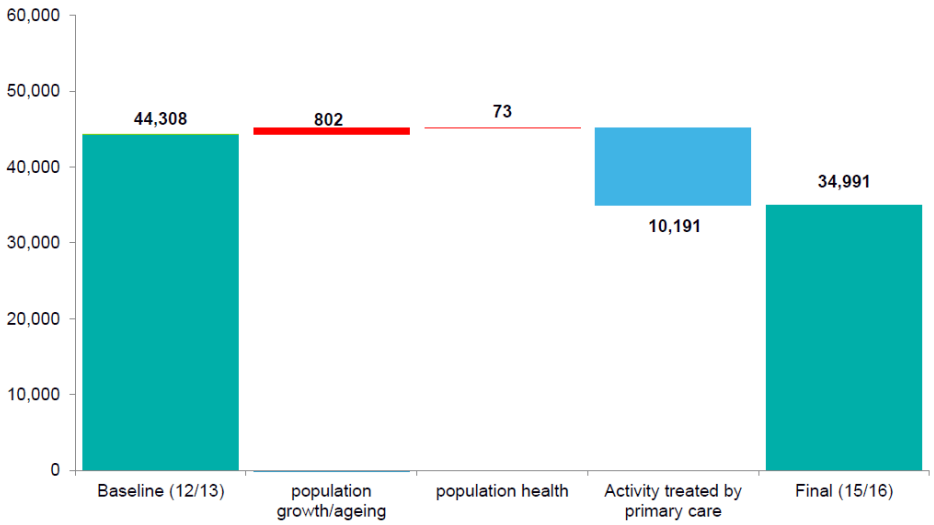
**6.3.1** Taking all of the assumptions above, the four assumptions with the most impact are:

- Removal of the Walk In Centre GP registered list – equating to a reduction in primary care managed attendances of 12,968.
- A&E attendances amenable to primary care management – equating to a shift of activity of 10,191 from secondary to primary care.
- Proposed extension to primary care walk in access – equating to an addition in primary care managed attendances of 7,708.
- Patient choice to self treat and not access the urgent care facility – equating to a reduction in primary care managed attendances of 4,641.

**6.3.2** The net effects of all assumptions made, including demographic changes are:

- A reduction in secondary care from 44,308 to 34,991 attendances per year.
- An increase in out of hours from 11,524 to 12,152 face to face attendances per year.
- An increase in primary care walk in from 69,195 to 71,259 attendances per year.
- A reduction in ambulance arrivals to Medical Assessment Unit (MAU) from 8,253 to 8,199 arrivals per year.

## Figure 6.4: Impact of modelling factors – A&E




## Figure 6.5: Impact of modelling factors – Out of hours face to face

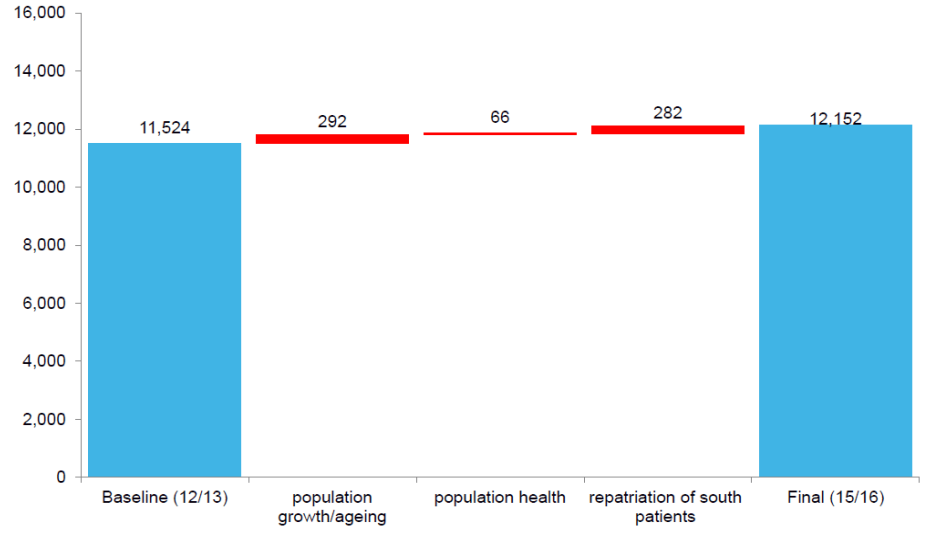


**Figure 6.6: Impact of modelling factors – Walk in primary care**

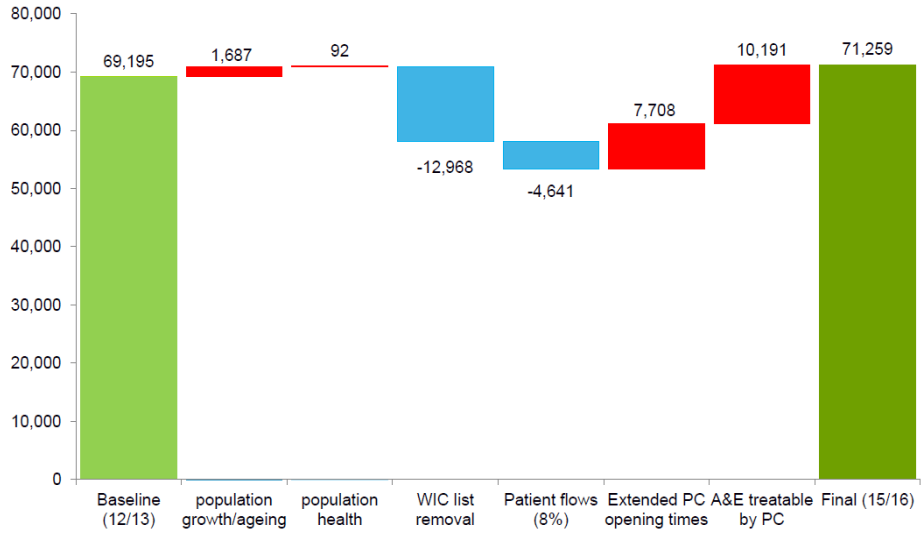
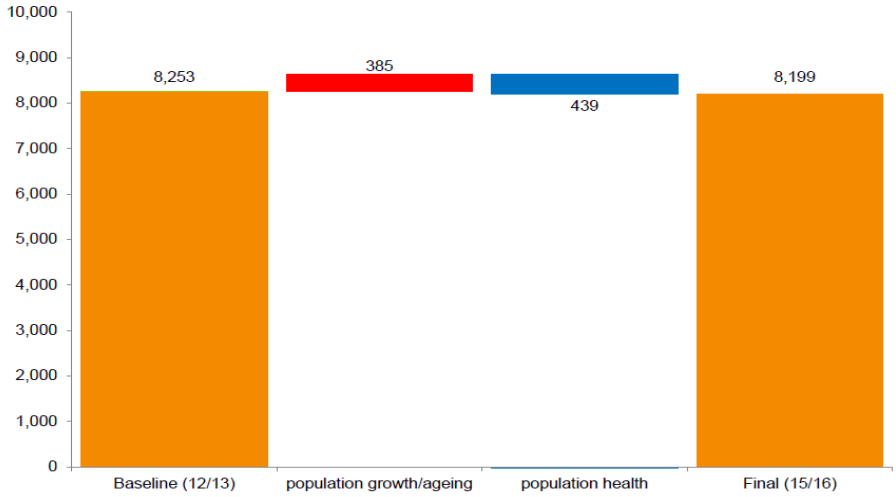



**Figure 6.7: Impact of modelling factors – Ambulance arrivals to MAU**




## 6.4 Financial implications

**6.4.1** The current financial envelope for urgent care services at Solihull Hospital, excluding the costs of patients who are later admitted to hospital (either in MAU or on a Ward), is £6.4m per annum, as set out in Fig 6.8 below. This includes the costs associated with patients registered with non-Solihull CCGs. Fig 6.9 sets out forecast activity levels by CCG.

**6.4.2** These costs are based on a mixture of activity types, some of which are prescribed by national tariff rules while the remainder is based on locally negotiated prices. In April 2014 Solihull CCG will be required to revise its contract values to reflect the 2014/15 national tariff where it applies, and as

such the financial envelope set out above may change during the development of the service specification.

6.4.3 Further to this, some of these costs are based on existing contracts that are inclusive of other add-on services that are not directly associated with patients that pass through the doors of urgent care providers on the Solihull Hospital site. An example of this is Out of Hours, which includes the cost of telephone triage and home visits.

**Figure 6.8: Solihull Hospital: Urgent Care Forecast Expenditure 2013/14**

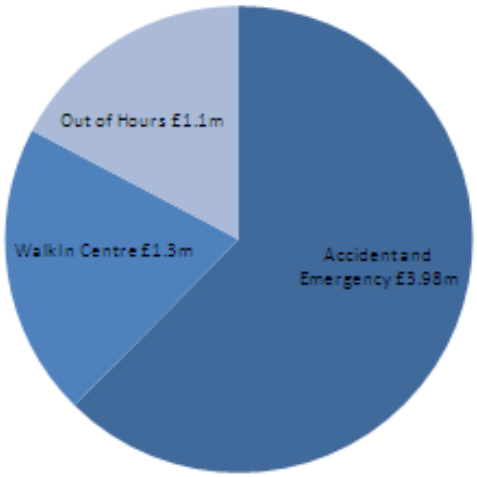
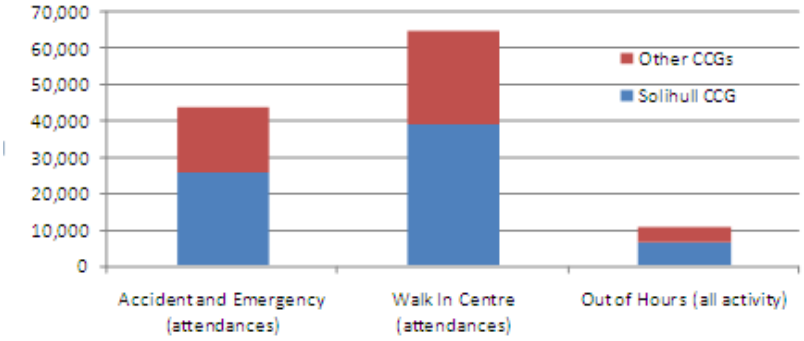



**Figure 6.9: Solihull Hospital: Urgent Care Forecast Activity 2013/14 by CCG**




6.4.4 While the figures above effectively set a maximum budget for the redesign of urgent care in Solihull, this budget cannot be viewed in isolation as there are knock-on costs that arise from the onward flow of patients into the hospital. As such, the future service model will need to consider the rates of conversion from attendance at the front door to admission in an assessment unit or ward.

6.4.5 While the case for change in Solihull is clearly not financially driven, there may be efficiencies or cost reductions that are identified as the service model develops – and to some extent this would be expected given the areas of duplication that have been identified previously in this document. The precise nature of how the potential benefit would be realised will ultimately depend upon the how the services are reconfigured and the resultant procurement process.

6.4.6 Any such benefits would be reinvested in patient care in Solihull.

6.4.7 It is anticipated that there will be capital costs associated with the development of a co-located urgent care centre and these will be borne by the provider (s) of these services.

## 6.5 Standards and Ethics

6.5.1 A&E departments, and indeed, the proposed urgent care centre model are currently and will continue to be heavily monitored both locally and nationally. There are numerous standards that currently apply to the existing services and they would continue to be applied in any new proposed service. As part of the service specification process there will be a specific section devoted to ensuring that existing standards and ethics are applied where appropriate and developing new ones if required.

## 6.6 Workforce Implications

6.6.1 The service specification will detail the level of resource required for the proposed Urgent Care Centre. This will cover different levels of staff, different days of the week and different times of day and will allow a full workforce plan to be developed.

6.6.2 Using the activity implications described at section 6.3 it is anticipated that the current staffing resource across all providers will be sufficient to deliver the requirements of the new Urgent Care Centre.

6.6.3 By streamlining the service and creating a one front door with a one front desk there will be an opportunity to review the workforce requirements and potentially make some efficiency related savings.

6.6.4 In addition there will be an opportunity for members of staff working within the proposed Urgent Care Centre to broaden their skills and experiences by working together and learning from other professionals.

## 6.7 Wider implications

6.7.1 The proposed Urgent Care Centre would have little impact on current services. In many instances services would be improved. The table shows the impact on other services available on the Solihull Hospital site:

### Table 6.1: Service impact of proposed arrangements

| Services | Current Service | Proposed Model |
|---|---|---|
| **Trauma** | N | N |
| **Acute Surgery** | N | N |
| **A&E (MIU)** | Y | Y (renamed) |
| **Acute Medicine (AMU)** | Y (Selected) | Y (Selected) |
| **Rehabilitation** | Y | Y |
| **Outpatients** | Y | Y |
| **Diagnostics** | Y | Y |
| **Paediatrics** | N | N |
| **Community Services** | Y | Y |
| **Mental Health (RAID)** | Y | Y |
| **Primary Care OOH Service**<br>**Provided off site** | Y (6pm-10pm)<br>Y (after 10pm) | Y<br>N (On site) |
| **Primary Care Walk in Centre**<br>**With Registered List** | Y (Off site)<br>Y | Y (On site)<br>N |

# 7. Next steps

*This section describes how the urgent care review of services on the Solihull Hospital site will move forward, including the public engagement process and potential implementation of the new service model.*

## 7.1 Approvals Process

**7.1.1** This version of the Business Case will be considered by the Solihull CCG Governing Body on January 8th 2014.

**7.1.2** It will then be taken to the Healthier Communities Scrutiny Board on January 9th 2014 along with a plan for public consultation and engagement process.

## 7.2 Consultation and Engagement Process

**7.2.1** It is anticipated that the public engagement process will begin on Wednesday 15th January 2014 and will run until Easter 2014.

**7.2.2** The objectives are:

- To engage a range of internal and external stakeholders with the urgent care review and in particular, the proposed changes on the Solihull Hospital site.
- To enable to public and staff to provide their views on the proposed urgent care strategy.
- To test public and staff support for the proposed changes.
- To provide a channel for staff and external stakeholders views to inform the decision making process.
- To meet the 'four tests' set out by the Secretary of State for Health.

**7.2.3** Key stakeholders within the engagement process are:

- Patient groups
- Community groups and organisations
- Voluntary groups and organisations
- Campaign and special interest groups
- The media
- Clinicians
- Solihull Health and Wellbeing Board
- Clinical Commissioning Groups in neighbouring areas
- Independent healthcare contractors, including pharmacists, dentists and optometrists
- Local health representative committees
- NHS commissioning staff
- NHS provider staff
- NHS staff side representatives
- The councils' official decision making bodies
- Healthier Communities Scrutiny Board
- Individual councillors
- Officers with relevant specialist knowledge

## 7.3 The Outcome

**7.3.1** Throughout the consultation and engagement process feedback will be collated and a report produced. This feedback will also be used to help shape a service specification document that will be required to detail the urgent care service to be provided on the Solihull Hospital site.

**7.3.2** The service specification document will be written by Solihull CCG and will be presented to the Solihull CCG governing body for approval in summer 2014. It will cover:

- Activity and case mix
- Governance
- Finance
- Estates
- Workforce and training
- Clinical pathways (including Entry to and Exit from to the system)
- Performance issues
- Information and Technology
- Communications

**7.3.3** Following the production and approval of the service specification a period of service procurement will be undertaken. It is anticipated that this will last for 9 months.

## 7.4 Implementation

**7.4.1** Changes to the urgent care services provided on the Solihull Hospital site would begin in April 2015.

**7.4.2** The governance arrangements will seek to assure local stakeholders that:

- Any service changes are being made in a way that ensures patients safety.
- Plans are in place to ensure that any service changes do not adversely affect performance.
- All stakeholders including staff, patient and public groups are fully aware of any service changes before they are made.

**7.4.3** A full Risk assessment will be produced as part of a project implementation plan. Providers and Commissioners will work together to understand the risks and, where necessary, take action to eliminate, control or mitigate them.

## 7.5 Conclusion

**7.5.1** This business case seeks to make the case to commence a public consultation and engagement process relating to the redesign of urgent care services on the Solihull Hospital site. It is being submitted to the Solihull CCG governing body for approval and to the Healthier Communities Scrutiny Board for guidance relating to public engagement.

# APPENDICES

## Appendix 1: Self assessment against the Secretary of State for Health 'four tests'

| Test | Requirement | Solihull CCG Activity |
|---|---|---|
| **Support from GP commissioners** | **Commissioners will need to consider the engagement / involvement that may need to take place with practices whose patients will be significantly affected by the case for change, inviting views and facilitating a full dialogue where necessary. Local commissioners will need to demonstrate the nature of the discussion with consortia or with other appropriate bodies as a proxy. For example, the commissioner could obtain written sign off from relevant local consortia representative.** | **Solihull CCG has engaged with local GP practices through direct contact and via their two consortia; Solis and Sirius. Regular meetings with consortia boards have allowed Solihull CCG to update Solis and Sirius on a frequent basis.**<br>**The CCG lead for Urgent Care is a local GP. He has been part of the Project group and specifically participated in the Patient Reference Group and the Clinical Reference Group.** |
| **Strengthened public and patient engagement** | **The National Health Service Act 2006 requires local health organisations to make arrangements in respect of health services, to ensure that users of those services such as the public, patients and staff are involved in the planning, development, consultation and decision- making in respect of the proposals. Local commissioners should engage Healthwatch and Health Overview and Scrutiny Committees to seek their views.** | **Solihull CCG has involved the public, patients and staff throughout the review process. There have been numerous meetings with Patient Participation Groups (PPGs) and the CCG formed a Patient Reference Group (PRG) containing representatives from PPGs and other patient interest groups. The PRG worked alongside the Clinical Reference Group (CRG) to develop the proposed model.**<br>**The review has been sponsored by the Solihull Health & Wellbeing Board. Healthwatch and Solihull HCSB have been engaged throughout the process. Solihull CCG and representatives from the PRG presented the proposed solution to the HSCB in November 2013.** |
| **Clarity on the clinical evidence base** | **It is recommended that clinicians should lead in gathering this evidence, considering current services and how they fit with the latest developments in clinical practice, and current and future needs of patients.** | **Solihull CCG created a Clinical Reference Group (CRG) to lead the urgent care review. The CRG was made up of local clinicians from all service providers and other clinical experts and was tasked with the development of a clinical model for the Solihull Hospital site that is sustainable and meets the future needs of patients. A literature review of current evidence was gathered and visits to other hospital sites were undertaken.** |
| **Consistency with current and prospective patient choice** | **Local commissioners will need to consider how the proposed service reconfiguration affects choice of provider, setting and intervention; and the choice this presents the patient compared with the current model of provision. Commissioners will need to ensure this consideration is part of any dialogue with local clinicians, Healthwatch and Scrutiny Committees. In meeting the choice test,** | **Solihull CCG has worked with the CSU to assess the impact of the proposed model. This has covered two main areas.**<br>**Firstly, an overview of the activity being undertaken on the site was produced along with a model forecasting future activity to ensure that the model was sustainable.**<br>**Secondly, an Equality Impact Assessment was undertaken to ensure that any proposed changes to the service on the Solihull Hospital site do not adversely impact any of the protected patient groups** |

| | | |
|---|---|---|
| | **commissioners will want to make a strong case for the quality of proposed services and improvements in the patient experience.** | **as defined by the Equality Act 2010. It was concluded that since there are no planned diminution of existing services there are no negative differential impacts to any of the protected patient groups.** |

## Appendix 2: Terms of Reference for Solihull Urgent Care Review Groups

**Terms of Reference**

**Clinical Reference Task and Finish Group**

**Accountable to:**

Solihull CCG Urgent Care Programme Board

**Purpose:**

The purpose of the Group is to understand how the current urgent care system in Solihull operates, including its strengths and weaknesses, agreeing a clinical case for change and ultimately produce options for a simplified clinical model that improves patient outcomes. The options should focus on the clinical viability of any proposed new models and not on the contracting issues associated with any changes to service.

**The overall remit of this group is:**

- To be clear that any changes are clinically robust
- To determine, review and agree issues for a case for change
- Put forward to the Solihull CCG Urgent Care Programme Board all options that have been considered
- Make recommendations to the Solihull CCG Urgent Care Programme Board regarding the preferred clinical model that should be put forward for public consultation
- Consider Clinical, Operational, Financial and Political implications of options and consider any further work required
- To determine a process for clinically evaluating options
- To receive views and experiences from a patient perspective from the Patient Reference Group
- To provide information to the Patient Reference Group
- To receive and take into account data and information provided by the Provider Group

**Work will include:**

- Providing clinical expertise to ensure clinical models offer the best opportunity to realise benefits
- Ensure clinical leadership supporting the clinical redesign of services across organisations, based on the agreed principles for integration, and meeting the needs of local residents as outlined in the published commissioning intentions
- Foster a culture of continuous quality improvement
- Promote clinical leadership
- Promote patient centred care using Solihull CCG's "Jack and Eileen" approach.
- Patient representative role is to observe the process and where appropriate feed in views and experience from a patient perspective

**Facilitation**

Independent Facilitation- Nigel Edwards (Senior Fellow-Kings Fund)
National expert in Urgent Care-Professor Matthew Cooke

**Chair:**
Independent chair- Dr Charles Ashton

**Membership**

Sirius representation
Solis representation
CCG Governing Body representation
Heart of England FT representation
Walk in Centre representation
Out of Hours representation
Solihull Community Services representation
Mental Health representation
West Midlands Ambulance Service representation
Lead Commissioner for Urgent Care: Birmingham and Solihull
Social Care representation
Patient representation

**Frequency of meetings:**

This group will meet three or four times over the summer with representation from all Providers and other relevant Clinical Experts of Urgent Care in Solihull.

**Decisions:**

The remit of this group is to put forward recommendations on potential options, but commissioning decisions will ultimately be made by the CCG Governing Body following ratification by the Health and Wellbeing Board.

Any decision relating to Public Consultation is the responsibility of the Local Authority.

**Agendas and papers:**

An appropriate set of papers for each meeting will be sent out at least 3 days before each meeting.

**Minutes:**

A set of formal minutes will not be produced for these sessions however a summary of discussions will be provided following each meeting. These notes may be used for press release and stakeholder briefing purposes.

**Conflict of Interest**:

Any actual or potential conflicts of interest must be declared and the CCG has a process for dealing with these conflicts.

**Terms of Reference**

**Solihull Patient Reference Group**

**Accountable to:**

Solihull CCG Urgent Care Programme Board

**Purpose:**

The purpose of the Patient Reference Group is to ensure that the patient voice is heard and taken into account in any redesign of services on the Solihull site.

There is a Clinical Reference Task and Finish Group (CRG) that has been set up to look at clinically viable options for the Solihull site.

**The overall remit of this group is:**

- to understand and inform the process of the CRG
- to receive and scrutinise information from the CRG
- to feed views and experiences from a patient / resident perspective back to the CRG
- to participate with the CRG in agreeing options for change

**Facilitation**

NHS Solihull CCG.

Clinical Advisors of the clinical reference group CRG will be present at the meetings.

**Membership**

A representative cross section of Solihull Residents including:

- Sharon Woodcock (independent chair)
- Jenny Lanfermeijer, patient representative on the Clinical Reference Group
- Up to 3 further PPG representatives
- A Solihull Walk in Centre patient representative
- Up to 3 HEFT Local Patient Governors
- Up to 3 Local Experts By Experience
- Healthwatch
- Dr John Davenport (clinical advisor)
- Professor Matthew Cooke (clinical advisor)

Appointment will be made to vacant posts through an open, independent and transparent process, subject to meeting the criteria within the job description and needing to balance the Solihull geographic and demographic population profile where possible.

**Frequency of meetings:**

It is likely that the group will meet three or four times over the summer/autumn, (likely to be fortnightly during September and October) however it is envisaged that the group will continue to need to meet until any consultation is completed.

**Decisions:**

The remit of this group is to understand and review the process undertaken by the Clinical Reference Task and Finish Group (CRG), to be a critical friend and to support the CRG to develop options for service change that meet the design criteria already agreed.

Any decisions will be made by the Solihull CCG Urgent Care Programme Board which is sponsored by The Solihull Health and Wellbeing Board.

Any decision relating to Public Consultation will be subject to national policy and scrutinised locally by The Solihull Healthier Communities Scrutiny Board.

This group can raise any concerns about the fairness and transparency of the CRG process with the programme team or programme board.

**Agendas and papers:**

An appropriate set of papers for each meeting will be sent out at least 3 days before each meeting.

**Minutes:**

A set of formal minutes will not be produced for these sessions however a summary of discussions will be provided following each meeting. These notes may be used for press release and stakeholder briefing purposes.

**Decisions:**

The remit of this group is to work with the CRG to put forward joint recommendations on potential options for service change to the urgent care system provided from the Solihull Hospital site. Commissioning decisions will ultimately be made by the CCG Governing Body following ratification by the Health and Wellbeing Board.

**Conflict of Interest**:

Any actual or potential conflicts of interest must be declared and the CCG has a process for dealing with these conflicts.

**Terms of Reference**

**Provider Group**

**Accountable to:**

Solihull CCG Urgent Care Programme Board

**Purpose:**

The purpose of the Provider Group is to ensure that all Providers of services on the Solihull Site are kept up to date with the review process and have an opportunity to ensure that data/information being used is accurate.

**The overall remit of this group is:**

- To understand the process of the review
- To receive information about the review from the project team
- To provide data and information to inform the review
- To agree data and information that is used to inform the review and latterly any potential modelling
- To agree joint communication messages
- To represent and feedback into respective organisations

**Chair:**

Meetings will be chaired by the Chief Officer Redesign of Solihull CCG.

**Membership**

- Representation from Solihull Hospital – Heart of England NHS FT
- Representation from Badger out of Hours Service
- Representation from the Solihull Healthcare and Walk-in Centre
- Representation from West Midlands Ambulance Service

**Frequency of meetings:**

It is likely that the group will meet three or four times over the autumn, however it may be necessary for the group to meet on other occasions as necessary. This will be reviewed in November.

**Agendas and papers:**

An appropriate set of papers for each meeting will be sent out at least 3 days before each meeting.

**Minutes:**

A set of formal minutes will not be produced for these sessions however a summary of discussions will be provided following each meeting.

**Decisions:**

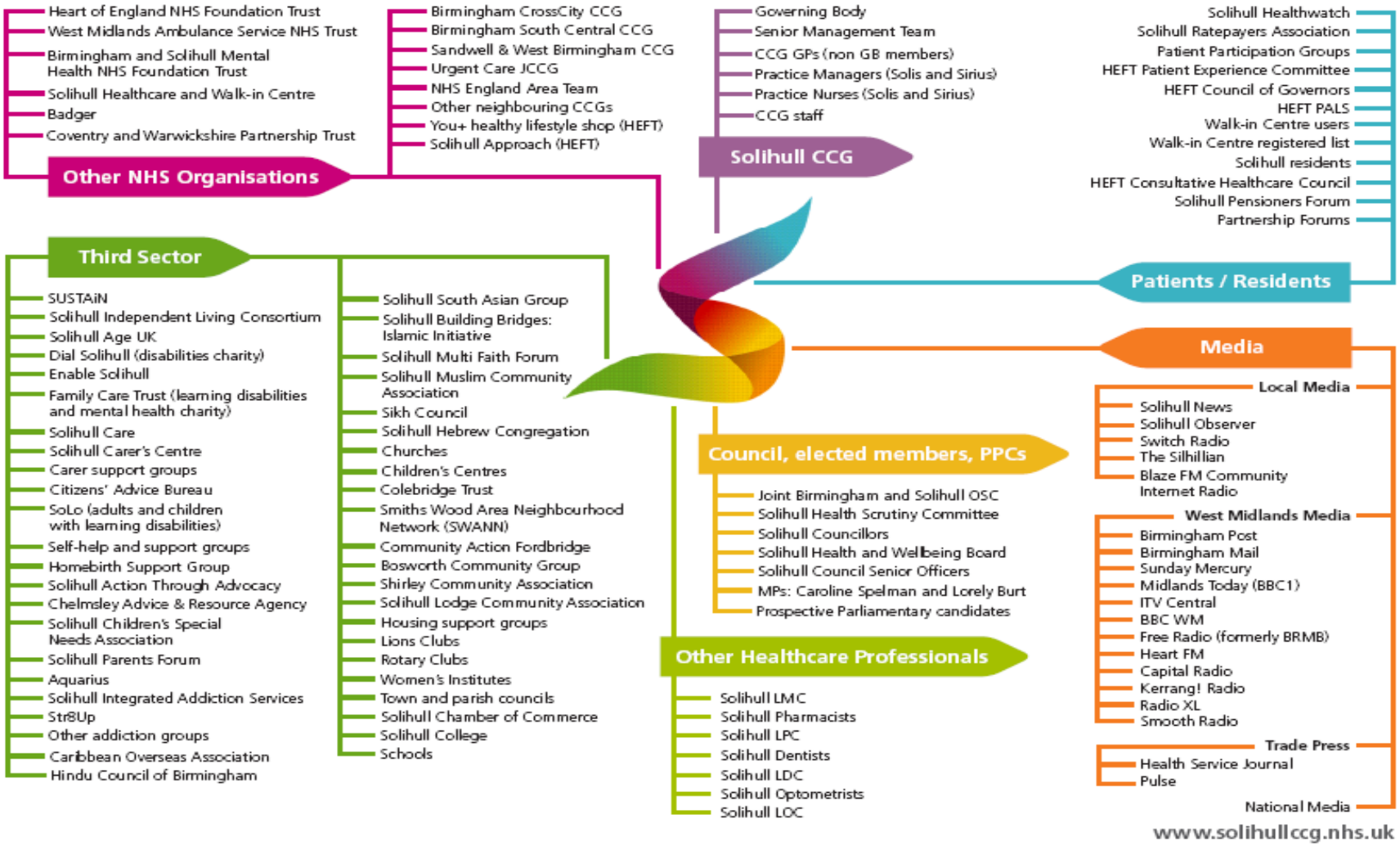
Commissioning decisions will ultimately be made by the CCG Governing Body following ratification by the Health and Wellbeing Board.

Any decision relating to Public Consultation is the responsibility of the Local Authority.

**Conflict of Interest**:

Any actual or potential conflicts of interest must be declared and the CCG has a process for dealing with these conflicts.

## Appendix 3: Stakeholder Map



## Appendix 4: Equality Analysis for Solihull Urgent Care

### Contents

## Executive Summary

Central Midlands Commissioning Support Unit (CSU) provides equality and diversity support to Solihull CCG. As part of this support, the Equality and Diversity Team of the CSU was asked to undertake an equality analysis of the clinical case for change for urgent care services as part of the review of Urgent Care services on the Solihull hospital site. The CCG has committed to make this review an inclusive process.

## Scope of the Equality Analysis

The document '*Solihull Urgent Care: Case for Change'* (Solihull CCG; July 2013) is focused on the issues which necessitate a reconfiguration of urgent care services and facilities at the Solihull site. This equality analysis has therefore considered the potential impact of the case at an early stage. Further information can be gathered as the review progresses through the consultation stages and when concrete options, or proposals, are put to Solihull communities.

## Methods

Solihull CCG adopted a process for Equality Analysis at its inception in April 2013. For the urgent care review, in anticipation that a much wider group of stakeholders would be engaged in the process, an equality analysis 'route map' was produced by the CSU to illustrate how each stage could progress. A summary of this route map is attached at Appendix 1.

A wide range of reports, statistical information, and transferable learning from equality analyses of urgent care services in other parts of the country were used as part of this analysis. A full list of these appears at the end of this document. In addition, equality information statistical returns from provider organisations were compiled, and additional service information was requested from those organisations directly involved in providing urgent and emergency care. We used these to try to understand the provision for protected characteristic groups (s.4 Equality Act 2010) and for non-statutorily protected groups who have significant healthcare needs (e.g. homeless people; migrants; travelling communities). The conclusions and inferences made in this analysis have been made using these materials.

## Conclusions

The clinical case for change for the Solihull site, specifically, is clear. It is designed to improve health outcomes for residents and visitors to Solihull. The intention to rehabilitate facilities, improve access and navigability for patients, to remove unnecessary duplication and significantly enhance patients' experiences of urgent care should offer a positive and beneficial impact for all patients, including the statutorily protected characteristic groups. There is no planned diminution of existing services. In this context there are no negative differential impacts identified at this stage for any of the protected characteristic groups covered by the Equality Act 2010. However this will need to be reviewed further at the consideration of options stage, and there are opportunities identified in this analysis for further engagement with different communities.

More detailed consideration of urgent care services ***operationally*** can be made by ensuring that equality considerations are built into pre-qualification questionnaires (PQQs), specifications and by requiring providers to conduct further equality analyses on their service operations. Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services, with regular (quarterly) reports submitted to the commissioner which are required to demonstrate statutory compliance with s.149 of the Equality Act 2010. All NHS Trusts and private sector providers commissioned by

the CCG will be required to demonstrate compliance with s149 (the Public Sector Equality Duty), and this requirement is included within the standard form of NHS Contract.

## Summary of Recommendations

1. **The CCG works with strategic partners to pursue the opportunities and risk mitigating actions highlighted in the report in paragraphs 3.5-3.13.**

2. **CCG to begin harmonising data collection categories for equality groups to match the 2011 Census categories with flexibility to enable patients to self-define where this is possible.**

3. **The CCG works with its provider organisations to improve on the routine collection of equality information from patients, and by staff, and to harmonise the collection methodologies between providers so that comparative statistics are available.**

4. **Ensure that equality considerations are built into pre-qualifying questionnaires (PQQs); service specifications; and by requiring providers to conduct further equality analyses on their service operations. Establish contractual information requirements which consider equality in the provider workforce and in the delivery of services, with a requirement to report on these and demonstrate compliance with s.149 of the Equality Act 2010.**

5. **The CCG explores the availability of benchmark data for similar services in other CCG areas to help establish baseline positions.**

6. **Opportunities to consult across the protected characteristic groups should be built in to proposed engagement and consultation as this project, and the urgent care review generally, progresses. This could be supplemented by an Urgent Care survey of 3rd sector representative organisations/umbrella groups working with people from Protected Characteristic groups.**

7. **Further work is required to identify any geographical disparities in the location of homeless people and their needs; to research the health experiences of homeless people; and to explore the potential to more efficiently prevent or reduce ill-health and to respond more appropriately to their healthcare needs.**

8. **Engage with social housing organisations – eg Local Authority/Housing Associations; and with Tenants' and Residents' Associations or 'Federations of TRAs' – this offers a cost effective route to capture views and concerns from significantly marginalised groups.**

# 1. Introduction

## Drivers for the review

1.1 At the Solihull site there are currently four ways to access urgent care services. Although there is communication between these services, they are run and managed separately in three cases. In terms of the Solihull site any review of emergency services provision will involve the Solihull Hospital Accident & Emergency Department (A&E), the Solihull Healthcare Walk-in Centre (SHWiC) currently sited in temporary accommodation in a car park, the BaDGER GP Out of Hours (OOH) Service, which operates on the Solihull site and the Solihull Medical Assessment Unit (MAU).

1.2 The Clinical Reference Group has identified several areas where there is variance from best practice.

- The system is confusing to operate in from a staff perspective with duplication and with people not necessarily in the right place at the right time to respond to the needs of patients.
- There are risks inherent to how the current system works –the current service offering does not accurately describe what is really there. Risks may therefore result when patients present at a location not best suited to their medical needs.

1.3 Other issues identified include:

- Lack of patient confidence – patients need confidence in the person/system that they are contacting (increasing the confidence of patients in our services)
- No clear pathways for rapid access to diagnostics
- Information is not easily and quickly shared
- Overburdened Heartlands A&E department
- Not managing Frailty in an optimal way
- Absence of onsite Paediatrics at Solihull Hospital
- Access/pathways are poor to social care, alcohol services and mental health

## Aims of the Equality Analysis

1.4 Central Midlands Commissioning Support Unit, as part of its support to Solihull Clinical Commissioning Group, was asked to help facilitate an Equality Analysis on the Urgent Care clinical case for change focussed on the Solihull Hospital site. The aims in producing this report are to:

i. Establish a baseline on current usage of urgent care services at the Solihull hospital site with regard to **protected characteristic groups**.
ii. Assess the equality impact on the local population of potential changes as part of the urgent care review in Solihull.

iii. To use the process of Equality Analysis, as guided by the route map (Appendix 1) to inform decision-making.
iv. Identify opportunities to promote equality.
v. Recognise the potential risks to the review from not addressing inequalities.
vi. To suggest ways to mitigate these risks.
vii. For the report itself to offer a record of the factors which have been considered and have influenced the thinking in the urgent care review.

1.5 The **'protected characteristic groups'** are defined in Part 1 of the Equality Act 2010 and cover people who are specifically offered protection by the Act. Before the Equality Act, all NHS organisations already had to demonstrate that they were treating people of different races, people with a disability, and men and women fairly and equally. The 2010 Act has added groups of people to the equality duty:

- **Age** - People of different ages – referring to a person belonging to a particular age or age group
- **Sexual orientation -** Lesbian, gay and bi-sexual people – whether a person's sexual attraction is towards their own sex, the opposite sex, or to both sexes.
- **Gender reassignment** - People who are transitioning from one gender to another. A person who is Transgender is someone who expresses themselves in a different gender to the gender they were assigned at birth. Although the legislation covers gender reassignment, we recognise that the term **'trans'** better encompasses the wider community.
- **Religion or belief** - People with a religious or philosophical belief, (or people without a religion or belief e.g. Atheism). Generally a belief should affect your life choices or the way you live for it to be included in the definition. Political beliefs are not afforded protected characteristic status.
- **Pregnancy and maternity** - Women who are pregnant or expecting a baby (Pregnancy) and the period after the birth (Maternity). Maternity may refer, for example, to maternity leave in the employment context, or – in the non-work context – protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.
- **Marriage and civil partnership** - People who are in a civil partnership or are married. Marriage is currently defined as a 'union between a man and a woman'. Same-sex couples can have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same way as married couples on a wide range of legal matters.

## The Public Sector Equality Duty

1.6 Clinical Commissioning Groups (CCGs) are now listed as public authorities in Part 1 of Schedule 19 to the Equality Act 2010. This means that Solihull CCG is subject to the general Public Sector Equality Duty required by s.149 of the Act. S.149 states that the CCG must *"have due regard to the need to*:

i. Eliminate discrimination, harassment, victimisation, and any other conduct prohibited by the Act;
ii. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
iii. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

1.7 Having *due regard* for advancing equality (2nd aim) involves:

- **Removing or minimising disadvantages** experienced by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low

*1.8 In the case of R (Brown) v Secretary of State for Work & Pensions [2008] EWHC 3158 (Admin).the Court set out some principles for public bodies to guide them in compliance with the duty to give due regard to relevant equality needs. These include that:*

- When a public authority makes decisions that do or might affect an equality group, it must be made aware of its duty to have due regard to the equality goals in the Equality Duties. An incomplete or mistaken appreciation of these Duties will mean that 'due regard' has not been paid.
- The 'due regard' must be exercised with rigour and with an open mind. It is not a question of 'ticking boxes'. The Duty has to be integrated within the discharge of the public functions of the authority. **It involves a conscious and deliberate approach to policy-making** and needs to be thorough enough to show that 'due regard' has been paid before any decision is made.
- If the public authority has not specifically mentioned the relevant general Equality Duty when carrying out a particular function, this does not mean that the Duty to have 'due regard' has not been performed. However, it is good practice for the policy itself or the public authority to make reference to the Duty and any code or other non-statutory guidance. This will reduce the chance of someone successfully arguing that 'due regard' has not been paid to equality considerations. This is also likely to enable a public authority to ensure that factors relevant to equality are taken into account when developing a policy.
- It is good practice for public authorities to keep an adequate record showing that they have actually considered their Equality Duties and pondered relevant questions. Appropriate record-keeping encourages transparency and will discipline those carrying out the relevant function to undertake their Equality Duties conscientiously.

# 2. Background

## Usage patterns at the Solihull site

2.1 This section presents the data available from each of the following four services:

- Solihull Medical Assessment Unit (MAU)
- A&E
- Solihull Walk In Centre
- BaDGER (GP Out of Hours service)

It compares these figures to Solihull demographics known from the 2011 Census. It is important to note that patients from outside Solihull also access these services. All figures shown for usage of these services are for *all patients* using the service. This means that care is needed when comparing to the Solihull population. However, data analysis has shown that there are only a few minor differences between the profiles of patients using these services who are registered in Solihull and those using these services who are registered outside Solihull.

## Data Availability

2.2 A summary of data was obtained from the Heart of England Foundation Trust relating to MAU and A&E. This covered admissions to MAU and attendances at A&E (Minor Injuries Unit) between 1st April 2012 and 31st March 2013 – a full financial year. Data of particular relevance for this assessment was the age, gender, and ethnicity profiles which were available for both services. Unfortunately, no other data relating to protected characteristics was available because the provider does not have systems in place to collect it.

2.3 A summary of data was obtained from the Badger (GP Out of Hours service) relating to patient attendances at their Solihull site between 1st April 2012 and 31st March 2013. Data of particular relevance for this assessment was limited, unfortunately, to the age profile only. Gender is captured by Badger but was not part of the data extract obtained by the CCG. No other data relating to protected characteristics was captured. It should be noted that Badger currently has plans to start capturing ethnicity information from patients in the future.

2.4 A summary of data was obtained from the Solihull Walk In Centre. This covered attendances at the centre between 1st February 2012 and 31st January 2013 including age/gender and high level race profile.

## Age

### Table 1 – Service use by age April 2011-March 2012

| Age Band | Solihull Population | MAU | A&E | Solihull Walk in Centre | Badger |
|---|---|---|---|---|---|
| 0-15 | 18% | 0% | 21% | 21% | 36% |
| 16-64 | 63% | 48% | 66% | 64% | 53% |
| 65-84 | 17% | 35% | 11% | 13% | 9% |
| 85+ | 3% | 16% | 2% | 2% | 1% |

2.5 Solihull hospital does not offer a secondary care paediatric service. The data used for the MAU and A&E age breakdowns is from Apr 2011 – Mar 2012 to enable the same age bands to be used as with the Walk in Centre and Badger data.

2.6 These figures suggest that a large number of children are seen by the Badger Out of Hours service, and a significant number of people aged over 65 (51%) are seen in MAU. Further exploration is required (for example using comparative analysis with similar services in other CCG areas) to see if these figures are disproportionately high. A&E attendances are significantly lower by over 65s (13% compared to 20% population) as are Walk-in-Centre attendances (15% compared to 20% population).

## Sex

### Table 2 – Service use by Sex April 2012 – March 2013

| Sex | Solihull Population | MAU | A&E | Solihull Walk in Centre | Badger |
|---|---|---|---|---|---|
| Male | 49% | 44% | 53% | 42% | n/a |
| Female | 51% | 56% | 47% | 58% | n/a |

2.7 The Walk In Centre and MAU see more women, proportionately, than are present in the Solihull population. Significantly more men are seen in A&E. Comparisons with similar services will help to establish whether this is a typical (or an atypical) baseline position.

## Race (ethnic origin)

### Table 3 – Service use by Race April 2012-March 2013

| Race | Solihull Population | MAU | A&E | Solihull Walk in Centre | Badger |
|---|---|---|---|---|---|
| White | 86% | 85% | 77% | 89% | n/a |
| Asian / Asian British | 7% | 8% | 15% | 8% | n/a |
| Other Ethnic Groups | 1% | 5% | 5% | 1% | n/a |
| Black or Black British | 2% | 1% | 2% | 0% | n/a |

| | | | | | |
|---|---|---|---|---|---|
| Mixed | 2% | 1% | 2% | 1% | n/a |

2.8 The data available for race has, unfortunately, been aggregated to broad descriptors such as 'Asian/Asian British', but does not allow for more specific consideration of racial and cultural difference (for example the Census 2011 distinguished between white groups and between Indian, Pakistani, Bangladeshi etc). A specific recommendation is made by this report **[Recommendation 1]** to begin harmonising data collection for equality (including racial) groups, to match (as a minimum) the 2011 Census categories with flexibility to enable patients to self-define. This would allow for further exploration of some of the apparently high figures for A&E attendance by 'Asian/Asian British' groups and the 0% Walk in Centre use identified for 'Black/Black British groups'. It will also inform targeted engagement and outreach work with specific communities in order to better understand user expectations and perceived choices of urgent care services. No meaningful conclusion can be drawn from this information at this stage.

## Religion

## Table 4 – Service Use by Religion April 2012 – March 2013

| Religion | Solihull Population | MAU | A&E | Solihull Walk in Centre | Badger |
|---|---|---|---|---|---|
| Christian | 66% | n/a | n/a | n/a | n/a |
| No Religion or not stated | 28% | n/a | n/a | n/a | n/a |
| Muslim | 3% | n/a | n/a | n/a | n/a |
| Hindu | 2% | n/a | n/a | n/a | n/a |
| Sikh | 2% | n/a | n/a | n/a | n/a |

2.9 Religion is increasingly being recognised as an important signifier of customs and traditions which may have a bearing on health and prevalence of ill-health (for example dietary habits). It can also help, in consideration alongside data on race, to identify physical, cultural, or behavioural barriers to accessing health and social care services. There are sometimes concerns expressed about the work required to capture and analyse such information and whether or not it is proportionate. However, provider organisations are subject to the public sector equality duty and need to demonstrate that they are eliminating discrimination, and minimising disadvantage across all protected characteristic groups. This information can also usefully be compared to a provider's workforce data (for race and religion) to demonstrate if the composition of the workforce reflects the communities it serves? The absence of data here does not allow for any form of analysis.

## Protected Characteristics Data Summary

2.10 The following table shows each protected characteristic group and the information available from our extractions of data for each of the four services covered in this paper, and the Solihull population as a whole.

## Table 5 – Summary of Data for Protected Characteristic Groups

| Characteristic | Solihull Population | MAU | A&E | Solihull Walk in Centre | Badger* |
|---|---|---|---|---|---|
| Gender Reassignment | | | | | |
| Age | | | | | |
| Disability | | | | | |
| Race | | | | | |
| Sexual Orientation | | | | | |
| Gender | | | | | |
| Religion or Belief | | | | | |
| Pregnancy and Maternity | | | | | |
| Marriage and Civil Partnerships | | | | | |

| Key | |
|---|---|
| | Data not collected |
| | Partial collection |
| | Data Collected |

* Badger does not currently capture Race (ethnicity information) but plans to in the future. Badger does capture gender. It was simply not extracted during this project.

## Summary of usage data

2.11 Because of the significant gaps in data collected, it is difficult to draw any reliable conclusions about the use of Urgent Care facilities at the Solihull site, and in some cases, no analysis is possible. Establishing a baseline in line with our first aim has therefore not proved to be possible at this stage in the project. However it has been very useful to discover that there are data gaps. The CCG is advised to work with its provider organisations to improve on the routine collection of equality information, and to harmonise the collection methodologies so that comparative statistics are available. We understand that this will need to be proportionate, and may need to be accompanied by appropriate training for staff so that questions are asked confidently, with sensitivity to patients' circumstances (not when a person is in pain, discomfort or anxious about waiting to be seen), and with promotion among patients so that they can be reassured of the reasons why data is being collected, how it will be used, and the anonymous nature of aggregated data.

## 3. Equality Impact of the case for change

3.1 In the absence of useful data about service use, consideration is given at this early stage to the scope of the case for change as guided by the initial drivers articulated by the Health and Wellbeing Board (set out in the case for change document - Solihull CCG, July 2013).

3.2 The following discussion of impact refers to the case for the Solihull site only.

### General Points

### Assumptions in our analysis

3.3 We have assumed:

i. That any reconfiguration of the facilities at the Solihull site will still utilise the same local area and any re-siting of provision will be proximate. In this regard there are no issues arising from re-location and so current transport connections to reach the site will persist.

ii. The drivers for change emphasise the intention to enhance services and improve efficiencies by reducing unnecessary duplication, and offering clinicians and patients alike greater clarity along the treatment pathway. No planned diminution of service has been identified.

iii. A programme of further stakeholder engagement and stakeholder consultation will take place to elicit the views of people, their experiences, and to identify improvements which can be built in to the design and planning of new facilities.

### Anticipated benefits

3.4 All protected characteristic groups are anticipated to either benefit from the proposed case for change, or at least not to experience any deterioration from the current standards of service. The summary table below includes a column which looks at opportunities and mitigating risks. These comments cover both the outline case for change, but also anticipate the potential for the CCG as commissioner, and for prospective providers, to plan ahead. Some of the seldom heard groups can then be better engaged - as part of the urgent care review process - in order to improve the patient experiences of protected characteristic groups.

### Future Work

3.5 Further work is required so that:

- Data collection of service use needs to be improved across all providers.
- Opportunities to consult across the protected characteristic groups should be built in to proposed engagement and consultation as this project, and the urgent care review generally progresses.

| Protected Group | Potential Impact | Opportunity/Risk mitigation |
|---|---|---|
| **Age** | There is a relatively higher proportion of older people in the Borough, with 18.8% of the population aged 65 and over compared with 16.5% in England and 17.2% in the West Midlands. This is estimated to be 22% by 2021 representing a significant challenge to health and social care services.<br>Research nationally suggests that despite the high mortality rate due to accidents involving older people, this is not reflected in a higher rate of attendance at A&E (also suggested by usage figures in section 2 above).<br><br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the consideration of options stage.** | Opportunity to consider accessibility to specific facilities as they are developed for older people; for parents with young children; and to consult. NHS 111 pilots' usage data indicates high use of the service for patients aged 0 to 4, and those over 80 when compared to the average use (DH 2012; p18). This is a potential beneficial use of technology as part of the overall integration of services. However please note that Older people also appear to be reluctant to use the telephone to access out-of-hours care(DH 2012; p20). |
| **Sex** | **No negative differential impact identified** | **No specific issues identified** |
| **Disability** | The coherent integration of pathways across health and social care is a recurring concern nationally for patients with a disability and for carers.<br>Physical access to facilities and the availability of suitable equipment to meet the specific needs of people with different disabilities (particularly when emergency treatment is required) also figures prominently.<br><br>Concerns have been expressed nationally regarding reconfigurations of urgent and emergency centres about mental health emergency care and the joint working between services not receiving adequate attention.<br><br>Local health providers in Solihull have indicated that access to mental health services in an emergency is problematic and needs to be addressed.<br><br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the consideration of options stage, and specific consideration given to pathways for people with a Learning Disability and people with a mental health problem.** | Opportunity to consult people with disabilities,(including mental health problems) – both directly and through representative organisations - as part of review; to consider accessibility improvements for people who have mobility problems, and/or who use mobility aids; for visually impaired people (colour schemes, &signage); Hearing impaired people and communication options; consideration of the appropriate reception and treatment for patients with a learning disability who arrive at an urgent care facility and whether staff are trained and able to discern the person's needs.? Work undertaken in Lincolnshire in 2011 demonstrated that people with learning disabilities, although a small percentage of the population (0.3%), accounted for 6% of the Accident and Emergency budget. Over the next 20 years we will see a doubling in the number of people with learning disabilities. (ADASS 2013; p6) |
| **Protected Group** | **Potential Impact** | **Opportunity/Risk mitigation** |
| **Race** | Solihull's Black and Asian Minority Ethnic (BAME) population has more than doubled since the 2001 Census and now represents nearly 11% of the total population. Generally the greatest proportion of BAME residents live in the Urban West of the borough and in | Opportunities to consult different ethnic groups as part of the urgent care review – both in 'mainstream' consultation events and outreach work. Review to consider if appropriate interpreting |

| | | |
|---|---|---|
| | the 3 North regeneration wards. Nationally, the Afiya Trust suggests that "many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities". (Afiya Trust 2010)<br><br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the consideration of options stage.** | facilities available for patients whose first language is not English. Commissioner's service specifications and procurement process may wish to highlight public sector equality duty and set contractual information requirements on providers to demonstrate how they comply with statutory provisions. Provider opportunities to consider workforce development and talent management, recruitment and promotion of equal opportunity policies. |
| **Religion/Belief** | Significant increase in Muslim, Hindu and Sikh populations since 2001 – doubling in size – although overall populations are relatively small compared to neighbouring authorities in Birmingham. The majority of Solihull Muslims and Hindus live in the Urban West of the Borough and therefore are local to the Solihull site. Sikh communities are more dispersed across the Borough.<br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the consideration of options stage** | Opportunity for providers to consider workforce composition and planning as local populations change and to consider the cultural sensitivity of services provided. |
| **Sexual Orientation** | Although no specific issues have been identified with the case for change in Solihull; Issues have been identified nationally with same sex partners not having easy access to loved ones in emergency/urgent circumstances, or not being included in consultations in the same way that heterosexual couples/married partners would.<br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the consideration of options stage** | Opportunity to gather further evidence from LGBT groups locally/regionally to see if anecdotal reports of poor experiences can be addressed. |
| **Protected Group** | **Potential Impact** | **Opportunity/Risk mitigation** |
| **Gender reassignment** | No specific issues with case for change but anecdotal issues raised nationally with trans groups around courtesy of treatment, respect and dignity issues for a person's preferred identity.<br><br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the consideration of options stage** | There are concerns in trans communities about recording gender reassignment status and the potential for identifying people where postcode information is also identified. Opportunity to engage further and for Providers to review policies for reception and treatment for patients and carers; and training for staff. |
| **Pregnancy and Maternity** | **No negative differential impact identified** | Access and mobility issues should be considered for visitors and ability for mothers to breastfeed; for parents to change babies as part of Providers' consideration of service use. |
| **Marriage/Civil Partnership** | No specific issues with case for change. Issues have been identified nationally with same sex partners not | Further evidence potential as part of consultation to supplement anecdotal |

| | | |
|---|---|---|
| | having easy access to loved ones in emergency/urgent circumstances, or being included in consultations in the same way that heterosexual couples/married partners would<br>**No negative differential impact identified** | information. |

## Groups not protected by statute

3.6 There are some key groups which are not covered by the Equality Act but are vulnerable, often marginalised, and have a significant impact on health services.

## Homeless people

3.7 Solihull Council has identified an increase in homeless presentations from 431 in 2007/2008 to 492 in 2011/2012 (14% increase) which they identify as being influenced by the decline in the economy since 2008 (Solihull MBC; 2012).

3.8 The Health Profile for Solihull (Public Health England, 2012) states that for health indicator 3 – Statutory Homelessness –Solihull is significantly worse than the England average (3.7 people per 1000 compared to the England average of 2 per 1000).

3.9 Homeless people attend A&E up to six times as often as the general population; are admitted four times as often and once admitted, tend to stay three times as long in hospital as they are invariably much sicker. As a result, acute services are four times, and unscheduled hospital costs are eight times those of general patients. Nearly 90% of all 'NFA – No Fixed Abode' admissions are emergency admissions compared to around 40% for the general population. (Deloitte Centre; p5)

**3.10 Because of the trend in homelessness in Solihull and the disproportionate impact of homelessness on the costs of health provision – particularly skewed towards urgent and emergency care - the review of urgent care should involve social housing providers and homelessness organisations as part of an integrated approach, and further work to identify any geographical disparities in the location of homelessness people; to research the health experiences of homeless people; and to explore the potential for more effective and earlier interventions to prevent or reduce ill-health and to respond more appropriately to their healthcare needs.**

## Travelling Communities

3.11 The Equality and Human rights Commission have stated:

> **"There is evidence that groups about whom very little research has been conducted, notably Gypsies and Travellers, asylum seekers and refugees, have particularly low levels of health and wellbeing. Those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, have difficulty in accessing services and their needs are often different and unknown."**
>
> (EHRC 2010)

3.12 70 Gypsy or Irish Travellers are living in Solihull Borough - a new population group introduced for the 2011 Census (Solihull MBC 2013). Trend information in this group is not available and so we have no prior baseline from which to assess the impact on this group. It would be useful, as part of the urgent care review, to explore ways to better understand the health needs of the Solihull based travelling

communities and how they access healthcare. However, any such work and the resource commitment will need to be proportionate. Anecdotal information about healthcare demands may offer an appropriate starting point.

## Migrants (including refugees and asylum seekers)

3.13 Data for Solihull is not robust and complicated by local flows of people between local authority areas, particularly bordering Birmingham. Information collated by the West Midlands Strategic Migration Partnership (2011) indicated that there is a high correlation between 'Flag 4' GP registrations (where a person registering with a GP whose previous address is outside the UK is flagged (and a different flag is given to a returning migrant where this is known)); and NI No. (National Insurance Number registrations – the number of new NI Nos. granted to workers from outside UK is an indicator of migrant flow). This estimated the number of migrants to be between 2 and 3 per 1000 of population. Although the planned changes for urgent care are unlikely to negatively impact on migrants, the urgent care review offers an opportunity to engage with support workers (eg Entraide (Mutual Aid – a Lottery funded charity based in Chelmsley Wood which supports asylum seekers, refugees, and migrants living in and nearby Solihull) to discover the experiences of migrants in Solihull and whether access to primary care has any impact on the demand for urgent care.

## Deprivation and Usage

3.14 It is a reasonable working hypothesis to conclude, in the context of the Marmot described *'causes of the causes'* that the indicators of socio-economic deprivation are likely to have a differentially negative impact on ill health for people living in the North of the Borough and that this may lead to potentially greater demands on health services generally, including urgent care services. The trend in deprivation (as evidenced by IMD figures) shows that indicators for health, income and employment are all downward.

3.15 The Public Health Observatory (PHO) creates a "deprivation score" for each GP practice from 1-10 with 1 being the most deprived and 10 being the least deprived. Using this methodology, the arrangement of Practices in Solihull is:

## Table 6 – GP Practices groups by Public Health Observatory deprivation 'score'

| Score | GP Practices |
|---|---|
| 1 | Arran, Bosworth, Craig Croft |
| 2 | Green Lane, Kingshurst (no longer exists) |
| 3 | Church Road, Chester Road, The Castle |
| 4 | |
| 5 | Grafton Road, Manor House Lane, Parkfield |
| 6 | |
| 7 | Hobs Moat, Meadowside, Northbrook, Richmond, Coventry Road |
| 8 | Solihull Walk in Centre |
| 9 | Haslucks, Park, St. Margarets, Yew Tree |
| 10 | Arden, Balsall Common, Bernays, Blossomfield, Blythe, Dorridge, Hampton, Jacey, Monkspath, Tanworth Lane, Village |

The location of these practices can be seen in Map 1 on the following page:

## Map 1 - Location of Solihull GP Practices (2012)


3.16 By using "registered GP practice" structured using the PHO classification as a surrogate for deprivation level, and combining with the usage data discussed in **section 2** we can populate the table on the following page to consider geographically located deprivation against usage.

## Table 7 – Service Use by PHO Deprivation Score

| Deprivation | Solihull Population | MAU* | A&E | Solihull Walk in Centre | Badger** |
|---|---|---|---|---|---|
| 1 | 10% | 5% | 6% | 7% | 3% |
| 2 | 6% | 2% | 3% | 2% | 0% |
| 3 | 11% | 5% | 6% | 6% | 0% |
| 4 | 0% | 0% | 0% | 0% | 0% |
| 5 | 7% | 4% | 5% | 4% | 1% |
| 6 | 0% | 0% | 0% | 0% | 0% |
| 7 | 16% | 22% | 22% | 16% | 25% |
| 8 | 1% | 1% | 1% | 28% | 1% |
| 9 | 12% | 15% | 16% | 10% | 17% |
| 10 | 37% | 47% | 41% | 28% | 53% |

***** Note MAU in the above table should read ***"all inpatient non-elective admissions"*** as this is the data we have used here. MAU is a large percentage of these admissions however.

** Note we are missing Badger data in this table for the North Solihull practices which could affect these figures. However, given the location of the Badger site it may be that patients from North wards would use another Out of Hours serviced for out of hours care.

3.17 Solihull hospital (and its co-located facilities) is located in the South of Solihull. The North based GP practices are located closer to Heartlands hospital, which offers more services in total than Solihull. The figures therefore show for these facilities, as expected, disproportionately less use by people in the North of the Borough. Approximately two thirds of activity on the Solihull site comes from Solihull registered patients. The deprivation percentages shown relate to Solihull registered patients only. When looking at the patients from outside Solihull there are a lot of practices to consider and we have not been able to determine the deprivation levels for these.

## 4. Recommendations and Key messages

1. **The CCG works with strategic partners to pursue the opportunities and risk mitigating actions highlighted in the report in paragraphs 3.5-3.13.**

2. The data available on services for protected characteristics groups and for other service users is poor. Consequently the conclusions in this analysis necessarily carry caveats because of gaps in data. Data collection on all protected characteristic groups needs to be improved by provider organisations who themselves are subject to the public sector equality duty and require such information to demonstrate statutory compliance. **A specific recommendation is to begin harmonising data collection categories for equality groups to match the 2011 Census categories with flexibility to enable patients to self-define where this is possible. This would allow for further exploration, for example, of some of the apparently high figures for A&E attendance by different groups and inform targeted engagement and outreach work with specific communities in order to better understand user expectations and perceived choices of urgent care services. No meaningful conclusions can be drawn from this information at this stage.**

3. Information is inconsistent across provider organisations even in the limited circumstances where it is collected (for age, sex and race (ethnicity)). This makes comparisons between providers, or efforts to determine an aggregated picture problematic. **The CCG is recommended to work with its provider organisations to improve on the routine collection of equality information, and to harmonise the collection methodologies between providers so that comparative statistics are available**. We understand that this will need to be proportionate, and may need to be accompanied by appropriate training for staff so that questions are asked confidently, with sensitivity to patients' circumstances (not when a person is in pain, discomfort or anxious about waiting to be seen), and with promotion to patients so that they can be reassured of the reasons why data is being collected. There is a persistently high percentage of 'not stated' in equality monitoring which suggests that work is needed to explain to respondents how it will be used, and the anonymous nature of aggregated data.

4. More detailed consideration of urgent care services ***operationally*** can be made by **ensuring that equality considerations are built into pre-qualification questionnaires (PQQs), service specifications and by requiring providers to conduct further equality analyses on their service operations**. Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services, with regular (quarterly) reports submitted to the commissioner which are required to demonstrate statutory compliance with s.149 of the Equality Act 2010. All NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with s149 (the Public Sector Equality Duty), and this requirement is included within the standard form of NHS Contract.

5. **Further exploration is required (for example using comparative analysis with similar services in other CCG areas) to see if the service-use figures offer an appropriate baseline and to identify numbers which may be disproportionately high or low.** For example, the Walk In Centre and MAU see more women, proportionately, than are present in the Solihull population. More men are seen in A&E. Comparisons with similar services in other areas will help to establish whether this is an expected or atypical baseline position.

6. **Opportunities to consult across the protected characteristic groups should be built in to proposed engagement and consultation as this project, and the urgent care review generally, progresses**. This

could be supplemented by an Urgent Care survey of 3rd sector representative organisations/umbrella groups working with people from Protected Characteristic groups.

7. Because of the upward trend in homelessness in Solihull and the disproportionate impact of homelessness on the costs of health provision, **the review of urgent care should involve social housing providers and homelessness organisations as part of an integrated approach.** Further work is required to identify any geographical disparities in the location of homeless people and their needs; to research the health experiences of homeless people; and to explore the potential to more effectively prevent or reduce ill-health and to respond more appropriately to their healthcare needs.

8. There are significant areas of public housing in North Solihull and therefore important opportunities to **engage through partnerships with social housing organisations – eg Local Authority/Housing Associations; and with Tenants' and Residents' Associations or 'Federations of TRAs' – this offers a cost effective route to capture views and concerns.**

## Conclusion

The concerns of the Marmot review was with the 'social determinants' of ill-health or the 'causes of the causes' of health inequalities – those fundamental social and economic conditions which have been shown to have an impact on how healthy a person will be during the course of their life. This includes the conditions in which people are born, grow, live, work and age. It includes an individual's education and employment opportunities in life and their earning potential; it can include belonging to a minority group or being socially excluded from mainstream society. Inequalities in the social determinants of health act as barriers to addressing health disparities. The recommendations in this analysis, coupled with the suggested actions to take advantage of opportunities and to mitigate risks (paragraphs 3.5 - 3.13), will help to ensure that disadvantages experienced by some vulnerable groups in accessing urgent and emergency care can be minimised, and that the statutory duty to ensure 'due regard' to protected characteristic groups is honoured.

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