NHS Dorset

NHS Dorset
Commissioning Proposal

1. TITLE OF PROPOSAL

Weymouth Integrated Assessment and Treatment Service Project – Weymouth Urgent Care Centre

2. EXECUTIVE SUMMARY

There are currently three different community services, separately contracted, based at Weymouth Community Hospital (WCH);

- The GP led Walk In Centre (WIC) – provided by The Practice PLC
- Minor Injuries Unit (MIU) – provided by Dorset HealthCare University NHS Foundation Trust
- Out of Hours (OOH) Service – provided by South Western Ambulance NHS Trust (SWAST)

These services respond to and treat patients, who walk in or are triaged from 111, with a varying range of primary care needs, minor alignments, minor injuries and urgent care needs. The current services create duplication and ineffective use of local NHS resources.

Tied into the current contract for the WIC, and operating from the same building, there is a GP practice with relatively small registered patient list (approx. 450 patients) accepting patients with relatively difficult and chaotic lifestyles or with addictions. In addition the practice hosts the Violent Patients/Zero Tolerance Scheme. Within Dorset, no similar arrangement exists.

This proposal describes bringing together and integrating the WIC, MIU and OOH to become one Urgent Care Centre (or service). The Urgent Care Centre (or service) will offer assessment and treatment that will meet the needs of the local population in Weymouth, surrounding population of Mid and West Dorset and visitors to the area. This service model informs the Clinical Service Review (CSR); through efficient and effective ways of working this model promotes a sustainable healthcare solution for the local health economy.

The Urgent Care Centre (or service) will provide quick medical advice, diagnosis and/or treatment for less serious illnesses and injuries which require immediate care but which do not require the full services of an Accident and Emergency (A&E) Department. The service will have single point of access, a strong focus on triage and assessment on patients presenting, patient education and self-management. The service will be responsible for reducing A&E attendances, working alongside the local A&E department and other local services to promote appropriate and best use of local services.

If this proposal is approved, the future option for the Registered Patient List and Violent Patients/Zero Tolerance Scheme will be led by NHS England, Wessex Area Team, working in partnership with the CCG to progress. Direction and oversight will be provided from the Primary Care Committee.

The work undertaken has presented a further opportunity to consider the future service model for the provision of Portland MIU to ensure a sustainable, effective and quality service to meet the needs of the Portland population. Working alongside CSR and the Urgent and Emergency Care programme these opportunities will be explored.

3. CONTACT DETAILS	
Name, address and role of lead contact:	Hannah Nettle – Principal Programme Lead Luna Hill - Principal Locality Lead
Telephone:	01305 213 519
Email of Lead Contact:	Janny.Campbell@dorsetccg.nhs.uk
Email mailing list for all to be included in circulation:	

4. BACKGROUND AND STRATEGIC ONTEXT	10

Provide a brief overview of the reasons for the proposal and how the proposal was initiated. Set out how the proposal fits with strategic objectives of the service and the CCG, and whether it links to national requirements or targets.

Under national direction by the Department of Health and 'equitable access scheme'; PCTs were mandated to commission GP-led health centres– commonly referred to as "Darzi centres" – between 2008 and 2010 and these reflected three major health care policy goals:

1. Improving access to primary care
2. Modernising the NHS to make it more responsive to patients' lifestyles
3. Offering more choice to patients.

Dorset PCT commissioned the GP-led Walk In Centre in Weymouth as a priority over other areas of Dorset, due to well publicised Public Health data of overall demographics of deprivation and greatest associated health needs. Weymouth has well recognised health issues linked to homelessness and substance misuse.

The contract for the Walk In Centre was due to expire in June 2014. The Clinical Commissioning Committee in November 2013 supported a contract extension creating the opportunity to see if the GP Walk In Centre, MIU and OOH services, all sited in the same building (Weymouth Community Hospital) could work better together.

The proposal for an integrated urgent care centre was initiated due to some of the known issues of inefficient use and duplication of NHS resources of the currently commissioned services. This list in not exhaustive but to name a few examples; lack of service integration leading to services having separate receptions desks that are sited next to each other, each having separate IT systems, duplication of workforce and no single point of access for patients that can cause confusion.

By identifying the current issues and problems with the current services, the following objectives were agreed to support improvement and development of the current services:

- Integrated working between existing services (MIU/OOH/WIC) based at Weymouth Community Hospital to improve healthcare for those who live in and visit south Dorset

• Focus of meeting the needs of vulnerable, homeless and disadvantaged • Helping the patient see the right professional at the right time • Using resources efficiently to the benefit of local community and visitors • Ensure best communication between all those involved in an episode of care • Achieve the new service by 2016 at the latest This proposal meets overall CCG priorities to support urgent care and support systems resilience by: • Ensuring appropriate use of the services • Reducing A&E attendances by working collaboratively with A&E department, GP locality practices and other community based services. • Providing a sustainable model, demonstrating value for money. • Realising benefits through efficient and effective use resources. The proposal supports and enhances the following national requirements and direction of travel: • The NHS Five Year Forward View published by NHS England on the 23rd October 2014 has informed the need for integrated urgent care service to be provided from the Weymouth Community Hospital. • Transforming urgent and emergency care services in England, published by NHS on the 13th November 2013 • Walk This Way: Estimating Impacts of Walk In Centres at Hospital Emergency Departments in the English National Health Service, Ted Pinchbeck (SERC and London School of Economics) December 2014 • Supports and fits and with the Clinical Services Review emerging models of care, delivering quality, safe and sustainable services.	

1.0 National Priorities	Tick as appropriate
1.1 Cleaniness and healthcare associated infections	✓
1.2 Access to personalised and effective care	✓
1.3 Improving health and reducing health inequalities	✓
1.4 Reputation, satisfaction and confidence in the NHS	✓
1.5 Financial balance	✓
2.0 Strategic principles CCG 2014-19	
2.1 services designed around people;	✓
2.2 preventing ill health and reducing inequalities;	✓
2.3 sustainable healthcare services;	✓
2.4 care closer to home.	✓
3.0 Ambition CCG 2014-19	✓
3.1 integrated health and social care services designed around the individual;	✓
3.2 financially and clinically sustainable services delivered in an innovative way	✓
3.3 focus on services not institutions	✓

4.0 Transformational Change Programmes CCG 2014-19	
4.1 Better Together Programme and Better Care Fund;	
4.2 Clinical Services Review;	✓
4.3 Urgent Care Review	✓
4. Relevant NSF Targets & NICE guidance (specify):	
5. Other	

5. CURRENT SERVICE PROVISION

What is provided, where, how and to whom?
Historical activity data should be included if available.

The GP Led Walk In Centre is provided by The Practice PLC, the Minor Injuries Unit is provided by Dorset University Healthcare NHS Foundation Trust and the Out of Hours Service provided by South West Ambulance Service Trust. The three services are all provided from the Weymouth Community Centre, and are sited next to each other, sharing the same front reception desk.

Services Delivered:

GP Walk In Centre
Hours of operation: 8.00 to 20.00 7 days a week
Number of patients seen: circa 25,000 attendances per annum

Provides appropriate ongoing treatment and care to all Registered Patients or Non Registered Patients, taking account of their specific needs including:

- Advice in connection with the Patient's health, including relevant health promotion advice
- Primary care follow-up including post-operative dressings and suture removals
- For other services, using the Choose and Book system wherever this is appropriate, and including booking and organisation of ambulance transport as required
- primary medical care services required in extended hours over the full week (i.e. 8am to 8pm 7 days per week, 365 days per year) for immediately necessary treatment of any person to whom the Provider has been requested to provide treatment owing to an accident or emergency at any place in the Health Centre Area
- DVT clinic (run by the practice but receiving referrals from the locality and walk in centre)
- Chlamydia screening

Registered Patient List – The Practice

Minor Injuries Unit
Hours of operation: 8.00 to 22.00 7 days a week
Number of patients seen: Circa 14,000 attendances per annum.

- Minor Injury Staff provide assessment, examination, care and management of patients who attend with an urgent/emergency care need without appointment. Evidence based care is provided to patients who attend with minor injury and ailment needs. Onward referral is made where necessary to associated specialist in primary and secondary care.
- Minor Injury Staff promote health and social wellbeing for patients who walk in without appointment, providing practical help and advice to the particularly in relation to smoking

cessation, sexual health and accident prevention across all ages.

- This service is provided across all ages across Dorset CCG.
- Temporary residents who present are assessed and treated within the unit.
- X ray facilities vary across community hospitals but when open are available for MIU patients (at WCH site: Monday –Friday 9-5pm; Portland site 3 days a week 9-5pm). Provided through a Service Level Agreement with Dorset County Hospital.

Weymouth Out of Hours service

Hours of operation: 18.30 to 23.00 (at WCH) from 23.00 OOH switches to West Dorset GP on call, based at Dorchester, until 08.00 7 days a week, including bank holidays.
Number of patients seen: circa 4,000 contact per annum + 2,000 telephone calls/advice

In an emergency when the GP surgeries are closed patients can contact the OOH service on 111. Other than in an emergency, patients are advised to use this service before attending the A&E department at the hospital.

Calls to the service are received by trained operators who decide on an initial course of action. This can include such things as suggesting the nearest treatment centre (Weymouth Community Hospital in this case), arranging a district or twilight nurse visit or for any call such as chest pains or difficulty breathing to be redirected to the 999 ambulance service.

Other calls are passed to triaging doctors who can request home visits from either GPs or Emergency Care Practitioners. Triage is the term used to allocate the appropriate response to your healthcare concern.

Home visits are prioritised as follows:

- Emergency home visits within one hour
- Urgent home visits within two hours
- Routine home visits within four to six hours

6. CASE FOR CHANGE/NEED	**6**
What problem/issue is this proposal trying to address? *Include, where relevant:* • *the epidemiology of the condition(s) addressed by the proposal – incidence, prevalence.* • *the reasons for the proposed changes – findings of needs analysis, benchmarking against national/local standards.* **1. The need for Urgent Care Centre in Weymouth** 1.1 Weymouth and Portland locality needs: Weymouth and Portland is a relatively small locality but has a high population of just over 70,000. Weymouth's population will expand by approximately 10% in the next 15 years, with the largest housing growth around Chickerell, and further development planned in Chickerell and Littlemoor. The planned housing development in the locality is approximately 3,500 units in the next 15 years. The Public Health Profile 2013 still identifies the following issues which are worse than the England average in Weymouth and Portland locality:	

- Deprivation
- Teenage pregnancy rates
- GCSE attainment
- Drug misuse
- Hospital stays for self-harm
- Sexually transmitted infections

Violent crime, binge drinking and smoking rates continue to be an issue. In year 6, 17.9% of children are classified as obese.

Life expectancy is 11.3 years lower for men in the most deprived areas of Weymouth and Portland than in the least deprived areas

The locality is largely urban and has a higher proportion of older people compared to the national average. The locality is one of the most deprived in Dorset with ten areas within the 20% most deprived in England. An analysis of health and the wider determinants which highlight poor outcomes for housing with no central heating, provision of informal care, general reported health (including limiting long-term illness), incidence of colorectal cancer, hospital stays for self-harm, emergency hospital admissions for coronary heart disease and heart attacks, elective admissions for hip and knee replacements and deaths from all causes for those under 65 years old.

1.2 Supporting urgent and emergency care system resilience:

There is local need for such a model to support the system resilience for urgent and emergency care. With mounting A&E attendances, it is proposed urgent care centres can support efforts to reduce the burden and pressure on A&E departments. This is further supported by Dr Ted Pinchbeck findings in December 2014 'Walk This Way: Estimating Impacts of Walk In Centres at Hospital Emergency Departments in the English National Health Service, (SERC and London School of Economics)' results indicate that Walk In Centres have significantly reduced attendances at hospital Emergency Departments in places close by, but suggest that only between 10-20% of patients seen at hospital-based Walk In Centres and between 5-10% patients seen at other Walk In Centres were diverted from the more costly high acute facilities at hospitals.

From Weymouth and Portland locality 92.3% of all A&E attendances go to Dorset County Hospital (DCH). From mid Dorset 93% and West Dorset 82% of the locality A&E attendance go to DCH.

It is also known that currently that DCH A&E receive approximately 408 patients per quarter from Weymouth and 5936 (per quarter) from other sources other than from a GP (all those with W&P postcode).

DCH A&E attendances are also higher after 17.00. The proposed model will look to work closely alongside DCH A&E workforce to divert patients into other appropriate services. It will also strengthen the skills and expertise of staff at the Urgent Care Centre to ensure appropriate referrals are made to the A&E department.

1.3 Problems identified with the current services; Walk In Centre, Minor Injuries Unit, and Out of Hours services

Inefficient use / duplication of NHS resources, these problems have been supported from

stakeholder feedback:

- Three separate reception areas for GP led Walk In Centre, Minor Injuries Unit, and Out of Hours service – leading to confusion and some duplication of staff and resources.
- Three separate IT systems for GP led Walk In Centre, Minor Injuries Unit, and OOH. IT that is not integrated and can create multiple transfers of information for the same patient. There are Information & clinical governance issues linked to this.
- No single access point for patients; further adding to the confusion of knowing what service is the appropriate service to access during urgent or emergency episode.
- Services are not integrated; prevents staff working together, utilising skills and expertise across services, creates issues with continuity of care
- Separate governance structures and policies

1.4 Evidence and data intelligence supporting inefficient use of service of NHS resources:

Whilst the GP led Walk In Centre is well utilised and sees 24,000 patients a year (approx. 4.6- 6.8 per hour), 65% of patient attendances at the GP led walk in centre are from local GP practices. Nearly half of all attendances (45%) of patients attended for coughs, colds, sore throats, tonsils, medication issues (This is misuse of medication, failed to pick up prescriptions or the chemist not having prescription available). By improving the triage process, signposting and increasing patient education many patients could self-manage their conditions, and can make use of local pharmacy to support self-management. Local alignment schemes can support those most in need with access to free medication. This can then free up time of clinicians to support those with an urgent care need.

We also know that activity mainly drops off from 16.00-20.00 in both the Minor Injuries Unit and Walk In Centre, which is the busiest time for A&E attendances. Children (0-9 year olds) and older people are high users of the Walk In Centre and OOH services combined.

The MIU could be further utilised, the service sees 14,000 patients a year (2-3.5 patients per hour). Mondays are the busiest day of the week; activity often drops at the weekend. 25% of attendances for MIU are for dressings and wound care, including leg ulcers.

The OOH service could also be further utilised, the service sees 4,000 patients a year. It is busier at weekends (sat 2.6 patients / sun 1 patient per hour) than weekday evenings (0.6 patients per hour).

7. PROPOSED OUTCOMES/SERVICE SPECIFICATION & PATHWAY	**9**
How will the proposal change what is currently in place? *What commissioning outcomes do you anticipate achieving with the proposal?* *Where appropriate, provide an outline of the service that you are planning to implement. Give a brief description of the care pathway. Estimate the number of patients expected to benefit from the service.* *Are there any other treatment options?* **Proposed Service Model** The proposed service model focuses on meeting the following objectives:	

- Integrated working between existing services (MIU/OOH/WIC) based at Weymouth Community Hospital to improve healthcare for those who live in and visit south Dorset
- Focus of meeting the needs of vulnerable, homeless and disadvantaged
- Helping the patient see the right professional at the right time
- Using resources efficiently to benefit the local community and visitors
- Ensure best communication between all those involved in an episode of care
- Achieve the new service by 2016 at the latest

The proposed service model is to deliver an effective Urgent Care Service based from Weymouth Community Hospital.

Through the tendering process bidders will be asked to consider alternative ways of delivering the OOH element of the service model. If alternative ways of delivering the OOH element are not put forward bidders will instead be ask to describe how they will work along the existing contracted SWAST OOH service. Ensuring integrated working so the service is still seen as one service to patients and other local services. The CCG would look at varying the OOH contract, specifically for Weymouth and Portland, to enable this different model of delivery.

Proposed Service Model

Current	**Proposed Model**	**Benefits**
Opening times: WIC: 08.00to 20.00 7 days a week MIU: 08.00 to 22.00 7 days a week OOH: 18.30 to 23.00 Mon to Fri, weekends 08.00 to 23.00	One service opening hours: 08.00 to 23.00, after 23.00 switching to Dorchester Out of Hours service 23.00 to 08.00.	- Improved access to higher skill mix 08.00-23.00 - Integrated working between existing services - Use resources efficiently to the benefit of local community and visitors
Separate services with separate receptions - can be confusing for patients and the local services	One service, a single reception	-User-friendly -Improve navigation so the patient sees the right professional first time -Use resources efficiently to the benefit of local community and visitors
Patients access the service by walk in or referral	No change	No change

WIC - GP led MIU -Nurse led OOH - GP led	When patients present to the service the triage assessment and advice will be supported by a senior clinician.	-Improve navigation so the patient sees the right professional first time for the need
Patient education and self-management of long term conditions	Greater focus on patient education to manage long term conditions as well as the use of other local health services.	-Patients feel empowered to manage their health own conditions -knowledge of what services can best support their health need.
Workforce: A range of skills and expertise across the three services. Local Workforce is well respected	One service bring existing workforce together to enhance skills and expertise.	-Use resources efficiently to the benefit of local community and visitors
Separate IT systems	IT system to be compatible with the GP locality IT system.	-Allows high quality, consistent communication between all of those involved in an episode of care
Partnership working already taking place with other local health services.	Strengthen and enhance partnership working with the A&E department in Dorchester, the locality GP practices, local pharmacy, mental health team and Community Alcohol and Drug Advisory Service and the sexual health services.	-Use resources efficiently -Further supports improve navigation so the patient sees the right professional first time for the need

With strong marketing, promotion and patient education this service should be seen to all (Patients and the local health economy) as a community based urgent treatment service. Currently there is lack of clarity for patients and the local health economy of the current service offer. Patients often seeing the services as an additional GP practice with immediate access or being used as a pharmacy.

In addition, this service model aims to:

- Provide quick and timely medical advice, diagnosis and/or treatment for less serious illnesses and injuries
- Provide Immediate care for patients not requiring full A&E services
- Signpost and provide patient education and self-management
- Enable appropriate use of existing local services, expected to see signposting to GP, pharmacy, existing health services where clinically appropriate.

This model also offers opportunities for interesting careers for staff, through broadening options for personal development. This model can further support attracting and sustaining the local workforce into to the future.

The procurement process would enable provider's opportunities for further innovation to build on the outline service model to achieve the desired objectives.

The proposed service outcome measures are outlined in section 9

8. EFFECTIVENESS OF PROPOSED SERVICE

1

Outline the clinical effectiveness of the proposed change/development. (The findings of relevant research should be summarised). What is the strength of evidence for the desired effect?

In line with the 5 year forward plan, we believe the proposed changes will support the desired system changes required to support urgent care for patients and further systems resilience.

As stated by NHS England (*Transforming urgent and emergency care services in England*, *November 2013) '*national figures indicate 40 per cent of patients who attend an A&E department are discharged requiring no treatment. Stating many of these individuals could have been helped just as well closer to home, for example at their own GP's surgery or a local GP run Urgent Care Centre, provided the services were accessible and convenient'. The proposed model would provide a service close to home and accessible to help patients with urgent care needs.

This model further support the following opportunities outlined by NHS England (*Transforming urgent and emergency care services in England*, *November 2013)* for meeting urgent care needs closer to home:

- 'When patients contact their GP's surgery with an urgent problem they receive a variable response, and may be directed elsewhere to other parts of the local healthcare system'. We are also aware of variable access issues to GP practices that further impact and cause patients to attend at the A&E department, as support by NHS England and local intelligence. This model can offer access to primary care without considerably increasing the overall workload of other busy and pressured services within the local healthcare system, such as the local GP practices and A&E. However, achieving outcomes initially will be challenging and will require support from the wider health community to support a shift in culture and pattern of the local population accessing services.

- This model also aspires to work closer with community pharmacies that are an underutilised resource. Local pharmacy offers convenience to patients as well as the skills and expertise to advise on minor illness, medication queries and other problems. This proposed model lends itself to benefit from further utilising the local pharmacy offer, workforce skills and expertise available.

- This model will also support better patient navigation around the system, helping the patients to be seen in the right place by the right professional at the right time, and reduce the occasions where conflicting information and advice. This model can further support the NHS 111 in delivering a fast and effective service for patients.

- 'Where patients are informed, empowered and supported they are effective at self-managing conditions'. Particularly for individual living with a long-term condition, such as diabetes or asthma. This service will promote and support education of self-care by providing accessible and reliable advice and information to help people take responsibility for their own health. The service will also work with the community and voluntary sector

for access to support services and advice.

- This model and Urgent Care Centre (or service) aims to improving integration with DCH. This model aims to create a network of care whereby the interface between DCH and the urgent care centre allows information and expertise to be exchanged. Thus enable the Urgent Care Centre (or service) and patients to obtain specialist advice or directly access to secondary care clinics or similar services when required. 'This approach has been shown to improve health outcomes and patient satisfaction'. This supports care to be provided closer to home, reduced A&E attendances and admission avoidance.

9. OPTION DEVELOPMENT

4 / 5

Describe the potential benefits to the individual. Consider: access/convenience, patient experience, improved outcomes, efficiency, patient safety, value for money etc.
Describe the benefits to society e.g. addresses inequalities

In developing this proposal, a wide range of options have been explored. These include high option development (see appendix 1) considering the level of integration, the service model, the service coverage, the location and opening hours.

The shortlisted options recommends that the service model should be delivered differently, service coverage should complement other local services and opening hours should be staffed according based on demand These recommendations met both the project objectives and the critical success factors.

Weymouth Community Hospital was shortlisted as the preferred location. It was agreed that the services should be integrated for benefits of a single brand, access and utilising skills and expertise of the current workforce. The form of integration considered contractual options for future.

Following this process and after careful consideration, two options were taken forward to detailed economic appraisal, alongside a 'do minimum' benchmark ('Option A'). These options were:

Options to take forward

		Model	Integration	Location	Service coverage	Hours
A	Do minimum	Current	As now	WCH	Current	Current
B	Shortlist	Do differently	Single 'triage' and IT, single 'brand'	WCH	To complement other services	24/7 staffed accordingly based on demand
C	Shortlist	Do differently	Single structure	WCH	To complement other services	24/7 staffed accordingly based on demand

Option B:

- Service model do differently (described in section 7)
- Level of integration only through of single 'triage' and IT, and having a single 'brand' (this would be delivered through separate management structures and contracts).

- Based at Weymouth Community Hospital (WCH), to complement other services
- Service should be delivering 24 hours over 7 days. With Dorchester OOH supporting 23.00 to 08.00 cover (this is not sited from Weymouth Community Hospital).

Option C:

- Service model do differently (described in section 7)
- Level of integration through a single structure (this would be delivered through one management structure and contract).
- Based at Weymouth Community Hospital (WCH), to complement other services
- Service should be delivering 24 hours over 7 days. With Dorchester OOH supporting 23.00 to 08.00 cover (this is not sited from Weymouth Community Hospital).

The Project Board considers that Option C offers the most appropriate balance of cost, benefit and risk. It has the lowest cost per benefit point, and the lowest risk score.

Both Option B and Option C are clearly preferable to the 'Do minimum' 'option, confirming the overall value for money of the development. In light of this evaluation, it is recommended that Option C be chosen as representing the optimum balance of cost, benefit and risk.

9. BENEFITS

4 / 5

Describe the potential benefits to the individual. Consider: access/convenience, patient experience, improved outcomes, efficiency, patient safety, value for money etc.
Describe the benefits to society e.g. addresses inequalities

Benefits have been apprised for each of the options (see appendix two for appraisal soring)

Option C gained the highest benefit scoring to achieve the below following benefits:

- Single access, single reception that is as user-friendly as possible
- Single clinical triage, assessment and advice by a senior clinician
- Improve navigation so the patient sees the right professional first time
- Patients educated on local service and self-management of conditions
- Best use of clinical skills and expertise
- IT systems (working together)
- Improved access to diagnostics
- Fits with NHS 5 year forward and direction of travel, joint vision across the local healthcare system

10. RISKS

3

Outline any risks to patients either from not funding the proposal or inherent risks or potential harm to patients from the proposed intervention.

Risks have been apprised for each of the options – (see appendix three for appraisal soring)

Option C gained the lowest benefit scoring for the following risks identified:

- Building costs and overheads increase
- Destabilise workforce and workforce losses
- Triage and assessment not effective, demand on service continues to increase
- Patients still bounced around the system
- Culture of the current system not developing/changing to support achieving outcomes
- IT systems do not integrate
- Unclear expectations of the service remit
- Ineffective governance arrangements
- Service not sustainable and activity unmanageable

If this this proposal is not funded the following risk or harm to patients could exist:

- Lack of service offer would create additional risk to not meeting the health needs of the local population, particularly the vulnerable, homeless and disadvantaged
- Placing further demand on an already pressured local health care system, particularly A&E and local GP practices, preventing services be able to respond to the increased demand urgent and emergency episodes
- Leave patients in further confusion and vulnerable during an already stressful healthcare event/episode

11. HUMAN RESOURCES — 2

Does this proposal have any HR management implications. Are there likely to be any TUPE issues? Has HR been consulted/involved?

It is not expected that there would be TUPE issues, standard TUPE rules would apply. However during the planning and the procurement acquisition phase HR will be fully involved in the process. It has been highlighted that the Minor Injuries Unit staff have been TUPED several times. Therefore any service provider would need to manage the TUPE process and workforces relations sensitively.

12. INDICATIVE FINANCIAL TEMPLATE	2

Depending on tendering process and options put forward in respect of OOH will mean the financial envelope will vary

Weymouth Current Expenditure:

Excluding OOH

Total Expenditure for Unregistered Patients (Walk In)	£854,188
Total income from out of area walk ins	£(85,419)
	£768,769
Proportion of W & P MIU (84% of total based on usage) (Breakdown attached)	£670,014
Total Financial Envelope	**£1,438,783**

Including OOH

Plus Weymouth and Portland OOH service:	£417,103
Total Financial Envelope	**£1,855, 886**

13. COST-EFFECTIVENESS	2
Will the proposed service be more cost-effective than current service provision? The effectiveness and cost-effectiveness in relation to other treatment/service options should be summarised with relevant research where appropriate. Cost per Quality Adjusted Life Year (QALY) It is most likely that cost benefits will be realised from the walk in patients, whereby the current contract incentivises contacts and activity. Savings are not anticipated from the MIU and OOH service. Main source of efficiencies; • By managing the demand and activity to the urgent care centre • Recharge of non-Dorset registered patients circa 10% of income (equates to approx. £150k) • Maintaining current A&E attendance levels (in the short term, initial 1-2years of the contract) • Reduction in A&E attendances and admissions (long term, beyond 2 years of the contract). • Potential for synergies for workforce, shared reception for example. No further cost benefits have been identified, although these may become apparent during the providers returning tenders.	

14. PROCUREMENT – ASSESSMENT OF THE MARKET	2
Give an assessment of whether it is felt the market could address any of the development needs highlighted. What if any are the barriers to market entry, the strength of the provider landscape and other market forces at play. This should also support the options development with regard to timing, what, if any, market development/stimulation will be required and support the service/cost model adopted. Assessment of the Market In parallel with the service development and stakeholder engagement workstreams the procurement team has undertaken a market engagement exercise to support the final proposal for the services. At the time of writing, the engagement has undertaken two of its three phases, namely; • Market intelligence (who is out there) • Market engagement (inform, consult, involve, improve) • Market intervention (getting what we want) – To be undertaken following approval. Adverts were placed highlighting the projects and direct contact was made with all current providers to encourage expressions of interest. A prospectus detailing the services and the results from the stakeholder and staff engagement was shared with those who expressed an interest. A market engagement event was held on the 22 January with 18 organisations in attendance. These comprised: Four NHS Foundation Trusts Six Private/Primary Care organisations Six voluntary/third sector organisations Two pharmacy organisations (including the LPC)	

Various themes were explored in depth by groups of providers which included:

- Triage and demand management
- Integrated care and partnerships
- IT Systems and enabling technology
- Diagnostics and pathology
- Service barriers and enablers
- Working with voluntary and community organisations
- Contractual model and finances
- Portland minor injuries unit

Following the event, one to one meetings were held with providers to explore individual organisations approach to the CCGs plans.

The comments and advice received during the engagement will be used to develop the CCGs plans to acquire the services.

15. STAKEHOLDER SUPPORT AND INVOLVEMENT

7 / 8

How acceptable is this proposal to patients? Describe the level of support for the proposal from stakeholders including GPs, other health and social care professionals, voluntary and community groups, patients, carers, the general public. Include the findings of any patient / public engagement.

Describe what involvement stakeholders have had in developing the proposal.

1. Partnership engagement and view seeking:

1.1 Initial Engagement

Local partners include; South Western Ambulance NHS Foundation Trust, Dorset County Hospital NHS Foundation Trust, Dorset HealthCare University NHS Foundation Trust and The Practice PLC (current health provider of the GP-led Walk in Centre). All these partners input throughout all of the project stages

At various stages of the project tailored engagement events took place. The CCG has engaged with (please note this list in not exhaustive):

- Staff from the current services
- Local GPs
- Patient Health Network members
- Dorset Health and Overview Scrutiny Committee members
- Local Councillors
- Social Services
- Wider engagement from a range of organisations and representatives (invitation extended to carers groups, BME representatives, Mental Health Forum, Age UK, Dorset Community Action, Community Alcohol and Drug Advisory Service).

Views were sought on the current service, as well as areas for development.

A patient survey was also undertaken, to engage with the public and service users and gain their views of the current services. Public views were sought via a paper survey, over the period of a

week, distributed by reception staff, across all 3 current services. Of the 150 surveys 91 were returned giving a positive return rate of 61%.

1.2 Service Model development

Further events took place in November and December 2014 (Phase 2 engagement), for staff working within the affected services, wider stakeholders and Weymouth Health Network. These events were well attended and supported (in total, approximately 75 people attended the events). Attendees were given a brief presentation on the proposed service model and were invited to comment on it, specifically regarding whether they felt that the proposal would meet the project objectives and the role of Community and Voluntary sector in the proposed service model.

This was followed by an 8 week public engagement from 19 December 2014 to 13 February 2015. A document outlining the background of the project and the slides from the stakeholder engagement events was published on NHS Dorset CCG's website. The public was invited to comment on the same questions asked at the stakeholder events, via an online survey.

2. Stakeholder feedback on the proposed service model:

Feedback from stakeholders, including the wider general public, has been positive with overall support of the proposed model. We have also received constructive feedback to build on the proposed service model, as well as important considerations for the future service specification, if the commissioning proposal is approved by the CCG.

The following themes from the feedback:

- **Better Integration:**
  - Great opportunity for joint working between services
  - Single service will ensure good information governance
  - Less duplication and confusion for patients and the wider local health economy
- **Opportunity to expand/utilise current staff skills:**
  - Staff would appreciate more interesting careers with broader options for personal development with an integrated service
- **Patient focussed service:**
  - 'A very thorough and accurate assessment of things as they stand at the moment and the changes required to provide a comprehensive, economically run, patient friendly service'

Constructive feedback to support the development of the service model proposal and the service specification :

- Ensuring adequate staffing levels during periods of high demand e.g. summer months and bank holidays
- Support work/life balance for staff
- Important to publicise opening hours of new service and its function – as an alternative to A&E
- Process of integrating services needs to be handled with care, particularly staff and IT
- Strong leadership/management in service to ensure service works well

Based on feedback the following is being considered within the service model to harness the skills and expertise of the community and voluntary sector :

- Voluntary organisations to be given the opportunity to share their knowledge and experience with the staff in the Urgent Care Centre, so that information and skill set

can be transferred • Consider developing volunteers skills to support the service • Voluntary and Community Sectors to be given a defined role	

16. EVALUATION PLAN

How do you plan to measure whether the anticipated outcomes/benefits have been realised?

Monthly contract monitoring meetings to monitor the effectiveness of the service. The following outcome measures and KPIs will be monitored:

Outcomes measures:

- Reduction of A&E attendances, measured by the following subsets:
  * Reduced unplanned attendance at A&E following urgent care presentation within the previous 24 hours.
  * Reduced re-attendance at the Urgent Care Centre following attending the urgent care centre within the previous 24 hours.
  * Reduced unplanned attendance at A&E at weekends and after 17.00pm on weekdays
- A year on year reduction of people presenting for reasons such as coughs, colds, tonsils, miss-medication issues.
- Working with the GP locality a reduction of admissions for patients living with the following Long Term Conditions.
- Evidence of a high level of patient and carer satisfaction.

Other KPIs relating to:

Access:

- All patients attending the service where there is an urgent care need, within 60 minutes of the patient arriving at the service a clinical decision needs to be made as to whether the patient will be treated in the service or discharged or whether they need to be transferred to an A&E.
- All patients attending the service will have their clinical needs triaged, assessed and properly met and they will have been seen, treated and discharged within a maximum of 4 hours from the time of their arrival (95% is the current national A&E standard).

Patient Flow/ Complex and Frail:

- Should patients with minor illnesses arrive at the service who are triaged as suitable for routine care, they will be signposted to the appropriate service.
- The clinical decision will rest with the triage as to whether patients receive assessment & treatment on the spot or are re-directed, where appropriate, back to their General Practice, Pharmacy or Existing Community Services. *Expected to see signposting to GP, pharmacy, existing health services where clinically appropriate.*
- The Provider will supply a summary of each episode of care to the patients registered GP by no later than 08.00 on the next working day

Prevention and demand:

- Uptake of secondary care clinics and pathways / ambulatory care through use of direct referral if deemed appropriate and linked with the presenting condition
- Collaborative working with registered GP to report, investigate and intervene on recurrent episodes of care for individual patients

Responsive and Flexible:

- The service meets the needs of vulnerable and disadvantaged patients/carer
- Continuous process and planning for service improvements, e.g. asking patients, the public and stakeholders about how the service can be improved
- The service is easily accessible, well known and well regarded by patients and the public.
- The service provided is safe, patient centred and delivered to the highest standards.
- The service will provide patient education and improve patient's knowledge of self-care and self-management of long term conditions and use of other local health services, e.g. for minor aliments
- Regular staff satisfaction surveys / Staff Improvements, e.g. canvassing ideas for improvement from staff

Prescribing:

- Ensure compliance with NICE/Good Practice and CCG Medicines Management guidance and protocols
- Ensure compliance with the schedule for effective prescribing
- Ensure compliance with the pathway for emergency prescribing

17. FEASIBILITY

Outline any feasibility issues such as risks/barriers/delays to implementation e.g. workforce issues (recruitment, training needs), access to diagnostic capacity, equipment procurement, theatre capacity. Consider the robustness of the service and its sustainability in the longer term.

What timescale is envisaged?

The service needs to be in place by the 30th June 2016 to prevent gaps in service. This provides 15 months for a procurement group to secure a contract and oversee implementation.

2014
May – Plan aligned with CSR
June – Advertise requirements
July – Provider Briefing and pre-qualification
August – Issue Tenders
Mid-September – Return tenders
October – Complete initial evaluation and provider interviews
November – Final clarification and Governing Body approval
December – Standstill and preferred bidder dialogue
2015
January – Work through draft contracts and due diligence
February – Complete due diligence and finalise contracts (may
March to June – Mobilisation
End June – Contract start

Risk and Issues to consider:

IT
Workforce
Equipment and space
Training and development

Wider system issues:

Primary Care Development, supporting access to general practice Changing patient behaviours and patters for use of services Public health promotion and message about use of local services A&E department working with the Urgent Care Centre to support appropriate service signposting The registered patient list, ensuring CCG have service provision (potential enhanced service) in place to support more complex patients.

For CCG use only

CCG PROGRAMME BOARD RECOMMENDATION/CONCLUSION/FEEDBACK

CCG EVALUATION PANEL AND RECOMMENDATION/CONCLUSION/FEEDBACK
Outcome of evaluation panel, to include comments made at the programme board, requests for further information/actions/reassurance etc

CCG GB RECOMMENDATION/CONCLUSION/FEEDBACK

CCG APPROVAL	**NAME**	**DATE**
Agreed by Governing Body (Chair to sign) Signed.....		

Appendix One: High Level Option Development

Weymouth Integrated Assessment and Treatment Service High Level Option Development

Please note this exercise was done at a high level therefore assumptions have been made on some of the options, for example further development of the service model and level integration development will continue to meet project Objectives and Critical Success Factors (CSF)

Shortlisting Key

Y	Supports the objective and the CSF
YY	Strongly supports the objective and the CSF
YYY	Overwhelmingly supports the objective CSF
N	Does not support the objective and the CSF
N/Y	Partially meets the objective and the CSF
SL	Shortlist
DM	Do minimum

OBJECTIVES

Objetives should be directly related to your 'problem statement'

1	Integrated working between MIU / WIC / OOH services currently provided in Weymouth Community Hospital to improve healthcare for those who live in and visit south Dorset
2	Focus on meeting needs of vulnerable, homeless and disadvantaged
3	Help the right patient see the right professional at the right time
4	Use resources efficiently to the benefit of local community and visitors
5	Ensure best communication between all those involved in an episode of care
6	To achieve new service by 2016 at the latest

CSFs

'Critical Success Factors' are the other things that need to be considered in choosing options. The usual ones are shown below.

1	Acceptability to stakeholders
2	Achievability within time constraints
3	Likely affordability (based on high level assumptions)
4	Sustainability
5	Strategic fit - for example, supportive of greater integration between services in future

"Nature of model"

There are possible options to consider with regards to the nature of the model, particularly the function/s of the service/s that could be provided in the future. The below options were considered in light of the objectives and the critical success factors, the following conclusions can be drawn:

		A1	A2	A3
		Current	"Minimal" - assess, treat, redirect	Do differently
Objectives				
1	Integrated working between MIU / WIC / OOH services currently provided in Weymouth Community Hospital to improve healthcare for those who live in and visit south Dorset	N	Y/N	y
2	Focus on meeting needs of vulnerable, homeless and disadvantaged	N	N	Y
3	Help the right patient see the right professional at the right time	Y/N	Y	Y
4	Use resources efficiently to the benefit of local community and visitors	N	Y	Y
5	Ensure best communication between all those involved in an episode of care	Y/N	y	Y
6	To achieve new service by 2016 at the latest	Y	Y	y
CSFs				
1	Acceptability to stakeholders	Y	N	Y
2	Achievability within time constraints	Y	Y	Y
3	Likely affordability (based on high level assumptions)	Y	Y	Y
4	Sustainability	N	Y	Y
5	Strategic fit - for example, supportive of greater integration between services in future	N	Y	Y
6				
7				
8				
9				
10				
	SL / DM / reject:	DM	REJECT	SL

There are options for the scope of the services on offer, in particular the range of functions the service will offer. It was re confirmed during this process that the current service is not sustainable or fit for the future in relation to the duplication of workforce and lack of integration across the current services. Option two was considered to be a strong option for the future as this would enable sustainability in relation to the workforce and affordability of services on offer. However, there was some concern this would not meet the needs of the vulnerable, homeless and disadvantaged who require a greater range of assessment and treatment options. It was noted that this option could be viewed as unacceptable to patients who currently access the services and are positive about the services currently on offer. On this basis option two was rejected.

It was considered that option three could meet all of the key objectives and CSFs, however the detail to understand what and how is done differently needs to be fully explored. When proposed service model/s are developed this will need to be re- considered again against the objectives and CSFs.

Form of Integration

There are possible options to consider with regards to the form of integration that could exist between the current services; MIU, Walk In Centre and OOH services. The services currently operate under separate management and contracts. The below options were considered in light of the objectives and the critical success factors, the following conclusions can be drawn:

		B1	B2	B3	B4	B5
		As now	Single 'triage', other services as now	Single 'triage', single IT	Single 'triage' and IT, single 'brand'	Single structure
Objectives						
1	Integrated working between MIU / WIC / OOH services currently provided in Weymouth Community Hospital to improve healthcare for those who live in and visit south Dorset	N	N	Y	YY	YYY
2	Focus on meeting needs of vulnerable, homeless and disadvantaged	N	n/a	n/a	n/a	n/a
3	Help the right patient see the right professional at the right time	N	y	y	y	YY
4	Use resources efficiently to the benefit of local community and visitors	N	Y	Y	Y	YY
5	Ensure best communication between all those involved in an episode of care	N	N	N	YY	YY
6	To achieve new service by 2016 at the latest	Y	Y	Y	Y	Y
CSFs						
1	Acceptability to stakeholders	Y	Y	Y	N	N
2	Achievability within time constraints	Y	Y	Y	Y	Y
3	Likely affordability (based on high level assumptions)	Y	Y	Y	Y	Y
4	Sustainability	N	Y	Y	Y	YY
5	Strategic fit - for example, supportive of greater integration between services in future	N	Y	Y	Y	Y
6						
7						
8						
9						
10						
	SL / DM / reject:	DM	REJECT	REJECT	SL	SL

There are five options for the scope of integration of the current services. Option two and three were discussed at some length recognising that single triage/assessment is an absolute must for the new service. This will ensure the patient has access to the most skilled and experienced professional at the right time for the assessment. It was also recognised that assessment and signposting service for treatment options, apposed to delivering the treatment, could also enable the patient to still see the right professional for their needs if that service was available at the time required. It was also discussed that it is essential to consider and bring in social aspects and appropriate social services during the single triage/assessment. It was considered that both these options did not address the treatment requirements which was considered a key function of the future service, on this basis options two and three were rejected. It is also important to note that option three gained further weighting due to the fact that integration of services is only possible if the services have a single IT platform for access to

Option four and five were both shortlisted on the basis that they meet the objectives and most of the CSFs. If services are delivered in the right way, both options are possible, even in different management and contracting structures. Services can be integrated and have single branding so the patient sees the services as one, not as three separate services. Option five has the strongest weighting as preferred option, however MIU staff have undergone 'TUPE' five times, this could have significant impact on staff HR matters and morale. Concern was raised that one service in single structure and contract can create specific cultural issues that could get embedded and not challenged. This may be a potential benefit of having three separate staff/service cultures working together.

Location

There are possible options to consider for the location of the future services to be provided from in the Weymouth and Portland area. The services are currently provided are based at Weymouth Community Hospital. The below options were considered in light of the objectives and the critical success factors, the following conclusions can be drawn:

		C1	C2	C3	C4	C5	C6
		WCH	Westhaven	Littlemoor	Split services, eg use of local supermarket		
Objectives							
1	Integrated working between MIU / WIC / OOH services currently provided in Weymouth Community Hospital to improve healthcare for those who live in and visit south Dorset	Y	Y	Y	N		
2	Focus on meeting needs of vulnerable, homeless and disadvantaged	Y	N	Y	Y		
3	Help the right patient see the right professional at the right time	Y	Y	Y	Y		
4	Use resources efficiently to the benefit of local community and visitors	Y	Y	Y	Y		
5	Ensure best communication between all those involved in an episode of care	Y	Y	Y	Y		
6	To achieve new service by 2016 at the latest	Y	N	Y	Y		
CSFs							
1	Acceptability to stakeholders	Y	N	Y	N		
2	Achievability within time constraints	Y	N	N	N		
3	Likely affordability (based on high level	Y	N	Y	Y		
4	Sustainability	Y	Y	Y	Y		
5	Strategic fit - for example, supportive of greater integration between services in future	Y	Y	Y	N		
6							
7							
8							
9							
10							
	SL / DM / reject:	SL	reject	reject	reject		

Four different options were considered for the scope of location of the future services. Option two, three and four were discussed in some detail, it was recognised quickly that options two and four did not meet several of the objectives and CSFs and were rejected on this basis. Option three was the closest to meeting the objectives, however it was felt the Littlemoor site would not be ready within the timescales, on that basis the site was not further considered as an option for shortlisting.

Option four, the current site at Weymouth Community Hospital, was shortlisted on the basis that this meets the objectives and all of the CSFs. The positive patient and stakeholder feedback regarding access and parking at the site was considered in these discussions. This further supporting acceptability of this option by current patients.

Service Coverage

The services currently on offer provide walk in access for both the MIU and GP led Walk In Centre, anyone can access these services. Out of Hours GP service assess and treat patients both via triage from the call centre and from walk in access. Any future service needs to be consider in relation to the other local services provided, therefore service coverage options were considered. The below options were considered in light of the objectives and the critical success factors, the following conclusions can be drawn:

		D1	D2
		Current	**To complement other services**
Objectives			
1	Integrated working between MIU / WIC / OOH services currently provided in Weymouth Community Hospital to improve healthcare for those who live in and visit south Dorset	N	Y
2	Focus on meeting needs of vulnerable, homeless and disadvantaged	Y	Y
3	Help the right patient see the right professional at the right time	N	Y
4	Use resources efficiently to the benefit of local community and visitors	N	Y
5	Ensure best communication between all those involved in an episode of care	N	Y
6	To achieve new service by 2016 at the latest	Y	Y
CSFs			
1	Acceptability to stakeholders	Y	Y
2	Achievability within time constraints	Y	Y
3	Likely affordability (based on high level assumptions)	N	Y
4	Sustainability	N	Y
5	Strategic fit - for example, supportive of greater integration between services in future	N	Y
6			
7			
8			
9			
10			
	SL / DM / reject:	DM	SL

There are two options for service coverage of the future service model. Local patients have access to other local primary care services; e.g. pharmacy services or GP practices and intelligence gathered from the project team and data supports that patients could further utlise and access the appropriate and correct assessment and treatment service locally for minor alinment needs other than the GP led walk in service. Meeting strategic fit for the future, sustainability and efficient use of NHS resources objectives and CSF were key focal points in each of the options discussed and were not met for option one. Several of the other objectives and CSFs were also not met in option one. It was queried that option one 'the current patient group' maybe affordable and sustainable to meet the CSF, but this would need to be understood further.

Option two, ensuring the future service complements services including children services, was shortlisted as the preferred option as this meets all of the key objectives and SCFs.

Opening hours

There are options for the scope of opening hours for delivering the services on offer. The services are currently provided at varied times however the below options were considered in light of the objectives and the critical success factors, the following conclusions can be drawn.

NB: E2 refers to a 24/7 service. The service would not be provided 24/7 from Weymouth Community Hospital, between 23.00 - 08.00 the service will be delivered through the Out of Hours services provided from Dorchester.

		E1	E2	E3
		Current	24/7 staffed accordingly based on demand	Based on when other services are shut
Objectives				
1	Integrated working between MIU / WIC / OOH services currently provided in Weymouth Community Hospital to improve healthcare for those who live in and visit south Dorset	Y	Y	Y
2	Focus on meeting needs of vulnerable, homeless and disadvantaged	N	Y	Y
3	Help the right patient see the right professional at the right time	N	YY	N
4	Use resources efficiently to the benefit of local community and visitors	N	YY	Y
5	Ensure best communication between all those involved in an episode of care	Y/N	Y	Y
6	To achieve new service by 2016 at the latest	Y	Y	Y
CSFs				
1	Acceptability to stakeholders	Y	Y	N
2	Achievability within time constraints	Y	Y	Y
3	Likely affordability (based on high level assumptions)	Y	Y	Y
4	Sustainability	Y	Y	Y
5	Strategic fit - for example, supportive of greater integration between services in future	Y	Y	Y
6				
7				
8				
9				
10				
	SL / DM / reject:	DM	SL	Reject

Option one, the current service, fails to meet the objectives. Options three and four fail to meet the objectives and the CSFs. Option three thought to be most unacceptable to stakeholders due to limited access to the services, particularly with the positive feedback regarding good access of the current services. It was also considered that option three would not always enable the patient to always see the right professional at the right time, patients may end up accessing more acute services elsewhere. Option four failed to meet the objectives, in particular the effective use of resources. Current activity data shows resource not always being utilised during evenings and some weekend days.

Option two was the preferred option where the service is staffed accordingly based on the demand, this may include varied opening hours for the different services offered.

Shortlisting conclusion

	1	2	3	4	5
"Nature of model"	Current	"Minimal" - assess, treat, redirect	Do differently		
	DM	REJECT	SL	#REF!	#REF!
	1	2	3	4	5
Form of Integration	As now	Single 'triage', other services as now	Single 'triage', single IT	Single 'triage' and IT, single 'brand'	Single structure
	DM	REJECT	REJECT	SL	SL
	1	2	3	4	5
Location	WCH	Westhaven	Littlemoor	Split services, eg use of local supermarket	
	SL	reject	reject	reject	
	1	2	3	4	5
Service Coverage	Current	To complement other services			
	DM	SL	#REF!	#REF!	#REF!
	1	2	3	4	5
Opening hours	Current	24/7 staffed accordingly based on demand	Based on when other services are shut		
	DM	SL	Reject	#REF!	#REF!

Which permutations of options do we define to take forward?

	Model	Integration	Location	Service coverage	Hours
Do minimum	1	1	1	1	1
Shortlist	3	4	1	2	2
Shortlist	3	5	1	2	2

Options to take forward

		Model	Integration	Location	Service coverage	Hours
A	Do minimum	Current	As now	WCH	Current	Current
B	Shortlist	Do differently	Single 'triage' and IT, single 'brand'	WCH	To complement other services	24/7 staffed accordingly based on demand
C	Shortlist	Do differently	Single structure	WCH	To complement other services	24/7 staffed accordingly based on demand

Appendix Two: Benefits Appraisal

The benefits delivered by each option have been appraised using a weighting and scoring methodology. The benefits were identified through the project board. The benefits are those identified by as being delivered to patients, carers, staff, volunteers, the NHS. The results are set out below

		Option A - Do minimum		Option B - separate mgt strutures, but single brand, single triage and IT systme		Option C - Single struture	
They are set out in more detail in the 'Strategic Case' section of the Business Case to which this	weighted score	raw / likehood	weighted	raw / likehood	weighted	raw / likehood	weighted
paper is an annex.	8	0	0	3	24	8	64
•Single access, single reception that is as user-friendly as possible	10	0	0	8	80	10	100
•Single clinical triage, assessment and advice by a senior clinician	8	0	0	4	32	8	64
•Improve navigation so the patient sees the right professional first time	14	0	0	4	56	6	84
•Patients educated on local service and self-management of conditions	12	2	24	6	72	7	84
•Best use of clinical skills and expertise, joint vision across local healthcare system	12	2	24	4	48	7	84
•IT systems (working together)	12	0	0	4	48	6	72
•Improved access to diagnostics	12	4	48	4	48	4	48
•fits with NHS 5 year forward direction of travel and CCG Clincial Services Review	12	0	0	3	36	8	96
	100	8	96	40	444	64	696
		3		2		1	
			2		2		1

Appendix Three: Risk Appraisal

The options have different risk profiles. An assessment has been made of the various risks. Each risk is given a score from 1 - 5 for its potential impact (1 = 'minor', 5 = 'catastrophic') and its likelihood of occurrence under each option (1 = 'very unlikely', 5 = 'very likely'). The product of the two scores gives an overall risk score for the option. The higher the score, the more risk the option carries.

		Option A - Do		Option B - separate		Option C - Single	
	impact	likehood	risk score	likehood	risk score	likehood	risk score
Building costs and overheads increase	3	2	6	3	9	2	6
Destablise workforce and workforce losses	4	0	0	2	8	2	8
Traige and assessment not effective, demand on service continues to increase	3	5	15	2	6	2	6
Patients still bounced around the system	3	4	12	3	9	3	9
Culture of the current system not developing/changing to support achieveing outcomes	4	3	12	3	12	3	12
IT systems do not integrate	3	5	15	3	9	3	9
Unclear expectations of the service remit	5	4	20	2	10	1	5
Ineffective governance arrnagements	5	0	0	4	20	2	10
Service not sustainable and activity unmanageable	5	5	25	3	15	2	10
	35		105		98		75
			3		2		1