hammersmith & fulham

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Wednesday 30 January 2019
6pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Vanessa Andreae - H&F Clinical Commissioning Group (Vice-Chair)
Janet Cree - H&F Clinical Commissioning Group
Councillor Ben Coleman - Cabinet Member for Health and Adult Social Care (Chair)
Councillor Adam Connell - Cabinet Member for Public Services Reform
Councillor Larry Culhane - Cabinet Member for Children and Education
Steve Miley - Director of Childrens Services
Keith Mallinson - Healthwatch Representative
Anita Parkin - Director of Public Health
Lisa Redfern – Strategic Director of Social Care and Public Services Reform
Glendine Shepherd - Head of Housing Solutions
Dr Tim Spicer - H&F Clinical Commissioning Group
Sue Spiller - Chief Executive Officer, SOBUS

Nominated Deputy Member
Councillor Patricia Quigley – Assistant to the Cabinet Member Health and Adult Social Care
Councillor Lucy Richardson, Chair, Health, Inclusion and Social Care Policy and Accountability Committee

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Date Issued: 22 January 2019

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

30 January 2019

Item		**Pages**
1.	**MINUTES AND ACTIONS**	4 - 12

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health & Wellbeing Board held on 21 November 2018; and

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

If a Member of the Board, or any other member present in the meeting has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Member with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Member must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where members of the public are not allowed to be in attendance and speak, then the Member with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Members who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Members are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4. NHS LONG TERM PLAN 13 - 16

The NHS Long Term Plan was published on the 7th of January 2019. This report examines the national plan, which sets out a policy and service development agenda for local NHS services.

5. PRIMARY AND URGENT CARE PROPOSALS - PRE-CONSULTATION BUSINESS CASE 17 - 118

The CCG is under financial pressure and needs to ensure it is using money in the most efficient way. This report considers the urgent care contracts that are up for renewal and the current demand for services. The report also discusses whether savings can be made by reducing services when there is little or no usage from residents.

6. ISOLATION AND LONELINESS To Follow

7. WORK PROGRAMME Verbal

The Board is requested to consider discuss the items proposed for the work programme and suggest any amendments or additional topics to be included in the future.

8. ANY OTHER BUSINESS

9. DATE OF NEXT MEETING

The Board is asked to note that the date of the next meeting scheduled for the municipal year 2018/2019 is Wednesday, 20 March 2019.

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Draft Minutes

Wednesday 21 November 2018

PRESENT

Committee members:
Councillors Ben Coleman (Chair) and Larry Culhane
Vanessa Andreae, H&F CCG
Janet Cree, H&F CCG
Steve Miley, Director of Children Services
Anita Parkin, Director of Public Health
Keith Mallinson, H&F Healthwatch Representative
Lisa Redfern, Strategic Director of Adult Social Care and Public Services Reform

Nominated Deputies Councillors:
Lucy Richardson, Patricia Quigley

Officers: Martin Calleja, Head of Health Partnerships; Simon Cave-Brauner, CCG Transformation Lead, NW London Collaboration of CCGs; Katie Estdale, Service Development, Policy and Governance Manager; Charly Williams, Strategic Commissioner, Wendy Lofthouse, Mental Health Commissioning Manager, H&F CCG; Sarah Rushton, Director of Local Services West London NHS Trust

156. MINUTES AND ACTIONS

Clarity was provided regarding minute No. 152, membership of joint delivery boards, and coproduction. Martin Calleja confirmed that the aim was to ensure that residents were involved in developing services. Invitations would be sent to finalise membership for the boards for the next board meeting in early 2019 with the process led by and supported by Public Service Reform who are leading on this. Councillor Quigley stated that coproduction should be integral to the process of determining membership from the outset. Councillor Coleman agreed that there should be people with disabilities involved in the recruitment and selection process and acknowledged that despite the challenges of co-production, this should be started at the earliest opportunity. Officers would continue to work in consultation with policy officers and members of the Disabled Peoples Commission, and had successfully recruited five people who will be part of the implementation group.

Vanessa Andreae requested that the commitment to establish an action tracker to compliment the minutes be established for the next board meeting and this was agreed.

Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

RESOLVED

1. That officer representation on the joint delivery boards would be coproduced and that having disabled representation would be assured.
2. An action log tracker will be established for the next board meeting; and
3. That the minutes of the previous meeting be agreed.

157. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Tim Spicer, H&F CCG (Vice-chair) and Sue Spiller.

158. DECLARATIONS OF INTEREST

None.

159. HAMMERSMITH & FULHAM ADULTS MENTAL HEALTH SERVICE OVERVIEW

Sue Roostan introduced the report which provides the first complete overview of the mental health provision across agencies to be completed in some time and serves as a good starting point for the Board's chosen 2018/19 mental health focus. The current report details services for adults aged 18 to 65. Overviews for Child and Adolescent Mental Health Services (CAMHS) and services for residents aged 65+ will follow by the end of the financial year. These will be prepared jointly by the Council and the CCG following the same format.

It was acknowledged that the review had been a challenging process, involving a high number of sources and individuals involved and should be considered 'ongoing'. A range of key strengths were highlighted including improvements to acute bed management and discharge, access to urgent care, early intervention and psychological services. A range of challenges and opportunities were also clearly set out that had both a service and financial impact. These included the need to reduce dependency on high cost placements and strengthen and better co-ordiante the social care, community support and primary care offer.

The following key issues were discussed;

Bringing the work of the West London led programme and local Joint Delivery Board together and consolidating co-production.

The review recognised that West London Mental Health Trust was delivering a programme of service development across H&F, Ealing and Hounslow CCGs and a local Joint Delivery Board had been established to support and compliment this programme of work. A strong commitment to co-production was highlighted and the review set out a wide range of initiatives across

sectors that were already up and running – bringing together this work was a key requirement.

Keith Mallinson welcomed the commitment to co-produce, observing that there were many voices not represented in shaping services. He asked about the West London local services transformation programme, which "continue to implement the shifting settings of care" and asked whether this was on-going? It was clarified that this was a live programme and was being supported through patient involvement and co-production for key areas e.g. the review of standards for acute services.

Janet Cree clarified that the likeminded strategy was part of the overall strategy for H&F, and across NW London. Martin Calleja added that the Council had participated in preparing about this vision and it had been coproduced with residents although its implementation could have benefited from closer involvement of ASC. It was agreed bringing together the continuing programme with the work of the local Joint Delivery Board would resolve this issue. address the gap.

Martin Calleja clarified that around 60% of the £44 million was spent on acute services. The level of need would have to be serious, if residents were to try and access those services. In terms of shifting settings of care, many residents wanted to remain in their own homes while accessing services. Sarah Rushton added that there were a high number of patients who were in receipt of community services, who could also receive primary health care services. It was possible to move through services by discharging from community services, and finding primary care services to support them. It was noted that the primary care team for H&F was not large, had operated with a large caseload although demand and resource levels needed further consideration.

ACTION: Martin to work with CCG and Trust leads to ensure the West London Programme effectively interfaces with local work.

Further analysis including resident experience, levels of funding and needs.

It was recognised the review was service, finance and performance led and the voice of residents and associated insights were not present. It was agreed a complimentary piece of work was needed to provide a full picture.

Councillor Coleman welcomed the helpful comments made and added that there was an issue for the Council as to how residents engaged with services, and satisfaction levels. In terms of a future focus, more work should be done on evaluating satisfaction, to review and strengthen future services. With reference to page 18, the map did indicate areas with the highest number of residents in receipt of mental health services but with no detail as to why. Understanding why would help tailor preventative services and support, a level of detail that was not currently provided by the JSNA. He also asked

about the why there was a frequency concentrated in certain areas, which was partly understood to reflect where services were located, for example, care homes.

Lisa Redfern referred to page 17 of the Agenda, 1.3, and how NHS and Social Care spend in H&F compared to other boroughs. It was understood that a closer analysis of this data was required to consider the balance of investment across other boroughs. Martin advised that there was further analysis to do in this area.

Lisa referred to page 29 of the Agenda and acute in-care patient admissions. H&F performance on delayed discharges of care has improved significantly. Janet Cree referred to comparative investment data across the three boroughs and responded that H&F contribution to supported housing was relatively higher, compared to the other boroughs, which indicated a level of disparity in terms of CCG funding.

Lisa Redfern stated that CCG spend on supported housing exceeded £1 million for WCC and RBKC, and represented a severe underinvestment compared to the level of investment in the other boroughs.

Wendy Lofthouse responded noted that the whole investment picture needed to be considered and that the % CCG funding on all rehabilitation and placements compared with or was higher in H&F than WCC and RBKC i.e. that was where the money was tied up and work needed to be done to reduce use and lengths of stay. The need to enhance clinical and support levels in supported housing was highlighted as a major priority to support this and a business case was being developed.

ACTION: PSR to set out further analysis work – including the development of key business cases - that will be undertaken in Q4 taking on board the key points raised.

Understanding of and access to services by residents – counselling services

Councillor Quigley referred to page 16 of the Agenda and asked about local needs and access to counselling services - using the example of if a person consulted their GP about depression type symptoms. She asked how easy would it be for them to get support and the period spent on a waiting list. Janet Cree responded that there were two issues with this highlighted reference, where severe and high mental health needs were indicated, with two different cohorts. A GP could consider depression and anxiety, and determine the severity of need which would inform the pathway and prioritisation of services.

Councillor Quigley was aware of residents who had waited over 10 weeks for counselling treatment. Vanessa Andrea confirmed that the service KPI (key performance indicator) for this provision was a maximum of six weeks and that this was being monitored with Hammersmith and Fulham performed well compared to many other areas. She also advised that the GP would ‘hold’ the case through the waiting time providing other services to support the patient

ACTION: CCG to confirm patient waiting times for counselling treatment

Keith Mallinson commented that depression could be prompted by non-clinical issues such as debt, or poor housing. Martin Calleja added that one of the key conclusions from the review was that there was a need for a joined-up plan for tier-one services and that, if feasible, for Public Health and primary care commissioners to undertake a piece of work on this.

Lisa Redfern highlighted the need to be clearer about what might a resident of H&F could expect in terms of services if they have depression or anxiety in terms of primary care.

Lisa Redfern added that GP and mental health leads needed to develop the mental health offer further, setting out how these could work in conjunction with secondary mental health services. It was suggested that there was a lack of clarity and information available on this and about what a resident can expect. Although there was no implication that services had been inaccessible, anecdotal feedback from residents has suggested improvement in understanding of that the offer is and how to access services was is needed. Vanessa Andreae referred to a fully interactive portal through which residents could understand what was available in the area on the primary care side.

It was agreed that there needs to be an easier way to access services, for example, an advice station that could offer a single point of contact, with a dedicated support officer who could help signpost services. Access difficulties applied equally to those who had prematurely discharged because of a missed appointment, and the question was asked as to how these patients could be more easily identified, particularly if they hoped to continue to seek treatment. Councillor Richardson reported that she was aware of a resident who had been medicated as part of their treatment for psychosis, but had received no help, advice, or guidance.

Vanessa Andreae suggested that it would be helpful to invite Dr Beverly Macdonald to the next board meeting where MH is a substantive item.

ACTION: PSR to ensure that one of the key focal points for co-production is a review of how local MH services are communicated and accessed.

Child and Adolescence Mental Health Services

Steve Miley highlighted the need to identify mental health triggers for children and at-risk groups such as refugees and looked after children and was

concerned about how they could be helped. Social workers had reported significant concerns about this sub-group of children, partly because of their traumatic experiences.

ACTION: This area of service to be time tabled for presenting to a future board meeting led by the Trust – including the position on at risk groups.

S136 Holding Suites

Lisa Redfern highlighted a further area of work around Section 136 holding suites and the reduction of these in London. These suites were areas of safety, where the police could exercise powers of detainment (technically an arrest), and detain individuals in them, as the nearest place of safety. Here, they would be assessed, receive treatment, or be released. There was a concern that there were insufficient suites in the area that meet required standards and that an action plan for North West London was needed to address the issue. The aim was to ensure sufficient, good quality spaces in a safe environment with continuity of care. It was noted that the number of suites in North West London would reduce from three to one and that further discussion about this was required, given the concerns expressed by ADASS (Association of Directors of Adult Social Services) members, who had formally opposed the planned reductions because of fears for patient safety. There was a necessity to engage in the London wide discussion about this issue, particularly in terms of how the Council could engage in the wider decision-making process underpinning the reductions.

ACTION: Lisa to identify via ADASS who the London representative is, regarding the reduction of section 136 suites in London

Potential Service Cuts

In the context of the CCG plans for financial cuts, Councillor Coleman asked if the CCG currently had any plans to reduce mental health services, as part of the CCGs financial recovery plan. Janet Cree confirmed that in terms of the review the CCG would try to ensure effective use of resources, but there were no plans now. It was reiterated that the CCG had an internal target to achieve £20 million in savings, and, £27 million in the following year, but that there was no intention to set out to reduce funding. The CCG would continue to review and evaluate their resources; however, they would be considering areas where there was no statutory requirement to deliver services.

It was acknowledged that the CCG was facing significant financial pressures. Janet Cree indicated that the CCG would try to give notice of any changes to services and that there would be transparency. As plans were developed, these would be considered by the governing body.

ACTION: Janet to provide information about the details regarding mental health service provision and any services that are regarded as non-statutory as the recovery plan develops

RESOLVED

That under Section 100A (4) of the Local Government Act 1972, the public and press be excluded from the meeting during the consideration of the following items of business, because it contains the likely disclosure of exempt information, as defined in paragraph 3 of Schedule 12A of the said Act, and that the public interest in maintaining the exemption currently outweighs the public interest in disclosing the information.

Councillor Coleman welcomed Simon Cave-Brauner to the meeting. It was explained that the CAMHS report was currently excluded from publication as this had not yet been approved by NHS England. Production of the report had also been delayed by NHS England with guidance being issued late. It was accepted that the timeframe for preparing the plan and gaining sign off from the Council could be better managed in future and to allow the HWB the opportunity to consider this more fully by including this in the Boards future work programme. It was agreed that an appropriate date for considering this next year would be agreed to avoid a repeat of this situation.

Simon Caver-Bauer explained that differences in provision usually lay in pockets of deprivation. Steve Miley confirmed that in the case of looked after children, they had begun to consider the offer and were starting to address this but some services may be provided outside of the Borough. Services would be recommissioned within the Borough for 18+ and for school aged pupils of 11+. These had been successfully piloted and were now being extended to all schools. Services for refugees will be addressed in early intervention work.

ACTION: Agreed that the CCG and Children's Services provide a report on intervention work supporting refugees

Councillor Coleman briefly outlined concerns about lack of involvement of the voluntary sector. It was acknowledged that the CCG had consulted broadly, engaging with diverse community groups such as LGBTQ, BAME and learning-disabled groups. Referring to a recent email, Councillor Coleman expressed concern that the email indicated that the voluntary sector had largely been ignored. Councillor Coleman queried the whether the eight CCG collaborative arrangement was operationally working, if there was no one to identify in terms of engagement.

ACTION: It was agreed that Janet Cree would contact Mark Easton regarding better utilisation and involvement of the voluntary sector

RESOLVED

That the report be noted.

160. ISOLATION AND LONELINESS

Charly Williams provided a brief report on the recent Social Isolation and Loneliness (SIL) workshop, which was held on 14 November 2018. to the meeting was attended by 35 people representing a wide range of interests and was used to generate and share ideas. The overall aim had been to kick start a community based project to tackle SIL. Feedback from the meeting was positive – dialogue had been challenging and residents were encouraged to co-produce their own solutions with ideas ranging from 'wellbeing on wheels' to a 'dragon's den' style approach'. Analysis of actions arising from the event was on-going, but it was hoped that there were would be some innovative outcomes that could be developed further.

In terms of actions, Councillor Coleman confirmed that there would be a focus on one main theme. Some of the ideas suggested will certainly be taken forward such awarding micro grants, recognising that a small amount of funding would be required to go a long way. Anita Parkin added that clarity was required around actions and that the two workshops had generated good ideas that they hoped to implement, continuing the momentum gained so far. Councillor Coleman suggested that Council staff themselves may have their own contributions and suggestions for alleviating SIL. In discussing the Frome GPs, Vanessa Andreae offered to contact the H&F GP Federation, as experienced professionals based on the frontline, working with residents.

The discussion moved to social prescribing. Janet Cree confirmed that there wasn't any current funding for social prescribing but that there had been two pilot projects. There were no current plans to sustain these beyond the period of the project but there was work currently being undertaken at ICP (integrated care partnership) level. It was acknowledged that some of the smaller socially prescribed projects had been quite successful. Councillor Coleman was keen to explore ways in which small grant funding could be sourced from Public Health funding to help kick start social prescribing within the Borough, recognising that there were many local businesses within the Borough that were keen to contribute. It was a challenge to develop something that was sustainable as part of core services. In terms of practical actions, Martin Calleja suggested that a report from Public Health, identifying how individuals could be referred to services might be helpful. This information could be provided in a booklet format highlighting local voluntary sector services for residents to access. These could be provided to every GP practice and could formulate part of the 'making every contact count' approach.

ACTION: HWB to further consider future development of social prescribing.

Additional Issues raised around finanical management

Councillor Coleman highlighted concerns around the way in which the CCG had addressed significant areas of financial reduction and the impact this might have on local social care provision. This was around required S75 savings and the potential for a shortfall in required CCG savings in year (up to £1.25m) to be passed directly to the Council to deal with. He and Lisa

Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

Redfern expressed serious concern regarding the potential impact of this on residents. They advised that bringing this to the board was in line with its interest in major issues that will have an impact on local services.

Janet Cree clarified that the position on required savings was part of an ongoing process and that she felt the CCG had been clear about the need to explore and take up every opportunity for delivery of savings at the earliest opportunity and that there was still work to do. She also noted that she considered that putting this as an unscheduled item on a joint board was neither appropriate or helpful. She also felt a much wider discussion around all aspects of BCF funding was needed.

It was agreed that further and continued dialogue on these matters was required, particularly given the serious impact that the financial withdrawal of section 75 funding could have on residents. It was agreed that any further focus at the board would be scheduled so that all members were prepared for it.

161. WORK PROGRAMME

Noted.

162. DATES OF NEXT MEETINGS

The next meeting of the Board was noted as Wednesday, 30 January 2019.

Meeting started: 6pm
Meeting ended: 8.05pm

Chair ....

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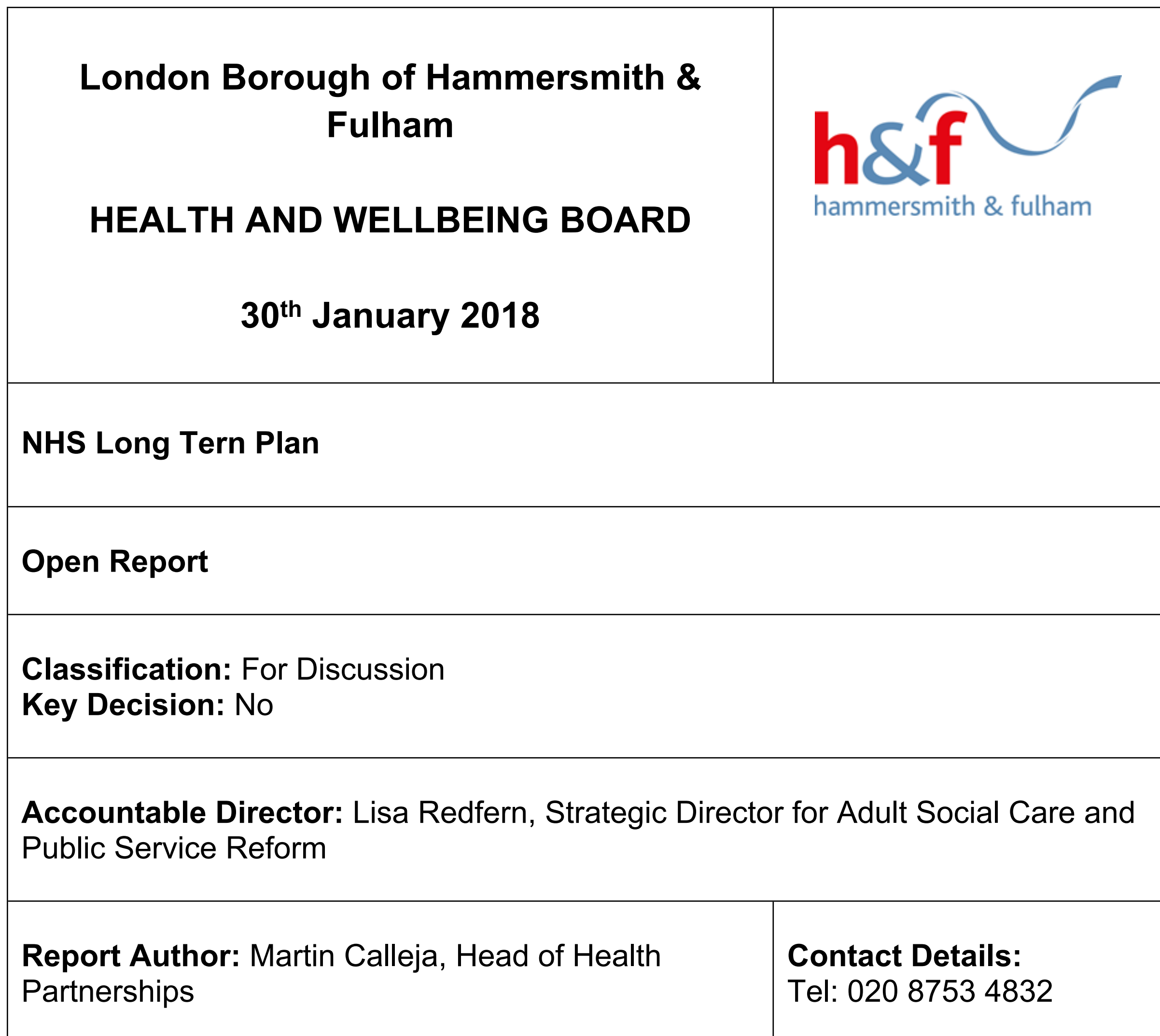


London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **30th January 2018**	hammersmith & fulham
NHS Long Tern Plan	
Open Report	
Classification: For Discussion **Key Decision:** No	
Accountable Director: Lisa Redfern, Strategic Director for Adult Social Care and Public Service Reform	
Report Author: Martin Calleja, Head of Health Partnerships	**Contact Details:** Tel: 020 8753 4832

1. Summary

1.1 The NHS Long Term Plan was published on the 7th of January 2019. This national plan sets out a policy and service development agenda for local NHS services. It aims to accelerate the re-design of patient care and future-proof the NHS for the decade ahead. It is supported by an increase in funding for the next five years.

1.2 The plan has significant implications for social care services and advises that further proposals for social care and health integration will be set out in the forthcoming Green Paper on adult social care. This will be published 'at the first opportunity in 2019'.

1.3 The official NHS summary of the local plan and link to the full document is set out in appendix 1. The plan covers two broad and interrelated agendas. This first sets out a range of continuing commitments for service improvement and better outcomes. The second sets out the requirements for system change and

transformation including the key changes that constitute a ‘new service model for the 21st Century’.

1.4 The Board are asked to take an initial consideration of;

- The impact of the key changes and requirements set out for local NHS and Social Care services.
- What the overall additional funding provisions and specific commitments (for targeting a higher share of funding for areas with high health inequalities, funding of new evidence based NHS prevention programmes and supporting financial recovery) mean for Hammersmith and Fulham.
- How local governance and management arrangements will need to work and evolve. Firstly, to deliver the initial local plan and five-year local plan (by April 19 and Autumn 2019 respectively) and secondly, in response to the increased focus on NHS organisations working with their local partners, as ‘Integrated Care Systems’ - growing out of the current network of Sustainability and Transformation Partnerships (STPs) – to plan and deliver services.

1.5 Key and specific local issues relevant to this consideration include;

1.5.1 The CCG’s current financial position and developing plan to achieve recovery. Specifically, how this may impact on delivery of all the plan’s required commitments and aspiration for sustainability.

1.5.2 The proposed mandate for Integrated Care Systems, working across borough boundaries, to lead on the development of local health services and the assumption in the new plan that increased investment in community and primary care will not necessarily reduce the need for hospital beds. This has implications for the developing North-West London Sustainability and Transformation Plan (STP) and position for Charing Cross Hospital.

1.5.3 The developing local agenda for preventing illness and tackling health inequalities and role of the Health and Wellbeing Board in strategic leadership and managing resources. Specifically, the complementary role of the NHS to that of local government that is set out in the plan and the commitments set out for increasing social prescribing.

NHS

The NHS Long Term Plan – a summary

Find out more: www.longtermplan.nhs.uk | Join the conversation: #NHSLongTermPlan

Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment.

Our plan has been drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. And they have benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.

This summary sets out the key things you can expect to see and hear about over the next few months and years, as local NHS organisations work with their partners to turn the ambitions in the plan into improvements in services in every part of England.

What the NHS Long Term Plan will deliver for patients

These are just some of the ways that we want to improve care for patients over the next ten years:

Making sure everyone gets the best start in life	• reducing stillbirths and mother and child deaths during birth by 50% • ensuring most women can benefit from continuity of carer through and beyond their pregnancy, targeted towards those who will benefit most • providing extra support for expectant mothers at risk of premature birth • expanding support for perinatal mental health conditions • taking further action on childhood obesity • increasing funding for children and young people's mental health • bringing down waiting times for autism assessments • providing the right care for children with a learning disability • delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy.
Delivering world-class care for major health problems	• preventing 150,000 heart attacks, strokes and dementia cases • providing education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths • saving 55,000 more lives a year by diagnosing more cancers early • investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital • spending at least £2.3bn more a year on mental health care • helping 380,000 more people get therapy for depression and anxiety by 2023/24 • delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.
Supporting people to age well	• increasing funding for primary and community care by at least £4.5bn • bringing together different professionals to coordinate care better • helping more people to live independently at home for longer • developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home. • upgrading NHS staff support to people living in care homes. • improving the recognition of carers and support they receive • making further progress on care for people with dementia • giving more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

How we will deliver the ambitions of the NHS Long Term Plan

To ensure that the NHS can achieve the ambitious improvements we want to see for patients over the next ten years, the NHS Long Term Plan also sets out how we think we can overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. **Doing things differently:** we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

2. **Preventing illness and tackling health inequalities:** the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

3. **Backing our workforce:** we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

4. **Making better use of data and digital technology:** we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

5. **Getting the most out of taxpayers' investment in the NHS:** we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly-used products for cheaper, and reduce spend on administration.

What happens next

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), which are groups of local NHS organisations working together with each other, local councils and other partners, now need to develop and implement their own strategies for the next five years.

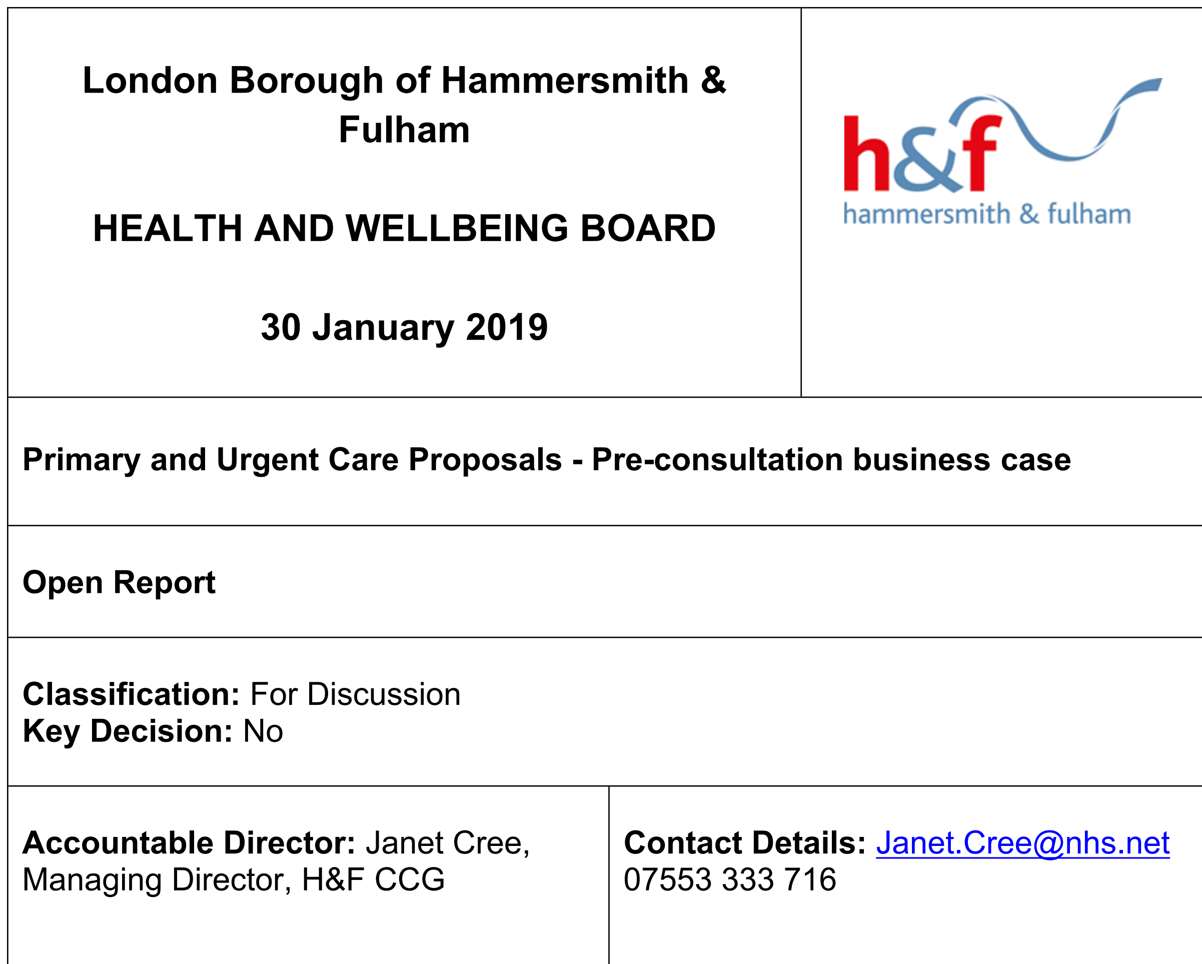
These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

This means that over the next few months, whether you are NHS staff, a patient or a member of the public, you will have the opportunity to help shape what the NHS Long Term Plan means for your area, and how the services you use or work in need to change and improve.

To help with this, we will work with local Healthwatch groups to support NHS teams in ensuring that the views of patients and the public are heard, and Age UK will be leading work with other charities to provide extra opportunities to hear from people with specific needs or concerns.

Find out more

More information is available at www.longtermplan.nhs.uk, and your local NHS teams will soon be sharing details of what it may mean in your area, and how you can help shape their plans.



London Borough of Hammersmith & Fulham HEALTH AND WELLBEING BOARD 30 January 2019	hammersmith & fulham
Primary and Urgent Care Proposals - Pre-consultation business case	
Open Report	
Classification: For Discussion **Key Decision:** No	
Accountable Director: Janet Cree, Managing Director, H&F CCG	**Contact Details:** Janet.Cree@nhs.net 07553 333 716

1 Summary

1.1 The CCG is under financial pressure and needs to ensure it is using money in the most efficient way. The urgent care contracts are up for renewal so it is an opportune time to look at the current demand for services and to discuss whether savings can be made by reducing services when there is little or no usage from residents. Our data suggests that what we are currently paying for is not good value for money.

1.2 As part of this, the CCG is also looking at GP appointments provided outside core hours.

1.3 The report sets out four options. Consultation on these is planned to commence in early February lasting six weeks.

1.4 The Health and Wellbeing Board is asked to consider the report and provide feedback on the approach to consultation and whether it would like to formally respond to the consultation.

Primary and urgent care proposals

Pre-consultation business case

08 January 2019

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Executive summary

This paper from Hammersmith and Fulham CCG looks at the urgent care and out of hours primary care provision in the borough and makes proposals about the hours of those services.

Included is the case for change which includes the digital vision of the CCG to increase ease of access to services, the current usage of the two urgent care centres and the out of hours services as well as the public and stakeholder engagement to date and plans for consultation. Plans for consultation have taken into account best practice identified through The Consultation Institute and by looking at the Council's own approach.

The CCG is looking at this now as it is under financial pressure and needs to ensure it is using money in the most efficient way. The urgent care contracts are up for renewal so it is an opportune time to look at the current demand for services and to discuss whether savings can be made by reducing services when there is little or no usage from residents. Our data suggests that what we are currently paying for is not good value for money.

The proposals, set out in chapter 4, are:

- To make no changes to the Urgent Care Centre at Charing Cross
- To change the hours of the Urgent Care Centre at Hammersmith Hospital to close it overnight from Midnight to 8am when it has a low volume of attendances and the majority do not require the services of the UCC.
- To reduce the number of GP appointments available outside the core hours of 8am to 6.30pm by 155 GP appointments a week in line with demand
- To look at the number of hubs providing weekend plus services to all Hammersmith & Fulham residents registered with any GP in the borough.

The consultation is currently planned to start in early February 2019, subject to appropriate assurance and decision making. It will cover the whole borough and neighbouring boroughs where there is a regular flow of activity to Hammersmith UCC. Consultation period is planned to be over six weeks. We will develop printed materials and a section on our website for all the information on the proposals as well as questions for people to respond to. Translations would be available online or on request. More information on this is set out in chapter five.

Hammersmith and Fulham Clinical Commissioning Group Governing Body were asked to agree the following and did so:

- **Approve** the pre-consultation business case
- **Approve** the CCG starting public consultation on the proposals set out in the pre-consultation business case (subject to NHS England assurance).
- **Approve** the consultation approach set out in the pre-consultation business case

1. Case for change

1.1 About the London Borough of Hammersmith & Fulham

Hammersmith & Fulham is a London borough to the West of London and is bordered by the Thames to the South. Covering an area of $6.33m^2$, the borough has around 183,000 residents making it one of the smallest boroughs in London. It is part of the NW London Collaboration of CCGs which includes eight London Boroughs and is also part of the NW London Health and Care Partnership (or STP).

The borough has 41 pharmacies, 29 GP surgeries with a total registered population of 252,357[1], two hospitals – both with an urgent care centre - and one emergency department (ED). The two hospitals are just two miles apart as the crow flies, or 2.4 miles apart by road.

It is a diverse London borough and a large proportion of the population are young working age residents with a low proportion of residents aged 65 and over (although this is increasing), and the fifth lowest number of children of any London borough.

- The area has high levels of migration in and out of the borough, and significant ethnic and cultural diversity.
- 32% of the population is from Black, Asian and Minority groups (BAME).
- Levels of affluence vary widely, creating inequalities within small geographical areas.
- Life expectancy for men is 79.1 years and 83.3 years for women.
- Around a third (29%) of children under 16 in Hammersmith & Fulham were classified as living in poverty in 2011, higher than London (27%) and England (21%) according to official definitions.
- Foreign-born residents made up 43 per cent of the Borough's population in 2011 - up from 34 per cent in 2001 (London 37 per cent and England & Wales 13 per cent); this is the tenth highest level of any local authority in England & Wales.
- 14.5 per cent of households have no people that speak English as a main language; this is the thirteenth highest proportion in England & Wales.

1.2 Digital vision – right care, right place, first time

Hammersmith & Fulham CCG's vision for digital innovation is simple - to make it easier for residents to access the care they need and to increase choice.

At a time where over 78% of UK adults[2] (including 77% of 55-75 year olds[3]) have a smartphone and wish to access services at a time convenient for themselves, it is essential for the local NHS to respond to that demand and ensure that healthcare,

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[1] NHS Digital, October 2018
[2] Ofcom 2018 communications market report
[3] Deloitte 2017

where appropriate, can be provided in a way that harnesses the advantages offered by modern technology.

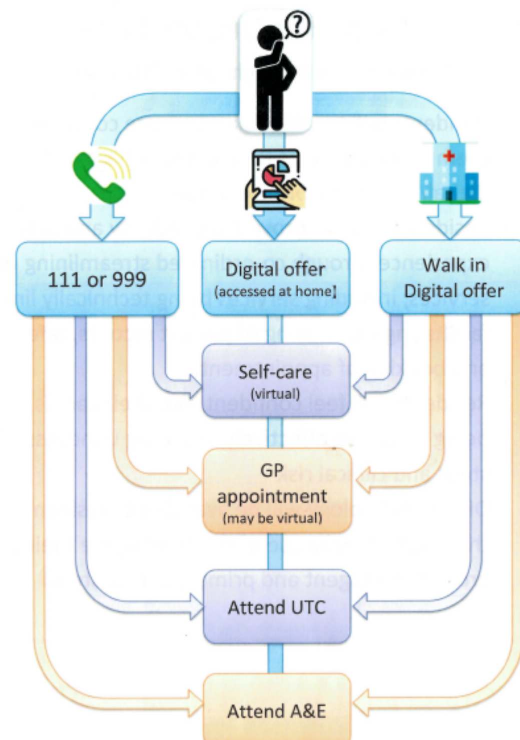
As well as providing convenience for patients, the implementation of the digital vision will lead to greater efficiencies for our staff. In addition, making it easier for patients to access the information they need will increase understanding of the appropriate setting of care for their concern and reduce mis-use of services such as the Emergency Department (or A&E), leaving them more able to focus on those who need life-saving treatment.

The benefit also extends to those who may prefer more traditional routes of accessing information and appointments as there will be fewer people using those routes meaning it should be quicker to do things like get through to your GP surgery on the phone.

Hammersmith & Fulham CCG's vision is that an individual's first point of contact would be through a digital channel, creating a single point of access for patients to access Primary or Urgent Care via an integrated digital model. Unlike models such as GP at Hand, the digital offer being developed by the CCGs for Hammersmith & Fulham will not affect a patient's registration with their practice.

Hammersmith & Fulham CCG have set four principles for their digital vision:

- Residents will be able to access care convenient to themselves at a location of their choice (this may be digital, telephone or face to face)
- Residents have improved accessibility and patient experience through coordinated streamlining of services, including being technically linked facilitating the sharing of patient records, referrals and booking of appointments
- Residents will feel confidence that their care is being managed effectively, reducing unnecessary steps and clinical risk
- Digital technology will be available to resident that wish to make use of this to navigate their way around the urgent and primary care system.



1.3 Financial challenges

Hammersmith & Fulham CCG is in a challenged financial position. Like other CCGs, it has a limited amount of money to spend and needs to ensure budget is used as effectively and fairly as possible for all patients and residents. It is therefore

appropriate to look at the services we provide, their effectively and utilisation and consider how we can best provide services for everyone.

Our data suggests that what we are currently paying for is not good value for money as we are paying for some services that have under usage from residents. Out of hours GP appointments are currently provided through three different ways. This has resulted in the CCG spending going beyond national requirements and our data suggests that this also results in a different level of access depending on where you live in the borough. Whilst we recognise that extended hours provided in practices are valued by patients, we need to ensure that our spend on this is in line with the nationally-commissioned service (DES).

It is estimated that the financial implication of the proposals in this document would be a cost saving in the region of £1million per year for Hammersmith and Fulham.

1.4 Primary and urgent care

We have an opportunity to consider how we harness technology to improve our offer for those who would benefit from digital access, and to free up capacity within more traditional access routes for those who prefer these.

The contracts for urgent care centres at Hammersmith Hospital and Charing Cross are coming to an end and, in line with national guidance, we are implementing Urgent Treatment Centres. The draft NW London performance indicators for Urgent Treatment Centres are set out in appendix 1.

As urgent care and urgent treatment centres form the urgent end of primary care access, it was also deemed necessary and appropriate to review our wider GP appointment access outside of core hours, and how this should look in the future.

Hammersmith & Fulham CCG is taking this forward by looking at the status quo to understand the utilisation of these services, whether the current operating hours are the most appropriate and how a modern digital offering can enhance the primary and urgent care provision in the borough.

2. Status quo

2.1 Hammersmith Urgent Care Centre (UCC)

Hammersmith UCC is currently open 24/7 and based at Hammersmith Hospital in the north of the borough. The UCC has been standalone since the Emergency Department, or A&E, closed in September 2014. It was at this point that it became a 24/7 UCC service as part of the implementation of Shaping a Healthier Future.

The UCC is adjacent to one of the most deprived wards in the borough according to Indices of Multiple Deprivation data.

Hammersmith UCC is a contract held by Imperial and operated by London Central & West Unscheduled Care Collaborative (LCW).

2.1.1 Current attendance levels

Hammersmith UCC saw nearly 33,000 patients in 17/18, an average of 629 a week. Just under 8% of all attendances occur in the period between midnight and 8am.

Table 1: Hammersmith UCC: Average number of attendances – by time of day and day of the week, 17/18

Hammersmith - 17/18 - average per week

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Row total	Period total
00:00-01:00	1	1	1	1	2	2	1	10	48
01:00-02:00	1	1	1	1	1	1	1	6	
02:00-03:00	1	1	0	0	1	1	1	5	
03:00-04:00	1	0	0	0	0	1	1	3	
04:00-05:00	0	1	0	0	0	1	1	3	
05:00-06:00	0	1	0	0	0	1	0	3	
06:00-07:00	1	1	1	1	1	1	1	6	
07:00-08:00	2	2	2	2	2	2	1	11	
08:00-09:00	5	4	4	4	3	3	3	26	581
09:00-10:00	7	6	6	6	6	5	5	40	
10:00-11:00	7	6	7	7	6	7	6	46	
11:00-12:00	7	7	8	6	6	7	7	48	
12:00-13:00	8	6	6	6	6	7	6	45	
13:00-14:00	7	6	6	6	5	7	7	42	
14:00-15:00	7	6	5	5	5	6	6	41	
15:00-16:00	6	6	5	5	5	7	5	39	
16:00-17:00	6	5	5	5	5	6	5	37	
17:00-18:00	6	6	6	6	6	5	4	40	
18:00-19:00	6	6	6	6	5	5	4	39	
19:00-20:00	6	5	6	6	5	5	4	37	
20:00-21:00	5	6	5	5	4	4	4	33	
21:00-22:00	5	5	4	4	4	4	4	30	
22:00-23:00	3	3	3	3	3	3	3	22	
23:00-00:00	2	2	2	2	2	2	2	15	
	98	93	91	88	84	91	83	629	100%

Hammersmith - 17/18 - total in year

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Row total	Period total
00:00-01:00	73	68	69	60	92	85	69	516	2,527
01:00-02:00	45	49	43	37	45	61	52	332	
02:00-03:00	35	44	21	23	34	42	45	244	
03:00-04:00	29	26	23	21	18	30	33	180	
04:00-05:00	20	27	21	26	14	30	31	169	
05:00-06:00	23	32	22	20	21	31	25	174	
06:00-07:00	42	50	40	35	47	62	51	327	
07:00-08:00	81	80	84	90	87	87	76	585	
08:00-09:00	243	212	191	217	180	158	166	1,367	30,269
09:00-10:00	349	309	328	288	290	260	266	2,090	
10:00-11:00	360	337	348	350	337	355	296	2,383	
11:00-12:00	385	339	398	328	327	363	346	2,486	
12:00-13:00	399	314	318	292	321	351	336	2,331	
13:00-14:00	352	289	297	321	267	346	341	2,213	
14:00-15:00	343	333	279	281	278	327	314	2,155	
15:00-16:00	302	307	268	285	243	349	278	2,032	
16:00-17:00	303	285	258	284	245	326	245	1,946	
17:00-18:00	324	331	322	338	292	252	220	2,079	
18:00-19:00	312	333	326	311	276	261	228	2,047	
19:00-20:00	317	285	324	294	262	248	220	1,950	
20:00-21:00	268	306	279	248	225	206	208	1,740	
21:00-22:00	239	237	231	195	225	197	217	1,541	
22:00-23:00	166	153	151	162	154	180	156	1,122	
23:00-00:00	125	114	103	98	125	127	95	787	
	5135	4860	4744	4604	4405	4734	4314	32,796	100%

There is an average of seven visits a night and, although this can vary, 90% of all night times have between three and 11 attendances.

Graph 1: Hammersmith UCC: Number of night time attendances by date, 17/18

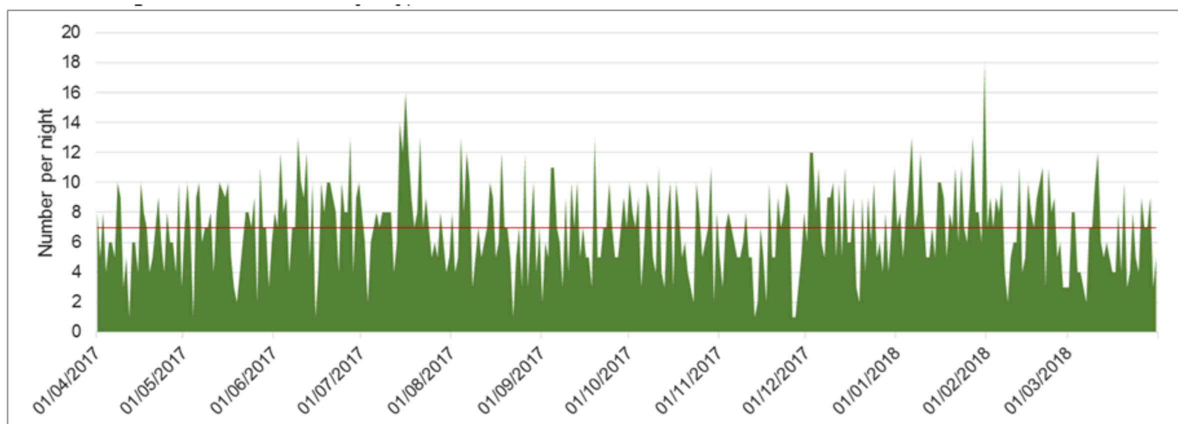


Table 2: Hammersmith UCC: Typical daily volume of attendances in a night-time (Midnight to 8am)

	Attendances
Average per night	7
Most common per night	5
Lowest per night - in year	1
Highest per night - in year	18

A third of people who use the service at night also use it during the day. However, repeat night time attendance is quite rare with only one in 10 patients coming at night more than once in the year.

Eight out of 10 night time attendances are for working age adults, with the rate of visiting higher for this group than for children and older people.

Table 3: Hammersmith UCC: Night-time attendances by age, 17/18

	Per week	Per month	Per year	%
0-4	3	11	131	5%
5-19	5	21	257	10%
20-44	30	129	1,550	61%
45-64	9	40	474	19%
65+	2	10	115	5%
Total	**48**	**211**	**2,527**	**100%**

The gender split at night is representative of the general population, unlike during the day, where women outnumber men. More information on the social-demographic breakdown of attendances is available in appendix 2.

A third of night time attendances are for people living in Hammersmith & Fulham (this is approx. 1-2 patients per night), followed by a quarter from Ealing. Over a half are from a 3km radius, such as East Acton and White City. This area tends to be more deprived than average for London. People from these areas may have slightly

higher rates of illness and disability than typical. Maps showing the location of attendees and average distance travelled are in appendices 3 & 4.

2.1.2 Clinical summary of attendances

Arrival

Overnight, 98% of attendees (which is on average 47 a week) to Hammersmith UCC self-present with the remaining 2% (on average one a week) sent by 111.

Table 4: Hammersmith UCC – Number of attendances by mode of attendance, 17/18

	Average daily number		Average weekly number		Percent of total	
	In night	In day	In night	In day	In night	In day
Walked In	7	82	47	577	98%	99%
Sent by 111	0	0	1	3	2%	1%
London Ambulance Service	0	0	0	1	0%	0%
Other	0	0	0	0	0%	0%
Total	**7**	**83**	**48**	**581**	**100%**	**100%**

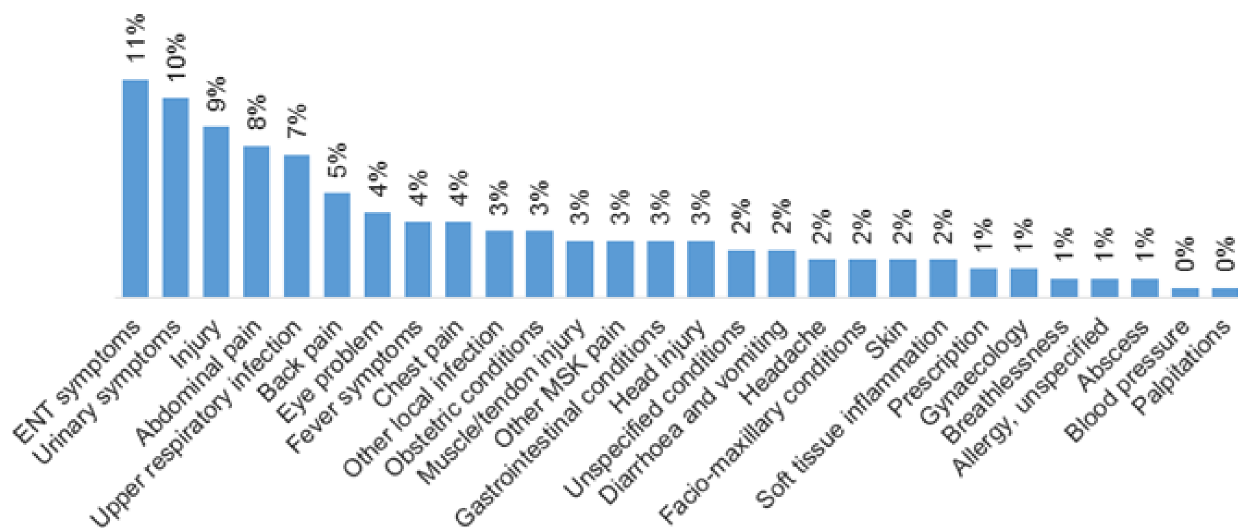
Reason for attendance

A clinical audit was carried out by Hammersmith and Fulham CCG of 250 records of 17/18 night time attendances with sufficient detail available on 238 of these records.

The 250 records were a random 10% sample of 17/18 night time attendances.

The graph below summarises the results of the clinical audit with regard to the presenting complaints/diagnosis of those attending Hammersmith UCC overnight.

Graph 2: Hammersmith UCC – Presenting complaint/diagnosis from audit of night time attendances



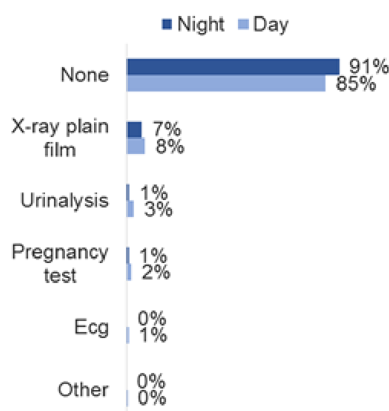
Treatment and investigations

For around three quarters of attendances, the treatment provided was advice and/ or simple medication. Most other attendances were given wound care/ dressing or simple MSK care such as slings/ tubigrips.

The graph below shows the investigations undertaken for those attending the UCC in 17/18, showing that the majority are discharged with no investigation. The data identifies 9% of patients needing investigation/ treatment at night, compared to 15% during the day.

On average, this equates to just 4 patients a week needing investigation or treatment overnight, compared to 85 patients per week during the day

Graph 3: Hammersmith UCC – investigations by day and night, 17/18



Outcomes

Routine data from the provider identifies an average of seven patients attending per night, of whom around six were discharged and one (15%) was referred to an emergency department (ED) which equates to seven per week.

Table 5: Hammersmith UCC – Number of attendances by outcome of attendance, 17/18

	Average daily number		Average weekly number		Percent of total	
	In night	In day	In night	In day	In night	In day
Discharged	6	70	41	492	85%	85%
Referred to Emergency Dept	1	13	7	89	15%	15%
Total	**7**	**83**	**48**	**581**	**100%**	**100%**

Data matching of NW London UCC and hospital admissions data (17/18) shows around 6-7% of patients attending the UCC at night time go on to be admitted as a non-elective admission the same day or following day after the attendance – around three a patients a week.

The clinical audit of 250 attendances at Hammersmith UCC between midnight and 8am identified 29% of night time attendances requiring UCC/ED attendances that night (12% UCC; 16% ED). Applied to daily numbers, this would equate to two of the seven current night time attendances requiring care in UCC/ED that same night (or 14 per week).

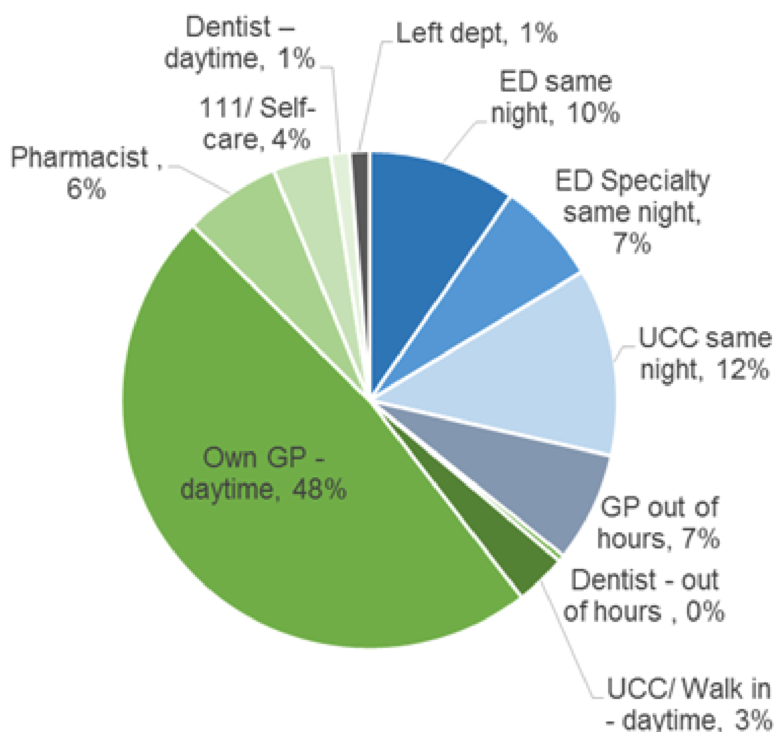
Table 6: Hammersmith UCC – Estimated number of night time attendances requiring UCC/ED same night (Audit percentage applied to attendance data)

	Average number per night	Average number per week	Percent of total
Need ED/ED Specialty same night	1	8	16%
Need UCC same night	1	6	12%
Need 'other' same night	1	4	8%
Need care next day	4	31	64%
Total	**7**	**48**	**100%**

Alternative care pathway

As reflected in table 6 above, the clinical audit found that suitable care for close to half (48%) of those attending at night would have been a GP appointment the following day. For those who do require an ED, currently the further onward transport requirement from this standalone UCC does add some clinical risk.

Graph 4: Hammersmith UCC – Outcome of clinical audit, appropriate presentation for those who came to UCC overnight



2.1.3 Workforce

Overnight, there are four staff in the urgent care centre:

- 2 Receptionists (shift 10pm – 8am)
- 1 GP (shift 11pm – 8am)
- 1 ENP (shift 8pm – 8am)

The provider is not reporting any issues filing these shifts as they are able to mitigate any emerging issues within their organisation. However, it is not without difficulty – the Provider has flagged that often shifts are harder to fill due to the clinical safety risks felt by staff of operating a standalone UCC overnight.

2.1.4 Financial cost of service

When the service moved to 24/7 in 2014, the additional contract value for the overnight hours was approximately £600,000 per year.

2.1.5 Performance

Hammersmith UCC has been fully compliant with the contractual five clinical quality indicators. We are moving towards reporting against the 14 NW London key performance indicators (KPIs) from 19/20 which are outlined in appendix 1.

Table 7: Hammersmith UCC – performance against five clinical quality indicators.

		Hammersmith UCC		
	target	July	Aug	Sept
Unplanned re-attendance at UCC within 7 days of original attendance	< 5%	3.3%	4.2%	3.5%
95th Percentile wait above 4 hours	95%	99%	99%	99%
Percentage of patients who left without being seen.	<5%	3.6%	2.3%	2.8%
Service Experience/FFT	>75%	99%	100%	100%
Median time to treatment (<60mins) minutes wait	50%	64.5%	76.3%	72.3%

2.1.6 Friends and family

The friends and family results from quarter two 2018/19 show that 99.6% would recommend the service at Hammersmith UCC to friends and families. This was out of 918 responses.

2.1.7 Care Quality Commission (CQC)

The February 2018 CQC inspection of Urgent and Emergency Care at Imperial did not include Hammersmith UCC.

2.2 Charing Cross Urgent Care Centre (UCC)

Charing Cross UCC is currently open 24/7 and is co-located with Charing Cross Hospital Emergency Department (ED) in the south of the borough. The ED at Charing Cross does not see children although the UCC does.

Charing Cross UCC is also operated by London Central & West Unscheduled Care Collaborative (LCW).

2.2.1 Current attendance levels

Charing Cross UCC saw just over 47,000 patients in 17/18, an average of 908 patients a week. Just under 11% of all attendances occur in the period between midnight and 8am with 4% occurring between 2am and 6am.

Table 8: Charing Cross UCC – Average number of attendances, by time of day and day of the week, 17/18

Charing Cross - 17/18 - average per week

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun		
00:00-01:00	3	2	2	3	2	3	3	18	99
01:00-02:00	2	2	2	2	2	2	2	14	
02:00-03:00	2	2	1	2	1	1	2	10	
03:00-04:00	1	1	1	2	1	2	1	9	
04:00-05:00	1	1	1	1	1	1	1	7	
05:00-06:00	1	1	1	1	1	1	1	9	
06:00-07:00	2	2	1	1	2	2	2	12	
07:00-08:00	3	3	3	3	3	3	3	20	
08:00-09:00	6	5	6	6	5	5	5	38	809
09:00-10:00	10	8	9	9	9	8	7	59	
10:00-11:00	11	10	9	9	8	10	9	66	
11:00-12:00	11	9	8	9	9	10	10	65	
12:00-13:00	10	8	8	8	7	10	9	62	
13:00-14:00	9	8	8	8	8	10	9	60	
14:00-15:00	9	8	8	8	7	10	8	59	
15:00-16:00	9	8	8	8	8	8	8	56	
16:00-17:00	8	8	7	8	8	8	7	54	
17:00-18:00	9	8	8	7	7	7	7	53	
18:00-19:00	9	8	8	8	7	7	6	53	
19:00-20:00	8	8	7	7	7	6	6	48	
20:00-21:00	7	7	7	7	6	6	6	45	
21:00-22:00	6	5	5	6	5	5	6	38	
22:00-23:00	4	5	4	4	5	4	4	30	
23:00-00:00	4	3	3	3	3	3	3	23	
	144	131	126	129	122	131	126	908	100%

36 attendances per week in 2am-6am slot

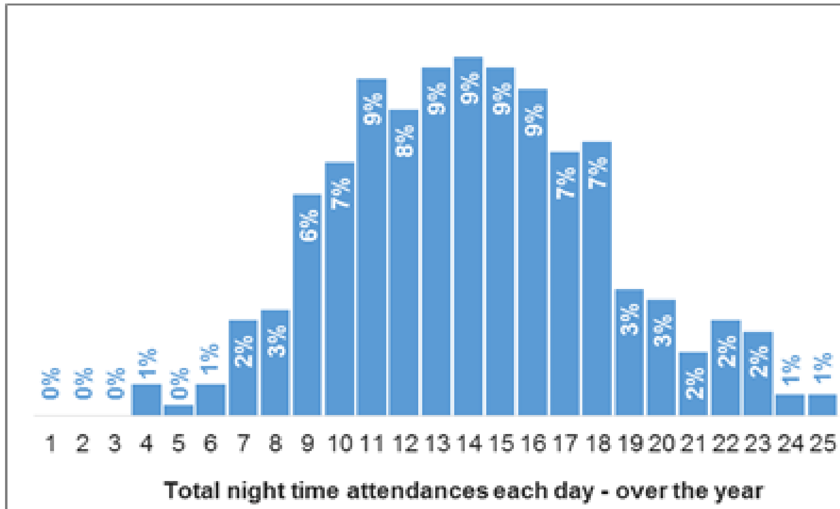
Charing Cross - 17/18 - total in year

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun		
00:00-01:00	132	126	123	143	124	139	138	925	5,150
01:00-02:00	97	112	98	102	94	111	92	706	
02:00-03:00	87	80	66	79	66	74	84	536	
03:00-04:00	66	61	54	80	74	80	71	486	
04:00-05:00	47	59	57	50	49	52	77	391	
05:00-06:00	75	47	72	65	59	58	71	447	
06:00-07:00	99	90	74	71	85	83	101	603	
07:00-08:00	173	155	142	141	151	158	136	1,056	
08:00-09:00	330	274	295	311	248	274	246	1,978	42,180
09:00-10:00	510	438	462	458	453	416	361	3,098	
10:00-11:00	589	508	460	481	421	496	485	3,440	
11:00-12:00	548	475	441	463	464	503	507	3,401	
12:00-13:00	547	427	419	422	388	516	491	3,210	
13:00-14:00	494	439	415	402	407	513	484	3,154	
14:00-15:00	468	427	412	437	391	496	436	3,067	
15:00-16:00	446	405	419	425	404	437	401	2,937	
16:00-17:00	401	429	388	397	397	419	364	2,795	
17:00-18:00	448	413	424	357	366	387	355	2,750	
18:00-19:00	462	441	397	418	370	343	323	2,754	
19:00-20:00	392	395	375	372	344	297	324	2,499	
20:00-21:00	349	369	342	351	306	315	315	2,347	
21:00-22:00	305	262	278	301	254	268	288	1,956	
22:00-23:00	231	242	206	232	242	213	222	1,588	
23:00-00:00	197	165	159	144	181	179	181	1,206	
	7493	6839	6578	6702	6338	6827	6553	47,330	100%

1,860 attendances per year in 2am-6am slot

There are typically around 14 visits a night, although this can vary considerably. 90% of all night times (midnight to 8am) have between 8 and 20 attendances.

Graph 5: Charing Cross UCC – Night time attendance count, 17/18



Graph 6: Charing Cross UCC – Number of night time attendances by date, 17/18

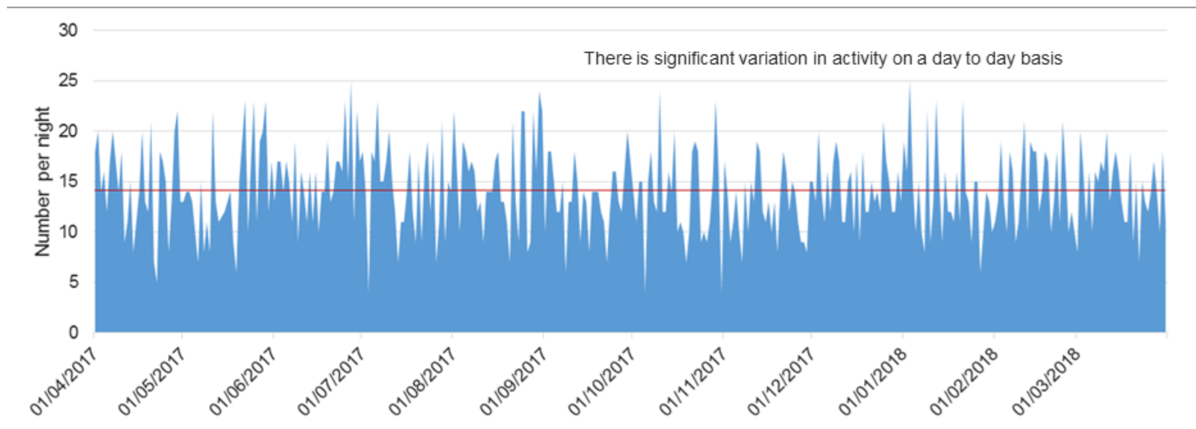


Table 9: Charing Cross UCC – Typical daily volume of attendances in a night-time (Midnight to 8am)

	Attendances
Average per night	14
Most common per night	14
Lowest per night - in year	4
Highest per night - in year	25

A quarter of people who use the service at night also use it during the day. Repeat night time attendance is quite rare with only one in 10 patients coming in at night more than once in the year.

85% of attendances between midnight and 8am are for working age adults, with the rate of visiting higher for this group than for older people and much higher than for children.

Table 10: Charing Cross UCC – Night-time attendance by age, 17/18

	Per week	Per month	Per year	%
0-4	1	5	64	1%
5-19	6	26	317	6%
20-44	60	259	3,110	60%
45-64	25	107	1,280	25%
65+	7	32	379	7%
Total	**99**	**429**	**5,150**	**100%**

Men are over-represented at night compared to the general population, unlike during the day, where women outnumber men. More socio-economic information on Charing Cross UCC overnight attendees can be found in appendix 5.

Half of night time attendances are for people living in Hammersmith & Fulham (H&F), followed by 1 in 10 from Ealing. The majority are from a 3km radius, such as Hammersmith/ Shepherd's Bush.

People from these areas may have slightly lower rates of illness and disability compared to London and deprivation is broadly similar. More location information on Charing Cross UCC overnight attendees can be found in appendices 6 & 7.

2.2.2 Clinical summary of attendances

Arrival

Overnight, 91% of attendees (around 90 a week) to Charing Cross UCC self-present, with 7% (7 a week) being sent by 111 and the remaining 2% (2 a week) arriving by ambulance.

Table 11: Charing Cross UCC – Number of attendances by mode of attendance, 17/18

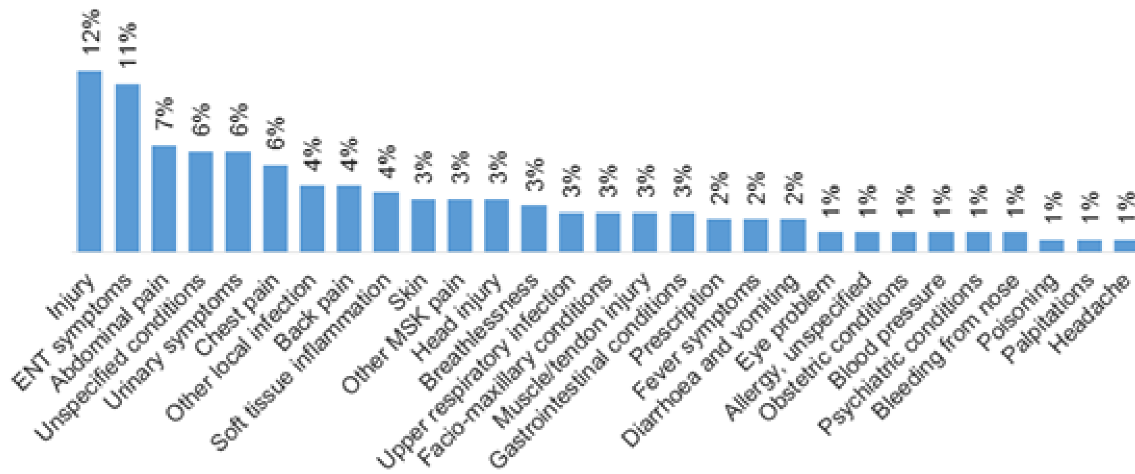
	Average daily number		Average weekly number		Percent of total	
	In night	In day	In night	In day	In night	In day
Walked In	13	110	90	773	91%	96%
Sent by 111	1	4	7	27	7%	3%
London Ambulance Service	0	1	2	8	2%	1%
Other	0	0	0	1	0%	0%
Total	**14**	**116**	**99**	**809**	**100%**	**100%**

Reason for attendance

A clinical audit was carried out by Hammersmith & Fulham CCG on 250 records of night time attendees at Charing Cross UCC. There was sufficient detail available on 245 of these records. The sample for the clinical audit was a completely random sample of 5% of overnight attendances in 17/18 (comparable to the Hammersmith Hospital sample size).

The graph below summarises the presenting complaints/diagnosis of those attending Charing Cross UCC overnight.

Graph 7: Charing Cross UCC – Presenting complain/diagnosis from audit of night time attendances



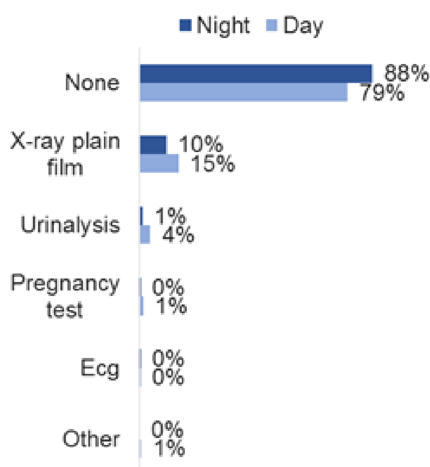
Treatment and investigations

As with Hammersmith UCC, for around three quarters of attendances, the treatment provided was advice and/ or simple medication. Most other attendances were given wound care/ dressing or simple MSK care such as slings/ tubigrips.

Routine NW London data identifies 12% of patients needing investigation/ treatment at night, compared to 21% during the day.

On average, this equates to just 12 patients a week need investigation or treatment overnight, compared to 170 patients a week during the day

Graph 8: Charing Cross UCC – investigations by day and night, 17/18



Outcomes

Routine data from the provider identifies around 14 patients attending per night, of whom around 11 were discharged and 3 (25%) were referred to an emergency department (24 per week).

Table 12: Charing Cross UCC – Number of attendances by outcome of attendance, 17/18

	Average daily number		Average weekly number		Percent of total	
	In night	In day	In night	In day	In night	In day
Discharged	11	87	74	611	75%	76%
Referred to Emergency Dept	3	28	24	198	25%	24%
Total	**14**	**116**	**99**	**809**	**100%**	**100%**

Data matching of NW London UCC and Hospital admissions data (17/18) shows around 5% of patients attending the UCC at night time go on to be admitted as a non-elective admission the same day or following day after the attendance – around 5 a patients a week.

The clinical audit found that 35% of those attending Charing Cross UCC between midnight and 8am required an ED or UCC that night. Applied to nightly numbers, this would equate to 5 of the 14 night time attendances requiring care in UCC/ED that same night (or 34 per week).

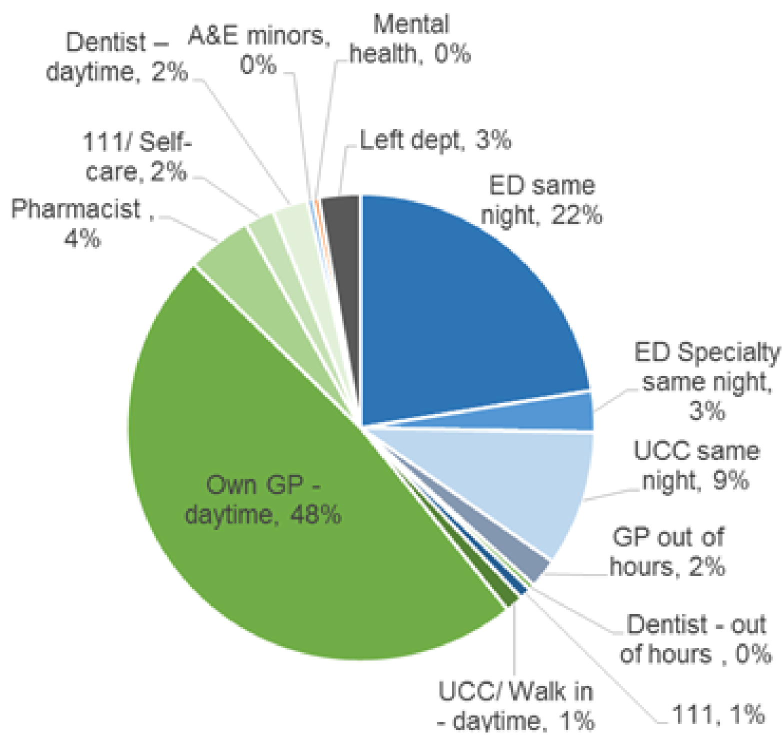
Table 13: Charing Cross UCC – Estimated number of time time attendances requiring UCC/ED same night (audit percentage applied to attendance data)

	Average number per night	Average number per week	Percent of total
Need ED/ED Specialty same night	4	25	25%
Need UCC same night	1	9	9%
Need 'other' same night	0	3	3%
Need care next day	9	61	62%
Total	**14**	**99**	**100%**

Alternative care pathway

As reflected in table 13 above, the clinical audit found that the suitable care for close to half (48%) of those attending at night would have been a GP appointment the following day.

Graph 9: Charing Cross UCC – Outcome of clinical audit, appropriate presentation for those who came to UCC overnight



2.2.3 Workforce

There are five staff in the UCC overnight:

- 2 Receptionists (shift 10pm – 8am)
- 1 GP (shift 11pm – 8am)
- 1 ENP (shift 8pm – 8am)
- 1 Health Care Assistant (shift 8pm – 8am)

2.2.4 Performance

Charing Cross UCC has been fully compliant with the contractual five clinical quality indicators. We are moving towards reporting against the 14 NW London key performance indicators (KPIs) from 19/20 which are set out in appendix 1.

Table 14: Charing Cross UCC – Performance against five clinical quality indicators.

		Charing Cross UCC		
	target	July	Aug	Sept
Unplanned re-attendance at UCC within 7 days of original attendance	< 5%	4.4%	4.9%	4.5%
95th Percentile wait above 4 hours	95%	99%	99%	99%
Percentage of patients who left without being seen.	<5%	4.3%	3.2%	3.4%
Service Experience/FFT	>75%	99%	97%	98%
Median time to treatment (<60mins) minutes wait	50%	52.2 %	54.1%	51.1%

2.2.5 Friends and family

The friends and family results from quarter two 2018/19 show that 98% would recommend the service at Charing Cross UCC to friends and families. This was out of 1147 responses.

2.2.6 Care Quality Commission (CQC)

The February 2018 CQC report on urgent and emergency services at Charing Cross had an overall rating of requires improvement. It is worth noting however that the actual report makes no reference to the UCC at Charing Cross Hospital.

https://www.cqc.org.uk/news/releases/imperial-college-healthcare-nhs-trust-rated-requires-improvement-cqc

2.3 GP appointments

2.3.1 Overview

There are 29 GP practices in Hammersmith & Fulham with a broad range of registered patient numbers. Data from October 2018:

- Largest practice – GP at Hand (raw 34,030, weighted 34,259)
- Second largest – North End Medical Centre (raw 19,602, weighted 17,048)
- Smallest practice – Salisbury Surgery (raw 1,182, weighted 1,171)

It should be noted that GP at Hand is a practice which offers digital-based services which, whilst a practice in Hammersmith & Fulham, has a high number of registered patients from outside the borough.

Hammersmith & Fulham CCG provides appointments for patients between 8am and 8pm, seven days a week through the weekend plus service. This national requirement will continue to be met.

765 additional GP appointments a week are currently commissioned through two schemes, extended hours and weekend plus.

2.3.2 Extended hours

Extended hours is about providing additional clinical capacity outside of core hours (8am-6:30pm). There are currently two schemes operating in Hammersmith & Fulham to deliver these appointments:

Local scheme: Under the locally commissioned services, (LCS) this is about individual GP practices providing the additional appointments to their own patients. 19 practices signed up to deliver the service in April 2018. The exact opening hours are flexible according to patient requirements but must be provided before or after core hours and any time over the weekend. Practices are not required to maintain service provision during Bank Holidays.

National scheme: Five practices in Hammersmith & Fulham are signed up to deliver extended hours as part of the national directed enhanced service scheme (DES). The national scheme mandates the number of extended hours that practices must provide per week based on a practice's list size.

2.3.3 Weekend plus

The service is aimed at providing additional clinical capacity outside of core hours for all patients registered in Hammersmith & Fulham to access and use. The CCG commission three Hubs; Brook Green Medical Centre, Cassidy Road Medical Centre and Parkview Practice. Each Hub is required to provide 1.5 hours per weekday and 12 hours over the course of a weekend. Whilst these appointments are available to all registered with a GP in the borough, it particularly ensures access to the patients of the five practices who currently do not provide extended hours services for their patients.

2.3.4 Current attendance levels

Average weekly utilisation of the appointments outside the core hours at the 19 practices operating the local extended hours scheme (LCS) is 82%.

Table 15: Utilisation of extended hours (LCS) at 19 sites in Hammersmith & Fulham (Weekly average)

Practice Name	Appointments offered	Appointments Booked	Appointments Attended	Utilisation
North End MC	43.7	43.2	38.7	**89%**
82 Lillie Road	62.6	59.7	56.3	**90%**
Richford Gate	27.5	27.0	22.7	**82%**
Brook Green MC	50.7	50.1	42.6	**84%**
Dr Jefferies	47.1	45.9	40.5	**86%**
Hammersmith Surgery	30.9	30.9	25.7	**83%**
Palace Surgery	27.5	24.6	22.4	**82%**
The New Surgery	32.3	31.3	28.0	**87%**
Bush Doctors	66.8	65.2	53.9	**81%**
Brook Green Surgery	36.1	35.3	28.9	**80%**
Sands End Clinic	50.5	49.3	39.4	**78%**
Dr Uppal	24.2	23.3	21.0	**87%**
Park Medical Centre	50.1	48.7	42.5	**85%**
Fulham Cross	19.7	17.5	15.7	**80%**
Dr Kukar, Parkview	13.8	10.0	8.8	**64%**
Salisbury Surgery	17.1	9.7	8.3	**48%**
Ashville Surgery	34.6	34.2	31.8	**92%**
Dr Kukar, Medical Centre	57.7	51.5	44.3	**77%**
	693	**657**	**572**	**82%**

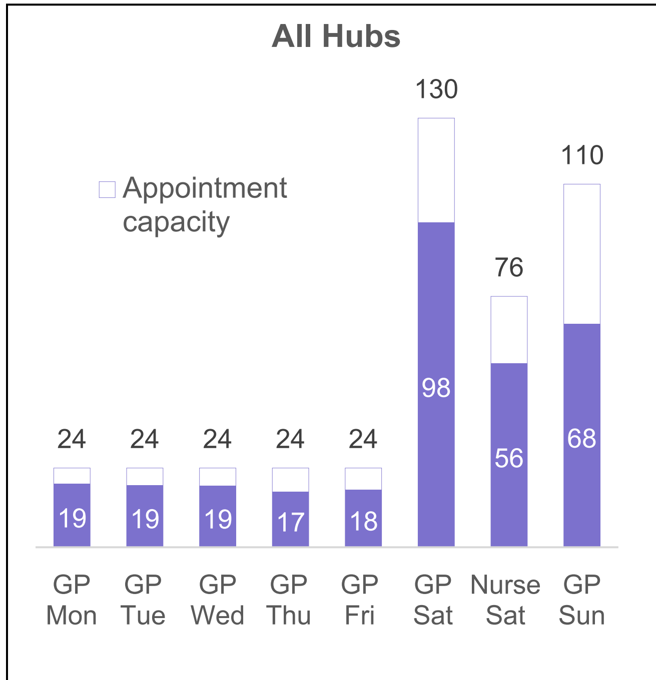
Average utilisation of the appointments outside the core hours at the three practices operating the national extended hours scheme (DES) is 83%. Although three practices have signed up to this scheme, only two have submitted returns to NHS England, meaning one signed up practice is not currently participating.

Table 16: Utilisation of extended hours (DES) at two sites in Hammersmith & Fulham (Weekly average)

Practice Name	Appointments offered	Appointments Booked	Appointments Attended	Utilisation
Lilyville Surgery	12.7	10.0	9.2	**72%**
Fulham Medical Centre	16.2	16.0	14.7	**91%**
	28.9	26.0	23.9	**83%**

Weekend plus – Average weekly utilisation of the appointments outside core hours at these three hubs is 72%.

Graph 10: Utilisation of weekend plus appointments at three hubs in Hammersmith & Fulham (weekly average)



2.3.5 Financial cost of service

- **Extended Hours Local Scheme (LCS)** funded from core CCG budgets (£614k)
- **Extended Hours Directed Enhanced Services (DES)** providing around eight hours a week funded from delegated budgets (£29k)
- **Weekend plus Services** providing 8am to 8pm, 7 day access to all patients registered and resident in the borough at three sites. Nurse appointments are available on a Saturday. This scheme is funded from core CCG budgets (£692k) and supplemented by General Practice Access Funding (GPAF) from NHS England (£480k).

3. **Involvement**

3.1 Principles & overview

Hammersmith & Fulham CCG have principles of engagement and co-design which have been developed with our patient partners. This sets out the importance of involving our residents and stakeholders from the start and listening to all views in the development of our plans.

We have undertaken pre-consultation engagement across two broad areas:

- Views on primary and urgent care
- Consultation approach

3.2 Public engagement

To date, the CCG has engaged with members of the public on primary and urgent care access at a number of local community events, focus groups and patient engagement events.

We have heard a range of views from the public, some of which have fed into our planned consultation approach and some of which are more relevant to the consultation itself and will therefore be considered at the appropriate time. A full list of the themes and feedback received to date can be found in appendix 11 and events held can be found in appendix 12.

3.3 Stakeholder engagement

3.3.1 Local Authority & political stakeholders

On 1 August a conference call took place to brief Cllr Coleman (Cabinet Member for Health and Adult Social Care) Lisa Redfern (Director of Adult Social Services) and Martin Calleja (Head of Health Partnerships) from the London Borough of Hammersmith & Fulham on plans to engage around possible changes to extended hours and weekend plus provision in the borough.

On 9 August the CCG responded to a subsequent letter from Cllr Coleman detailing the CCG's decision to engage and consult on the extended hours, weekend plus and Urgent Care Centre contracts at the same time. The letter proposed that a paper be taken to their health scrutiny committee.

Discussion has taken place at the CCG's Patient Reference Group, which includes both Cllr Quigley and representatives from Save our Hospitals in its membership, both in August and October 2018.

Cllr Patricia Quigley (Assistant to Cabinet) has been involved in discussions at the CCG's Patient Reference Group in both August and October.

On 12 October, the Hammersmith & Fulham CCG Managing Director, Head of Engagement and Director of Communications met with the Chair of the local Scrutiny panel and the Lead Councillor for health to outline the proposals, the clinical assurance process and agree the outline for the Scrutiny meeting item in December.

On 4 December the CCG presented a detailed paper at the Hammersmith and Fulham Council Health, Inclusion and Social Care Policy and Accountability Committee (HASPAC) and requested specific input on the approach to consultation. Committee members provided a number of comments and queries around the content of the proposals which were noted. The CCG has requested an opportunity to consult formally with the HASPAC in February 2019 on the proposals.

The following feedback on the proposed consultation process was provided by committee members:

- The contents of the paper should be shortened and simplified before sharing with local people;
- There needs to be more clarity within the paper as to whether the proposals stem from financial drivers;
- Would like to see clearer sequencing and timeline of how changes would be implemented and how the risk of changing pathways simultaneously which may impact on each other would be mitigated;
- Would like to know more on how the CCG will access seldom heard groups?

The following comments were made by members of the public present at the meeting:

- Important to ensure that people are actually fully aware of the current provision if they are to comment on proposals in an informed way;
- Need to show how we match availability to need rather than demand;
- Ensure we proactively reach out to people in the north of the borough, which has higher levels of deprivation and may have lower knowledge of what UCCs are.

On 11 December 2018 the CCG responded to a letter from Andy Slaughter which addressed the plans to bring forward proposals on urgent and primary care.

The paper presented to the Hammersmith & Fulham HASPAC was shared with Andy Slaughter MP, in lieu of a meeting which had to be cancelled due to the Brexit debate.

On 19 December, the CCG received a letter from HASPAC with supplementary questions following the earlier scrutiny meeting. The CCG is responding.

In early January 2019, information was sent to Councillors and MPs across Hammersmith & Fulham and neighbouring constituencies which are in the catchment of Hammersmith UCC. This provided an update on the proposals, a copy of this document and requested input into consultation process.

Also in early January, a letter was sent to Hammersmith & Fulham Health and Wellbeing Board to provide an update on proposals, a copy of this document and a request input into the consultation process and request time on the agenda for 30 January meeting.

3.3.2 Healthwatch

On Wednesday 25 July the CCG's engagement lead and Deputy Managing Director met with Healthwatch representatives to discuss engagement with young people. As part of this discussion, the intention to review and engage on current primary and urgent care access was shared. The CCG has been in on-going discussions with the Healthwatch CEO and officers via regular meetings and will continue to ensure that Healthwatch is closely involved throughout the consultation and engagement process.

Healthwatch has provided extensive support in gathering views of local people including by undertaking an "enter and view" on Hammersmith Urgent Care Centre to help gather engagement data on 22 September and 5 October 2018.

The draft report found that the UCC was delivering quick, safe, and effective urgent care services. The Dignity Champions observed that the clinical team provided a high standard of care in relation to dignity and respect. Patients and visitors had positive opinions about the UCC in general and spoke highly of the medical and administrative staff and the care they received.

The report is still awaiting finalisation following provider comments, but will be published by Healthwatch and signposted to by the CCG shortly.

3.3.3 GP practice staff

Information on the primary and urgent care access review was shared with GP practice staff via the CCG's weekly newsletter on 13 August 2018.

Initial discussions took place at the members' meeting and at network meetings on 8 August 2018 (North), 20 August 2018 (Central) and 23 August 2018 (South).

A further update on proposals and consultation approach was shared in letter to practices in early January.

3.3.4 Imperial College Healthcare NHS Trust

The Chief Operating Officer at LCW and the General Manager for Emergency Medicine and Urgent Care at Imperial have been fully sighted on the UCC element of the review. It was discussed at a performance meeting on 25 October 2018.

On the 2 November the Hammersmith & Fulham CCG Managing Director updated the senior Partners for Health team in a telephone conference. The plans and timeline were covered and the data set has been shared with them. Attendees included the Divisional Director of Operations, Medicine & Integrated Care ICHT, Interim Clinical Director, Division of Medicine & Integrated Care ICHT, Clinical Director for LCW and CEO of LCW.

In early January a letter was provided to LCW to share with their staff at Hammersmith UCC outlining the proposal, the consultation approach and inviting their feedback. We will working with their management team during the consultation period to discuss supporting further staff engagement.

4. Draft proposals

4.1 Draft proposal for Charing Cross UCC

It is not proposed to make any changes to the Charing Cross UCC opening hours.

We looked at the volume of patients, their acuity and the impact any change in hours would have on staff, patients and other services.

We considered a closure of Midnight to 8am and also a shorter closure of between 2am and 6am. Both were discounted as it was not felt to be clinically appropriate.

Volumes at Charing Cross UCC are higher overnight than at Hammersmith. Based on attendance levels and acuity, the CCG considered a closure between 2am and 6am. At this time, there are low numbers of attendances and most are low acuity patients, with a high number of patients leaving with no investigation and minimal treatment.

However, any closure in night time hours after midnight would impact shift patterns and ability to recruit staff to work overnight. Additional difficulty accessing the wider public transport system for staff may incur cost of alternative transport home (e.g. taxi).

In addition, it is anticipated that many of those seeking care overnight will continue to do so which is most likely to result in additional pressure on the co-located ED.

Finally, an overnight closure at Charing Cross UCC would increase the impact of patients currently attending Hammersmith UCC if that unit were to close overnight.

4.2 Draft proposal for Hammersmith UCC

It is proposed to change the Hammersmith UCC opening hours by closing overnight from midnight to 8am.

4.2.1 Rationale for plan and evidence base

As highlighted by the 17/18 data and clinical audit results which were outlined in section 2.1.1 and 2.1.2, there is a low attendance of patients with low levels of acuity at Hammersmith UCC between midnight and 8am, with 91% of patients attending leave with no investigation and minimal treatment.

Closing the standalone unit overnight moves us to a safer urgent and emergency care offering in Hammersmith and Fulham by reducing the entry points to out of hours services to improve the ease in which patients get to the right place, quicker.

4.2.2 Workforce modelling
If an overnight closure were to be put in place, overnight shifts would not be required; shift patterns could be changed to cover 8pm-midnight.

4.2.3 Impact on patients
The clinical audit demonstrated no anticipated negative impact to patients from a clinical perspective.

The clinical audit showed that from the average of seven patients attending per night the following would be the appropriate course of action if Hammersmith UCC were to close overnight:

- 16% (1 per night) would continue to require ED either urgent treatment or referral to specialty review
- 12% (1 per night) would need to attend an alternative UCC such as Charing Cross or St Mary's
- 8% (less than 1 per night) could access an alternative night service such as GP out of hours or dentist
- 64% (4 per night) could access alternative provision, including their own GP, the next day

It is recognised that whilst, on average, five patients a night attending Hammersmith UCC do not need to attend a UCC or ED, they have already chosen to do so and so it is prudent to assume they would continue to seek help overnight. That is addressed in the following section on impact on neighbouring trusts.

The digital offering being implemented by the CCG will aim to drive down those inappropriate attendances, helping to provide choice and direction to those seeking advice and care. The majority of attendees overnight are between 20 and 44, the age group most likely to have internet access at home, or own a smartphone, and therefore be best place to benefit from digital signposting.

The London Clinical Senate considered the proposals from Hammersmith and Fulham and found that, based on the evidence provided, there would be no effect on waits for treatment and that the proposed change to the opening hours of the Hammersmith UCC is clinically safe. More detail on this report from the Senate can be found in section 4.5 of this paper.

4.2.4 Patient transport implications
Charing Cross is the closest alternative UCC.

By car, it takes approximately 9-16 minutes (at 2am based on data from google maps).

By public transport, there are a few options depending on whether you take the option with shortest walking routes or the option with fewest bus changes. According to TfL data, accounting for waiting times and slower walking speeds, transport time at 2am varies from 16 – 35 minutes.

- A: 1 minute walk to bus stop, 72 to Hammersmith Bus Station, 295, N97 or 220 to Charing Cross, 1 minute walk into hospital. 16 minutes
- B: 5-10 minute walk to bus stop, 220 bus to Charing Cross, 1 minute walk into hospital. 22 minutes
- C: 1 minute walk to bus stop, N7 for 1 stop, 220 bus to Charing Cross, 1 minute walk into hospital. 35 minutes

If the CCG were to progress with the proposals, impact on transport and access times would be a key part of the consultation.

4.2.5 Impact on neighbouring Trusts and services

The impact is most likely to be on Charing Cross UCC due to its proximity. Whilst the clinical audit showed approximately two patients a night would need to attend a UCC, we are assuming all seven patients who currently choose to attend Hammersmith overnight could defer to Charing Cross UCC.

Due to the low numbers of attendees at Charing Cross UCC, especially between 2 and 6am when they see just 4% of their total attendances, it is understood this patient flow could be absorbed within current staffing levels.

Any patients currently attending Hammersmith UCC overnight and needing to be transferred to ED are currently most likely to be transferred to Charing Cross (subject to specialist needs) due to proximity. Therefore there is not expected to be any additional impact on Charing ED.

If the CCG were to progress with the proposals, detailed modelling of likely patient flow would be a key part of the consultation.

4.2.6 Financial implications

This will be confirmed during contracting but it is anticipated that the cost of commissioning the UCC service would reduce by approximately £600,000 a year.

4.2.7 Risks and mitigations

The key risk relates to Hammersmith UCC being a standalone unit meaning there is no alternative service on site during the proposed closure hours. Whilst there is a low volume of patient attending Hammersmith UCC, the following mitigations would be discussed as part of the consultation process:

- Clear clinical pathways for all patients arriving at the UCC – with specific reference to pathways for patients arriving close to closing time.
- Clear on-site signposting for those arriving outside opening hours
- Road signage changes around the hospital and on approaching roads
- Consideration of overnight patient transport service based on-site between midnight and 8am for a set period of time after the change of hours
- Consideration of free-phone outside the UCC which goes straight through to 111 between midnight and 8am.
- Communications campaign in the areas where most attendees come from

There would be an on-going review of patient numbers at both UCCs and the ED. Any expected changes to patient flow would be addressed within the contracting for the updated UTC specifications.

During consultation, we would also undertake equalities assessments to identify any specific health inequalities in the local area or groups with protected characteristics who would be adversely impacted.

4.3 Draft proposal for GP appointment volumes

Extended hours - Following a robust options appraisal, the CCG are proposing to decommission local extended hours scheme and transfer all practices to DES. The changes in extended hours provision we are proposing will see a reduction of 155 GP appointments a week. We currently commission 765 a week (19 practices providing the LCS and three signed up to provide the DES) and we would reduce that down to 610 through only commissioning the DES.

Weekend plus – A series of options have been developed, from do nothing to changing the number of hubs to changing the number of commissioned hours. This is still under consideration. The full list of options is available in appendix 9 for information.

4.3.1 Rationale for plan and evidence base

The changing digital landscape and Hammersmith & Fulham CCGs commitment to their digital vision means patients will have the choice of a digital first offer for accessing advice and care options.

There are currently around 10-25% average underutilisation across these appointments. The commissioned appointments outside core hours would be in line with current demand.

The proposal would ensure a more consistent offering to all patient across the borough.

4.3.2 Financial implication

Moving all practices to the national extended hours scheme (DES) will deliver financial savings:

- £597,998 per annum

There will also be fairer distribution of extended access funding based on registered list size rather than historic data.

4.3.3 Workforce modelling

This will be for practices to discuss at a local level.

4.3.4 Impact on patients

Appointments will still be available 8am-8pm, seven days a week, for all patients across the borough and the proposal is to commission within the current level of demand.

As is the case now, not all appointments will be at the patient's own practice and this may have travel implications for some.

4.3.5 Risks and mitigations

- Large drop in income in short period of time for 4 practices who will lose over £60k however this can be mitigated.
- Reduction of appointments offered across the borough by 39 hours per week although there is currently under utilisation of extended hours appointments. We will aim to increase utilisation of all extended availability including weekend plus hubs
- Patient satisfaction decreases as a result of reduced level of access. The introduction of a digital first platform will enhance access
- Practices may not sign up to the DES (as the scheme is less financially favourable and inflexible) which may further reduce access. CCG will facilitate sign up. Introduction of a digital first platform will enhance access

4.4 NHS England – Four tests

4.4.1 Strong public and patient engagement

We have undertaken pre-consultation engagement across Hammersmith and Fulham as outlined in chapter three. Our plans for consultation take on board feedback from this phase of work which is set out in chapter five.

4.4.2 Consistency with current and prospective need for patient choice

The proposals from Hammersmith and Fulham respond to current patient usage of services as shown in chapters two and four. In addition, the wider vision of Hammersmith and Fulham CCG to increase the digital offering in the borough will substantially increase patient choice.

4.4.3 Clear clinical evidence base

The clinical review undertaken in chapter two underpins the proposals put forward and was supported by the findings of the London Clinical Senate which is set out in more details in chapter five.

4.4.4 Support from Clinical Commissioners

These proposals are bought forward by the clinical commissioners of Hammersmith and Fulham.

This section does not include the Simon Stevens test for bed capacity as the proposals being put forward do not impact bed numbers in the borough.

4.5 Clinical assurance

The London Clinical Senate considered the proposals from Hammersmith and Fulham CCG and provided a formal response which can be found in appendix 13.

The Senate supports the proposed change to opening hours at the Hammersmith CCH and the CCG's initial proposals for a new model for primary and urgent care in Hammersmith and Fulham. It finds that the proposed change to the opening hours of the Hammersmith UCC:

- is clinically safe
- will improve the safety of care when compared to the current model.
- will not materially affect the capacity of out of hours primary care services in Hammersmith and Fulham to provide a service to the residents of the borough

The Clinical Senate advises that the Hammersmith and Fulham CCG:

a) provides more detail on its risk mitigation plan for the change in hours at the Hammersmith UCC. This should include describing how patients will get from Hammersmith to Charing Cross if they go there for treatment in the period after the change in opening hours and how the change in opening hours will be publicised
b) provides more detail on how it will develop its proposed new primary care out of hours offer, i.e. the 111 pathways and its digital offer. It should also consider increasing its investment in community services, particularly for the population living closest to the Hammersmith Hospital
c) ensures that the changes to the provision of primary care Out of Hours and Urgent care in Hammersmith are used as an opportunity to emphasise and, if necessary, redefine the CCG's OOH/Urgent Care pathway for children.
d) continues to consult with patients, carers, Healthwatch, and other stakeholders about its new clinical model for out of hours primary care
e) considers further the effects of the proposed changes on other services in NW London, especially the Hospitals and UCCs nearest to Hammersmith Hospital.

4.6 Equalities impact

An Equality & Health Inequality Impact Analysis Screening Tool (EHIA screening) has been completed and is attached in full as Appendix 10. The screening document is currently under review by the NW London Chief Nurse and Director of Quality, who will use the information provided to determine whether a full EHIA is required.

The purpose of the EHIA screening is:
• To better understand the impact on the nine protected characteristic groups of the proposals outlined above
• Examine any barriers to accessing relevant care for these groups
• Examine benefits of introducing a introduction of a digital front end for accessing healthcare for these groups

It is important to undertake this analysis from the user-perspective, to focus on the various impacts as the patient may experience them. With this in mind, in addition to gathering data from a wide range of sources including JSNAs and National Audit Office reports the CCG has:

- collated all our community feedback received over the past year relating to primary and urgent care to consider where our gaps are
- undertaken pre-consultation engagement with a range of groups focusing on primary and urgent care access
- proposed holding a public equality workshop at the beginning of our formal consultation, with some supplementary face to face outreach work in the community. Any identified gaps in data and evidence in the EHIA will also be addressed via on-going engagement and the formal consultation process

4.7 Wider NW London picture

Shaping a Healthier Future (SaHF), in 2012, set out the NW London vision for improving care across the eight boroughs. It looked at improving out of hospital provision, centralising key services and ensuring that people had access to the right care at the right time and in the right place.

A significant number of improvements have been made across NW London as a result of SaHF and the vision is continued in the NW London sustainability and transformation plan.

One element of SaHF related to making the nine urgent care centres 24/7. It created a specification for UCCs that was higher than the national specification and agreed that a consistent 24/7 offering to all residents would ensure a more efficient and equitable service.

For safety reasons, the ED at Hammersmith Hospital was closed. The UCC onsite increased to 24/7 as part of the mitigation to the closure.

Hammersmith and Fulham is the only borough in NW London to have two UCCs, only one of which is co-located with an ED. It is now over four years since the closure of Hammersmith ED and there is awareness of the lack of ED service at the site.

Hammersmith & Fulham CCG are clear that the proposals outlined in this paper remain in line with the clinical vision of SaHF. The borough continues to provide a 24/7 UCC services in the borough and infact provides an increased UCC provision to its residents, compared to other boroughs, during the day time. A map of all current urgent and emergency care provision in NW London is in appendix 8.

5. Next steps

5.1 Regulator assurance

We are currently in discussions with NHS England and following their assurance process. This will run in parallel to the Governing Body decision which is why that will be made ‘subject to regulator assurance’.

5.2 Governance and decision making

This PCBC is provided to the Governing Body to enable them to make a decision in public about whether to move to consultation.

Post consultation, a further Governing Body decision making meeting will take place to make review the outcomes of consultation and make decisions relating to implementation.

5.3 Indicative implementation timeline

Subject to the outcome of consultation, we anticipate that we could commence implementation for the urgent care centre from Q2 2019 onwards.

Extended Hours Timeline

Action	Date
Governing Body approval to move to consultation	15-Jan-19
Public consultation commences	01-Feb-19
Public consultation ends	15-Mar-19
Post consultation analysis; options appraisal and recommendations	Apr-19
Governing Body approval of post consultation recommendations	11-Jun-19
Develop Extended Hours contract variation as per recommendations from Governing Body	Jun-19
Serve notice on the Extended Hours specification and issue the contract variation to practices	Jun-19
Contract variation and service changes commence	01-Oct-19

Weekend Plus Timeline

Action	Date
Governing Body approval to move to consultation	15-Jan-19
Public consultation starts	01-Feb-19
Public consultation ends	15-Mar-19
Post consultation analysis; options appraisal and recommendations	Apr-19
develop internal procurement process in preparation for Governing body approval	Apr-19
Governing Body approval of post consultation recommendations	11-Jun-19
Serve notice on the Weekend Plus contract to all three hubs	Jun-19
Internal procurement process commences	Jun/July -19
Internal procurement process ends	Aug-19
Weekend Plus contract awarded to a provider	Sep-19
Weekend Plus service changes commence	01-Oct-19

5.4 Consultation

It is proposed to start a public consultation in February 2019 on the proposals in this document. The consultation would be six weeks long.

5.4.1 Target audience

- Patients & public:
  - Those who are registered with a GP in Hammersmith & Fulham
  - Those in the core area of users of Hammersmith UCC
  - Those with protected characteristics
  - Seldom heard groups
- GPs/staff in Hammersmith & Fulham
- Stakeholders across Hammersmith & Fulham

5.4.2 Objectives

- Deliver an open and transparent consultation
- Ensure the public voice helps shape the development of these plans
- Develop clear public materials
- Keep stakeholders updated on the issues and hear their views
- Support provision of information through the scrutiny process
- Reach a wide and representative sample of the population with a good geographical spread

5.4.3 Timeline

There are three phases of communications and engagement activity:

1. Pre consultation engagement (September 2018 – January 2019)
2. Consultation & engagement (February – March 2019)
3. Outcomes & implementation (April 2019 onward)

5.4.4 Audience involvement

- We will work closely with our lay partners and local Healthwatch
- We are working with the equalities team to ensure that any engagement and consultation addresses any issues or gaps identified.
- Focus groups with members of the public will test communications materials

5.4.5 Engaging on our pre-consultation and consultation approach

At engagement events to date we have received useful feedback from patient, community and voluntary sector representatives on: what information should be included in our consultation and engagement document; how the information should be presented; and how we should engage and get the message out. All feedback received is being given due regard as we pull together our plan for consultation.

We also co-produced the questions for our pre-consultation engagement with local residents, CVS representatives and Practice Managers at our 21 August workshop.

You said	We did / proposed
"In favour of having multiple access routes to care (telephone, walk in, face to face, digital) with one patient representative noting that 'one size does not fit all.'"	Proposals cover a digital offer to cover UCCs and primary care, to expand access options.
"We need to know why people are going to the UCC rather than making a GP appointment."	Pre-consultation engagement questions include asking whether people have tried making a GP appointment before using UCC, and why they use the UCC
"Not happy for NHS 111 to be the main access point into extended hours as it doesn't operate well enough"	Added a question about 111 into our pre-consultation engagement questions and linked in with 111 procurement engagement piece
"North of the borough has greatest health inequality and services should reflect this e.g. ED in north of borough"	Engagement strategy includes ensuring that we engage at plenty of events located in the north of the borough and cover a range of outreach activities including homeless hostels, St Mungo's
"Should expand online content so that you can get video consultations from your own GP practice, or in a way which does not require de-registering from your current GP practice. Have this be accessible via app. Shouldn't have to de-register from your own practice and join GP @ Hand to get this service."	Proposals cover possible development of a digital offer in all H&F practices.
"How confident are we that technology will improve experience, safety and accommodate different demographics?"	Proposals for the digital offer include testing out models with patients via PPGs and wider engagement.
"What services are available locally need better promotion as people don't know about it – via PPGs and other routes."	Proposals cover the need for a less confusing, more integrated and streamlined offer in Hammersmith and Fulham. Advertising what is available will be supported by a local signposting campaign the CCG is planning for early 2019 with the Queen's Park Rangers FC, to raise the profile of local services and 111. The CCG is also delivering leadership training to PPG and potential PPG members.

5.4.6 Printed materials and translation

Similar to the approach taken by local Trusts and the local council, we will not be printing all materials. The current proposal is to print summary materials to raise awareness of the consultation and key issues which direct people to the website and support our engagement team. We will provide printed translated materials on request.

All information will be available on line where they can be automatically translated.

5.4.7 Consultation activity

Audience	Channel	Detail
Public	Social media Website Media GP screens Posters/leaflets Engagement GP practice patient groups Locations across the borough (libraries, cafes, sports centres etc). Ensure engaging in north of borough	Consultation document online Printed feedback form to support engagement activity Summary consultation materials (printed) Detail on website Online feedback form Frequent social media directing people to where they can find out more and have their say Short animation to provide overview of issue and options for feedback Town Hall style events Attendance at public meetings where there will be high footfall Engagement at GP surgeries and UCC sites Town centre stalls Outreach to key local groups and community centres Posters in locations across the borough (GP surgeries, hospitals, community centres, libraries etc) Information on GP screens Focus groups Press releases Media briefings

		Workshops with BAME groups, facilitated by local CVS organisations able to interpret where needed Attend Community Champion events locally Engage with PPGs, PPE network and PRG Homeless hostels, St Mungo's
Specific patient groups – patients using the services in question	Direct contact Leaflets/posters in situ	Summary leaflet in Hammersmith UCC Leaflets available for patients using evening and weekend services
Healthwatch, lay reps	CCG lay rep meetings ILPG Meetings with HW	Copy for websites and newsletters Request for support in distributing consultation and engagement material Regular updates to HW and lay partners on progress Meeting with Healthwatch to get formal response to consultation and engagement
Community, voluntary and third sector organisations*	Newsletters Engagement	Copy for websites and newsletters Request for support in distributing consultation and engagement material Attend meetings/events to reach more people Direct engagement and focus groups where appropriate
GPs and their surgery staff	Network and federation meetings Practice Manager forums Staff room posters Extranet information	Attend meetings to provide update on work Share consultation and engagement materials along with feedback forms. Copy for GP surgery websites Letter summarising engagement and consultation approach we will be taking so they are able to reassure patients and direct them to the relevant place for information
Pharmacists	Letter	Letter outlining plans and how to feedback

CCG staff	Octopus Intranet Staff briefing Mark's Mail	Briefing note to all H&F staff and all NW London engagement leads Update to all staff via usual internal communications channels Regular briefing to JSMT and Programme Exec especially on any cross cutting issues being raised
Specific staff groups eg UCC staff	Staff meetings Staff room information Intranet	Continued engagement Briefing materials to respond to patient enquiries HR side reassurance/Q&A
Political stakeholders – MPs, Councillors, Assembly Members	Stakeholder newsletters Meetings JHOSC/HASPAC HWBB	Letter at start of consultation/engagement providing key information, materials and links to further information Gain feedback on consultation plans as well as the detailed proposals Attend key meetings as requested

6. Appendices

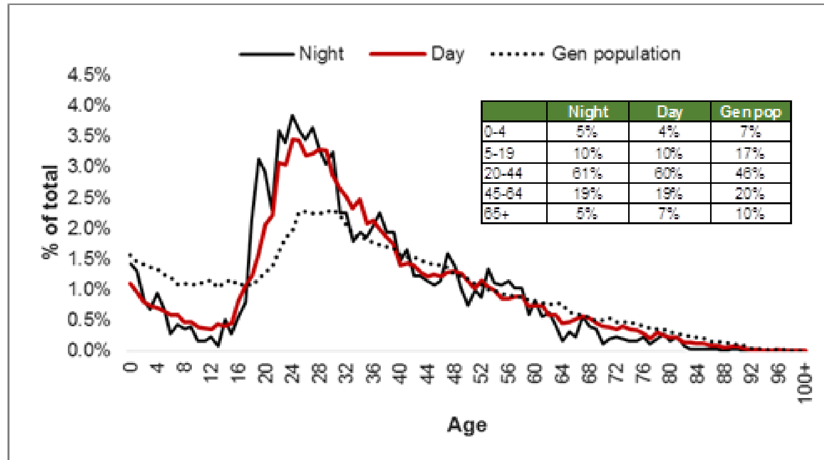
Appendix 1: Draft NW London Urgent Treatment Centre key performance indicators

No.	KPI	Definition	Proposed Target	Proposed Baseline
KPI 1	Ambulance Handovers	Percentage of non-emergency handovers by ambulance service within 15 mins	**100%**	**95%**
KPI 2	Adult Clinical Assessment	Percentage of adult patients who have their initial brief clinical assessment and navigation within 20 minutes (15 min?)	**98%**	**90%**
KPI 3	Child Clinical Assessment	Percentage of paediatric patients who have their initial brief clinical assessment and navigation within 15 minutes	**98%**	**90%**
KPI 4	A&E 4 Hour Wait	Number/ percentage of patients referred from UTC to ED within 2 hours. Baseline of 70% to allow for complex patients to be managed longer in UTC	**98%**	**70%**
KPI 5	A&E 4 Hour Wait	Number/ percentage of patients treated and discharged from UTC within 4 hours	**98%**	**95%**
KPI 6	A&E 4 Hour Wait	Patients referred to ED from UTC	**>5%**	**7%**
KPI 7	Patient Redirection	Percentage of patients assessed for UTC who are deemed suitable for primary, community care or out of hospital service that are then redirected to primary care or out of hospital service	**info only**	**info only**
KPI 8	Prescribing	Adherence to CCG formulary	**98%**	**90%**
KPI 9	Unregistered patients helped to register	Percentage of non-registered patients helped to register with a GP	**98%**	**90%**
KPI 10	GP Information Transfer	Percentage of patients registered with a GP, who have information regarding their access of UTC services sent to their GP by 8am the next	**98%**	**90%**

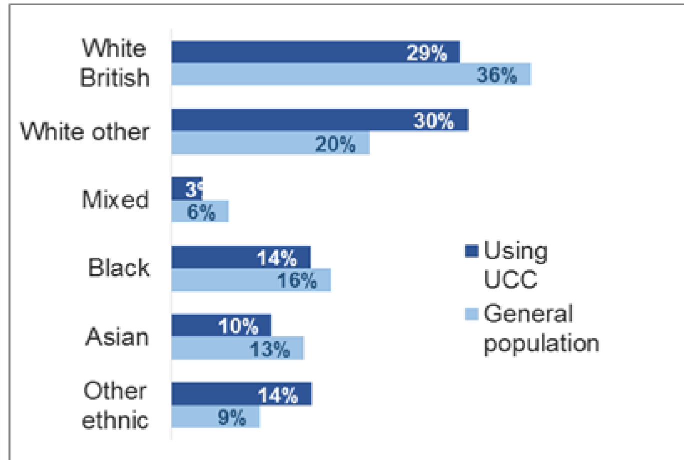
		working day (where the patient consents to this.)		
KPI 11	Unplanned re-attendance	Number/percentage of patients who have an unplanned re-attendance at UTC within 7 days of original attendance	**0%**	**2%**
KPI 12	Left without being seen	number/percentage of patients who leave the UTC without being seen	**0%**	**2%**
KPI 13	Expected Activity	Seen, treated and discharged or redirected by UTC	**60%**	**55%**
KPI 14	Wait time	Percentage of routine patients seen within 30 of their scheduled appointment	**90%**	**70%**

Appendix 2: Hammersmith UCC - Socio-economic characteristics of attendees, 17/18

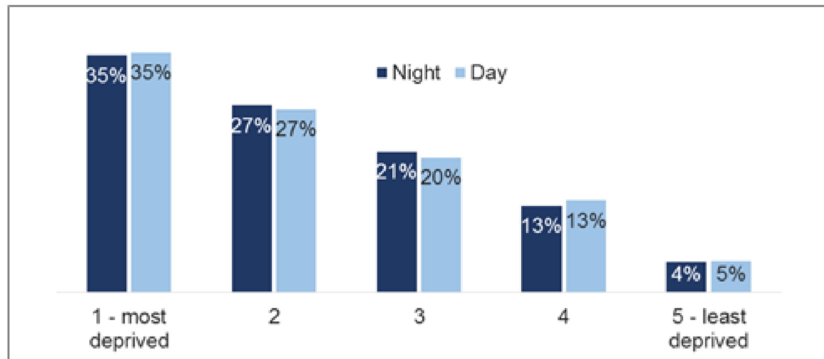
Attendances by age – % of total by night and day and gen pop*



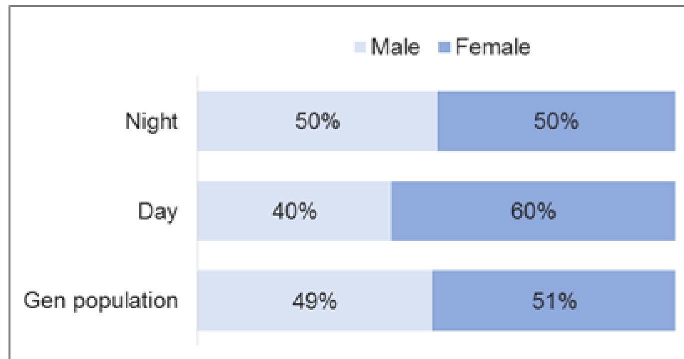
Night attendances by ethnicity Ethnic profile of day very similar to night



Attendances by area deprivation (IMD 2015) – night and day

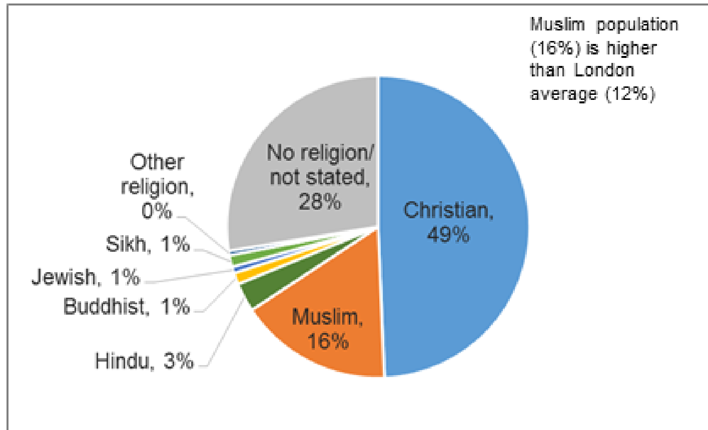


Attendances by gender – by night, day and gen pop* NWL

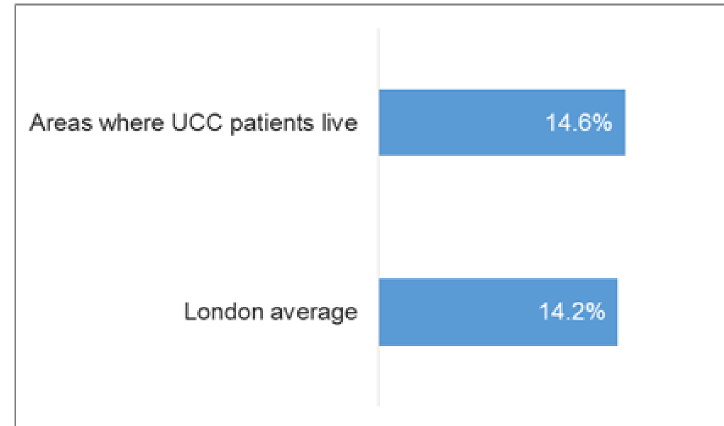


*General population figures have been calculated by taking the 2011 Census profile of LSOAs where there were attendances in 17/18. This was then weighted to account for volume of attendances in those LSOAs

Estimated* religion of patients attending
Based on 2011 Census data applied to location of attendances



Estimated* limiting long-term illness of patients attending
Based on 2011 Census data applied to location of attendances. CAUTION: this does not account for the age mix of those attending and is an area estimate only



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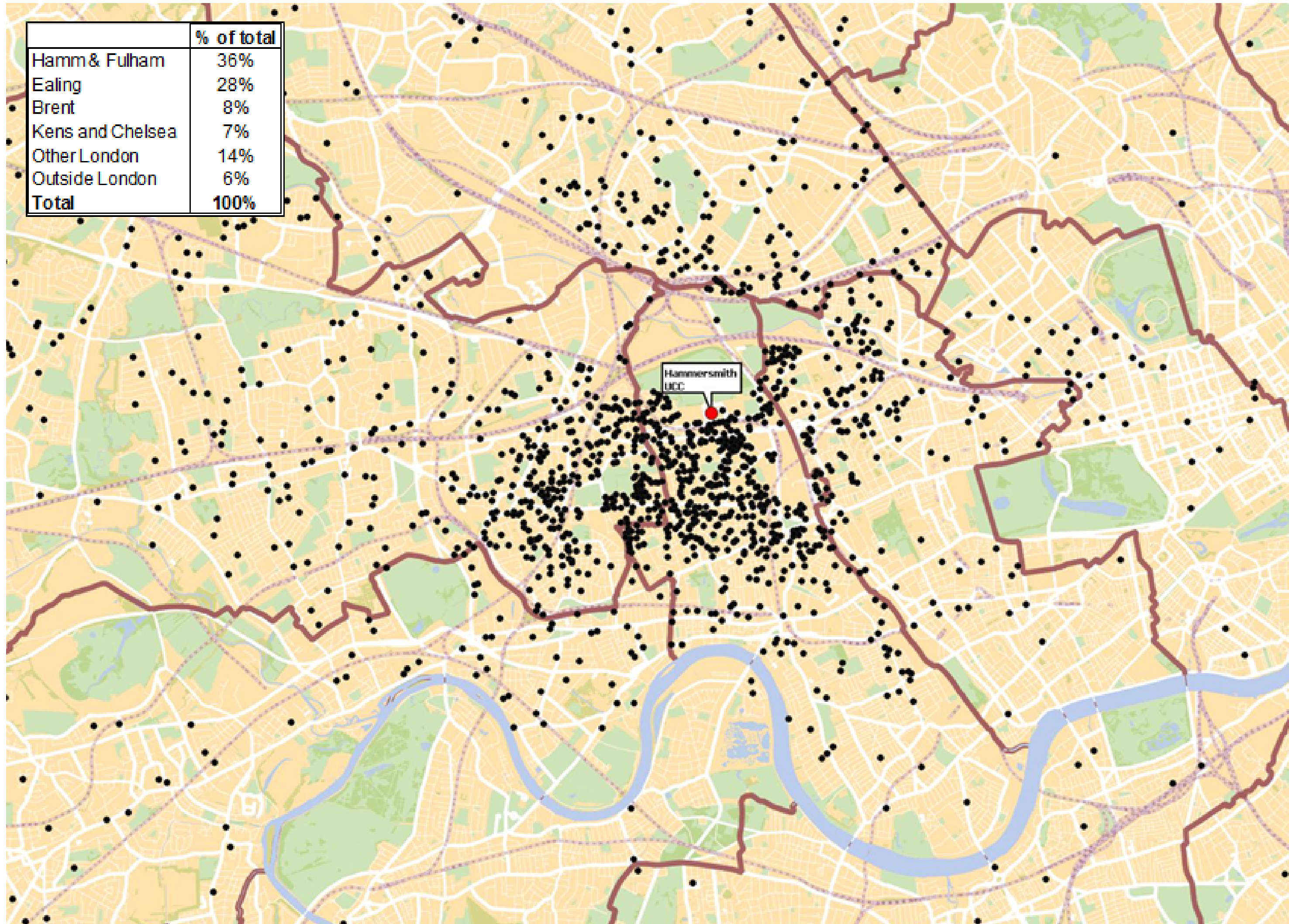
*No data was available on religion or long term illness/ disability of those attending the UCC. Therefore, ethnicity and limiting long-term illness were estimated, based on taking the 2011 Census profile of LSOAs where there were attendances in 17/18, which was then weighted to account for volume of attendances in those LSOAs.

It is important to note that this is an estimate based on an area profile ; ethnicity and disability of actual attendees may differ from these estimates if the UCC attracts particular cohorts of patients not typical of the areas they live in.

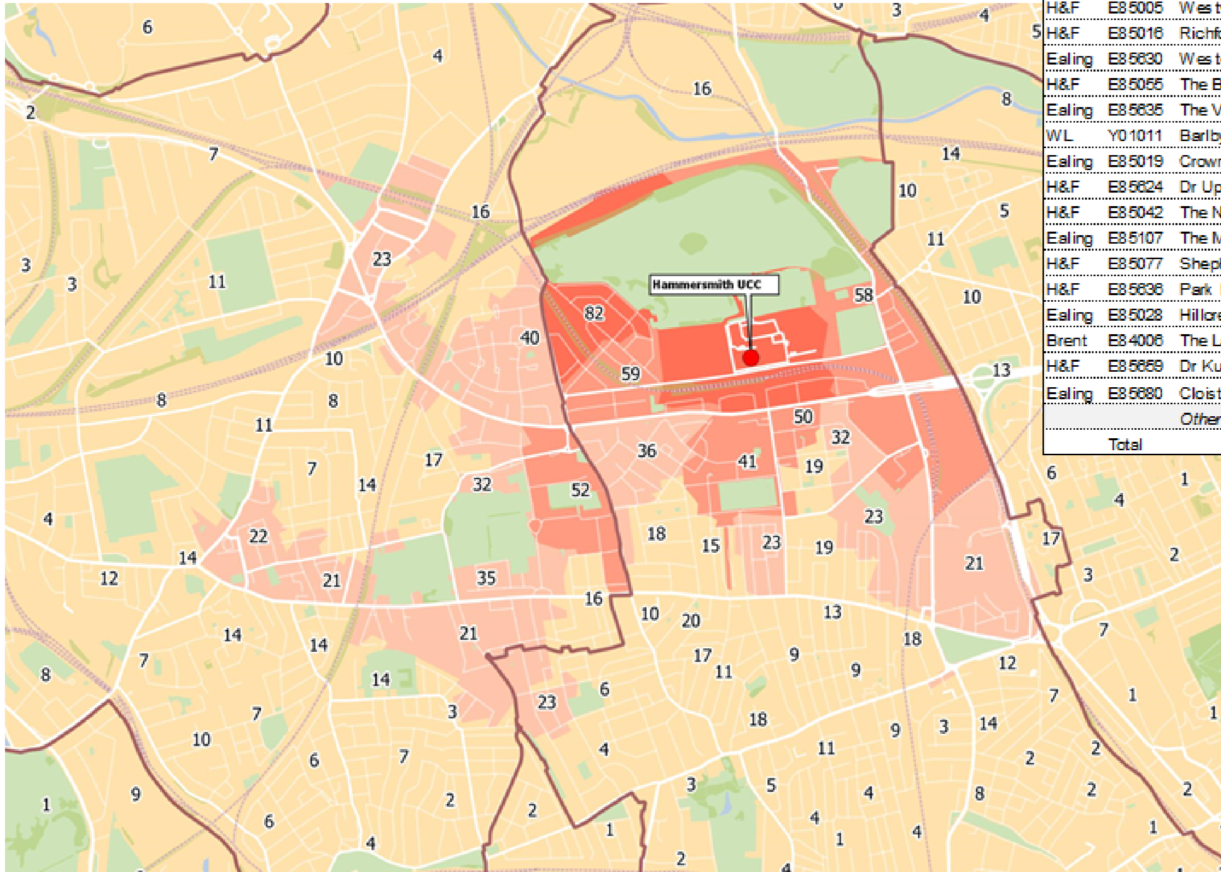
Appendix 3: Hammersmith UCC – Location of night attendances, 17/18



	% of total
Hamm & Fulham	36%
Ealing	28%
Brent	8%
Kens and Chelsea	7%
Other London	14%
Outside London	6%
Total	**100%**

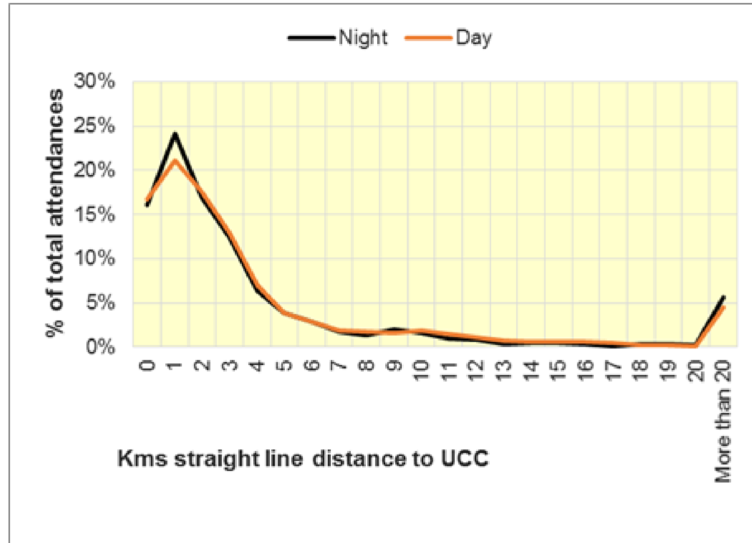
Top 20 highest GP Practices			
CCG	**Code**	**GP Practice**	**% of total**
H&F	V81999	Practice not known/ not reg	15.3%
H&F	E85048	Parkview Practice	4.5%
H&F	Y02589	H&F Centres for Health	4.4%
H&F	Y02906	Canberra Practice, Parkview Ctr for H&W	3.3%
H&F	E85748	The Medical Centre (Dr Kukar)	3.0%
H&F	E85005	Westway Surgery (Dr Dasgupta & Partner)	3.0%
H&F	E85016	Richford Gate Medical Practice	2.9%
Ealing	E85630	Western Avenue Surgery	2.9%
H&F	E85055	The Bush Doctors	2.6%
Ealing	E85635	The Vale Surgery	2.2%
WL	Y01011	Barlby Surgery (AT Medics)	2.0%
Ealing	E85019	Crown Street Surgery	1.8%
H&F	E85624	Dr Uppal & Partners, Parkview	1.7%
H&F	E85042	The New Surgery	1.6%
Ealing	E85107	The Mill Hill Surgery	1.3%
H&F	E85077	Shepherd's Bush Medical Centre	1.3%
H&F	E85636	Park Medical Centre	1.3%
Ealing	E85028	Hillcrest Surgery	1.2%
Brent	E84006	The Law Medical Group Practice	1.1%
H&F	E85659	Dr Kukar, Parkview	1.1%
Ealing	E85680	Cloister Road Surgery	1.1%
		Other practices	40.5%
	Total		100.0%

Count of night time attendances over 17/18, by LSOAs closest to site

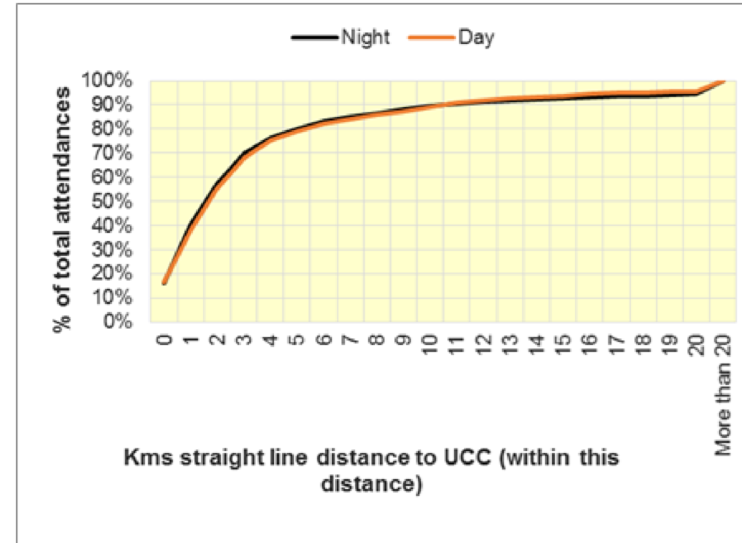


Appendix 4: Hammersmith UCC – Night attendances by distance to UCC, 17/18

Proportion of attendances by distance from home to UCC
Where postcode known. Straight line distance (Kms)



Proportion of attendances living within a certain distance from UCC Cumulative. Where postcode known. Straight line distance (Kms)



Night	% of Attendances
Less than 1km	16%
Less than 3km	57%
Average (median)*	*2.5 km*

Day	% of Attendances
Less than 1km	17%
Less than 3km	55%
Average (median)*	*2.7 km*

*Median has been used rather than mean to avoid the impact of a small number of attendances a considerable distance away e.g. Scotland

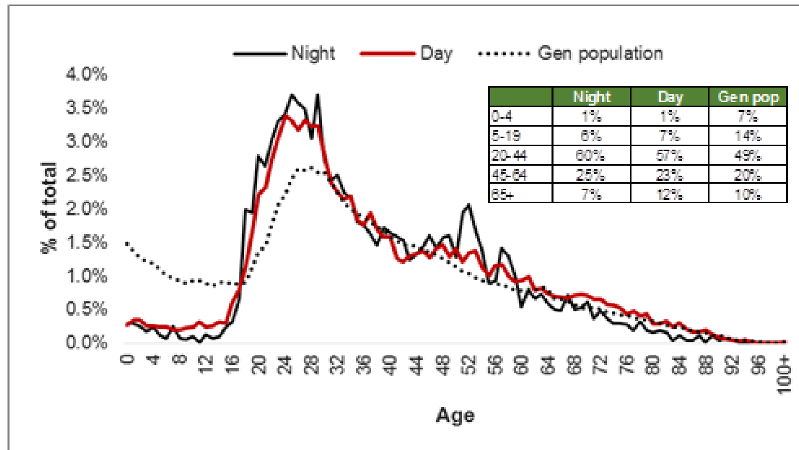
Night - by age	0-4	5-19	20-44	45-64	65+
Less than 1km	16%	27%	15%	14%	17%
Less than 3km	62%	69%	56%	55%	57%

Repeat attendances (within 7 days) which occur at night time show a similar pattern of geographical coverage to total attendances:

- 45% H&F
- 26% Ealing
- 6% K&C
- 23% other

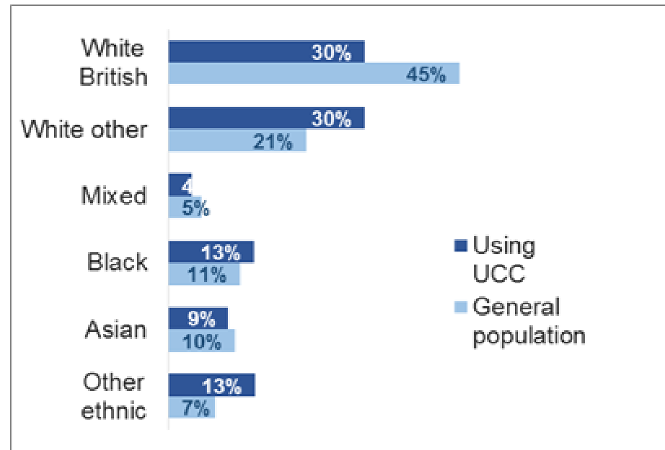
Appendix 5: Charing Cross UCC – Socio-demographic characteristics of attendances, 17/18

Attendances by age – % of total by night and day and gen pop*

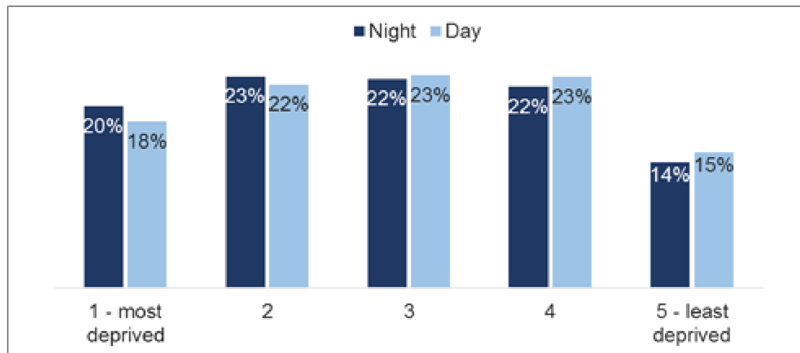


	Night	Day	Gen pop
0-4	1%	1%	7%
5-19	6%	7%	14%
20-44	60%	57%	49%
45-64	25%	23%	20%
65+	7%	12%	10%

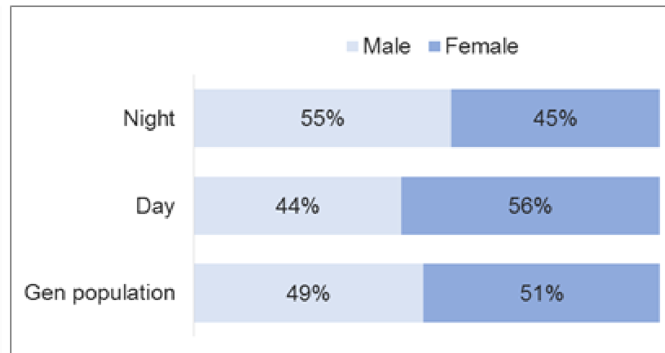
Night attendances by ethnicity Ethnic profile of day very similar to night



Attendances by area deprivation (IMD 2015) – night and day



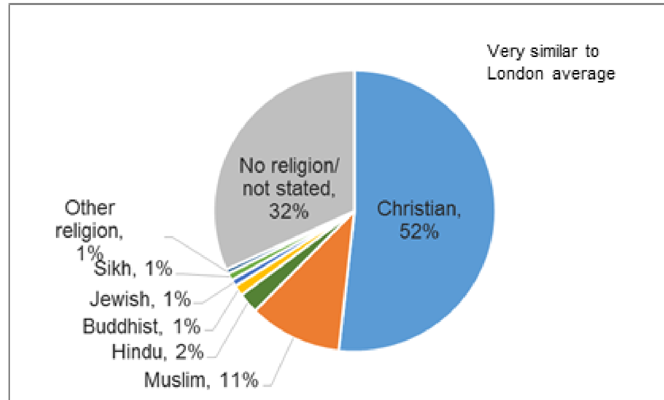
Attendances by gender – by night, day and gen pop* NWL



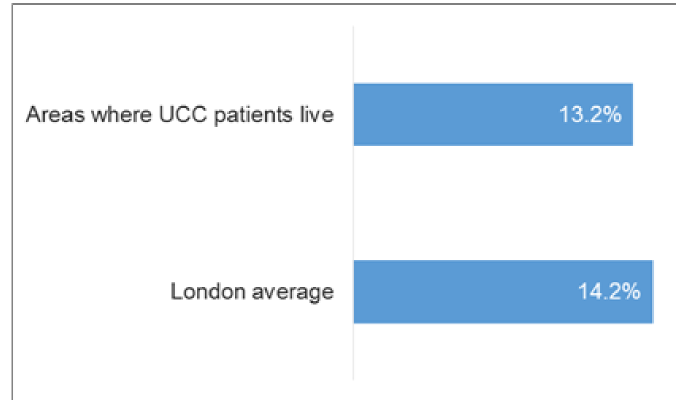
*General population figures have been calculated by taking the 2011 Census profile of LSOAs where there were attendances in 17/18. This was then weighted to account for volume of attendances in those LSOAs

Hammersmith and Fulham
Clinical Commissioning Group

Estimated* religion of patients attending
Based on 2011 Census data applied to location of attendances



Estimated* limiting long-term illness of patients attending
Based on 2011 Census data applied to location of attendances. CAUTION: this does not account for the age mix of those attending and is an area estimate only



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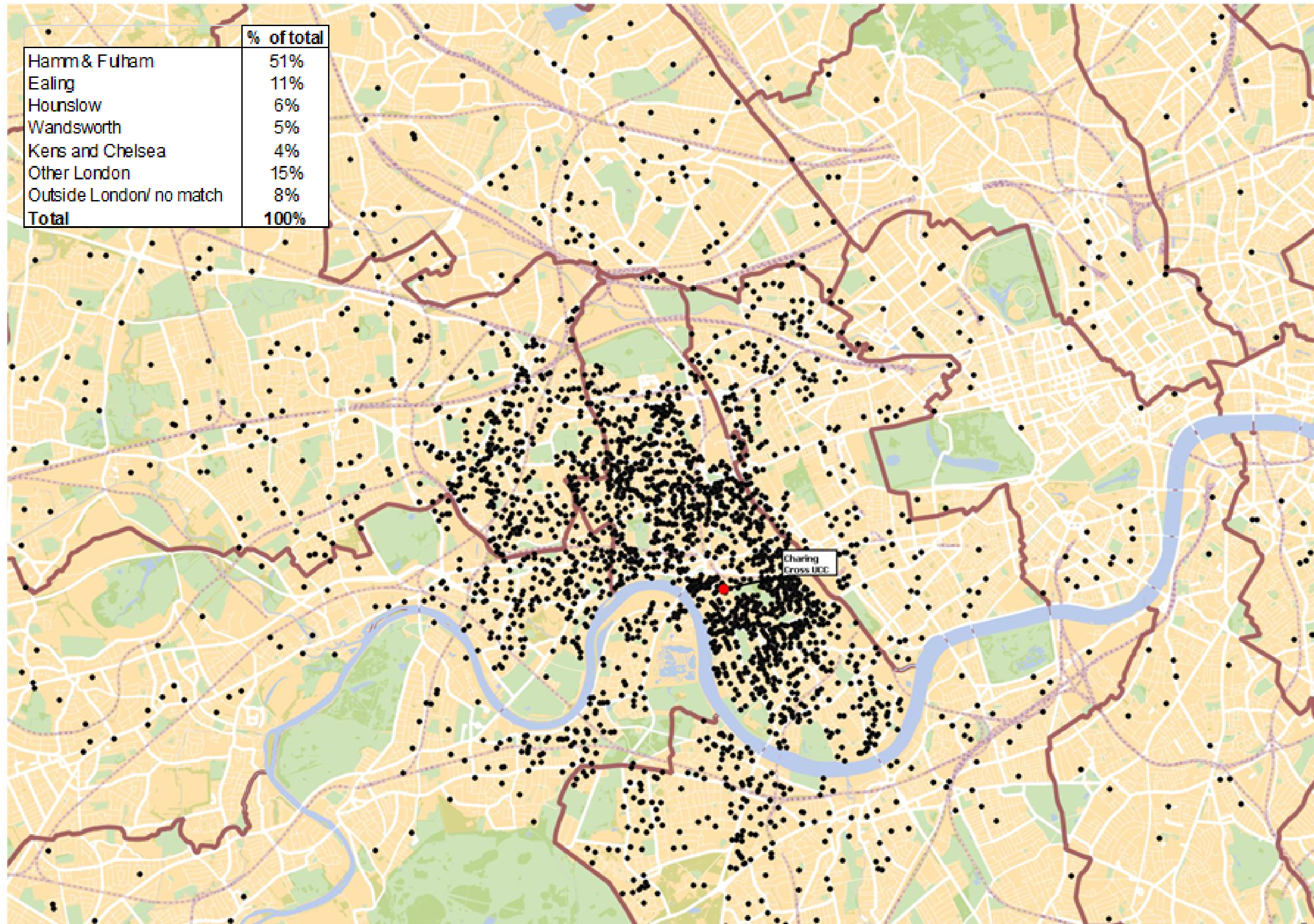
*No data was available on religion or long term illness/ disability of those attending the UCC. Therefore, ethnicity and limiting long-term illness were estimated, based on taking the 2011 Census profile of LSOAs where there were attendances in 17/18, which was then weighted to account for volume of attendances in those LSOAs.

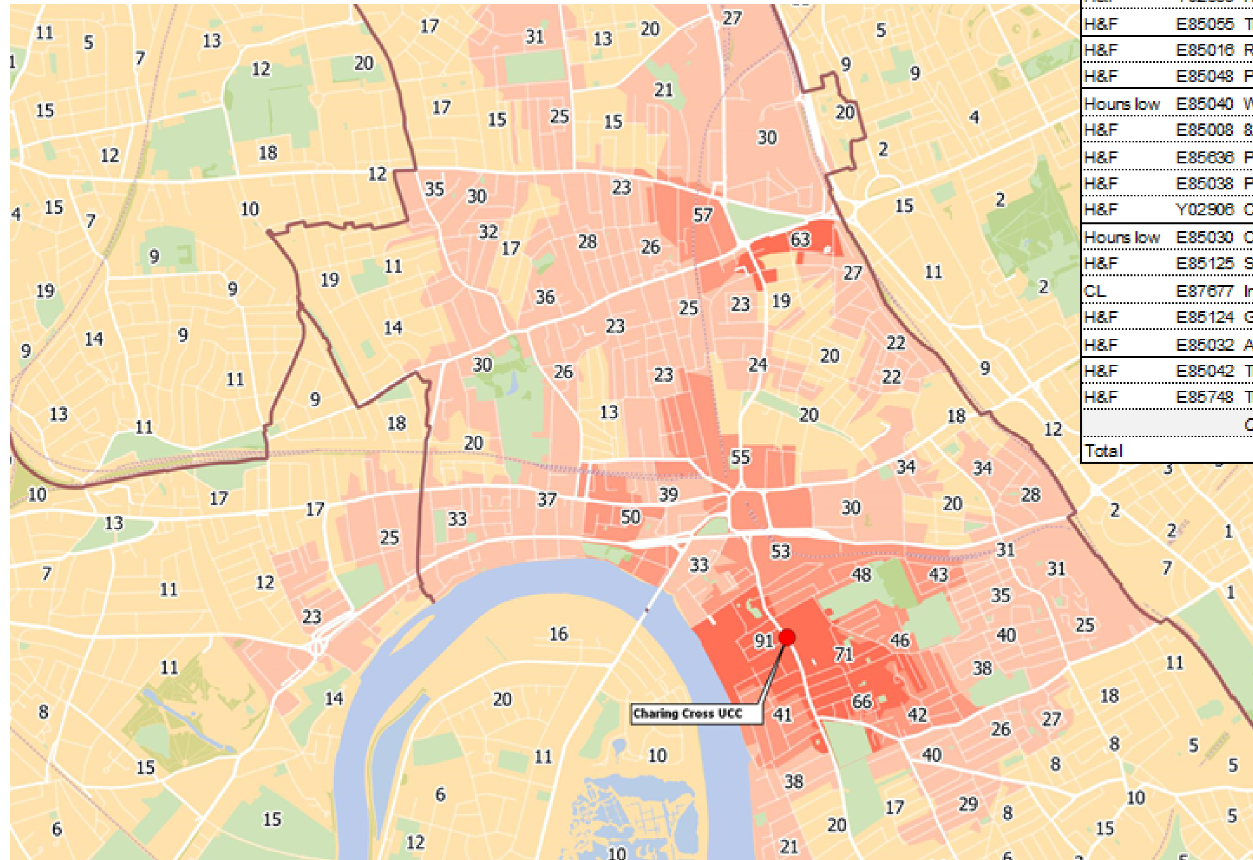
It is important to note that this is an estimate based on an area profile ; ethnicity and disability of actual attendees may differ from these estimates if the UCC attracts particular cohorts of patients not typical of the areas they live in.

Appendix 6: Charing Cross UCC – Location of night attendances, 17/18



	% of total
Hamm & Fulham	51%
Ealing	11%
Hounslow	6%
Wandsworth	5%
Kens and Chelsea	4%
Other London	15%
Outside London/ no match	8%
Total	**100%**

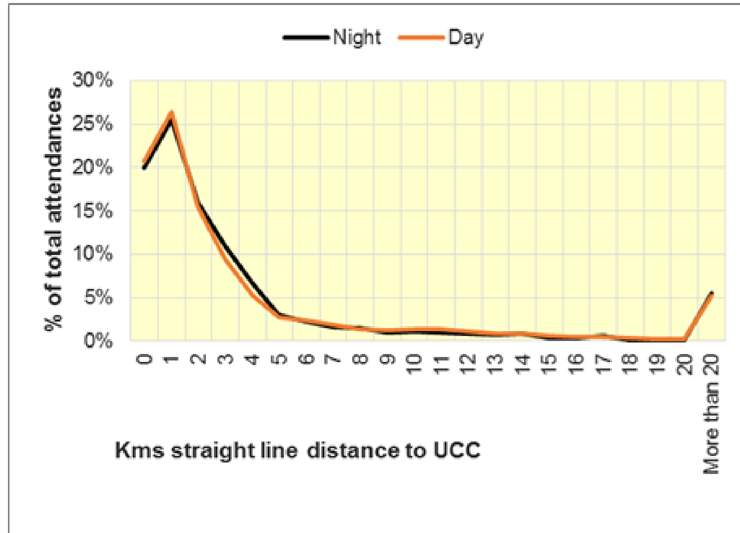
Count of night time attendances over 17/18, by LSOAs closest to site



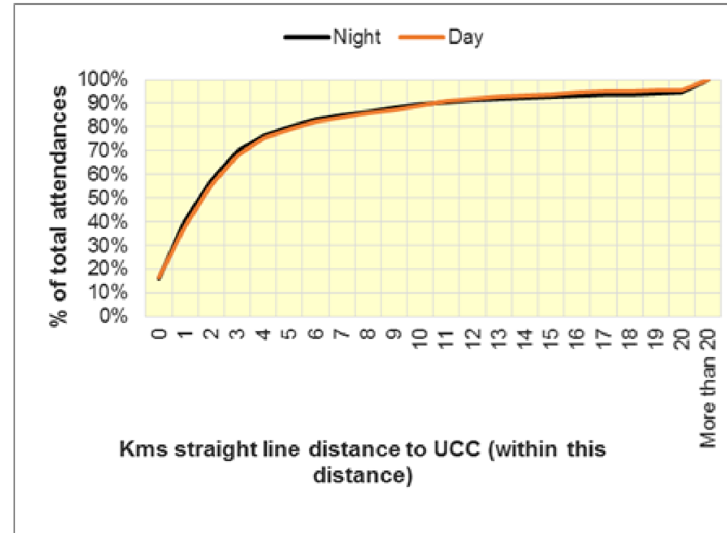
Top 20 highest GP Practices - NWL only, 17/18			
CCG	**Code**	**GP Practice**	**% of total**
H&F	V81999	Practice not known/ not reg	12.8%
H&F	E85003	North End Medical Centre	6.0%
H&F	E85020	Brook Green Medical Centre	4.6%
H&F	E85029	Dr Jefferies, 292 Munster Road	4.6%
H&F	E85033	Hammersmith Bridge Surgery	4.6%
H&F	Y02589	H&F Centres for Health	4.6%
H&F	E85055	The Bush Doctors	4.4%
H&F	E85016	Richford Gate Medical Practice	2.7%
H&F	E85048	Parkview Practice	1.9%
Hounslow	E85040	West4GPs	1.8%
H&F	E85008	82 Lillie Road Surgery	1.7%
H&F	E85636	Park Medical Centre	1.7%
H&F	E85038	Palace Surgery	1.5%
H&F	Y02906	Canberra Practice,Parkview Ctr for H&W	1.4%
Hounslow	E85030	Chiswick Health Practice	1.3%
H&F	E85125	Sterndale Surgery	1.3%
CL	E87677	Imperial College Health Centre	1.2%
H&F	E85124	GP at Hand	1.2%
H&F	E85032	Ashchurch Surgery	1.2%
H&F	E85042	The New Surgery	1.1%
H&F	E85748	The Medical Centre (Dr Kukar)	1.1%
		Other practices	37.5%
Total			100.0%

Appendix 7: Charing Cross UCC – Night attendance by distance to UCC, 17/18

Proportion of attendances by distance from home to UCC
Where postcode known. Straight line distance (Kms)



Proportion of attendances living <u>within</u> a certain distance from UCC Cumulative. Where postcode known. Straight line distance (Kms)



Night	% of Attendances
Less than 1km	20%
Less than 3km	61%
Average (median)*	*2.3 km*

Day	% of Attendances
Less than 1km	21%
Less than 3km	63%
Average (median)*	*2.2 km*

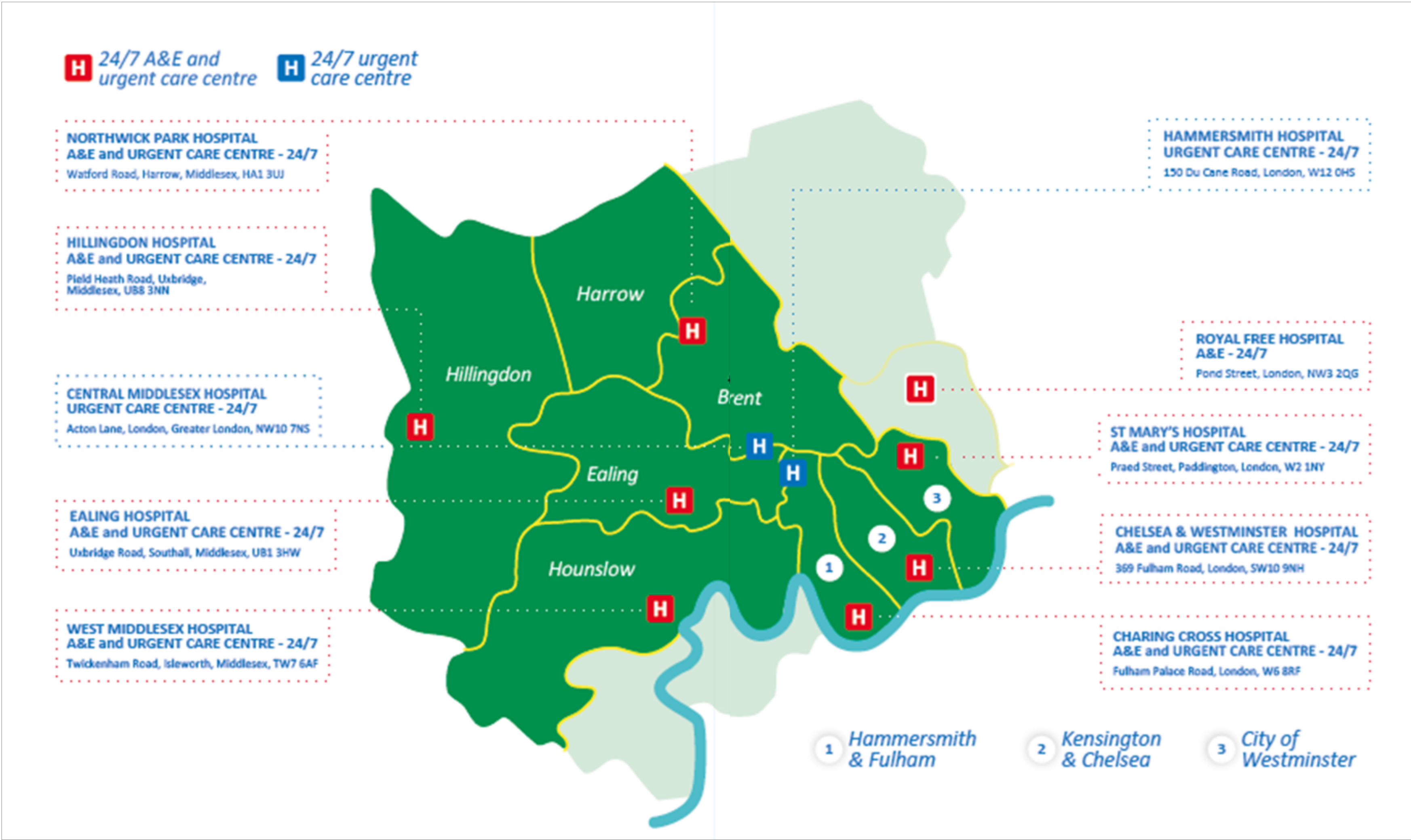
*Median has been used rather than mean to avoid the impact of a small number of attendances a considerable distance away e.g. Scotland

Night - by age	0-4	5-19	20-44	45-64	65+
Less than 1km	16%	18%	21%	20%	18%
Less than 3km	59%	59%	60%	63%	68%

Repeat attendances (within 7 days) which occur at night time show more concentration in H&F than total attendances:

- 62% H&F
- 13% Ealing
- 6% Hounslow
- 19% other

Appendix 8: 24/7 services in NW London



Appendix 9: Weekend plus options

Option	Benefits	Risks
Option 1 Do nothing	1 hub per network, evenly distributed across the borough	No financial savings Inequitable utilisation of appointments (C.50% of appointments are used by the hubs own patients)
Option 2 Reduce number of commissioned hubs	Financial savings Reduce number of appointments available to be utilised by a hubs own patients Less contracts for the CCG to manage.	Demand could exceed capacity of 1 or 2 hubs and so activity may increase in other areas such as UCC, WIC, ED Reputational risk to CCG of changing number of delivery sites
Option 2a Reduce number of commissioned hubs from 3 to 2	Financial Savings: £184,387 per annum	98 fewer GP appointments per week 26 fewer nurse appointments per week
Option 2b Reduce number of commissioned hubs from 3 to 1	Increased financial savings: £359,036 per annum	196 fewer GP appointments per week 52 fewer nurse appointments per week
Option 3 Retain three weekend plus hubs but reduce number of commissioned hours	Financial savings Maintains current distribution of hubs across the borough, with 1 hub in each network. Increased utilisation of appointments	Inequitable utilisation of appointments (some appointments are reserved for the hub practice's registered patients) Reduced number of appointments
Option 4 Include the commissioning of the weekend plus hubs within the scope of the urgent treatment centre/APMS Practice future specification	Financial savings Takes into account all patient access, not just Weekend plus Simplifies patient pathway Potential to improve resource utilisation	Potential reduction in number of sites providing Weekend plus .

Appendix 10: EHIA screening

Equality & Health Inequality Impact analysis screening tool

Introduction

The purpose of this Screening Tool is to help you decide whether or not you need to undertake an Equality and Health Inequalities Analysis (EHIA) for your project or piece of work. It is your responsibility as the project lead/policy owner to take this decision having worked through the Screening Tool.

Once completed, please email the CCG's Executive Equalities Lead who will convene an EHIA meeting to sign off the Screening Tool and approve your decision i.e. to either undertake an EHIA or not to undertake an EHIA.

When completing the Screening Tool, we suggest you consider the nine protected characteristics and how your work would benefit one or more of these groups. The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

NHS England has agreed an additional definition which relates to inclusion health and people with lived experience. Inclusion health has been used to define a number of groups of people who are not usually provided for by healthcare services and covers people who are homeless, rough sleepers, vulnerable migrants, sex workers Gypsies or Travellers and other multiply excluded people. The definition also covers Female Genital Mutilation (FGM), human trafficking and people in recovery. Please consider these groups too in your analysis.

Part A

Title of procedural document: Access to Primary and Urgent Care services in Hammersmith and Fulham

Proposals:

- Closure of Hammersmith Urgent Care Centre (UCC) overnight between midnight and 8am

- Introduction of digital vision for residents of Hammersmith & Fulham
- Decommission local extended access scheme and commission practices to deliver extended access under the national scheme
- Reduce number of Weekend Plus hub locations
- Reduce number of commissioned weekend plus hubs in Hammersmith & Fulham CCG

What are the intended outcomes of this work? Include outline of objectives and function aims

A review of primary and urgent care services across Hammersmith & Fulham has indicated that the Hammersmith UCC and the Weekend Plus hubs are under-utilised and do not offer value for money for the population of Hammersmith & Fulham. It is proposed that this will be addressed by:

- Closure of Hammersmith Urgent Care Centre overnight between 12 midnight and 8am due to low attendance and low level of acuity
- UCC attenders diverted during these hours to alternative options including a new digital first offer, NHS 111, next day primary care services, pharmacies, alternative urgent care services
- A primary care offer in H&F which is consistent with national expectations set out in the Five Year Forward View and the H&F Primary Care Strategy, ensuring equity of access in line with population need
- Patients fully aware of where and how to access advice from primary care, through a streamlined and well-advertised offer
- GP appointments available 8-8 Mon-Fri and 12 hours at the weekend, somewhere in the borough, in a way which provides value for money to the taxpayer
- Introduction of a digital front end for accessing healthcare to residents of Hammersmith & Fulham to make it easier for residents to access the care they need and increase choice.

What are the intended outcomes of this work? **Include outline of objectives and function aims (continued)**

The aim of this EHIA is:
• To better understand the impact on the nine protected characteristic groups of the proposals outlined above
• Examine any barriers to accessing relevant care for these groups
• Examine benefits of introducing a introduction of a digital front end for accessing healthcare for these groups

It is important to undertake this analysis from the user-perspective, to focus on the various impacts as the patient may experience them. With this in mind, the CCG has:

- collated all our community feedback received over the past year relating to primary and urgent care to consider where our gaps are in terms of groups and focus points
- already undertaken pre-consultation engagement with a diverse range of groups focusing on primary and urgent care access
- proposed holding a public equality workshop in the first week of our formal consultation, with some supplementary face to face outreach work in the community. Any gaps in evidence will also be addressed via on-going engagement and the formal consultation process

Who will be affected? e.g. patients, staff, service users etc.

- Patients attending Hammersmith UCC overnight
- Staff working night shift at Hammersmith UCC
- Other urgent care providers such as Charing Cross UCC
- GP practices within Hammersmith & Fulham
- Staff working at the Weekend Plus hubs
- Staff working at the GP practices outside of core hours
- Patients attending their GP practice outside of core hours
- Patients attending the Weekend Plus hubs
- All patients for introduction of a digital front end for accessing healthcare; either directly or indirectly

Evidence

What evidence have you considered? List the main sources of data, research and other
sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.

Background to the borough
Hammersmith & Fulham is a London borough to the West of London and is bordered by the Thames to the South. Covering an area of 6.33m2, the borough has around 183,000 residents making it one of the smallest boroughs in London. It is part of the NW London Collaboration of CCGs which includes eight London Boroughs and is also part of the NW London Health and Care Partnership (or STP).

The borough has 41 pharmacies, 29 GP surgeries with a total registered population of 252,357, two hospitals – both with an urgent care centre - and one ED. It is a diverse London borough and a large proportion of the population are young working age residents with a low proportion of residents aged 65 and over (although this is increasing), and the fifth lowest number of children of any London borough.

- The area has high levels of migration in and out of the borough, and

significant ethnic and cultural diversity.
• 32% of the population is from Black, Asian and Minority groups (BAME).
• Levels of affluence vary widely, creating inequalities within small geographical areas.
• Life expectancy for men is 79.1 years and 83.3 years for women.
• Around a third (29%) of children under 16 in H&F were classified as living in poverty in 2011, higher than London (27%) and England (21%) according to official definitions.
• Foreign-born residents made up 43% of the Borough's population in 2011 - up from 34 per cent in 2001 (London 37% and England & Wales 13%); this is the tenth highest level of any local authority in England & Wales.
• 14.5 per cent of households have no people that speak English as a main language; this is the thirteenth highest proportion in England & Wales.

Urgent Care Centre

H&F CCG has completed extensive analysis of attendance at both Hammersmith & Charing Cross UCCs overnight. This was used to successfully present a case for change to the NHSE Clinical Senate on 20th November 2018.
The following factors have been considered:
• Current contract for the urgent care centres is due to end in April 2019.
• HFCCG will need to commission revised services in line with the new national specification for urgent treatment centres in 2019
• Opportunity to review current urgent care services and determine whether changes need to be made
• Based on current service utilisation the urgent care centre at Hammersmith Hospital does not provide value for money
• Workforce challenge of resourcing over night shifts.
• Suitable alternative urgent care provision is available including Charing Cross UCC
• HFCCG is looking to introduce a digital first offer for urgent care and GP practices which will improve timely access and reduce the need for face to face consultation
• Introduction of a digital front end for accessing healthcare should reduce the use of the urgent care provision as people are directed to more appropriate service alternatives

Data sources

- JSNA 2013-14, housing support and care JSNA, Clinical Senate paper, National Audit Office GP access report
- Bhatia R, Wallace P. Experiences of refugees and asylum seekers in general practice: a qualitative study. BMC Fam Pract 2007;8:48
- O'Donnell CA, Higgins M, Chauhan R, et al. Asylum seekers' expectations of and trust in general practice: a qualitative study. Br J Gen Pract 2008;58:e1–11
- Lindenmeyer A, Redwood S, Griffith L, et al. (2016) Experiences of primary care professionals providing healthcare to recently arrived migrants: a qualitative study. BMJ Open
- Full EQIA completed by Babylon GP at Hand

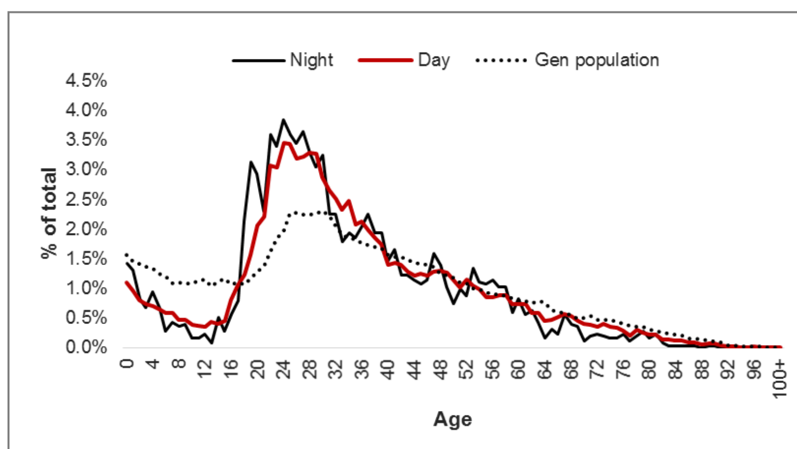
1. Age. Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare

Demographics

Hammersmith and Fulham is a small borough located in West London. The age profile of the borough is common to other inner city areas in that it has a very large young working age population and smaller proportions of children and older people. The differences are particularly striking compared to nationally, with the proportion of the total population aged 65+ just over half that of England. Compared to London, the borough has the 5th lowest proportion of children, 4th highest of young working age residents and 9th lowest of retirement age. The gender split is broadly similar, but with more women in the older age groups due to their longer life expectancy.

Urgent care centre

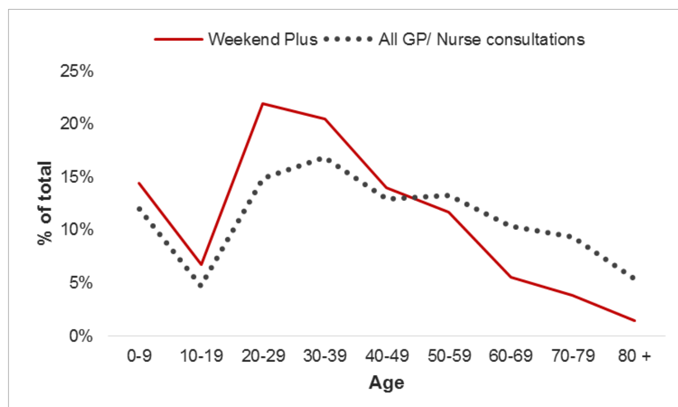
Over 80% of night time attendances are for working age adults, with the rate of visiting higher for this group than for children and older people.



There is nothing to suggest that a particular age cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight and being diverted to other alternative urgent care services. However, this will be sense checked with local people as part of our engagement and consultation work. Transport links have been analysed to ensure alternative urgent care services are accessible for all age groups.

Primary Care

Age profile of Weekend Plus consultations, compared to all (standard) GP/ Nurse Consultations, Oct-Dec 18



Around three quarters (74%) of Weekend Plus consultations are for patients aged 20-69, compared to around two thirds (68%) for standard consultations. Around 5% of Weekend Plus consultations are for patients aged 70+ - just a third of the proportion for standard consultations (15%). The younger age profile of patients for Weekend Plus may have an impact on levels of disability (likely to be lower) and pregnancy and maternity (likely to be higher). See following sections.

The fact that the majority of people accessing Weekend Plus appointments are working age adults should be taken into account when taking any decisions around hub location and number of hubs.

The introduction of a digital front end for accessing healthcare will be available to all age groups. The previous experience of GP at Hand suggests working age adults particularly value this approach to accessing health care. However this may also help older residents and those with a family access healthcare in a more convenient way without the need for a face to face attendance. It is important to consider the potential implications of digital exclusion and how this might disproportionately affect some groups over others.

2. Disability. ***Consider and detail (include the source of any evidence) on attitudinal, physical and social barriers.***

Demographics

Urgent Care Centre

Data regarding disability status for attendees at UCC is not available. However, from data analysis all attendees are walk-in (i.e. are not conveyed by ambulance nor directed by 111). 91% of attendees are discharged with no investigations and no significant treatment.

Primary care

Broad categorisation of disability is not captured in the GP data (instead, data is captured around very specific diseases and conditions). It is not possible to establish whether those using Weekend Plus have differing levels of disability to standard users of general practice. However, the young age profile of Weekend Plus users suggests that levels of disability are likely to be considerably lower than for standard

GP consultations. Overall, self-reported levels of limiting long term illness were slightly lower in H&F (12.6%) than London (14.2%) (2011 Census).

Barriers/impact

Urgent Care Centre
There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight and being diverted to other alternative urgent care services. However, this will be sense checked with local people as part of our engagement and consultation work.

Primary care
The development of the digital first offer may also help residents with a disability access urgent care in a more convenient way without the need for a face to face attendance. However, it is important to note that since 2016, the number of disabled adults who had used the internet in the last 3 months increased by 5% to 9 million in 2017. Across all age groups, the proportion of adults who were recent internet users was lower for those that were disabled, compared with those that were not. For a specific group of people with a disability (those without smartphone or internet access) this access route may be unsuitable due to low adoption of technology.

Physical access/transport can act as a barrier to healthcare for disabled people. Patients with mental health conditions that mean that leaving their home is a challenge can use the service for initial consultations. A digital offer could provide a route to GP care without the need for a person to travel for an initial conversation. However, for those with complex needs and those who have a requirement for multiple follow-ups in person, the service may less suitable. The CCG's pre-consultation engagement with a focus group of mental health service users demonstrated a mix of views, with some patients feeling digital access would be beneficial but others concerned that it would not meet their complex needs.

Those with some visual or hearing impairment may have difficulties when understanding information given during a GP appointment. Visually impaired people can experience barriers to accessing primary care in cases where staff do not have the necessary skills to communicate. The online nature of the service may add to communication barriers for those who have impairments to their vision and hearing. However, these issues could potentially be mitigated by considering what features in a digital offer might make access easier for this group – e.g., a 'playback' facility. The use of BSL and interpreting services for online consultations would need to be considered. The accessible information standard offers an opportunity for further improvements.

According to the EQIA work undertaken for GP at Hand, deaf people would like to be able to communicate with primary care professionals using written or text

communications. This option could be considered as part of a new digital interface. The needs of deaf people will be further sense checked during consultation through discussions with the CEO of Action on Disability.

Any digital offer could be sense checked with patients with learning disabilities prior to roll out to ensure that it is accessible and the language is simple and easy to understand.

Although the data suggests that there is likely to be a lower proportion of patients with disabilities accessing Weekend Plus services, it will be important to take into consideration accessibility of hub locations during any decision making process – taking into account mobility issues and distance of travel.

3. Gender reassignment
Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment

Demographics
It has been estimated that there are 20 transgender people per 100,000 population. A total of 47 patients are identified on GP lists as being under the gender reassignment 'Read code'. In the period from Oct-Dec 18, no patients classified under this Read code used Weekend Plus. GP recording of marriage and civil partnership exists but is not of sufficient quality to carry out analysis.

Barriers/impact

Urgent care centre
There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services), reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours. However, we will sense check this with LGBT groups during our engagement process.

Primary care
Although there is a lack of evidence, the little that is available indicates that transgender people experience health inequalities (e.g. Transgender Sexual and Reproductive Health: Unmet Needs and Barriers to Care April 2012 National Centre for Transgender Equality), including sexual health inequalities, which may include higher rates of STIs, and difficulties accessing services and relevant information. Some individuals who have undergone gender reassignment may have a greater need for privacy. The first appointment of the day may be preferred if waiting areas are less occupied, offering the most discretion. Individuals who have undergone gender reassignment may have a greater need for privacy when accessing primary care than other sections of the population. Engagement with young transgender persons undertaken to date suggests that this is an issue locally, as it is nationally, which needs addressing. Digital access might help in offering the confidentiality

sought by the transgender community for initial consultations and a 'safe space' for healthcare. The CCG is also investigating options to roll out an initiative called "Pride in Practice" to help address feedback and reduce health inequalities for this protected group.

As regards proposed changes to Weekend Plus and extended hours, we do not have any data which suggests a disproportionate impact on the transgender community (other than the potential reduction in beginning and end of day appointments). However, due to the lack of data available in this area we will be aiming to sense check this information with transgender persons as part of our engagement process. There is a data gap when it comes to the LGBT community due to a lack of robust equality monitoring. When introducing a digital offer it may be worth considering addressing this by ensuring a robust and consistent approach towards this monitoring across H&F practices.

4. Marriage and Civil Partnership

Demographics
GP recording of marriage and civil partnership exists but is not of sufficient quality to carry out analysis.

Barriers/impact
There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services), reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours. However, this will be sense checked with local people as part of our engagement and consultation work. We have also not identified any adverse or disproportionate impact as regards primary care related proposals.

5. Pregnancy and maternity
Consider and detail (including the source of any evidence) on working arrangements, part- time working, infant caring responsibilities

Demographics
According to GP systems, around 4% of pregnant women used the Weekend Plus service in the 3 month period of Oct-Dec 18, compared to 75% for general consultations (around 2% of all Weekend Plus consultations are for pregnant women). Although there may be a degree of under-reporting in GP Practice systems, it seems clear that use of Weekend Plus among pregnant women is very low.

Barriers/impact

Urgent care centre
There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight and being diverted to other

alternative urgent care services. A smaller proportion of women attend the UCC in the night compared to the day.

Primary care

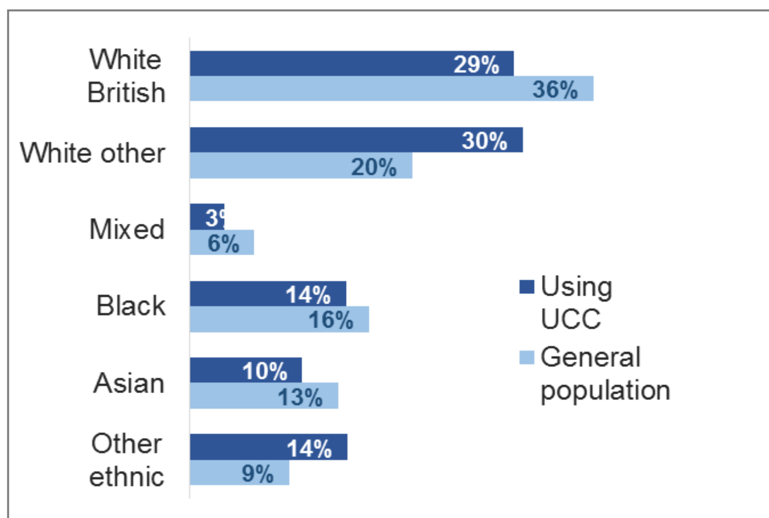
It is worth noting that NHS England considers it advisable for women who are pregnant or planning to become pregnant to have on-going face to face consultation and review, therefore a digital offer might be of less use to this cohort. On this basis it would also be beneficial for pregnant women to retain continuity of care, which is unlikely when accessing care via Weekend Plus hubs. Given that only 4% of the weekend plus service users are pregnant women, a reduction in locations/appointments is less likely to disproportionately affect this group.

6. Race. Consider and detail (including the source of any evidence) on different ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers

Demographics

One in four of the borough's population were born abroad. The population in the borough is socioeconomically and culturally diverse. Although the proportion from White British groups is similar to London (and accounts for less than half the population), a quarter are from 'other white' backgrounds. This is reflected in the range of European languages spoken in the borough. One third (32%) of the population are from Black, Asian and minority ethnic (BAME) groups, up from 22% in 2001. Hammersmith and Fulham has a small Asian population but a similar Black population to the London average and larger than average proportions from the 'Mixed' and 'Arab' categories.

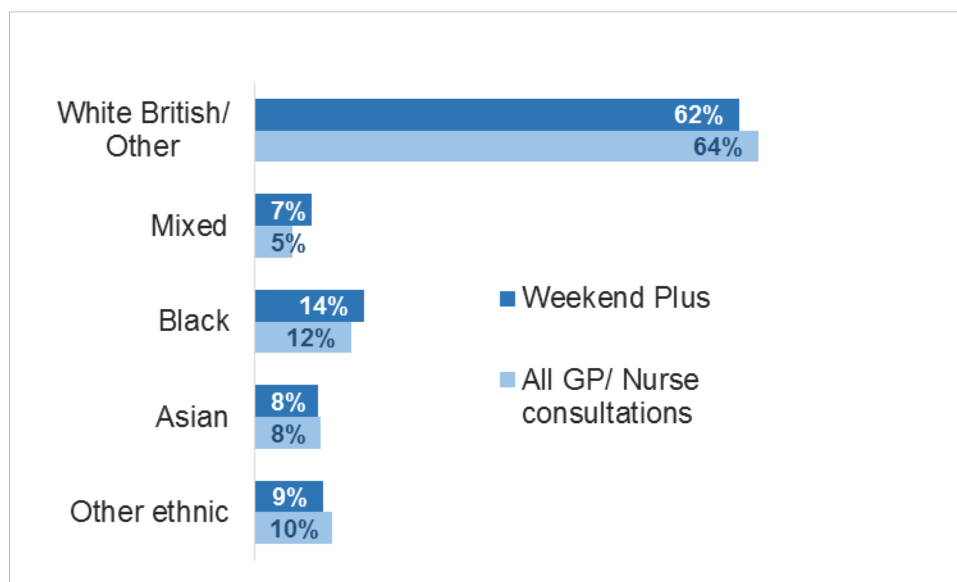
Night attendances at UCC by ethnicity (Ethnic profile of service users during the day very similar to during the night)



Primary care

Attendances at Weekend Plus by ethnicity

Ethnic profile of Weekend Plus consultations, compared to all (standard) GP/ Nurse Consultations, Oct-Dec 18 (where recorded – from GP Systems)



The ethnic group of those attending Weekend Plus is broadly similar to the profile for all standard consultations, with just over a third from BAME (including mixed) groups. Although there are slightly more from Mixed and Black ethnic groups using Weekend Plus, this is unlikely to be statistically significant.

Barriers/impact

Urgent care centre

There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services), reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours. However, this will be sense checked with local people as part of our engagement and consultation work.

Primary care

An NAO report focusing on access to GP services (2015) shared that BAME groups tend to prefer same day appointments and to see a GP over other practice staff. GP preference is deemed more important to many than opening hours, and many have shared their comfortableness with seeing a nurse if the GP is not available. Whether patients can access the same professional each time they need or want to is described as continuity of care. 62% of White patients received continuity of care, compared to only 47% of Black and Asian patients. 65% of all patients were happy to see a nurse if the GP was unavailable. 83% wanted to consult a GP specifically - GP Patient survey 2015. This has also been confirmed locally through the CCG's community engagement work with BAME groups. The main barriers or reasons for

poor satisfaction were cited as poor language proficiency; lack of acculturation, and provider side discrimination (stereotyping and bias). National issues reported for some BAME groups include short time frames to book appointments in the morning, queues at practices, concerns about interpreting, and long waits for routine appointments.

Community engagement undertaken to date suggests that the availability of an accessible route for an interpreter is highly important for BAME groups who experience language barriers. According to the GP patient survey 2015, the South Asian population has the lowest reported satisfaction rate with the process of making an appointment, with a high proportion unable to make an appointment. Also, the uptake of GP registration by recent entrants to the UK has been low. It would therefore be important to consider how any new service could meet these accessibility needs and to engage BAME groups and relevant community and voluntary sector leads when promoting and explaining any new service offer.

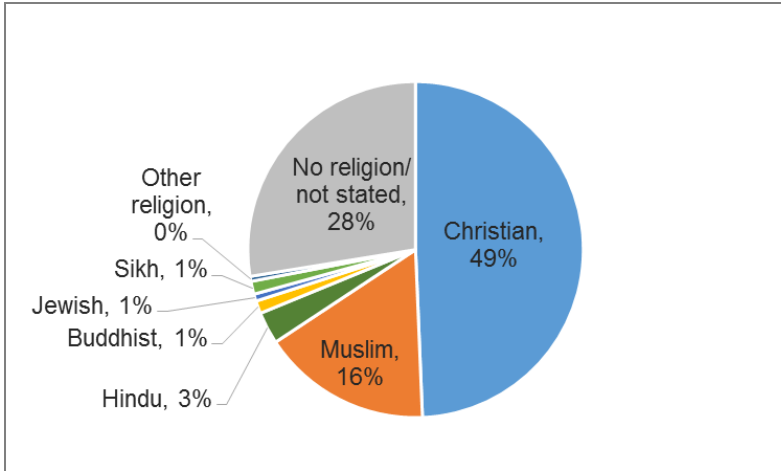
The CCG will consider how the issues described above can be addressed through any proposed changes in primary care. For example, cultural sensitivity training could be coproduced with local groups and delivered to GP practice staff (including receptionists) and actions taken to ensure that any digital offer is accessible to these community groups.

The data suggests that there is no statistically significant difference between the proportion of BAME groups accessing Weekend Plus as opposed to core hour appointments. There are no immediately apparent reasons why BAME groups would be disproportionately impacted by proposed changes for Weekend Plus and extended hours - particularly as BAME groups have expressed a preference for continuity of care and same day appointments, neither of which are available via Weekend Plus. However, the engagement process will allow us to sense check this with local people.

7. Religion or belief. Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief

Demographics
GP recording of religion/ belief is not consistent enough for routine analysis. It might be possible to look at addressing a more robust and consistent approach towards gathering this information via a digital offer. Information from the 2011 Census suggests the most common religion in H&F is Christianity (54%), followed by Islam (10%).

Estimated religion of patients attending the Urgent Care Centre based on 2011 Census data applied to location of attendances



Barriers/impact

Urgent care centre

There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services), reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours. However, we will sense check with local people as part of our engagement and consultation work. According to LBHF's Housing support and care JSNA Hammersmith and Fulham Council has established a Social inclusion Forum which brings together key officers from public, private, voluntary, community & faith sector organisations to deliver improved social inclusion outcomes for local residents. The CCG will contact LBHF to see whether this group is still running and if so if we can engage with them over the coming months. We have also contacted Sobus to ask if we can be put in touch with any faith groups they have been working alongside.

Primary care

Some faith groups restrict how women (and sometimes children) interact with health providers e.g. some women not able to see GP without permission from husband or other male in household or without male accompanying them. Introducing a digital method of accessing care may allow women greater freedom in being able to access care in their own home; however, this is of course dependent on their level of digital access at home. Timings for religious activities such as prayer can make attending set appointment times outside the home more challenging. It is possible that a digital offer could make this easier, depending on appointment times etc within this.

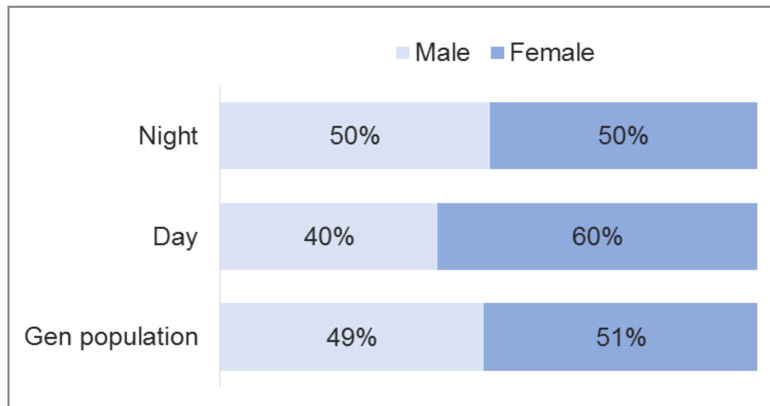
8. Sex

Consider and details (including the source of any evidence) on men and women (potential link to carers below)

Demographics

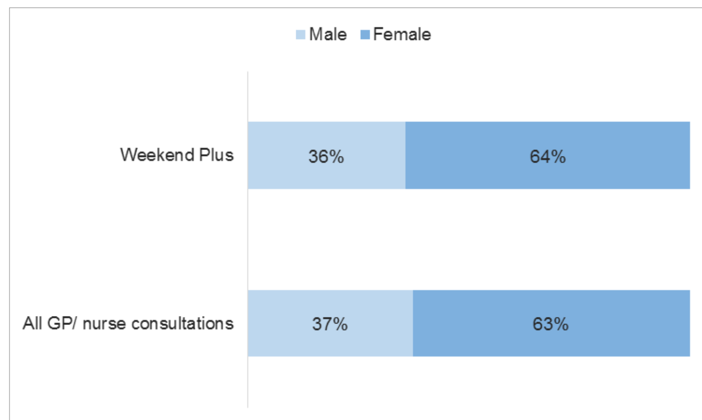
Urgent care

A smaller proportion of women attend the UCC in the night compared to the day.
Attendances by gender – by night, day and gen pop:



Primary care

Gender profile of Weekend Plus consultations, compared to all (standard) GP/ Nurse Consultations, Oct-Dec 18



Both Weekend Plus and standard GP consultations are nearly twice as common among women than men.

Barriers/impact
Urgent care centres

There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services), reduction in appointments offered at the Weekend

Plus hubs or appointments offered at their own practice outside of core hours. However, we will sense check with local people as part of our engagement and consultation work.

Primary care
According to the EQIA for GP at Hand, young men are under-using local primary care services leading to late presentation (substance misuse, sexual health and mental health.) However, younger men are choosing to register with GP at Hand, which may suggest that a digital offer could improve this cohort's engagement with primary care. A digital offer could potentially be developed which helped to target key messages to this cohort via approaches such as app notifications. The EQIA also references research suggesting that women attempt self-treatment more often and are more likely to consult a lay person for support. A digital offer could include a symptom checker chatbot with self-care advice.

9. Sexual orientation
Consider and detail (including the source of any evidence) on heterosexual people, as well as lesbian, gay and bi-sexual people

Demographics

- 3.3 million lesbian, gay and bisexual people in England - Stonewall
- 1.7% of adults in the UK identify themselves as lesbian, gay or bisexual.
- 2.5% in London. 3.3% of 16-24 year olds identify as gay, lesbian or bisexual – annual population survey 2015.

There is a data gap when it comes to the LGBT community, as the sexual orientation monitoring standard is less well established and has not been fully embedded across providers. When introducing a digital offer it may be worth considering addressing this by ensuring a robust and consistent approach towards this monitoring across H&F practices.

Barriers/impact

Urgent care centre
There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services), reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours. However, we will sense check with local LGBT people as part of our engagement and consultation work.

Primary care
Historic social or health system discrimination can impact a patient's comfortableness during a consultation for example those who identify as Lesbian, Gay or Bisexual were about one and a half times more likely to report unfavourable experiences especially relevant to primary care intervention. Engagement with young

LGB persons undertaken to date suggests that this is an issue locally, as it is nationally, which needs addressing. Digital access might help in offering the confidentiality sought by the LGB community for initial consultations and a 'safe space' for healthcare. The CCG is also investigating options to roll out an initiative called "Pride in Practice" to help address feedback and reduce health inequalities for this protected group.

10. Carers
Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.

Demographics
GP recording of provision of unpaid care is a significant undercount compared to 2011 Census data and can therefore not be reliably analysed. Census data identifies around 1 in 14 local residents in Hammersmith and Fulham who provide unpaid care (7%). Around 1 in 70 residents provide 50 or more hours a week.

Barrier/impact

Urgent care centre
There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight and being diverted to other alternative urgent care services. However, we will sense check with local carers as part of our engagement and consultation work.

Primary care
Again the development of the digital first offer may also help this cohort of residents access primary or urgent care in a more convenient way without the need for a face to face attendance. Often carers of disabled people use the internet to access services. Carers may benefit from use of a digital first offer as this will allow them to consult a primary care practitioner whilst continuing with their care responsibilities.

Local carers have expressed preferences for continuity of care, which is much less likely to be available via Weekend Plus appointments. It will be important to consider the needs of carers in any new offer and to engage with carers as part of our formal consultation.

11. Other identified groups
NHS England has agreed an additional definition which relates to inclusion health and people with lived experience. Inclusion health has been used to define a number of groups of people who are not usually provided for by healthcare services and covers people who are **homeless, rough sleepers, vulnerable migrants, sex workers Gypsies or Travellers** and other multiply excluded people. The definition also covers **Female Genital Mutilation (FGM), human trafficking and people in recovery**. Please consider these groups too in your analysis

Demographics
Data regarding other identified groups' status for attendees at UCC is not available.

Barrier/impact

Urgent care centre
There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services). However, this will be sense checked with local people as part of the engagement and consultation process.

Primary care
Recently arrived migrants may experience barriers to accessing GP services due to stigma, lack of understanding of how services work and a lack of community networks. Some might benefit from widening access to incorporate a digital offer, and it will be important to consider the need to undertake outreach and advertising once decisions have been made around the future of primary and urgent care to ensure that this and other community groups are aware of what is available to them from their local NHS. We have not identified data to suggest that this cohort of attendees would be adversely affected by the reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours. However, this will be sense checked with local people as part of the engagement and consultation process.

While some of these groups might not use the digital access route themselves it is hoped that they will benefit indirectly, from the increased capacity of healthcare services with more patients accessing the right care first time.

12. Consider and detail (including the source of any evidence) on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access

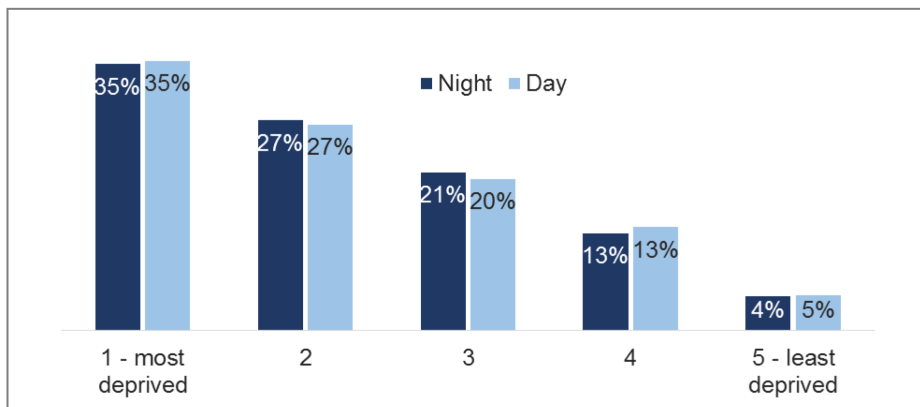
Demographics

Despite high house prices in the area, Hammersmith and Fulham was classified as the 55th most deprived borough in the country in 2010 according to the index of multiple deprivation, which is based on a range of economic, social and housing indicators. Pockets of deprivation are spread throughout the borough but are particularly focussed in the north of the borough.

These areas usually correspond to areas of social housing and poorer than average health.

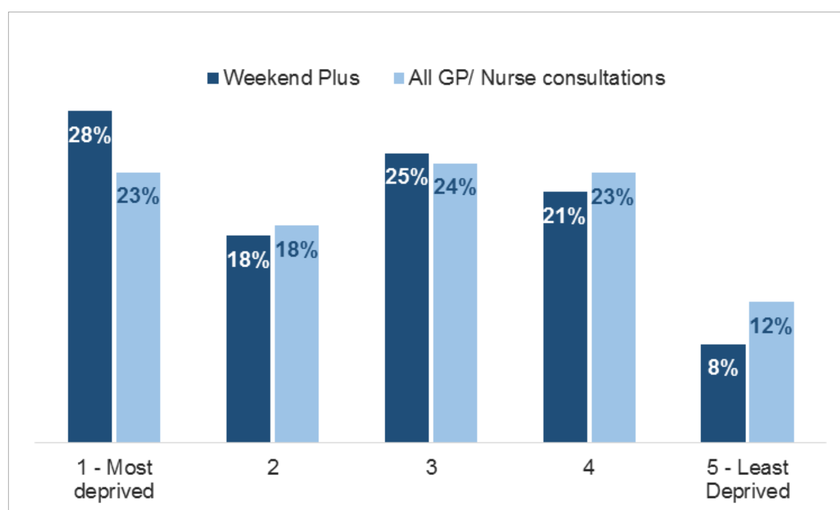
A third of children under 16 (29%) live in poverty according to official definitions, which is higher than London and England. The Job Seekers Allowance rate in November 2013 was 3.1%, similar to London (3.1%) and Great Britain (2.9%), but rates are almost double this in areas such as College Park & Old Oak and Wormholt & White City. This will be taken into account to inform our engagement and consultation approach.

Attendances to UCC by area deprivation (IMD 2015) – night and day



People from the areas surrounding the UCC may have slightly lower rates of illness and disability compared to London and deprivation is broadly similar

Deprivation profile of Weekend Plus consultations, compared to all (standard) GP/ Nurse Consultations, Oct-Dec 18 (based on London quintiles – 20% groupings)



Weekend Plus serves a slightly more deprived patient base than standard GP/ Nurse consultations, with a greater proportion of consultations falling into the 20% most

deprived in London (and a smaller proportion falling into the least deprived). This may relate to the location of the Weekend Plus hubs.

Barrier/impact

Urgent care centre
There is nothing to suggest that this cohort of attendees would be adversely affected by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services), reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours. However, this will be sense checked with local people as part of our engagement and consultation work.

Primary care
Certain groups like care leavers, students have transient home address. Online consultations as part of a digital offer could help to address this; however, the issue of digital exclusion for some groups including the homeless would need to be considered.

The fact that Weekend Plus serves a slightly more deprived patient base than standard GP/ Nurse consultations suggests that the CCG should consider carefully the potential impact of any changes to location of the hubs, and any necessary mitigations to ensure that more deprived patients are not disproportionately negatively impacted by any changes.

Summary on analysis. Considering the evidence please summarise the impact of your proposals. Consider whether the evidence shows potential for differential impact; if so, state whether adverse or positive and for which groups. How will you mitigate any negative impacts? How will you include certain protected groups in services or expand their participation in public life?

The National Framework reflects the new NHS framework and structures created by the Health and Social Care Act 2012 effective from 1 April 2013. Standing Rules Regulations have been issued under the National Health Service Act 2006, and directions are issued under the Local Authority Social Services Act 1970 in relation to The National Framework.

Considering the evidence there is nothing to suggest potential for differential impact and any adverse outcome caused by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services), reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours.

The development of the digital first offer may also help residents access primary and urgent care in a more convenient way without the need for a face to face attendance. Where we have identified barriers for certain protected groups, we are engaging in a

continuous process of examining how these can be mitigated and addressed in how we develop our proposals.

It is important to note that although this screening has been a desktop review:

1. It has been fully informed by and references feedback from community groups collected by the CCG over the past year and as part of our pre consultation engagement work.
2. Based on the information gathered through this screening process it will be important to sense check our findings with local residents and members of different protected groups. To this end the CCG will hold a public Equality Diversity System workshop in the first week of our formal consultation, with some supplementary face to face outreach work in the community. Any gaps in evidence will be addressed via on-going engagement and the formal consultation process.

Part B

B	The Public Sector Equality Duty
B1	*Could the initiative help to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)?* **YES** As part of the access review and proposals, it may be possible to tackle reported feelings from members of local BAME and LGBT groups that they experience a level of discrimination or that their experience is affected negatively by memories of historic discrimination.
B2	*Could the initiative undermine steps to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics? If yes, for which of the nine protected characteristics?* **NO**
B3	*Could the initiative help to advance equality of opportunity? If yes, for which of the nine protected characteristics?* **YES** The development of the digital first offer may help residents' access primary and urgent care in a more convenient way without the need for a face to face attendance. This may benefit residents including carers and those who require greater levels of privacy of access such as members of the transgender community.

B4	*Could the initiative undermine the advancement of equality of opportunity? If yes, for which of the nine protected characteristics?* **NO** **However, it will be important to ensure that feedback from protected groups informs the development of any digital offer so that it is equitable and promotes equality of opportunity.**
B5	*Could the initiative help to foster good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?* **NO**
B6	*Could the initiative undermine the fostering of good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?* **NO**

Part C

C	The duty to have regard to reduce health inequalities
C1	*Will the initiative contribute to the duties to reduce health inequalities?* **YES** The development of the digital first offer may help residents' access primary and urgent care in a more convenient way without the need for a face to face attendance.
	Could the initiative reduce inequalities in access to health care for any groups which face health inequalities? If yes for which groups? This may benefit residents including carers and those with a disability
C2	*Could the initiative reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups?* **YES** The development of the digital first offer may help residents' access primary and urgent care in a more convenient way without the need for a face to face attendance. This may residents including carers

Part D

D	Will a full Equality and Health Inequalities Analysis (EHIA) be completed?

D1	*What is the overall impact of your proposals of decision?* *Consider whether there are difference levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*
	There is nothing to suggest that attendees with protected characteristics' would be adversely affected by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services), reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours. The development of the digital first offer may help this cohort of residents access primary and urgent care in a more convenient way without the need for a face to face attendance.
D2	*Will a full EHIA be completed?* *Bearing in mind your previous responses, have you decided that an EHIA should be completed?*

Part E

E	Action required and next steps
E1	*If a full EHIA is planned:* *Please state when the EHIA will be completed and by whom.*
E2	*If no decision is possible at this stage:* *If it is not possible to state whether an EHIA will be completed, please summarise your reasons below and clearly state what additional information or work is required, when that work will be undertaken and when a decision about whether an EHIA will be completed will be made.*
E3	*If no EHIA is recommended:* A full EHIA is not required as there is nothing to suggest that attendees with protected characteristics' would be adversely affected by the closure of Hammersmith UCC overnight (and being diverted to other alternative urgent care services), reduction in appointments offered at the Weekend Plus hubs or appointments offered at their own practice outside of core hours. The development of the digital first offer may help this cohort of residents access primary and urgent care in a more convenient way without the need for a face to face attendance.

Part F

Action planning for improvement
Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes needs to be summarised (An action plan is appended for action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.
Extensive data has been collated and analysed to support the EHIA screening process. However, any gaps will be addressed through consultation with our local population, stakeholders and frontline staff.
Please give an outline of your next steps based on the challenges and opportunities you have identified.
Collating all feedback received to date and categorising it according to the protected group to identify specific themes and trends. Ensuring that we use the information gathered for this screening and an analysis of groups we have engaged with to date and information gathered to inform our consultation process.

Part G

Name and job title of person/s who carried out this analysis	Carol Lambe, Head of Commissioning and Delivery, HFCCG James Hebblethwaite, HFCCG Information Manager Coral McNeilly, Primary Care Lead, HFCCG Bethany Golding, Engagement and
Date analysis completed	07/01/19
Date analysis signed	
Name of Executive lead / reviewer	
Date of executive sign off	

Appendix 11 Public and stakeholder feedback to date

Group/focus	Feedback theme/trend	Suggestions
Patients, the public and lay members	• More time for those with language barriers, e.g. booking double appointment. Must be easy process and available to patients who need it. • Difficult that people who access out of hours GP appointments can't get a referral from these appointments. • Develop effective links and connection between the GP and hospitals. • Might take three weeks to get GP appointment, so we go to the UCC/A&E. • Unsure as to whether 111 services can make the appointment for you • Extended hours/weekend plus resulted in big inequalities of what different GP practices offer • It would help to know how core hour GP appointments online booking are being used • Not happy for NHS 111 to be the main access point into extended hours as it doesn't operate well enough • Is the interpreting service available on 111? How easily accessible? • Confused on how NHS 111service would be helpful. some experienced very good, quick response and appointment in the right place and time while other not used it/don't know it	• Where the UCCs are located at Hammersmith and Charing Cross? Need clear signposting in both hospitals and advertising. • Should allow direct self-referral into Weekend Plus • Better to have lots of different access routes as different people have different needs in different contexts (telephone, walk in, face to face, digital) • Digital access should be available where useful without having to de-register from your own GP practice. Video consultations should be available from your own surgery. Large portion of community not accessing digital or don't know how to use it • More GP emergency appointments / drop in / walk in access slots • We need training in using any app and online services • Need to use various ways of communication to ensure such health inclusive/protected characteristic groups kept informed and updated about the existing and changes in the local health care services • Focus on prevention services for people rather than treatment as patients • Use technology like digital services make GP more accessible • Access to primary care and UCCs- need to match availability to need not to demand

	• Patient asked how the £295 million CCG budget will address to allocate the health care and make services easy accessible to local people. Will CCG be working to cover the £17 million shortage? • Scepticism around technology and how confident are we that it will improve experience, safety and accommodate different demographics • Technology needs to be used appropriately; patient education may be required, and having an effective clinical triage process is essential. Important to have clear guidelines around what requires a video consultation and what requires a face to face appointment • Consider where we place services: currently we have several services in close proximity to each other, offering similar things. This can cause duplication as well as confusing people •	• Local people should know in advance where to go before closing a UCC, especially at night or emergency • Travel issues need to be looked such as age, children, mobility / disability • Patient education and signposting is key (including via PPGs) – make sure people know what is available to them. Information provided to patients needs to be simpler and clearer • Introduce interactive SMS system so you not only get an appointment reminder, but can respond with 'Y/N' to indicate whether you can still attend • Effective triage process to ensure no time is wasted, so you are seeing right person at right time •
Experiences at GP practices	• Lines too busy to get appointments from GP • Receptionists are rude, not helpful • Seeing same regular GP better health outcomes and hard to get appointment with same GP each time, this can mean you are waiting even longer for an appointment • Lack of available appointments and choice in appointment times	• Need urgent, timely apt when my child seriously ill, not 2 week wait • Better translation support in GP practices • Longer GP slots if you have multiple issues • Make more emergency GP appointments • Blood tests to be available at the local GP • More training should be provided to GPs to better support holistic needs of the vulnerable groups • Same day prescriptions

	• GPs don't listen to you as well as they should do • waiting times for GP appointments are too long • even waiting too long on phone to speak to a GP receptionist • only taking bookings between 8 and 9 am where line is always busy at that time • GP apt should cover more than one issue, waste time to book another apt again • GPs are too rushed specially with LTCs diagnosis • no time for Q&A • Previous engagement over the past year has identified a number of accessibility issues in general practice, including: difficulty getting through to make an appointment; language and privacy barriers for BAME and LGBT communities	• Be able to book urgent apt online and GPs emailed back in a reasonable time-frame • Check results online at any time • Call back or text reply two way text messaging other ways to contact GP practice • Minor injury and pharmacists in GP practice better • GP receptionists should be trained so that they are very clear on what is available to patients • Expand online content so that you can get video consultations from your own GP practice, or in a way which does not require de-registering from your current GP practice. Have this be accessible via app. • Ensure an integrated service and take lessons from impact of Vocare on UCC performance. •
Experiences around UCC	• People think accident and emergency and urgent care centre are the same thing • Actually not aware that UCCs open overnight • Unsure as to whether children can use urgent care centres • Majority of people refer to use CXH for its easy accessible location which is supported by different public transports • North of the borough has greatest health inequality and services should reflect this e.g. ED in north of borough •	• Ensure an integrated service and take lessons from impact of Vocare on UCC performance • Take into account Hammersmith UCC demographics of users and that it is a deprived area • Need to know why are people going to the UCC rather than GP appointments?
Weekend Plus	• Online: can be confusing, hard to access, can be useful to book online. Prefer telephone to book	• Need more promotion • Allow direct self-referral into Weekend Plus • Need good directions if not your surgery – text confirmations

	appointments – but only if you can get through. • Opening hours: would be more likely to be used if patients could call hub directly, depend on person • Mixed views on how helpful weekend appointments are • Difference in view on continuity of care – patients with LTCs wanted usual doctor	• Would be helpful to be able to get blood tests, health checks, BP with HCA
Extended hours	• Not happy for NHS 111 to be the main access point into extended hours as it doesn't operate well enough • In favour of having multiple access routes to care (telephone, walk in, face to face, digital) with one patient representative noting that 'one size does not fit all.' • Approval from GPs, Practice Managers and patient representatives of the idea of having other professionals, such as pharmacists and practice nurses, available at your GP practice during extended hours • Ensure we improve what we have, rather than reducing what we have – though some duplication can be looked at and avoided • Some patient representatives said they would want to see the same doctor consistently within their own practice. Ensure enough resource in	

	extended hours to provide continuity of care • Some patient representatives expressed a willingness to travel to other practices for appointments provided that these were within a reasonable distance. Others said they prefer to see their regular doctor for routine appointments, and only use out of hours provision at other practices when it is urgent • People who access out of hours GP appointments can't get a referral from these appointments • Not getting the exact same treatment via extended hours appointments as they would at a regular routine appointment	
Feedback from mental health service users	• GPs need to understand and have compassion for patients with mental health needs • Insufficient signposting to community-led mental health groups	• Better access to MH services and especially preventative services • Training should be provided to GPs to better support MH • Need an intermediate service for MH (IAPT and extreme sectioning) • GPs should not over-rely on prescribing medications for MH but should consider where therapy and social prescribing options are appropriate
Feedback from BAME groups	• Reception staff in GP surgeries often just brush you off • linguistic barriers to service and cultural taboos • 10 minute appointments are not enough for those with LTCs or required interpretation	• Need warm, welcoming receptionists & nurses • More interpreters both F2F & over the phone • Health advocacy needed • People should have a GP gender-choice • Better translation support in GP practices • Better signposting to services

Feedback from LGBT groups	• GPs often do not know how to support young trans patients • Some GPs display a lack of empathy/understanding	• Make GP consultation times longer for LGBT people with mental health issues • Continuity of GPs • Health and social care teams need to work together • More accessible LGBT sexual health clinics. • Training should be provided to GPs to better support LGBT people
Feedback from disabled people	• 10 minute appointments not enough for people who are disabled with complex needs	• Training should be provided to GPs to better support them
Feedback from young people	• Young people find it's hard to book appointments for themselves, they have to rely on their parents to do it • The booking systems aren't very accessible for them.	• Better accessible booking systems for them.
Feedback from carers	• Hard to get GP double appointments or joint appointments with the person they are caring for • 10 minute appointments are not enough	

Appendix 12 Pre-consultation engagement events

No	Event	Date	Patients, Lay members, local residents, public and CVS reps
1.	Patient Reference Group	Thursday 2 August	19
2.	Primary and urgent care access workshop	Tuesday 21 August	15 + 5 GPs & PMs
3.	HF-Community Champions - Summer Fair	Saturday 1 September	40
4.	Healthwatch Enter and View at Hammersmith Hospital Urgent Care Centre	Thursday 20 Sep and Friday 5 October	15
5.	Kick it/Healthy Hearts	Saturday 22 September	30
6.	Patient Reference Group	Thursday 4 October	16
7.	Session with Action on Disability group	Friday 5 October	9
8.	Education and Youth – World Mental Health Day	Wednesday 10 October	8
9.	Stall at Age UK event	Friday 19 October	20 and recruiting for PPG training - Leadership skills
10.	QPR Community Trust's weekly older people's club	Wednesday 7 November	18

11.	PPG Leadership training	Thursday 8 November	30
12.	Bayonne and Field Road Community Champions - yoga session	Wednesday 14 November	15
13.	Community Champions winter health event	Thursday 15 November	25
14.	Age UK - Health wellbeing Forum meeting	Wednesday 21 Nov 10:15 - 11:30	32
15.	Community Champions, Mental Health	Wednesday 21 Nov 12:00 – 15:00	12
16.	Youth Take Over Day	Friday 23 November	15
17.	Addison Community Champions winter event	Wednesday 5 December	24
18.	Patient Reference Group	Thursday 6 December	22
19.	HeadsUp (mental health service user involvement panel)	Wednesday 19 December	12
			Total: 362

Appendix 13 Formal response from London Clinical Senate

Advice for Hammersmith and Fulham Clinical Commissioning Group

A proposal to change the opening hours of the Hammersmith Urgent Care Centre.

Final – for submission to Commissioners.

December 17th, 2018.

Author Edward Ward, Clinical Senate Manager.

Summary & introduction

In October 2018, Hammersmith and Fulham Clinical Commissioning Group made a request for advice to the London Clinical Senate regarding proposals for:

- the Hammersmith Fulham UCC to close between 12.00 a.m. and 8 a.m. and for the UCC at Charing Cross to remain open for 24hrs, 7 days a week. Patients who would have attended the Hammersmith UCC will be directed to the Charing Cross UCC
- both the UCCs in Hammersmith and Fulham to become Urgent Treatment Centres (UTCs) and for the CCG to develop a new model for Primary and Urgent care in Hammersmith and Fulham. The new model will include a new digital first offer, NHS 111, next day primary care services, pharmacies, and alternative urgent care services

The CCG asked for the Clinical Senate's advice on whether their proposed changes to opening hours will ensure that the provision of safe, high quality out of hour's primary care to the residents of Hammersmith and Fulham continues. The Clinical Senate agreed to the CCG's request for a clinical review.

This report sets out the Clinical Senate's review of the proposals and their advice to the CCG. It contains the terms of reference for the review, the review's methodology, and the Senate's advice and recommendations to the CCG.

A summary of the Senate's advice to Hammersmith and Fulham CCG.

The Senate supports the proposed change to opening hours at the Hammersmith CCH and the CCG's initial proposals for a new model for primary and urgent care in Hammersmith and Fulham. It finds that the proposed change to the opening hours of the Hammersmith UCC:

- is clinically safe
- will improve the safety of care when compared to the current model.
- will not materially affect the capacity of out of hours primary care services in Hammersmith and Fulham to provide a service to the residents of the borough

The Clinical Senate advises that the Hammersmith and Fulham CCG:

a) provides more detail on its risk mitigation plan for the change in hours at the Hammersmith UCC. This should include describing how patients will get from Hammersmith to Charing Cross if they go there for treatment in the period after the change in opening hours and how the change in opening hours will be publicised
b) provides more detail on how it will develop its proposed new primary care out of hours offer, i.e. the 111 pathways and its digital offer. It should also consider increasing its investment in community services, particularly for the population living closest to the Hammersmith Hospital
c) ensures that the changes to the provision of primary care Out of Hours and Urgent care in Hammersmith are used as an opportunity to emphasise and, if necessary, redefine the CCG's OOH/Urgent Care pathway for children.
d) continues to consult with patients, carers, Healthwatch, and other stakeholders about its new clinical model for out of hours primary care
e) considers further the effects of the proposed changes on other services in NW London, especially the Hospitals and UCCs nearest to Hammersmith Hospital.

About the London Clinical Senate.

The London Clinical Senate is an independent body within NHS England. It exists to support the development of London's health services by providing independent, strategic, clinical advice to commissioners. Senate advice is provided as part of NHS England's assurance process for service changes.

The London Senate is part of network of 12 Senates across NHS England's regions. https://www.england.nhs.uk/ourwork/part-rel/cs.

A Clinical Senate's advice is impartial and informed by the best available evidence.

2) Background to the CCG's request for advice

The CCG's proposal.

Hammersmith and Fulham CCG propose to:

- close the Hammersmith Urgent Care Centre between 12 midnight and 8am
- divert the patients who would have attended the Hammersmith UCC during those hours to alternative options. These include the Charing Cross UCC, a new digital first offer, NHS 111, next day primary care services, pharmacies, alternative urgent care services
- develop each site as an Urgent Treatment Centre.

The Urgent Care Centres in Hammersmith and Fulham

Hammersmith and Fulham CCG commissions two urgent care centres (UCC); one at Charing Cross hospital and one at Hammersmith hospital. They are both open for 24-hours, 7 days a week. It is the only CCG in London to have two UCCs.The two Hammersmith and Fulham UCCs were opened in 2014 as part of the "Shaping a Healthy Future (SHAF)" reconfiguration. SHAF is the programme to reshape hospital and out of hospital health and care services in ***North West London.***
https://www.healthiernorthwestlondon.nhs.uk/

The Charing Cross UCC is co located with the Emergency Department (ED) at Charing Cross Hospital. The Hammersmith Hospital does not have an ED and that hospital is largely a provider of Tertiary services. Both UCCs are provided by a partnership between Imperial College Healthcare NHS Trust and London Central and West Collaborative (LCW), a local out of hour's provider. Both hospitals the UCCs are based in are part of Imperial. The UCCs' contracts with the CCG end in March 2019, though the CCG will extend those contracts, prior to re-procuring the UCCs as Urgent Treatment Centres (UTCs). The re procurements is expected to happen in 2019-20.

Given the reasons for the establishment of the 2 UCCs, and to obtain their views on the impact of the changes in NW London, the CCG has discussed the proposed changes with the NW London Clinical Programme Executive. This is the body which oversees the implementation of the Shaping a Healthy Future strategy. The Clinical Programme Executive is supportive of the proposed changes to opening hours at the UCC and of the CCGs new clinical model for 111 & Primary Care out of Hours services.

UTC Procurement

The CCG will use the opportunity afforded by the procurement to:

- replace the UCCs with UTCs.
- better align their primary and urgent care offerings to patients. This will include a new digital first offer, NHS 111, next day primary care services, pharmacies, and alternative urgent care services.

About the Hammersmith UCC.

The Hammersmith UCC is currently open 24/7. It is based at Hammersmith Hospital in the north of the borough. The UCC has been standalone service since the ED at Hammersmith Hospital closed in September 2014. It became a 24/7 service as part of the implementation of Shaping a Healthier Future. The UCC is adjacent to one of the most deprived wards in the borough, according to Indices of Multiple Deprivation data

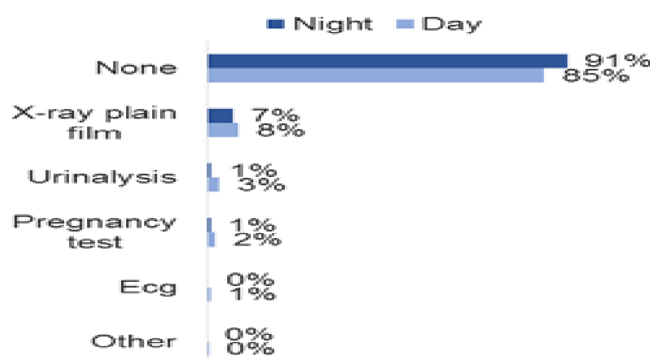
In 2017/18 the Hammersmith UCC saw nearly 33,000 patients, with an average of 629 patients seen a week. Just under 8% of all attendances occurred between midnight and 8am

Attendances:

Average per night	7
Most common per night	5
Lowest	1
Highest	18

The treatment provided by the Hammersmith UCC- the difference between day time and night time.

For around three quarters of attendances between 12.00am and 8.00am the treatment provided was advice and/ or simple medication. Most of the other attendances were for wound care/ dressing or simple MSK care such as slings/ tubigrips. The following graph of investigations undertaken for those attending the UCC in 17/18, shows that over 85% of patients were discharged with no further investigation. Between 12.00am and 8.00 am this number rise to 91%.

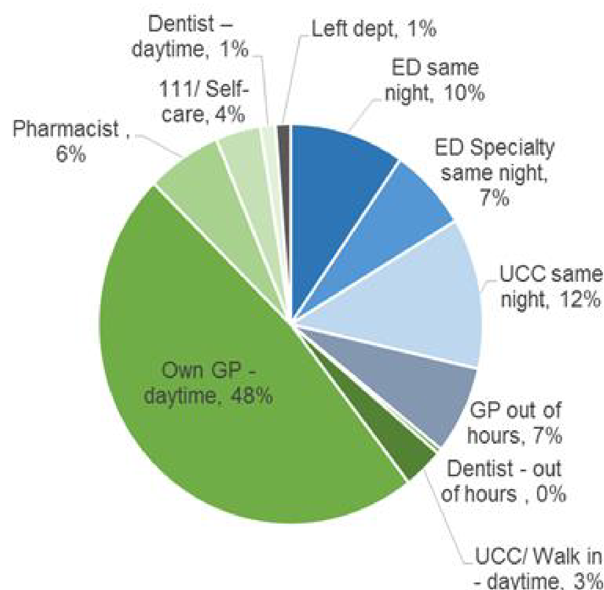


9% of patients needed investigation/ treatment at night, compared to 15% during the day. This equates to just 4 patients a week needing investigation or treatment overnight, compared to 85 patients per week during the day

A third of all night time attendances are from people living in Hammersmith & Fulham (H&F), followed by a quarter from Ealing. Over a half are from within a 3km radius, such as East Acton and White City. This area tends to be more deprived than average for London. People from this area may have slightly higher rates of illness and disability than typical.

Eight out of 10-night time attendances are for working age adults, with the rate of visiting higher for this group than for children and older people. A third of people who use the service at night also use it during the day. However, repeat night time attendance is rare with only one in 10 patients coming at night more than once in the year. The gender split at night is representative of the general population, unlike during the day, where women outnumber men.

The CCG's Clinical Audit of the Hammersmith UCC.
The CCG, as part of its case for change for the proposal to change the opening hours of the Hammersmith UCC, conducted a clinical audit of the use of the UCC and its outcomes. The clinical audit found that suitable care for close to half (48%) of those attending at night could have been provided by a GP appointment the following day.



Further information on the use of Hammersmith UCC can be found in the CCG's case for change. *See pages 9-15 of the case for change for further evidence on patients use of the Hammersmith CCG.*

Patients' use of the Charing Cross UCC
Charing Cross UCC is open 24/7 and is co-located with Charing Cross Hospital ED in the south of the borough. The ED at Charing Cross does not see children.

Attendance at the Charing Cross UCC.
In 2017/18 Charing Cross UCC saw just over 47,000 patients, an average of 908 patients a week. Just under 11% of all attendances occur in the period between midnight and 8am with 4% occurring between 2am and 6am.There are around 14 visits a night, although this can vary considerably. 90% of all night times (midnight to 8am) have between 8 and 20 attendances.

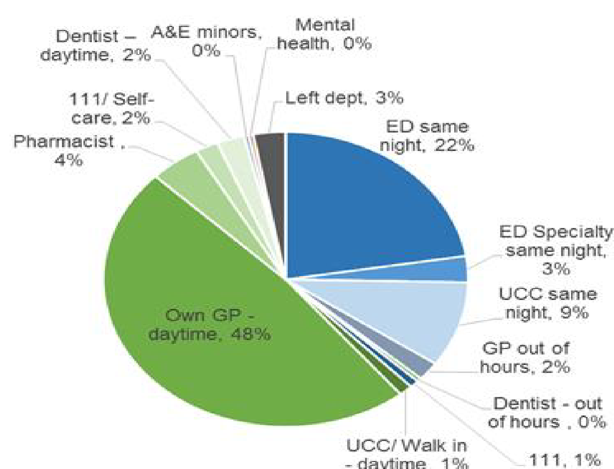
A quarter of people who use the service at night also use it during the day. Repeat night time attendance is rare with only one in 10 patients coming in at night more than once in the year.

85% of attendances between midnight and 8am are for working age adults, with the rate of visiting higher for this group than for older people and much higher than for children.

Men are over-represented at night compared to the general population, unlike during the day, where women outnumber men.

Half of night time attendances are for people living in Hammersmith & Fulham (H&F), followed by 1 in 10 from Ealing. The majority are from a 3km radius, such as Hammersmith/ Shepherd's Bush. People from these areas may have slightly lower rates of illness and disability compared to London and deprivation is broadly similar. More information on Charing Cross UCC overnight attendees can be found in appendices 6 & 7 of the CCG's case for change.

The CCG's clinical audit of Charing Cross UCC
Suitable care for close to half (48%) of those attending at night would have been a GP appointment the following day.



Review Methodology.

Making a request for advice from the Clinical Senate

NHS England's Assurance Process for service change.

"Planning, assuring and delivering service change for patients," *NHS England, March 2018*, *the guidance on managing service change in the NHS* asks NHS England to assure itself that a proposal for a major service change or reconfiguration satisfies the following four tests. A proposed change must show:

1. Strong public and patient engagement
2. Consistency with current and prospective need for patient choice
3. **A clear, clinical evidence base**
4. Support for proposals from commissioners

A request for advice on a service change is made by the body commissioning the service, also known as the sponsoring body. The Clinical Senate's role is to provide independent advice to Commissioner on the 3rd Test.The Senates assess the proposal to see that it has an underpinned by a clear, clinical evidence base and is aligned with clinical guidance and best practice.

The review of the change in hours at the Hammersmith UCC is a Stage 1 sense check review of the CCG's proposal for service change.

How the Clinical Senate conducted the review

The Senate's assesses a proposal for change and provides its advice through holding a clinical review of a Commissioner's Case for Change or business case. In this instance the review was conducted by the London Clinical Senate Council, sitting as a review panel, at its meeting on the 21st November. In addition to assessing the clinical evidence base for the proposed change the Senate considered if it:

- contains a clear articulation of patient and quality benefits
- fits with national best practice and clinical sustainability
- includes an options appraisal that considers a network approach, cooperation and collaboration with other sites and / or organisations.

The Clinical Senate's principles for improving quality and outcomes when conducting a review.

The London Clinical Senate has a set of principles which they believe are essential to improving the quality and outcomes of services. The Council will seek evidence of these principles in the issues it considers and promote them in the advice it provides. A proposal for change should:

- Promote integrated working across health and social car and ensure that there is a seamless patient journey
- Be patient-centred and co-designed (this includes patient experience, patient involvement in development and design of services).
- Reduce inequalities (this involves understanding and tackling inequalities in access, health outcomes and service experience – between people who share a protected characteristic and those who do not - and being responsive to the diversity within London's population).

- Demonstrate a parity of esteem between mental and physical health for people of all ages supporting self-care and health and wellbeing.
- Improve standards and outcomes (these include use of evidence and research, application of national guidance, best practice and innovation).
- Ensure value (achieving the best patient and population outcomes from available resources)

The Terms of Reference for the review of the proposed changes to Hammersmith UCC opening hours and clinical service model

The Review's Terms of Reference

The following Terms of Reference were agreed with Hammersmith and Fulham CCG.

The Clinical Senate's review of Hammersmith and Fulham CCG's proposal to change the opening hours and clinical service model of the UCC at Hammersmith Hospital seeks to establish:

1. That the proposed clinical model for the new services (i.e. the UTC, primary care and digital) has a clear, clinical evidence base (where this exists).

2. Whether the proposals for change in the UCC's opening hours and service delivery model:
   a. enable improvements in clinical care for patients
   b. are informed by best practice
   c. align with national policy and are supported by the STP plans and commissioning intentions

3. That if the Hammersmith Hospital UCC was closed overnight that there is a safe procedure/pathway for an ill patient arriving at Hammersmith Hospital to be transferred elsewhere.

4. What would the impact be on Charing Cross A&E of an overnight closure of the UCC at Hammersmith Hospital

5. That commissioners and providers have considered the effect of the proposed changes in opening hours on patient and carers, including the effect of travel times to other UCCs or EDs

6. Whether the CCG's proposed new clinical model for the UTCs, Primary Care and Digital services is:
   - clinically safe,
   - has the potential to improve the safety of care compared to the current model.
   - is sufficient to meet the demand for out of hours primary care

Exclusions.

The clinical review does not, unless there are clear interdependencies, cover services other than those provided at the two UCCs.

4) The Review.

The review took place at a meeting of the London Clinical Senate Council on the 21st November. The Senate Council sat as a Review Panel. They had chance to review the case for change produced by Hammersmith and Fulham CCG “Primary and urgent care proposals- Hammersmith and Fulham CCG November 2018” before the meeting. Hammersmith and Fulham CCG presented their case for change to the Senate Council. The presentation was made by Dr James Cavanagh, Vice Chair of the CCG and Dr Simon Douglass, the LCW Medical Director. Council members asked the CCG’ s representatives questions about the proposed changes. The Council then considered the proposal

The Senate Council’s membership is multi-professional. Members will have expertise in the services and pathways being considered. When required, the Council seeks further advice from other independent experts on specific issues related to the proposal for change.

Evidence considered by the Clinical Senate

Documentation relied upon

In making its decision the clinical senate relied, sitting as the Review Panel, reviewed the following documentation.
Primary and urgent care proposals- Hammersmith and Fulham CCG November 2018. This was circulated to all members of the London Clinical Senate

- **Presentation to the Clinical Senate- November 21st, 2018.** This was only circulated to Council Members who attended the council meeting on the 21st November.

The Clinical Senate Council meeting 21st November

The Council, in making its decision, also relied on evidence obtained from the presentations from the CCG and LCW made at the Senate Council meeting on the 21st of November.

How the Senate formulated its advice.

The Senate Council formulated its advice based:

- on a consideration and triangulation of the documents provided,
- discussions with the CCG and LCW
- the panel members’ knowledge and experience.

The Senate’s advice is provided in this report in section (8). The advice, as set out in report is the property of the sponsoring body, i.e. Hammersmith and Fulham CCG, and can only be shared or copied with their permission.

Conflicts of Interest, Confidentiality and Ownership of the report

The Council's review panel did not include anyone involved in the development of the proposals or associated with the bodies making the request. All council members declared any actual or potential conflicts of interests. This is set out in Appendix (1).

The report of the clinical review is the property of the sponsoring organisation. It can only be copied, transferred or published with their permission.

In determining their approach and formulating their advice the Clinical Senate Council relied on the following guidance:

- Clinical Senate Review Process: Guidance Notes, NHS England, August 2014 NHS England's Service Change Toolkit

- Planning, assuring and delivering service change for patients, NHS England, March 2018

5) A summary of the evidence heard at the Senate Council meeting, November 21st, 2018.

Presentation to the Senate Council. At its meeting on the 21st November, the Clinical Senate, sitting as a review panel, received a presentation from Dr James Cavanagh, Vice Chair of the CCG and Dr Simon Douglass, the LCW Medical Director. Both left the meeting once Panel members had completed their discussion with them of the CCG's proposal.

Patients use of the Hammersmith and Charing Cross UCCs between 12.00a.m. and 8.00 a.m.

Council members were informed of the low use of both sites during these times, but especially that of the Hammersmith UCC; which averages 7 visits a night. The CCG had conducted clinical audits of the use of both sites during these hours. The audits showed that at the Hammersmith UCC most visits were of low acuity, with 91% needing no further intervention. On average, one visits a night needed ED level care. The Hammersmith UCC was mainly used by the 20 -40 age group. The audit was based on a year's data and the CCG believed that audit's findings were consistent with other periods of time.

The clinical risk from a standalone UCC. Whilst the number of overnight attendances at Hammersmith is small, there is a clinical risk from the UCC not being co-located with an ED and so lacking access to the additional clinical support that an ED can provide out of hours. The specification for UTCs , see https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf point out the advantages of having a UTCs co-located with a hospital ED.

At present the Hammersmith UCC is staffed overnight by 1 GP, 2 receptionists and 1 extended nurse practitioner.

The effect of the proposed change to Hammersmith UCC's opening hours on out of hour care in the borough.

H&F is a small CCG with a wide range of primary care UC/OOH services available to its residents. Even after the proposed changes it will continue to have one 24hr UCC, one 16hr UCC, and 7-day primary care access. The CCG now wants to concentrate on improving their Primary Care unscheduled care offer via UTCs, digital access, 111, and recommissioning their extended primary care access service, i.e. the UTCs.

The CCG's analysis of the potential effect on the 4 hours wait target at CCH from the change in Hammersmith UCC's overnight opening hour shows it would have no discernible effect on access to the ED at Charing Cross.

Questions put to the CCG and LCW by Council members.

The Clinical Workforce. Council members asked how the CCG would manage the wind down of services at Hammersmith once the 12 a.m. closure was implemented; it would mean the last patient leaving after 12.00 a.m. Had they the workforce to manage this?

The CCG said they did have a sufficient workforce and that the management of patients still in treatment after 12.00. a.m. Having a sufficient workforce is part of their mitigation plan for clinical risk once the changes in opening hours are implemented.

Support from the CCG's digital offer for primary care access. The CCG said they were developing a digital offer for primary care access. This would include moving to using 111 as a means of direct booking and using 111 to provide better digital services for all patients registered with H&F GP practices. There would be no need for a patient to change the practice they were registered with to use the service.

See page 6 &7 of the CCG's case for change for further details on this part of their proposal.

Consultation with patients on the proposed changes in opening hours. The CCG was asked if they had contacted Healthwatch. The CCG said they had and they will continue to work with Healthwatch once the formal consultation starts. They will explain in more detail why Out of Hours Primary care is safer when provided from a co located site.

The effect on health inequalities of the changes in Hammersmith UCC's opening hours. Council members noted that the Hammersmith UCC was in the part of the borough with highest levels of deprivation; *see page 45 of the case for change*. The CCG said it was aware of this and had already conducted an equality impact assessment. They believe that the change of hours won't adversely affect access to health care for the population around the Hammersmith UCC. The CCG

also sees the move to digital as a way of improving access to primary care in that part of Hammersmith and Fulham.

Moving patients from the Hammersmith UCC when it's closed. Members asked if there had been a conversation with LAS about patients who might need to be moved overnight from the Hammersmith UCC to Charing Cross. Especially in relation to children (0-19) who are more likely to convert to convert to a 999 call. Data showed that an average of less than 1 person a night needed to be transferred. There will be phone at the entrance to Hammersmith UCC which, when closed will enable patients to directly call the 111 services.

The CCG said that it would not rely on LAS to transfer non-urgent patients to CCH UCC/ED and are in discussions as to how this will be done. This will be part of their risk mitigation plan.

The Paediatric Out of Hours Care Pathway

Members asked whether children would be directed to the CCH UCC as the ED at CCH does not provide a service for children?

The CCG though it would not be feasible to transport children to the Chelsea & Westminster ED as set out in the local pathway for paediatric emergency care. The CCG said it will assess again the risk to children needing out of hours urgent care following the reduction in the opening hours of the Hammersmith UCC.

6) The Senate's Findings

Meeting the review's Terms of Reference: The Senate Council's findings.
Based on the evidence in the CCG's case for change and the panel's discussions with the CCG the Senate found the following:

Term of Reference (1).

Did the proposed clinical model for the new services (i.e. the UTC, primary care and digital) have a clear, clinical evidence base (where this exists)

Findings

The Senate found that the proposed clinical model for the new services (UTC primary care and digital) did have a clear, clinical evidence base. This improvement should be particularly implemented in communities living closest to the Hammersmith Hospital as they are most affected and contain areas of high deprivation.

Term of Reference (2)

Do the proposals for the change in the UCCs' opening hours and service delivery demonstrate that they:

a. **Enable improvements in the clinical care for patients**

Findings

The Senate noted the improvements in patient safety that would arise from having the overnight UCC service based at the Charing UCC alongside the Charing Cross ED. However, the Senate Council recommends that the CCG needs to further clarify their pathway for paediatric out of hours primary care and be clear where children from the north of the borough, i.e. the area around the Hammersmith UCC would go to. The East Acton UCC and St Mary's Hospital ED both being nearer to this area than the Charing Cross UCC and ED or the Chelsea and Westminster ED.

b. were informed by best practice.

Findings

The Senate found that the CCG's proposals for the change of hours at the Hammersmith UCC and the development of the UTCs reflect best practice as set out in: https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

c. are aligned with national policy and supported by STP plans and commissioning intentions.

Findings

As mentioned above, the Clinical Senate found that the CCG's proposals align with standards for Urgent Treatment Centres and have the support of NW London Clinical Programme Executive. The Senate suggests that the CCG continues to work closely with the NW London programme executive on the effect the changes on the hospitals nearest to the Hammersmith UCC. This applies especially to the paediatric out of hours and emergency care pathway.

Term of Reference (3)

That if the Hammersmith Hospital UCC was closed overnight, there is a safe procedure/pathway for an ill patient arriving at Hammersmith Hospital.

Findings

The Clinical Senate found that the CCG had a safe procedure or pathway to ensure the safety of an ill patient arriving at the Hammersmith UCC when it's closed. For example, there will be a phone available outside the entrance to the UCC which, when the UCC is closed, can be used to put the patient through to the 111 services

However, Council members found it difficult to pull out the CCG's overall mitigation plan from the Case for Change. For example, the Senate council was concerned

about a lack of clarity on the arrangements children who might attend the Hammersmith UCC when it was closed.

The ED at Charing Cross does not provide a service for children and the current pathway for children requiring emergency care is for them to go to Chelsea and Westminster Hospital. Whilst the likely hood of a child needing ED level care attending is small the consequences of their not having the right care available are significant.

The Clinical Senate would therefore like to see the CCG do additional work on their out of hours paediatric care pathway. As part of their mitigation plan the CCG should alert Hammersmith Hospital's crash teams to the UCC's overnight closure.

Term of Reference (4)

What will be the impact on Charing Cross A&E of an overnight closure of the UCC at Hammersmith?

Findings

The Senate found that, based on the CCG's evidence, there would be no effect on waits for treatment at the CCH ED following the closure of the Hammersmith UCC overnight. None the less, the effect of the overnight closure on ED waiting times should be monitored by the CCG.

Term of Reference (5)

Have the commissioners and providers considered the effect of the changes in opening hours will have on patient and carers, including travel times.

Findings

The effect of the changes in travel times to patients and carers who use Hammersmith UCC are considered in the Case for Change. The Senate suggests that, as part of their mitigation plan, the CCG does further work to ensure that residents are fully aware of the changes in opening hours and how they can get to the Charing Cross UCC when the UCC is closed. Could their mitigation plan also describe any patient transport arrangements being made, including work with the London Ambulance Service. Again, this should be done as part of their review of the paediatric primary care and emergency out of hours care pathway. The Senate also draws the CCG's attention to the closeness of the UCC at East Acton and the ED at St Mary's to residents in the north of the borough.

Term of Reference (6)

Whether the proposed clinical model for the UTCs, Primary Care and Digital services is:

- **clinically safe,**
- **has the potential to improve the safety of care compared to the current model.**
- **sufficient to meet the demand for out of hours primary care.**

Findings

The Senate found that, based on the evidence provided by the CCG, the proposed changed in the opening hours of the Hammersmith UCC

- is clinically safe. However, further work is required on the paediatric out of hours care pathway
- does have the potential to improve the safety of care compared to the current model. The Senate welcomes that overnight urgent care service is co located with the Charing Cross ED
- is sufficient to meet the demand for out of hours primary care in Hammersmith and Fulham.

They contain an articulation of patient and quality benefits which fits with national best practice and clinical sustainability. However, the Senate finds that the proposal would benefit from further discussion on a network approach, cooperation and collaboration with other sites and / or organisations. See our comments on the closeness of the UCC at East Acton and the ED at St Mary's to residents in the north of the borough.

7) The Senate's Advice and Recommendations.

The Clinical Senate welcomes Hammersmith and Fulham CCGs request for advice on their proposal to change to the opening hours of the UCC at Hammersmith Hospital.

- The Senate finds that the proposal has a clear, clinical evidence base, is clinically safe and sustainable and will lead to improvements in patient care.
- The overnight closure should not adversely affect the provision of out of hours primary care in Hammersmith and Fulham.

Based on the evidence presented to it by the CCG and the review's findings the London Clinical Senate asks that Hammersmith and Fulham CCG.

- Note the findings of the Senate's review of the proposal and incorporate them into their case for change
- Explain further their mitigation plans and for how long they will be in place. There is a need for the right mitigation plan, one with a more detailed assessment of the clinical risks. The revised plan should contain communication and patient engagement plans

- Given the higher levels of deprivation in the area surrounding the Hammersmith UCC, there should be an impact assessment of the proposed changes and their effect on the population living closest to the Hammersmith UCC.
- To use the changes to the provision of primary care and Out of Hour and Urgent care in Hammersmith and Fulham as an opportunity to emphasise and, if necessary, redefine the OOH/Urgent Care pathway for children.
- To consider if there is a need for increased investment in community services as part of the development of the CCG's new primary care out of hours offer; particularly for the most affected communities closest to Hammersmith Hospital
- To consult with patients, carers, Healthwatch, and other stakeholders about its new clinical model for out of hours primary care
- To further review the effects of the proposed changes on other services in NW London, especially those hospitals and UCCs nearest to the Hammersmith UCC
- To provide more information on staffing at the Hammersmith UCC after its 12.00 am closure and how the CCG will ensure that there is adequate staffing until the service has completed the treatment of its last patient.
- To explain further the arrangements for transport between sites for patients requiring ED treatment when the Hammersmith UCC is closed. Could these arrangements be set out in further detail in the Mitigation plan.

Author

Edward Ward, London Clinical Senate Manager, December 17th, 2018.