Referral by East Riding of Yorkshire Council’s Health, Care and Wellbeing Overview and Scrutiny Sub-Committee to the Secretary of State for Health on the decision taken by East Riding of Yorkshire Clinical Commissioning Group regarding urgent care services in East Riding of Yorkshire

1. An explanation of the proposal to which the report relates

1.1 The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee (the “Sub-Committee”) was consulted by East Riding of Yorkshire Clinical Commissioning Group (the “ERY CCG”) on proposed substantial developments and variation to its Minor Injury Units (“MIUs”) and community beds in the East Riding of Yorkshire (the “East Riding”).

1.2 The consultation options and final decision taken by ERY CCG are laid out in detail at Appendix 1 and 2. In summary ERY CCG’s decision involves two elements, both of which are the subject of this referral:

(1) There are currently MIUs at six locations in the East Riding: Beverley, Bridlington, Goole, Driffield, Withersea and Hornsea. The CCG has decided to upgrade the first three MIUs to become urgent care centres (“UCCs”) and to close the latter three MIUs (save that at Driffield and Withersea there will be urgent care appointments for low level minor injuries at “8-8 centres”).

(2) There are currently “community beds” at East Riding Community Hospital (Beverley), Bridlington and Withersea hospitals. The CCG has decided to create an integrated community and intensive rehabilitation centre in a single location at East Riding Community Hospital in Beverley and to close the community beds at Bridlington and Withersea hospitals, with additional emphasis to be placed on patients staying in their own homes or ‘Time to Think’ beds.

2. An explanation of the reasons for making the referral and evidence in support of these reasons

2.1 In accordance with regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, the Sub-Committee makes its referral to the Secretary of State for Health on the following grounds:

- **Ground 1:** It considers that the proposal would not be in the interests of the health service in its area.
- **Ground 2:** It is not satisfied with the adequacy of content of the consultation.

2.2 The Sub-Committee does understand the need for change across the health and social care sector and recognise the financial challenges facing ERY CCG set against the context of the Humber, Coast and Vale Sustainability and Transformation Plan and the directive from NHS England for UCCs. However, the Sub-Committee does not feel the decision taken by ERY CCG is in the best interest of the East Riding as a whole, as detailed further in this report.

2.3 The decision by the Sub-Committee to make this referral was a cross-party unanimous resolution, not based on party political lines, but made in the best interests for its residents, having the health needs of East Riding residents at the heart of its decision.
2.4 **Ground 1: Proposals would not be in the interests of the health service in the East Riding**

**Equal access to services**

2.4.1 The East Riding, which covers approximately 930 square miles, has a population of approximately 336,685 (2015 Office for National Statistics Mid-Year Estimates) with the population predicted to reach 361,933 by 2039 (2014 Office for National Statistics Population Projections), which is a higher rate of growth than the national growth rate. The decision taken by ERY CCG effectively disenfranchises a population of approximately 62,000 from having access to local health services across the Holderness and Driffield areas of the East Riding. ERY CCG’s vision statement is “Better care, more locally, within budget, through transformation” yet its decision to remove local services from Driffield and Holderness areas seemingly goes against this principle. The current configuration of MIUs and community beds still provides a fairer, better access to care services. The concerns identified by the CCG about the current configuration, for example regarding the need for services to be better integrated and opening times, do not explain or justify its decision to disenfranchise this large section of the population.

**Topography, Demography and Deprivation**

2.4.2 Due to the large geography of the East Riding (compared with most local authority areas) and rurality, it is the Sub-Committee’s belief that the current placement of MIUs and community beds makes them accessible to East Riding residents. Across the Driffield and Holderness areas in particular, the existing placement of MIUs at Driffield, Hornsea and Withernsea and the existing community beds at Withernsea are strategically placed due to the distance and time required to travel to these settings. Indeed in the Council’s Local Transport Plan it highlights the necessity to have different transport provision across different locations of the East Riding due to its topography.

2.4.3 The Sub-Committee believe that ERY CCG has given inadequate consideration to topography of the East Riding and in particular the impact on residents having to travel further to access services. It is not just a matter of distance for residents in remote parts of Holderness but the time taken and practicalities of transport to reach Beverley UCC (which will now be the nearest UCC for Holderness residents). Due to the minor road network, low car ownership and limited public transport provision (with there being no direct bus route) it takes well over an hour to travel from Withernsea to Beverley, not to mention the financial burden placed on the patient or family members having to make these long journeys.

2.4.4 Travel time, deprivation, health inequalities, the rurality of the East Riding and car ownership for those in the most eastern parts of Holderness means that the decision taken by ERY CCG to close the community beds in Withernsea and Bridlington and the MIUs in Holderness and Driffield effectively denies access to minor injury services and care services for residents in those areas.

**Travel distance, journey time and public transport**

2.4.5 MIUs - The following map shows the catchments and populations for Driffield, Hornsea and Withernsea Minor Injury Units. There are 61,924 residents in the East Riding (18 percent of the total East Riding population) who live in one of these catchments, and would have to travel further to access their nearest MIU should their local facility close. Further details about the impact upon their travel times are shown in the following table (the table is colour-coded to correspond with the map).
2.4.6 The table below shows the impact on travel time should the Minor Injury Units be closed, a change which is particularly stark for those travelling by public transport. Given that there are some locations in those catchments where the proportion of households with no access to a car or van is high, the impact on public transport travel times should be considered. For the 18,969 residents in the Withernsea catchment, their average travel time by public transport to their nearest Minor Injury Unit would increase from 34 minutes to 86 minutes.

<table>
<thead>
<tr>
<th>Minor Injury Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catchment</td>
</tr>
<tr>
<td>Population</td>
</tr>
<tr>
<td>(2015 Mid-Year Estimates, ONS)</td>
</tr>
<tr>
<td>16,027</td>
</tr>
<tr>
<td>(5% East Riding pop)</td>
</tr>
<tr>
<td>21%</td>
</tr>
<tr>
<td>Currently</td>
</tr>
<tr>
<td>Average time for residents to MIU (driving)</td>
</tr>
<tr>
<td>Average time for residents to MIU (public transport)</td>
</tr>
<tr>
<td>Urgent Care Centres</td>
</tr>
<tr>
<td>IF MIUs are removed</td>
</tr>
<tr>
<td>Average time for residents to nearest UCC (driving)</td>
</tr>
<tr>
<td>Average time for residents to nearest UCC (public transport)</td>
</tr>
</tbody>
</table>

1 Catchments for the current MIUs in the East Riding have been created by assigning Census Output Areas to their nearest facility.
2.4.7 Community beds - The map below shows the catchments and populations for Withernsea and Bridlington community beds. There are 91,775 residents in the East Riding (27% of the total East Riding population) who live in one of these catchments, and would have to travel further to access their nearest community bed should their local facility close. Further details about the impact upon their travel times are shown in the table overleaf (the table is colour-coded to correspond with the map).

The table overleaf shows the impact on travel time should the community beds be closed; a change which is particularly stark for those travelling by public transport. Given that there are some locations in those catchments where the proportion of households with no access to a car or van is high, the impact on public transport travel times should be considered, particularly given that families and/or carers would have to make the journey too. For the 57,893 residents in the Bridlington catchment their average travel time to their nearest community beds would increase significantly.

---

2 Catchments for the current community beds in the East Riding have been created by assigning Census Output Areas to their nearest facility.
### Community Beds

<table>
<thead>
<tr>
<th>Catchment</th>
<th>Withernsea</th>
<th>Bridlington</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong> (&lt;br&gt;2015 Mid-Year Estimates, ONS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>33,882</td>
<td>57,893</td>
<td>91,775</td>
</tr>
<tr>
<td></td>
<td>(10% East Riding pop)</td>
<td>(17% East Riding pop)</td>
<td>(27% East Riding pop)</td>
</tr>
<tr>
<td>Aged 80+</td>
<td>1,945</td>
<td>4,075</td>
<td>6,020</td>
</tr>
<tr>
<td>One Person in Household with a Long-Term Health Problem or Disability</td>
<td>3,969  (28% of all households)</td>
<td>7,995 (31% of all households)</td>
<td>11,964 (29% of all households)</td>
</tr>
<tr>
<td>Zero cars or vans in household (%)</td>
<td>17%</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>Currently</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average time for residents to Community Bed hospital (driving)</td>
<td>16 mins</td>
<td>10 mins</td>
<td>12 mins</td>
</tr>
<tr>
<td>Average time for residents to Community Bed hospital (public transport)</td>
<td>41 mins</td>
<td>33 mins</td>
<td>35 mins</td>
</tr>
</tbody>
</table>

#### Integrated community and intensive rehabilitation centre at Beverley

- If Community beds are removed
  - Average time for residents to Community Bed hospital (driving): 37 mins, 18 mins, 25 mins
  - Average time for residents to Community Bed hospital (public transport): 99 mins, 150 mins, 130 mins

2.4.9 The use of community beds often has a longer term impact on families compared to other types of hospital visits; patients stay in hospital for a period of time. Families and/or carers would make multiple journeys, but should existing facilities close, given the extra time and distance, this risks more isolation for patients, and potentially a lengthier stay in the hospital.

2.4.10 The Sub-Committee consider that ERY CCG has not made a sufficiently thorough and objective assessment of travel, distance requirements, journey times and transport provision as part of its consultation and decision-making process, nor properly quantified what the expected acceptable minimum travel time should be for patients.

### Health Inequalities and Deprivation

2.4.11 The East Riding has an ageing population which is projected to grow at a much greater rate than nationally or regionally. In 2014, the 65+ population was 23.9 percent of the total population of the East Riding (compared with 17.6 percent in the Yorkshire & the Humber region and England); in 2037 it is projected to form 33 percent of the total population of the East Riding (compared with 24 percent regionally and nationally). This will inevitably place considerable additional pressures in the future on the provision of health and social care services; a particular issue when considering the future requirements of community beds.

2.4.12 Below is a summary of the health inequalities and deprivation in the Withernsea (South East Holderness), Hornsea (North Holderness) and Driffield (Driffield and Rural) areas (more detailed information which can be found at Appendix 5):

- **Life Expectancy**
  - Driffield and Rural, North Holderness, South East Holderness have a lower life expectancy than the both the East Riding and England averages, for both males and females.

- **Health is bad or very bad**
  - Health reported as bad or very bad: North Holderness and South East Holderness significantly higher than the East Riding and England averages.
• **Limiting long term illness or disability**
  Population with limiting long term illness or disability: North Holderness and South East Holderness significantly higher than the East Riding and England averages.

• **Prevalence of disease**
  General practices in Driffield and Rural, North Holderness and South East Holderness have a higher prevalence of some diseases than both the England and East Riding average. In particular: cancer, coronary heart disease (CHD), hypertension and rheumatoid arthritis.

• **Emergency Hospital Admissions**
  Significantly higher rates of emergency hospital admissions, particularly in South East Holderness.

• **Mortality**
  Significantly higher rates of mortality, particularly in South East Holderness and Driffield and Rural.

• **Access to a car or van**
  All three wards have a significantly higher proportion of households with no access to cars or vans, compared to the East Riding average.

• **Deprivation**
  South East Holderness and Driffield and Rural are two of East Riding’s most deprived wards. The area covering Withernsea town, falls within the 10 percent of most deprived areas nationally.

2.4.13 Clearly across the Driffield and Holderness areas there are high levels of health deprivation, something which the Sub-Committee feel ERY CCG has not fully taken into consideration when making its decision to close MIUs and community beds in these locations.

**Modelling and financial planning**

2.4.14 The Sub-Committee acknowledged that a considerable amount of detailed work had been undertaken by the CCG in developing its model to predict demand and finance. As stated previously, however, the Sub-Committee do not believe this to be a tried and tested model but rather an estimation tool which has not been tested on current financial costs but rather against predicted operational costs. There is therefore a lack of due diligence in the model and the Sub-Committee did not have the assurance that the model was sufficiently robust in dealing with a range of sensitivities to ensure a true picture of demand and need.

2.4.15 Assumptions had been made about number of patients and usage at the new UCCs yet these assumptions, which have some basis in theory, did not seem to be proven in similar situations elsewhere. Rather than the predicted reduction in minor injuries actually presenting at UCCs there could be a significant increase in the number of people presenting at A&E.

2.4.16 At its meeting with ERY CCG on 14 December 2016, the Sub-Committee recommended that ERY CCG consider re-running its model based on current financial costings, if feasible, and share the outcome of this with the Sub-Committee. ERY CCG responded that this was not possible as the model was created to address the
requirements of delivering an UCC operating for 16 hour per day. Updating the model to allow for current activity/parameter modelling would require significant variation to the model and therefore, would not provide the additional level of assurance that has been requested. The Sub-Committee therefore consider that the bespoke model developed by ERY CCG has not been tested robustly based on current operations, taking into account the very significant seasonal variations from visitors and tourists to the East Riding coast, and that due diligence has not been carried out to provide the necessary levels of assurance.

The need for cooperation and coordination with key stakeholders

2.4.17 The CCG had placed great emphasis on the importance of stakeholder engagement throughout the consultation yet it was noted that both Yorkshire Ambulance Service (“YAS”) and private residential care providers were conspicuous by their absence in the analysis of feedback from consultees set out in ERY CCG’s “Urgent Care Consultation and Response Report for Consideration and Decision by the Governing Body (Part A) March 21st 2017”. As previously stated, the Sub-Committee felt that there were no agreed protocols in place with YAS nor the residential care home sector, which would be needed in order to provide a firm foundation for the consultation proposals. The Sub-Committee has not seen any documental evidence during or after the consultation process that confirmed arrangements or protocols had been agreed with YAS or residential care homes. Further, it was evident that there had been a miscommunication between YAS and the CCG regarding ambulances taking patients to UCCs. This highlighted to the Sub-Committee that any verbal discussions that had taken place fell far below an acceptable standard of engagement and assurance that would be necessary as a basis for such far-reaching proposals.

2.4.18 The Council is in a position to know the availability of beds in the residential sector and had already advised ERY CCG of the very low level of availability. The Sub-Committee believe there to be limited evidence to support ERY CCG’s case that there are the required number and standard of beds available across the East Riding to successfully implement Time to Think beds as the overall occupancy rate for residential care beds is currently at 97 percent.

2.4.19 As can be seen from the letter the Sub-Committee received from the Holderness Health Alliance (who together represent the General Practices in Hedon, Hornsea and Withernsea and thus represent a large population of the East Riding), it is evident that the Holderness GPs did not support the consultation option proposals put forward by ERY CCG. They, together with the Sub-Committee, believe that for many Holderness residents the only option for urgent care will be the Emergency Department at Hull Royal Infirmary. This department is already under immense pressure, as is the ambulance service, which patients may well call upon to get there. The Sub-Committee echo the Holderness Health Alliance’s concerns and feel that the proposed 8-8 centre at Withernsea will not adequately cover patients’ needs, not least as it is very unclear what a “low level minor injury” is. Many patients with genuine needs will have to travel long distances to access services in an area with very poor public transport. Residents of Holderness were not given any option in the consultation to support services to be provided locally, with 77 percent of Holderness Respondents not supporting any of the options presented by ERY CCG.

2.4.20 The Sub-Committee were of the understanding that GPs had been informed by ERY CCG that additional funding would be provided to them which GPs were initially led to believe would help General Practice to support the 8-8 centre provision. This, however, was not the case, as ERY CCG has now confirmed that there are no plans to provide additional funding to General Practices to support the 8-8 centres as it considers this is not required. The only additional funding that ERY CCG is providing is £20,000
transitional funding available to each of the General Practices in Driffield, Hornsea and Withernsea to support navigation and signposting to help the public understand how to access the new system. This has been particularly misleading for GPs across the East Riding which may have affected their responses to the consultation proposals.

2.4.21 It is also a matter of some concern that at its meeting of 21 March 2017 the ERY CCG Governing Body dismissed comments and a request from a Governing Body Member representing the Holderness area to postpone the decision on the proposals under consideration until all facts and figures could be collated and verified and put before all members of the Governing Body. This individual was overruled and the Sub-Committee believes that by doing so the ERY CCG Governing Body failed to listen and take on board the views and needs of Holderness residents.

Lack of financial provision for future mitigation steps

2.4.22 At the CCG Governing Body meeting of 21 March 2017, a report on the financial position and forward plan was also presented. It was revealed that the CCG would be in deficit in the current year and was planning to run at an increased deficit (in excess of £6 million) for the near future with a view to implementing changes further in the future that would recover this position. Given the financial weakness in the modelling as stated earlier, combined with the future financial projections of the CCG, it would appear that the CCG has committed to a course of action for which there is no planned financial mitigation in place should the outcomes differ in reality from the estimates (for example, greater footfall figures and demand at the new UCCs), placing further pressure on the CCG’s financial plan. The Sub-Committee has placed particular emphasis on the importance of having mitigation measures in place in case of such eventualities before the changes are implemented.

2.4.23 It was also not evident to the Sub-Committee that the £20,000 transitional funding available to each of the General Practices in Driffield, Hornsea and Withernsea to support navigation and signposting to help the public understand how to access the new system had been included or worked into ERY CCG’s financial model presented and explained to the Sub-Committee in December 2016. This again emphasises to the Sub-Committee that ERY CCG’s financial model is not truly reflective of actual situation.

2.5 Ground 2: Not satisfied with the adequacy of content of the consultation

2.5.1 The Sub-Committee believes that the list of 81 options used for shortlisting did not consider maintaining one MIU (for example in Driffield or along the Holderness coast), or some other form of placed based service, whilst creating two or three UCCs. The Sub-Committee believe this to be a missed opportunity in the pre-consultation work and consultation options put forward. All consultation options for UCCs proposed the closure of MIUs at Driffield, Hornsea and Withernsea. The consultation options did therefore not provide any alternative options for residents in the Holderness and Driffield areas.

2.5.2 With regard to the community beds, again there was no alternative option presented for the closure of community beds at Bridlington and Withernsea Hospitals. Like the closure of the MIUs at Driffield, Hornsea and Withernsea, there was no option for keeping the status quo for community beds.

Pre-determination

2.5.3 It appears to the Sub-Committee that ERY CCG had already effectively committed to the closure of the MIUs at Driffield, Hornsea and Withernsea and the closure of community beds at Bridlington and Withernsea prior to the commencement of the
consultation as there was no provision within the new community services contract (that was out for tender at the time when the urgent care services consultation commenced) to retain MIU services or community bed provision in those areas and that tenders were based on the three UCCs being proposed, therefore allowing for no flexibility or alternative outcome from the consultation. The Sub-Committee therefore believe that ERY CCG has been predetermined in its decision prior to the start of the consultation and that the consultation process was flawed. It is axiomatic that any consultation must be carried out at a time when proposals under consideration are still at a formative stage, in order that consultees’ representations can then be conscientiously taken into account by the decision-maker.

3. **Evidence in support of these reasons**

3.1 The Sub-Committee has set out the main evidence in support of the reasons for making the referral alongside its explanation of the reasons - see previous sections.

**Proposals would not be in the interests of the health service in the East Riding**

3.2 The decision taken by ERY CCG substantially reduces services to nearly 62,000 patients in Holderness and Driffield areas. In doing so, the patients with the highest health needs and lowest access to transport will lose out. The Sub-Committee’s view is that this will impact further on their health and wellbeing.

3.3 Despite a large number of residents attending the consultation drop-in events, many residents were still aggrieved by the options presented by ERY CCG for consultation. As part of the consultation, nine petitions (totalling 11,657 signatures) and 13,304 standard letters were submitted to ERY CCG in support of retaining the MIUs and community beds and the Sub-Committee heard first hand some of these concerns at its meeting of 10 January 2017. The Sub-Committee does not feel that ERY CCG has given due weighting or taken on board the high level of public feeling expressed by these residents in making its decision.

3.4 After ERY CCG kindly held a workshop for the Sub-Committee to help explain and provide further detail on its modelling information, it was apparent to the Sub-Committee that the model does not replicate that which actually happens in reality and has not been tested in other comparable situations over different outcomes. The Sub-Committee therefore do not believe this to be a model, but rather believe an estimation tool.

3.5 The Sub-Committee feel that assumptions have been made about numbers of patients and usage of the new UCCs and community beds. The modelling for the new integrated community sub-acute and intensive rehabilitation centre at East Riding Community Hospital (Beverley) was based on just two days of audit figures (23 and 24 June 2016) which the Sub-committee do not believe is adequate to base a model for major service reconfigurations on.

3.6 It is estimated that around 9.9 million tourism day trips are made a year to East Riding, the majority of which will be visitors to the East Riding coast. It would appear that seasonal variation has not been factored into the tolerance and sensitivity of ERY CCG’s model in closing MIUs in the Driffield and Holderness areas as many of these visitors will have need to access minor injury services in the Driffield and Holderness area.

---

3 The Economic Impact of Tourism on East Riding District 2015 - Prepared by: Tourism South East Research Unit
3.7 Since the CCG Governing Body had made its decision, the Sub-Committee has received letters from the following individuals and organisations expressing extreme disappointment and disagreement with the decision (attached at Appendix 4):

- Letter from Graham Stuart MP & Sir Greg Knight MP
- Letter from Holderness Health Alliance
- Letter from Driffield Town Council
- Letter from Hornsea Town Council
- Letter from Withernsea Town Council
- Letter from Driffield Hospital Defence League
- Letter from Hornsea Cottage Hospital League of Friends
- Letter from a disabled activist

4. **A summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area**

4.1 The Sub-Committee has already summarised the evidence considered in reaching its conclusion that the proposals are not in the interests of the health service in the East Riding.

4.2 As set out above, the Sub-Committee does not feel that, when making its decision, ERY CCG has sufficiently answered or addressed the serious concerns raised regarding the particular needs of the Holderness and Driffield area with regard to travel and transport, deprivation, health inequalities and equality of access. As a result of the closure of the MIUs at Driffield, Hornsea and Withernsea and the community beds at Bridlington and Withernsea hospitals, patients from these areas will have to travel further for their care. Put frankly, what has been determined by ERY CCG is actually worse for residents of the East Riding as a whole and certainly for those in Driffield and Holderness areas. The Sub-Committee considers that the current configuration of MIUs and community beds, whilst nowhere near perfect, does work and meets the needs of residents equally throughout the East Riding. By contrast, the new arrangements will provide far worse access to care services in large stretches of the East Riding.

5. **An explanation of any steps that the health scrutiny body has taken to try to reach agreement with the relevant NHS body or health service provider**

5.1 The Sub-Committee is fully aware that local resolution of issues is to be preferred, and has endeavoured to achieve such resolution and avoid the need to make a referral to the Secretary of State. Regrettably, this has not been possible.

5.2 ERY CCG first came to discuss the consultation proposals and take on board comments from the Sub-Committee at its meeting on 13 September 2016. The CCG then presented the consultation at the Sub-Committee meeting of 15 November 2016. Following this meeting the Sub-Committee had initial concerns, amongst other things, regarding the bespoke model developed by ERY CCG to predict demand and finance. As such ERY CCG arranged a workshop with the Sub-Committee on 12 December 2016 and subsequent one-to-ones with individual members to provide more detail and clarity on its model. The Sub-Committee still had concerns and questions regarding the consultation proposals at this point and therefore an extraordinary meeting was called on 14 December 2016 that ERY CCG again presented at to answer further questions from members and provide a mid-consultation update.
5.3 On 10 January 2017 ERY CCG returned again to the Sub-Committee to provide a further update and answer further questions and concerns that were still unresolved from the Sub-Committee. Finally, following submission of its response to the consultation, the Sub-Committee was then requested to respond at extremely short timescales (just six days) to a Feedback Analysis Report sent by ERY CCG on 8 March 2017 (with a response to be received by ERY CCG by 14 March 2017) to see if the findings of analysis report altered the Sub-Committee recommendations on the consultation.

5.4 On 4 April 2017 ERY CCG returned to the Sub-Committee to inform members of the Governing Body’s decision and to explain how the decision had been made and the implications for residents across the East Riding of this decision.

5.5 Over the period of September 2016 to April 2017 the Sub-Committee has met and corresponded with ERY CCG on 13 occasions, which can be chronicled and evidenced below (attached at Appendix 3):

- Minutes of meeting of 13 September 2016 [Urgent Care Services - Consultation process]
- Minutes of meeting of 15 November 2016 [Urgent Care Services - presentation of consultation]
- Letter dated 21 November 2016 - Sub-Committee request for further information from ERY CCG following 15 November 2016 meeting
- Letter dated 2 December 2016 - ERY CCG response on additional Sub-Committee queries from 15 November 2016 meeting
- Minutes of meeting of 14 December 2016 [Urgent Care Services - further discussion]
- Letter dated 21 December 2016 - Sub-Committee request for information from ERY CCG following 14 December 2016 meeting
- Letter dated 6 January 2017 - ERY CCG response to Sub-Committee request for information following 14 December 2016 meeting
- Minutes of meeting of 10 January 2017 [Urgent Care Services - update]
- Letter dated 13 January 2017 - Sub-Committee formal response to consultation
- Letter dated 7 March 2017 - ERY CCG response to Sub-Committee formal response to consultation
- Letter dated 14 March 2017 - Sub-Committee response to Consultation Analysis Report and letter from ERY CCG dated 7 March 2017
- Letter dated 16 March 2017 - ERY CCG response to Sub-Committee response to Consultation Analysis Report
- Minutes of meeting of 4 April 2017 [Urgent Care Services - decision]

5.6 Between the close of the consultation on 17 January 2017 and the decision taken by the ERY CCG’s Governing Body on 21 March 2017, the Sub-Committee feel that ERY CCG has had sufficient time to consider its response and recommendations and did not offer to meet further with the Sub-Committee during that period to discuss further what form of place based services would be acceptable, as put forward in the recommendations. Throughout the consultation process and meetings with ERY CCG, the Sub-Committee has made clear that place based services needed to be maintained in Driffield and Holderness areas that met the specific needs of population that was particularly rural, isolated and displayed large areas of deprivation. The place based services that have been determined for Driffield and Withernsea following the decision of the ERY CCG’s Governing Body on 21 March 2017 are not, in the Sub-Committee’s opinion, a suitable replacement for the provision currently offered by the MIUs. Had ERY CCG been willing to work with the Sub-Committee during this period before making its decision then the need for this referral might have been avoided.
6. Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has been made

6.1 The Sub-Committee does not believe that ERY CCG has taken reasonably practicable steps to try and reach agreement within a reasonable period with the Sub-Committee. As part of the consultation the Sub-Committee submitted its response and made the following recommendations:

Proposed Options for Urgent Care Centres

Recommendations:

(i) That East Riding of Yorkshire Clinical Commissioning Group maintains some place based services in the Driffield, Hornsea and Withernsea areas (even if this means reduced hours - whether this be a Minor Injury Unit, a reduced Urgent Care Centre or something else to meet need, including seasonal variation) by re-considering the way place based services are commissioned across the system.

(ii) Providing some place based services in the Driffield, Hornsea and Withernsea are maintained then the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee would then support the creation of three Urgent Care Centres at Goole, Beverley and Bridlington.

Proposed Options for Wrap-Around Patient Care

Recommendations:

(i) The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee support the principle of what is being proposed in Option A, but not the closure of beds at Bridlington and Withernsea.

(ii) That East Riding of Yorkshire Clinical Commissioning Group fully reconsiders the population needs for community beds and residential and nursing care beds in totality to provide certainty of current and future need, given that current demand on beds is very high.

6.2 The Sub-Committee believe that since the close of the consultation on 17 January 2017 and the decision taken by the Governing Body on 21 March 2017, ERY CCG has had sufficient time to take reasonably practicable steps to try and reach agreement with the Sub-Committee on its recommendations but has not done so. In particular, the Sub-Committee does not consider that the 8-8 centres for low level minor injuries, booked via NHS111, adequately provides the place based services it suggested in its recommendations and that the people of Driffield and Holderness desperately require. Further, if 8-8 centres for low level minor injuries can be provided at Driffield and Withernsea then the same service should also be provided at Hornsea. In making its decision ERY CCG has completely disregarded the health needs of the town of Hornsea.

6.3 The Sub-Committee believe that ERY CCG has missed an opportunity to fully analyse the extensive feedback from the consultation and present revised proposals for a further consultation with East Riding residents.

6.4 Likewise, there is no evidence or correspondence from ERY CCG to suggest that since the closure of the consultation ERY CCG has properly reconsidered the population
needs for community beds and residential and nursing care beds in totality to provide certainty of current and future need, as the Sub-Committee had recommended. Nor has ERY CCG taken steps to try to reach agreement with the Sub-Committee in this regard.
Appendix 1

Consultation proposal options

Proposed Options for Urgent Care Centres

**Option 1:** East Riding Community Hospital Beverley (Beverley) and Goole MIUs are upgraded to urgent care centres.
Bridlington, Driffield, Hornsea and Withernsea MIUs are closed.

**Option 2:** Bridlington and Beverley MIUs are upgraded to urgent care centres.
Driffield, Goole, Hornsea and Withernsea MIUs are closed.

**Option 3:** Bridlington, Beverley and Goole MIUs are upgraded to urgent care centres.
Driffield, Hornsea and Withernsea MIUs are closed.

**Option 4:** Bridlington and Goole MIUs are upgraded to urgent care centres.
Driffield, Beverley, Hornsea and Withernsea MIUs are closed.

Proposed Options for Wrap-Around Patient Care

**Option 1 (CCG’s preferred option):** Create an integrated community sub-acute and intensive rehabilitation centre in a single location, supported by time to think beds.

- Community and Intensive Rehabilitation beds:
  - An integrated rehabilitation unit providing 12 community beds and 17 intensive rehabilitation beds (including stroke and palliative care) co-located at East Riding Community Hospital, Beverley.
  - Community beds at Bridlington and Withernsea would be closed.

- Home First Beds:
  - Improved rehabilitation and rapid response service in the patient’s own home (which may be a nursing or care home).

- Time to Think Beds:
  - 15 Time to Think beds provided in residential care settings at three locations within the boundaries of the East Riding (these are short stay to support improved discharge from hospital to home and would not be used by patients needing palliative care).

**Option 2:** Create a Home First Solution, supported by improved community rehabilitation and Time to Think beds.

- Community and Intensive Rehabilitation beds
- Stroke and palliative care would be provided in an acute hospital and would include Hull and East Yorkshire Hospitals, Scarborough Hospital, Scunthorpe Hospital, Goole Hospital, York NHS Foundation Trust. These would be paid for under existing payment/tariff arrangements. The current provision of community hospital beds at Beverley, Bridlington and Withernsea would be closed.

- Intensive rehabilitation would be delivered in the patient's own home (which could be a nursing or care home) or in a Time to Think bed.

- **Time to Think Beds:**

  - A higher number of Time to Think beds provided in residential care setting at locations within the boundaries of the East Riding (these are short stay to support improved discharge from hospital to home and would not be used by patients needing palliative care but would include intensive rehabilitation, rehabilitation and reablement).

- **Home First Beds:**

  - Improved rehabilitation, reablement and rapid response service in the patient's own home (which may be a nursing or care home).

  - Improved support for people needing non specialist palliative care would be delivered in the patient’s own home (which could be a nursing or care home).

  - Intensive rehabilitation (including stroke) would be delivered in the patient’s own home (which could be a nursing or care home).
Consultation outcome decision

Introducing urgent care centres

The decision made by the CCG Governing Body was to:

Create Three Urgent Care Centres at East Riding Community Hospital in Beverley, at Bridlington Hospital and at Goole District Hospital.

Together with - providing urgent care appointments for low level minor injuries at 8-8 centres at Driffield and Withernsea to be booked into via NHS111/Single Point of Access and undertaking the actions set out in the CCG’s full responses by locality. These provisions are made because Governing Body has listened to the concerns of local people during the consultation process.

These would replace the current minor injury units across the region.

Improving community beds/wrap-around patient care

The decision made by the CCG Governing Body was to:

Create an integrated community and intensive rehabilitation centre in a single location, at Beverley supported by 15 Time to Think Beds.

Together with the following actions:

1. The location of time to think beds at Bridlington and South Holderness specifically.
2. The availability of an additional 10 time to think beds during the transition period.
4. The review of palliative care services to ensure the provision of service that meets the needs of individuals.

This meant that community hospital beds at Bridlington and Withernsea Hospitals would close and the CCG would be able to support more people in, or close to, their own home, refocusing resources into community teams.

The potential impacts of these changes on people with characteristics protected by the equality act were presented in full in the Equality Impact Assessment (EIA), which Governing Body members had considered.

The changes to urgent care services were expected to be implemented over the next six to nine months, in a managed way to minimise impact to patient care.
Appendix 3

Chronology of correspondence between ERY CCG and the Sub-Committee and minutes of meetings

- Minutes of meeting of 13 September 2016 [Urgent Care Services - Consultation process] (page 17 - 19)
- Minutes of meeting of 15 November 2016 [Urgent Care Services - presentation of consultation] (page 20 - 30)
- Letter dated 21 November 2016 - Sub-Committee request for further information from ERY CCG following 15 November 2016 meeting (page 31 - 32)
- Letter dated 2 December 2016 - ERY CCG response on additional Sub-Committee queries from 15 November 2016 meeting (page 33 - 40)
- Minutes of meeting of 14 December 2016 [Urgent Care Services - further discussion] (page 41 - 45)
- Letter dated 21 December 2016 - Sub-Committee request for information from ERY CCG following 14 December 2016 meeting (page 46 - 47)
- Letter dated 6 January 2017 - ERY CCG response to Sub-Committee request for information following 14 December 2016 meeting (page 48 - 61)
- Minutes of meeting of 10 January 2017 [Urgent Care Services - update] (page 62 - 71)
- Letter dated 13 January 2017 - Sub-Committee formal response to consultation (page 72 - 77)
- Letter dated 7 March 2017 - ERY CCG response to Sub-Committee formal response to consultation (page 78 - 81)
- Letter dated 14 March 2017 - Sub-Committee response to Consultation Analysis Report and letter from ERY CCG dated 7 March 2017 (page 82 - 83)
- Letter dated 16 March 2017 - ERY CCG response to Sub-Committee response to Consultation Analysis Report (page 84)
- Minutes of meeting of 4 April 2017 [Urgent Care Services - decision] (page 85 - 94)
PRESENT: Councillors Hall (in the Chair), Aitken, L Bayram, Davison, Galbraith, Green, Jefferson, Kingston, Lisseter and Steel.

Officers present: Kerry Carroll - Interim Associate Director of Strategy & Planning (Northern Lincolnshire and Goole NHS Foundation Trust), Chris Clarke - Senior Commissioning Manager (NHS England), Paul Corlass - Deputy Director of Finance (Northern Lincolnshire and Goole NHS Foundation Trust), Quintina Davies - Head of Communications and Engagement (East Riding of Yorkshire Clinical Commissioning Group), Jane Hawkard - Chief Officer (East Riding of Yorkshire Clinical Commissioning Group), Kathryn Helley - Deputy Director of Performance Assurance & Assistant Trust Secretary (Northern Lincolnshire and Goole NHS Foundation Trust), Andy Kingdom - Deputy Director of Public Health, Dr Noel Tinker (Beverley and Molescroft Surgery), Alex Seale - Director of Commissioning and Transformation, John Skidmore - Director of Corporate Strategy and Commissioning, and Gareth Naidoo - Senior Committee Manager.

Also in attendance:

Councillor Owen (Deputy Leader) as observer.

Also in attendance: Press - 1
Public - 0

The Sub-Committee met at County Hall, Beverley.

418 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS - Members made the following declarations:

(i) Councillor Hall declared a non-pecuniary interest in minute 422 insofar as she is a member of Driffield Hospital Defence League;
(ii) Councillor Jefferson declared a non-pecuniary interest in minute 422 insofar as she is a member of Hornsea Forward Working Group at Hornsea Hospital.

422 IMPROVING URGENT CARE SERVICES IN THE EAST RIDING OF YORKSHIRE: SHAPING A HEALTHY FUTURE - FORMAL CONSULTATION PROCESS BRIEFING PAPER - The Sub-Committee received a report of the Chief Officer of East Riding of Yorkshire Clinical Commissioning Group (CCG) and presentation from Jane Hawkard - Chief Officer, Alex Scale - Director of Commissioning and Transformation and Quintina Davies - Head of Communications and Engagement from East Riding of Yorkshire CCG.

Urgent care in the East Riding encompassed a range of services which included ambulance services (NHS 111 and 999), community nursing and therapy services, Emergency Departments (A&E), specialist services (such as stroke, cardiac and trauma centres, social care, mental health services) as well as out of hours GP services, pharmacists, dentists, and minor injuries services.
The local urgent and emergency care system was fragmented with discrete services such as NHS 111, general practice, emergency departments, the ambulance service, walk-in centres and minor injury units - all offering a slightly different range of services available at varying times. Some services were also significantly underutilised and there were significant workforce pressures to deliver the current range of services.

In March 2016, The CCG published its Urgent Care Strategy (shaped with the involvement of patients, carers, the public and clinicians). The Urgent Care Strategy described the CCG’s response to the national vision for urgent and emergency care, whilst taking into account local needs and formed the basis the CCG local review of urgent care services.

The CCG’s aim for local urgent care services was to develop an integrated approach to urgent and emergency care and emergency medical admissions to hospital. To make this happen the CCG was working with hospitals, community care, primary care and ambulance services through joint service planning and sharing of clinical information across different agencies. Demographics and age profile of the East Riding would figure highly when evaluating and determining the outcome of the consultation.

Although the Strategy covered urgent and emergency care in its widest sense, improvements relating to the development of integrated urgent care centres and community bed provision would require substantial change to current services. As part of the CCG’s local urgent care review, it was preparing to formally consult with patients, carers, the public and other stakeholders so that their views could be taken into account as the CCG developed its approach to integrated urgent care centres and community bed provision. The consultation was due to commence at the end of October, with the final outcome currently due to be determined by the CCG Governing Body in March 2017. The CCG would be undertaking a mid-point review during the consultation to ensure that consultation responses were a representative spread of all cohorts. The Sub-Committee would receive a copy of the consultation proposals once published, as well as a stakeholder briefing.

The report and presentation provided greater detail as to who the CCG had involved in developing the proposed options for consultation and how the CCG would be undertaking its formal public consultation over a 12 week period. The statistical validity for the consultation was for the CCG to receive a minimum of 384 responses, however it was hoped and expected that this actual response rate would be far higher.

Members then discussed the following points:

- **Consultation with town and parish councils** - The CCG would be communicating with parish and town councils, however, due to the sheer number across the East Riding it would not be possible to attend everyone. Instead the CCG would be relying on Community Champions to encourage and raise awareness through their own networks and communities (ie GP Patient Groups, councillors via surgeries, etc.).

- **Drop-in sessions** - a minimum of seven public drop-ins across the East Riding would take place during November/December. Whilst the CCG did not expect these drop-in sessions to form a huge portion of the response to the consultation, Members still felt that the number of sessions/areas needed to be increased.

- **Consultation with the Council and schools** - the Council had been a part of the pre-consultation process, having had officers attend workshops and stakeholder events. Schools would be sent consultation information asking them to both respond and share with parents.
Engage with Healthwatch East Riding of Yorkshire - As the patient voice, Healthwatch was well placed to aid the CCG in its consultation. Healthwatch had agreed to support the CCG with increasing awareness of the consultation and encouraging people to respond.

Agreed - (a) that the Sub-Committee approve the proposed timescale for formal public consultation;

(b) that the Sub-Committee approve the range of ways that allow people to consider the information and provide informed views on the consultation;

(c) that the arrangements for enabling the Sub-Committee to provide a formal response to the consultation be approved, and

Agreed it be recommended -

(d) that the CCG consider increasing/extending the number of public drop-in sessions during the consultation period.
The Sub-Committee received a presentation on the Urgent Care Services and Wrap-Around Patient Care Consultation from Jane Hawkard - Chief Officer, Tracey Craggs - Assistant Director - Unplanned Care Transformation and Quintina Davies - Head of Communications and Engagement from East Riding of Yorkshire Clinical Commissioning Group.

In recognition that urgent and emergency care systems across the country were fragmented and under significant and growing pressure, NHS England had released the following in relation to transforming urgent and emergency care services:

- **Transforming Urgent and Emergency Care Services in England: Safer, Faster, Better (2015).**
- **Good practice in delivering urgent and emergency care - A Guide for local health and social care communities (2015).**

These guidelines were intended to support commissioners in achieving a significant redesign of urgent care to deliver a more joined up and consistent 24/7 urgent care service to provide the public with access to both treatment and clinical advice. To achieve this, the CCG developed its Urgent Care Strategy.

Two areas of the CCG Strategy proposed more substantial changes to current services to deliver the desired outcomes for patients and the public:

1. Introducing Urgent Care Centres (UCCs) in place of Minor Injury Units (MIUs):
• With consistent opening times, 16 hours a day, 7 days a week, 365 days a year.
• Providing a range of advice, treatment and diagnostics (including X-ray), with no variation between centres.
• Which are fully joined up with the wider urgent and emergency care system.

2. Improving wrap around patient care - quicker recovery, more independence:

• Having the right type of beds in the community to better meet the needs of people. Helping to prevent unnecessary hospital admissions.
• Earlier discharge home from hospital through strengthened support in the community at or close to home, delivering quicker return to independence.
• Helping to ease the pressure on Accident and Emergency departments.

The CCG had launched a period of 12 weeks of formal public consultation on these two areas, from 25 October 2016 and running until 17 January 2017.

The case for change had been developed with clinical and stakeholder engagement in line with NHS England guidance - Planning, assuring and delivering service change for patients (2015) and advice received from the Yorkshire and Humber Clinical Senate.

A mid-point review would be conducted to ensure responses were as representative of the local community as possible. As the consultation closed, time would be allocated for analysis to be fully completed. The consultation feedback report would be provided to the Sub-Committee, publicised and posted on the CCG’s website. A final decision based on all evidence collected would be made by the Governing Body on 21 March 2017.

**Proposed Options for Urgent Care Centres**

**Option 1:** East Riding Community Hospital Beverley (Beverley) and Goole MIUs are upgraded to urgent care centres.

Bridlington, Driffield, Hornsea and Withernsea MIUs are closed.

**Option 2:** Bridlington and Beverley MIUs are upgraded to urgent care centres.

Driffield, Goole, Hornsea and Withernsea MIUs are closed.

**Option 3:** Bridlington, Beverley and Goole MIUs are upgraded to urgent care centres.

Driffield, Hornsea and Withernsea MIUs are closed.

**Option 4:** Bridlington and Goole MIUs are upgraded to urgent care centres.

Driffield, Beverley, Hornsea and Withernsea MIUs are closed.

The CCG has not identified a preferred option for urgent care centres. The four options being consulted on were determined as they had met the agreed awaited criteria and they sat within the current affordability envelope.

The Sub-Committee put forward a number of questions to the CCG, whom provided a response at the meeting, as can be found at Appendix 1 of these minutes.
Members then discussed the following points:

- **Modelling - travel, transportation, distance and cost** - It was questioned whether travel time and cost for the public had been taken into consideration. The CCG stated that it had a statutory duty to provide transport for patients with a health need but had also considered the impact of transport during the modelling of the proposals. It was unclear whether the modelling was based on distance alone or also included travel time and the cost to the patient. A member questioned whether adverse weather conditions had been taken into consideration. The CCG replied that data showed there to be little increase in attendance at MIUs during the winter period.

- **Increased pressure on Ambulance services** - Members put forward the argument that if local MIUs were closed and patients had to travel further to receive treatment and had little means of transportation then it was likely that ambulance services would see an increase in demand. The CCG acknowledged that greater education of the use of ambulance services would need to be undertaken with the public to avoid this happening.

- **Provider and workforce consultation** - The CCG assured the Sub-Committee that it had engaged and involved providers and staff in the consultation process. This included officers of the CCG visiting staff in their establishments to engage with them in the process and seek their views. Once a decision had been made by the CCG Governing Body, provider staff would be engaged in the necessary Human Resources process. It was noted that, in general, GP surgeries had been proactive in supporting the CCG in carrying out its consultation.

- **Option to keep one MIU open alongside the creation of UCCs** - CCG confirmed that the option to keep a mixture of MIUs open alongside UCCs had not been considered as the aim was to have a consistent service in place across the East Riding.

- **Opening times and differing services available at MIUs** - The Sub-Committee was disappointed that the CCG had not fully addressed the inconsistent approach to MIU opening times and services offered at the different MIUs across the East Riding. Members felt that since the CCG became responsible for commissioning these services back in 2013 then it should have addressed this issue before now.

- **Holderness area provision of service** - The CCG did recognise the rurality and distance patients would be required to travel to seek treatment should the MIU particularly in Withernsea be closed. The CCG would be liaising with provider organisations to address this issue and see if GP and other community services could fill any void.

- **A Member challenged the figures associated with MIU attendance during 2015/16 as there were discrepancies between the figures on the FAQs and the Surrounding Area fact sheets as published on the CCG’s website**. Officers from the CCG resolved to rectify these figures as soon as possible and clarified that the number of patients seen during 2015/16 at MIUs were as follows:
  - Beverley - 13,063 attendances per annum
  - Bridlington - 19,051 attendances per annum
  - Driffield - 7,466 attendances per annum
- Goole - 16,112 attendances per annum
- Hornsea - 3,140 attendances per annum
- Withernsea - 2,813 attendances per annum

• Set up costs for UCCs - Costs for upgrading existing sites to UCCs were as follows:
  - Beverley: £67,433
  - Bridlington: £28,053
  - Driffield: £35,277
  - Goole: £12,463
  - Hornsea: £40,253
  - Withernsea: £25,178

  It was unclear, however, how these set up costs had been determined and what the projected running costs would be compared to those of MIUs.

• Smooth transition from MIU closure to opening of UCCs - Members were assured that a smooth transition would ensue and that services would not be closed before the UCCs were up and running and could be accessed.

Proposed Options for Wrap-Around Patient Care

Option 1 (CCG’s preferred option): Create an integrated community sub-acute and intensive rehabilitation centre in a single location, supported by time to think beds.

• Community and Intensive Rehabilitation beds:
  - An integrated rehabilitation unit providing 12 community beds and 17 intensive rehabilitation beds (including stroke and palliative care) co-located at East Riding Community Hospital, Beverley.
  - Community beds at Bridlington and Withernsea would be closed.

• Home First Beds:
  - Improved rehabilitation and rapid response service in the patient’s own home (which may be a nursing or care home).

• Time to Think Beds:
  - 15 Time to Think beds provided in residential care settings at three locations within the boundaries of the East Riding (these are short stay to support improved discharge from hospital to home and would not be used by patients needing palliative care).

Option 2: Create a Home First Solution, supported by improved community rehabilitation and Time to Think beds.

• Community and Intensive Rehabilitation beds
  - Stroke and palliative care would be provided in an acute hospital and would include Hull and East Yorkshire Hospitals, Scarborough Hospital, Scunthorpe Hospital, Goole Hospital, York NHS Foundation Trust. These would be paid for under
existing payment/tariff arrangements. The current provision of community hospital beds at Beverley, Bridlington and Withernsea would be closed.

- Intensive rehabilitation would be delivered in the patient’s own home (which could be a nursing or care home) or in a Time to Think bed.

- **Time to Think Beds:**
  - A higher number of Time to Think beds provided in residential care setting at locations within the boundaries of the East Riding (these are short stay to support improved discharge from hospital to home and would not be used by patients needing palliative care but would include intensive rehabilitation, rehabilitation and reablement).

- **Home First Beds:**
  - Improved rehabilitation, reablement and rapid response service in the patient’s own home (which may be a nursing or care home).
  - Improved support for people needing non specialist palliative care would be delivered in the patient’s own home (which could be a nursing or care home).
  - Intensive rehabilitation (including stroke) would be delivered in the patient’s own home (which could be a nursing or care home).

Whilst Option A was the CCG’s preferred option, it did see merit in Option B and viewed this as a longer term vision for delivering wrap-around patient care in the future and was therefore consulting on this to gauge stakeholder and public appetite for this in the future.

The Sub-Committee put forward a number of questions to the CCG, who provided the following response at the meeting, as can be found at Appendix 2 of these minutes.

Members then discussed the following points:

- **Time to Think Beds** - there was less community bed provision at the current sites (Beverley, Bridlington and Withernsea) than there would be in the proposed block of 25 beds at Beverley. Time to Think Beds would be provided in the Holderness, Bridlington area and also in one other area still to be determined. Any Time to Think Beds not being utilised would still have to be paid for by the CCG.

- **Safeguarding procedures for Time to Think Beds** - the current level of safeguarding requirements would ensue for all Time to Think Beds as if they were in community hospitals.

- **Palliative care nursing** - a Member raised concern over the lack of nurses and carers to undertake this role across the East Riding. The CCG confirmed palliative care provision was being reviewed, specifically focusing on Bridlington and Withernsea.

The Sub-Committee was strongly aggrieved that options for urgent care at Driffield, Hornsea and Withernsea had not been offered as a consultation option and that the reasoning behind the short list of options had not been clearly explained to members of the public. Members felt that they and the public had been misled over what the CCG would be consulting on.
Upon reflection of the presentation and questioning of the CCG the Sub-Committee was not satisfied that certain information had been clearly evidenced, particularly regarding the modelling of the options, and therefore could not, at this stage, make a fully informed response to the consultation. Upon receipt of this information, the Sub-Committee would then be submitting its formal response to the consultation.

Agreed - (a) That further information be sought from the CCG on the consultation proposals, particularly with regard to modelling of the options, so that a response to the consultation can be submitted by the Sub-Committee in due course, and

Recommended - (b) that the CCG undertakes a sustained public media campaign between now and the end of the consultation to make it clear how the proposed options were determined and why the options for keeping open the coastal MIUs were dismissed.
Appendix 1

Sub-Committee Questions on the Introduction of Urgent Care Centres (UCCs) in place of Minor Injury Units (MIUs)

Proposal for 2 or 3 UCCs

1. What would be the benefit of having only 2 UCCs rather than 3?

A smaller number of UCCs - 2 or 3 - will support the sustainability of the workforce enabling them to further develop and to retain their clinical skills and competencies which being able to access appropriate clinical support from other health care professionals.

2. What will be the cost savings if only going with 2?

This is not about saving money but our proposals mean that we could invest more money where it is needed to reduce duplication, make services less confusing and better used. The costs of running 2 vs 3 UCCs is not significantly different as there would be more activity diverted into A & E for minors (these costs have been factored into the modelling).

3. If it's not about saving money then why bother consulting on 2, why not just say there will be 3 and maybe consult on which 3 these should be?

We involved local patients, clinicians and social care professionals in developing ideas for how future services might look. We developed five tests (our review criteria) to check which scenarios might work best. Everyone involved had a say in which tests were most important to them. A total of 81 possible scenarios were then tested and scored using the first four tests. These ranged from keeping all 6 MIUs as they are now to not having any Urgent Care Centres. Those that proved to be realistic potential options had their finances analysed. This then helped us to identify the best options for formal consultation that delivered quality, safety and value for money. As with any consultation, we need to be able to give people a choice.

4. If only 2 UCCs are created will these savings from not creating a third UCC be redirected to other services and if so what?

The urgent care centres are one service that forms part of our wider integrated unplanned and urgent care system. Every penny we have that is identified for the provision of unplanned/urgent care is spent on unplanned/urgent care and will continue to be spent to deliver the integrated unplanned/urgent care system.

As mentioned above, there are no significant savings as having 2 UCCs would result in higher numbers presenting at A & E for minors.

There is a possibility that some more patients might attend A & E for minors if there were only two UCCs, we have looked at this as part of our modelling and we have identified that a lot of the activity that was being undertaken in the MIUs was for follow up of non-urgent needs and we anticipate that the majority of this activity will be redirected to existing non urgent commissioned services or directed to NHS111 or the Clinical Advice Hub.

What are the overall expected savings to be made by introducing Urgent Care Centres and closing MIUs?

This is not about saving money but our proposals mean that we could invest more money where it is needed to reduce duplication, make services less confusing and better used.
5. What will be the proposed opening times for each UCC if they are to be open 16 hours a day?

This has yet to be determined but we anticipate that this could be an early morning start and a late night finish (such as 8 am to midnight).

Providers and workforce

6. How well have you worked with providers and their staff? How have provider organisations been involved and actively fed into in the process to reach the preferred options?

Staff from provider organisations are always involved in discussions about service change. Such discussions occur at all levels of the organisation; Chief Executive to Service Managers. Representatives from Humber NHS Foundation Trust, Northern Lincolnshire and Goole NHS Foundation Trust, Hull and East Yorkshire Hospitals NHS Trust, York NHS Foundation Trust, Yorkshire Ambulance Service, East Riding of Yorkshire Council and Care Homes are members of the Stakeholder Forum which helped develop our tests and scenarios.

Staff views are being proactively encouraged throughout the consultation period.

7. Have you got the required staff and staff skills and resources in place?

We will be able to reallocate staff who already work in these roles and develop capacity where required. Working as part of an integrated care system we will be able to maintain and develop clinical competencies.

8. Workforce is a key element to successfully implement UCCs - how confident are you that staff will be willing to work at different sites particularly as at present they don’t know where they will be?

The staff currently rotate across 4 of the 6 MIUs. We have written to the current providers to seek assurance from them that they have appropriate arrangements in place to ensure their staff are fully briefed on our plans and can discuss any potential implications with line managers or human resources, etc. We are keen to stress that urgent care and community staff do an amazing job and our aim is to improve the whole system so that we can retain a workforce in the East Riding with the right skills that are able to work where they are needed and can make the best impact.

9. Does this consultation proposal go hand in hand with the requirements of the new community services contract and vice versa?

The new community services contract includes Minor Injury provision (with the exception of Bridlington MIU). No changes will be made to the existing Minor Injury Service provision until the outcome of the formal consultation process is known.

MIUs

10. Can you please provide greater detail about the evidence and weighting for disregarding Withernsea, Hornsea and Driffield MIUs in the process?

In developing our proposed options for consultation, we considered 81 potential scenarios. These included combinations introducing an Urgent Care Centre at Withernsea, Hornsea
and Driffield and keeping all Minor Injury Units as they are now. Following testing using our agreed criteria, our top 9 potential scenarios were costed, with those meeting our fifth and final test progressing to consultation. Our top 9 potential scenarios included the option to introduce an Urgent Care Centre at Withernsea, Hornsea and Driffield. However, introducing an Urgent Care Centre at Withernsea, Hornsea and Driffield does not feature in any of our four proposed options for public consultation on the basis of value for money.

11. **Was it ever considered to create 2 or 3 UCC and keep one MIU at Withernsea, Hornsea and Driffield open?**

   No - We did consider maintaining the status quo but our aim is to reduce confusion for patients and staff by introducing a consistent service across the East Riding.

12. **What would the costs be for keeping open at least one of the MIUs facing closure whilst also creating 2 or 3 UCCs?**

   This scenario has not been scored or costed.

13. **Who is responsible for the current MIU set up which offers different opening times and services? If this had been addressed in years gone by services might well have been better utilised, the public would have been less confused and such drastic action might not have needed to be taken by way of this consultation.**

   These services have been in situ for many years, they are run by a number of different providers and the CCG became responsible for the commissioning of these in 2013. This is our opportunity to improve urgent care services for the whole of the East Riding.

**UCC model**

14. **What assurance can be given that the proposed UCC model will work?**

   The UCCs will all be open consistent times and provide the same service offering. The CCG will closely monitor the contract to ensure this model works.

15. **What is the UCC model elsewhere in the country - will our model differ?**

   NHS England has issued ‘Commissioning Standards Integrated Urgent Care’ guidance which outlines the standards which commissioners should adhere to in order to commission a functionally integrated 24/7 urgent care access, treatment and clinical advice service (incorporating NHS 111 and Out-of-Hours (OOH) services). The aim is to bring urgent care access, treatment and clinical advice into much closer alignment through a consistent and integrated NHS 111 service model.

16. **Basically the sub-committee seek assurance that the options arrived at are ultimately the right ones for the East Riding. What are the facts, figures and reasoning that justify the closure of the MIUs at Driffield, Hornsea and Withernsea hospitals and the possible closure of MIUs at Goole, Bridlington and Beverley?**

   There a number of reasons why it is important for us to review current urgent care services. Some of these are based on national evidence provided by organisations such as the Department of Health and the Royal Colleges, but others are based on what we know at a local level as health professionals working closely with patients in East Riding of Yorkshire.
Facts, figures and reasoning have been fully considered in developing our Pre-Consultation Business Case which has been externally assured through NHS England Service Change and Assurance Team and the Clinical Senate. Details are available on-line.
Appendix 2

Sub-Committee Questions on the Wrap-Around Patient Care

1. Please explain in detail how both proposed options would work in reality - how will the system flow?

Community beds play an important role in preventing hospital admission by providing a higher level of care for patients (known as step up care) and providing a lower level of care for patients discharged from an acute hospital that are not quite well enough to go home (known as step down care).

Our beds are not used as much as they could be for this purpose, meaning, often, people remain in hospital longer. This causes blockages in acute hospitals which then has a knock-on effect for people waiting in A & E who may need to be admitted into hospital.

We would like to improve access to intensive rehabilitation (eg physiotherapy, occupational therapy), community nursing and reablement to support patients in or close to their own homes. Our data shows us that these ‘wrap-around’ style patient services would be more effective in supporting people back to independence as many patients don’t need the high level of medical or nursing input provided in a community hospital bed and would recover more quickly by being better supported in their own home.

2. In the FAQs it says that care models have been tested locally - what and where are these care models?

Last year we successfully piloted eight Time to Think Beds in local residential or care home settings. Time to Think beds are more flexible and offer short term NHS care, rehabilitation, therapy and support to help people back to independence whilst care packages are set up in their own home.

3. How confident are you that there will be bed capacity throughout the East Riding? What assurances have you got from providers to ensure there will be bed capacity?

We have engaged local care providers in our stakeholder work and we have been talking to local providers about the future models of care that we would like to deliver. Some care providers have informally indicated that they would be interested in working with us to develop a different type of business model that reflects what we are trying to do. We are aware that there are some challenges within the system locally in respect of nursing and care home capacity and we are working with our health and social care system partners to ensure that we will have enough capacity.

4. Option A you propose 15 Time to Think beds - where will these be? What arrangements are already in place should Option A be progressed?

Time to Think beds will be in a number of geographic areas across the East Riding of Yorkshire. We would plan specifically to locate beds in our coastal areas of Withernsea and Bridlington and one other location if Option 1 is supported by the consultation. No changes will be implemented until the outcome of the formal public consultation is known.

5. Do we have enough nurses, therapists etc to properly fulfil the Home First Beds and Time to Think Beds criteria?

Yes. Appropriate use of workforce was factored in during our testing of potential scenarios. We do not expect staff numbers to increase but the workforce may change to reflect the required skills and expertise required. We are not expecting staff to lose their jobs and we will work closely with our provider organisations to redeploy staff.
Dear Jane

Consultation on Urgent Care Services – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

I write on behalf of the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee following its meeting of 15 November 2016 when the consultation on Urgent Care Services was presented. The Sub-Committee would like to thank you and your colleagues for the initial presentation and, in so doing, undertaking the CCG’s duty to consult with the Sub-Committee on substantial developments and changes to health services in the East Riding.

Whilst the Sub-Committee welcomed the information provided during the meeting, it did feel that there were a number of areas where detailed or specific information was lacking or unclear and therefore, in order to aid the Sub-Committee in making a truly informed response to the consultation, requests further information/detail on the following points:

Proposed Options for Urgent Care Centres

(i) The modelling used to inform the weighting criteria for all the 81 scenarios.
(ii) Further information on weighting criteria – how exactly has rurality and transport been applied to the 81 options before the finance criteria was applied? Evidence on whether travel time, cost or mileage (including consideration of public transport availability) has been taken into consideration, rather than just distance?
(iii) What do the new standards for urgent care say about clinical risk in isolated rural areas i.e. quick ‘substandard care’ versus delayed ‘superior care’?
(iv) Please can a few example scenarios be provided on the different types of injuries/conditions that residents may present with at UCCs and how the system would flow?
(v) What is the clinical profession’s view on the new proposals? Do they have any reservation, concerns or fears?
(vi) How were the £5.29m costings to upgrade all MIUs to UCCs calculated? Is this based on the status quo or have new or alternative redesigned models to contract services/equipment been considered in the build-up of the status quo costs?
(vii) It has been repeatedly stated that the creation of UCCs and the closure of MIUs is not about saving money, yet it was stated at the meeting of 15 November 2016 that only the four options proposed out of the 81 options fell within the affordability envelope. What is this affordability envelope and what are the finances associated with this?
(viii) Why did the full list of 81 options not have the financial criteria element applied to them in the first instance – surely this would have given a truer reflection of the affordability and viability for each option?
(ix) What services will be left and how will the hospitals be utilised once the MIUs and bed closures have taken place at Driffield, Hornsea and Withernsea? How viable are these buildings in the future and what would happen if they have to be closed? What would be percentage net loss by the underutilisation of these buildings?
(x) Directing public to Bransholme MIU – is this not misleading to the public if there are no guarantees that this MIU will remain open if and when Hull CCG undertake a similar consultation exercise?
(xi) How confident are you that sufficient and competently trained staff will be available and in place to support the new systems?

Proposed Options for Wrap-Around Patient Care

(i) The modelling used to inform the weighting criteria for all the 70 scenarios.
(ii) Reduced bed capacity – what assurances/evidence can be given that there is capacity within the community to provide these beds?
(iii) What services will remain following the closure of community beds at Withernsea or Bridlington? This was not made clear in the meeting as it was mentioned that conversations would be had with providers after the beds had been closed. Does forward planning not dictate that such arrangements should have already been determined?
(iv) How confident are you that sufficient and competently trained staff will be available and in place to support the new systems?

In accordance with the requirements of the Health and Social Care Acts (2001 and 2012) and the Local Authority (Public health, health and Wellbeing Boards and Health Scrutiny) Regulations 2013 I would be grateful if a response to the above could be provided to the Sub-Committee by Friday, 2 December 2016.

Upon receipt of this information the Sub-Committee would then like to invite you back to a meeting in mid-December (to be arranged) to discuss your response to the above questions further.

I thank you for your cooperation in this matter and look forward to receiving your response in due course.

Yours sincerely

Gareth Naidoo – Senior Committee Manager
for the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee
Dear Barbara

ERY CCG Improving Urgent Care Services – Public Consultation

Thank you for giving us the opportunity to present Health, Care and Wellbeing OSC (HOSC) members with information regarding our improving urgent care services public consultation on 13 November 2016 and your subsequent letter of 21 November 2016. It is important to us that you are fully informed and we hope members found the session useful in better understanding the process we have gone through to develop our options for consultation.

At the meeting, you confirmed that a formal response to the consultation would be submitted by the HOSC before the consultation closes on 17 January 2017. However, in order to help you make an informed response on behalf of the whole of the East Riding of Yorkshire area, HOSC members felt that it would be helpful to be provided with more information regarding the modelling work which had been conducted to develop the proposed options. In particular, detail of how the CCG had arrived at the impacts on urgent care activity as part of each of the proposed options. Whilst the process was talked through at the meeting, we thought it would be useful to provide HOSC members with more detailed information. You have also asked a number of questions in your subsequent letter, which we have also supplied responses to (enclosed).

Pre-Consultation Involvement
In March 2016, the CCG set up a core steering group and a wider panel to look at ways to develop an improved service model for Urgent Care Centres and Wrap Around Patient Care. The group and panel included membership from the CCG, GPs, nurses and patient representatives. The CCG Governing Body and CCG Council of Members (representing all GPs in the East Riding) had a major say in decisions during development of the clinical case for change, long list of options and assessment process. The steering group identified potential scenarios and also collected those put forward by wider stakeholders. A long list of options was produced for consideration as future service models. In addition, the CCG established a Stakeholder Forum, made up of patient, clinical, partner and community representatives (including ERYC, Councillors, HOSC, MPs and Health Forums) from across the East Riding with a special interest in urgent care services. The Stakeholder Forum provided feedback and views on the planning process, including criteria and scenarios, as the CCG prepared for formal public consultation on a range of viable options. Information about the Stakeholder Forum is available on our website: http://www.eastridingofyorkshireccg.nhs.uk/urgentcare/stakeholder-workshops-1/

Developing Criteria and Scenarios
As mentioned in the consultation document, stakeholders were involved in developing and weighting a range of criteria for the CCG, as clinical commissioners, could use to calculate which scenarios might work best. Everyone involved had the opportunity to suggest potential scenarios for how future services could look. This resulted in the development of a long list of 81 potential scenarios for Urgent Care Centres and 70 potential scenarios for Wrap Around Patient Care. All the potential scenarios...
Better Care, more locally, within budget, through transformation

GP Chairman: Dr Luigina Palumbo                 Chief Officer: Jane Hawkard

were tested and scored using the agreed, weighted criteria. Those that proved to be realistic potential options were then costed using the fifth and final test regarding affordability, which helped us to identify our options for formal consultation. All the scenarios and how they scored by the three groups – CCG, Council of Members and Stakeholder Forum – are enclosed. A decision had been agreed in advance only to cost the top 6 highest scoring scenarios which is standard practice. For Urgent Care Centres, this actually resulted in a total of 9 scenarios being costed due to minor differences in the top 6 highest scoring scenarios from all three groups.

Modelling Tool
The CCG representatives at the HOSC meeting were clear that a modelling tool had been used to generate the impacts as recorded in the consultation document. This tool is based on pseudonymised patient activity at all six Minor Injury Units and minor activity at Accident and Emergency Departments during 2015/16. This data was used to model future activity depending on different scenarios and builds in potential population growth. At the meeting, the CCG offered to share the modelling tool with HOSC members. As the modelling tool is based on individual patient activity records, the CCG is unable to share the entire tool with HOSC members as this would breach the requirements of the Data Protection Act. In addition, due to the complexity of the resulting data, it is not felt appropriate to share in public, however, the CCG is willing to demonstrate the tool to HOSC members through a session conducted at the CCG in order to help HOSC fulfil its scrutiny duties and we understand this has now been scheduled for 12 December 2016. In advance of the session, we enclose a summary of how the baseline Minor Injuries Unit (MIU)/Urgent Care Centre (UCC) modelling has been completed.

Scoring Methodology and Assumptions
In addition to the criteria and modelling tool, the CCG agreed a number of assumptions (enclosed) and developed a scoring methodology (enclosed at appendix 5). The scoring methodology takes into consideration certain known limitations (e.g. area rurality, workforce levels, building capacity, etc.) and enabled the panel of clinicians, patients and CCG staff to score some of the criteria using a simple logical methodology. The assumptions agreed were used in the modelling of impacts for each possible scenario. At the above session, the CCG can run through a scenario with HOSC members, if deemed useful.

External Assurance
It is the CCG’s statutory responsibility to constantly review services to provide the best possible outcome for patients across the whole of our population. As explained at the HOSC meeting, the modelling, scoring methodology and assumptions have all been approved by the CCG Governing Body and were also used to inform the clinical case for change. As a further assurance to the CCG, the East Riding of Yorkshire Council Public Health function was asked to review the methodology for modelling bed numbers. This was subsequently conducted and agreed as entirely reasonable, given any unusual unpredictability of future demand.

Any consultation requires the CCG to go through external assurance processes. The Yorkshire and Humber Clinical Senate has conducted a review on the clinical case for change relating to urgent care and have supported the proposals. The Clinical Senate report is enclosed for your information.

In addition, the CCG has also received external assurance through the NHS England Service Change and Assurance Team (SCAT) process as well as through the Consultation Institute who are a well-established not-for-profit best practice Institute, promoting high-quality public and stakeholder consultation in the public, private and voluntary sectors.

Other considerations
As discussed at the HOSC meeting, the CCG is aware that transport is an issue due to the rural nature of the East Riding. The impact of this has been considered during the development of our plans, alongside other factors such as low attendance, inconsistency in service provision, clinical risk and improved NHS 111 clinical input (a copy of our Pre Consultation Business Case is enclosed at appendix 14). The CCG has a statutory duty to provide transport for patients with a clinical need and this is available for both emergency and non-urgent patient journeys. The East Riding of Yorkshire
Council is a key stakeholder and is aware of the CCG’s proposed options so they can factor this into their future plans for public and community transport.

The aim of the proposed service change is to improve urgent care provision for the whole of the East Riding population. To do this, the CCG is confident that the options presented provide improved services, over and above that which the MIUs can currently provide, and give improved access to urgent care services. Whilst it is recognised that some people may have to travel further to have their needs met, this would be in an Urgent Care Centre one stop shop that is well equipped and open considerably longer hours, which will provide a better experience for patients and clinical staff. An additional identified advantage to developing Urgent Care Centres is that ambulance crews would be able to take patients to these centres instead of A&E, if clinically appropriate, keeping them in the East Riding area. This is not possible with the current MIU system.

The CCG’s options are based on information that is available at this time and, through the public consultation, it is right that further information and insight is sought from local people across the whole of the East Riding so views can be taken these into consideration when making the final decision. We have also been clear that we will look at how we can minimise impacts of changes in services.

Please contact Quintina Davies, Head of Communications and Engagement, on 01482 315720 or quintina.davies@nhs.net to confirm details regarding the above session or to discuss any further queries regarding this matter.

Thank you for your ongoing support in scrutinising our proposals so that we can improve urgent care services for the whole of the East Riding.

Yours sincerely

Jane Hawkard
Chief Officer

Enclosures: See Supporting Papers

1. Final scores (by sub group) – Urgent Care Centres
2. Final scores (by sub group) – Community Beds
3. Assumptions – Urgent Care Centres
4. Assumptions – Community Beds
5. Scoring methodology – Urgent Care Centres
6. Scoring methodology – Community Beds
7. Urgent Care Centre Modelling Baseline Summary
8. Response to HOSC questions dated 21 November 2016
9. Travel Analysis – excerpt from Pre-Consultation Business Case and Appendix 12
10. Yorkshire and Humber Clinical Senate Report
11. Urgent and Emergency Care Facilities and System Specifications
12. List of services provided at Driffield, Hornsea and Withernsea Hospitals
13. MIU/UCC comparison information
14. Pre Consultation Business Case and appendices
Proposed Options for Urgent Care Centres

(i) The modelling used to inform the weighting criteria for all the 81 scenarios.

The modelling that has been used to inform the weighting criteria is enclosed. See attachment 5 (Supporting Papers) – Scoring Methodology – Urgent Care Centres.

(ii) Further information on weighting criteria – how exactly has rurality and transport been applied to the 81 options before the finance criteria was applied? Evidence on whether travel time, cost or mileage (including consideration of public transport availability) has been taken into consideration, rather than just distance?

Rurality and transport considerations are included in the scoring methodology - see attachment 5 (Supporting Papers) – Scoring Methodology – Urgent Care Centres. Rurality and transport analysis includes elements of travel time, mileage, car ownership, public transport (bus and rail) and community/voluntary transport options. In addition, consideration has been made to the East Riding of Yorkshire Council's Local Transport Plan, Rurality Plan and Settlement Network Plan which identifies future developments across the East Riding. Detail of this analysis regarding travel has been included as part of the Pre-Consultation Business Case development (excerpt enclosed at attachment 9 and 9a (Supporting Papers)).

In addition, it should be noted that the CCG has a statutory duty to provide transport for patients with a clinical need and this is available for both emergency and non-urgent patient journeys. Under the NHS Healthcare Travel Costs Scheme (HTCS), there is an opportunity for patients on a low income/benefits to claim help with travel costs and for carers/escorts (if it is medically necessary).

As mentioned in our letter, the CCG has offered HOSC members the opportunity to run through the scoring of a scenario at an internal session planned for December 2016.

(iii) What do the new standards for urgent care say about clinical risk in isolated rural areas i.e. quick ‘substandard care’ versus delayed ‘superior care’?

As a CCG, it would be clinically inappropriate to commission any service that would provide substandard care to patients. The clinical aspiration is to provide a safe, high quality and consistent urgent care walk-in offering for the public. The draft national Urgent Care Centre specification does not include specific reference to isolated rural areas but does state that, where possible, UCCs should be co-located with Emergency Centres (A&E) but recognises that standalone centres will also exist.

The impact of some longer travel times has been considered during the development of our plans, alongside clinical risk and improved NHS 111 clinical input. This has been externally reviewed by clinicians via the Yorkshire and Humber Clinical Senate (report enclosed at attachment 10 (Supporting Papers)).

The draft national Urgent Care Centre specification is enclosed (attachment 11 - (Supporting Papers)) but can also be found on our website at:

(iv) Please can a few example scenarios be provided on the different types of injuries/conditions that residents may present with at UCCs and how the system would flow?

The types of injuries/conditions that residents may present with at UCCs are included in the consultation document on page 14. It would be for the provider to determine how patients would flow through the system.

Further information regarding the comparison between the current and proposed new system can be found on attachment 13 (Supporting Papers), which is due to be issued to every household in the East Riding.

(v) What is the clinical profession’s view on the new proposals? Do they have any reservation, concerns or fears?

As mentioned in our letter, the Yorkshire and Humber Clinical Senate has conducted an independent review on the clinical case for change relating to urgent care and have supported the proposals. A copy of the Clinical Senate report is enclosed (attachment 10) and can also be found at:

http://www.eastridingofyorkshireccg.nhs.uk/urgentcare/publications-and-resources-1-1/

As part of this process, the CCG felt it important to gain a good understanding of the likely impact on primary care and local GPs have had the opportunity to express their concerns throughout the development of the options. This is referred to in attachment 3 (Supporting Papers) – Assumptions – Urgent Care Centres (5.16). The impact on the work of primary care and on other services delivered in the community hospitals (eg dressings) was identified at an early stage and continues to be considered as part of the formal public consultation.

The CCG Governing Body (which includes GPs) and CCG Council of Members (representing all GPs in the East Riding) had a major say in decisions during development of the clinical case for change, options and assessment process. The decision to support the proposed options for consultation was unanimous at the Governing Body meeting.

(vi) How were the £5.29m costings to upgrade all MIUs to UCCs calculated? Is this based on the status quo or have new or alternative redesigned models to contract services/equipment been considered in the build-up of the status quo costs?

This was a bottom up costing based on model patient flows and sufficient numbers of appropriate clinical staff required to meet the need of a UCC and treat patients presenting. The costs included support costs (reception staff, security, etc) as well the impact on A&E. Further detailed information about how costings have been calculated is included in attachment 3 – Assumptions – Urgent Care Centres.

(vii) It has been repeatedly stated that the creation of UCCs and the closure of MIUs is not about saving money, yet it was stated at the meeting of 15 November 2016 that only the four options proposed out of the 81 options fell within the affordability envelope. What is this affordability envelope and what are the finances associated with this?

Every penny of the funding the CCG receives is spent on health care and the CCG will invest what is needed in order to provide this proposed model of care within the allocated budget. However, as an accountable NHS public body, it is important that all services offer value for money. To assess the value for money of shortlisted scenarios, the tariff was calculated at an average cost of £70 based on current tariffs for A&E minor activity that could be undertaken at a UCC.
The CCG currently spends £3.2 million on Minor Injury Services (excluding attendance at an A&E with a minor). The estimated cost of the proposed options ranges from £2.9 million to £3.3 million.

(viii) Why did the full list of 81 options not have the financial criteria element applied to them in the first instance – surely this would have given a truer reflection of the affordability and viability for each option?

As a CCG, it was important that all the possible scenarios were considered equally against the agreed weighted criteria before taking financial affordability into account. The main principle underpinning the proposed service change was to improve quality, safety and access and not to save money; therefore the methodology was developed to identify these minimum requirements. Using this methodology, only those options that met the minimum standards were considered viable and then subjected to financial modelling. This approach is usually standard practice.

A decision had been agreed in advance to only cost the top 6 highest scoring scenarios. For Urgent Care Centres, a total of 9 scenarios were actually costed, ie, the top 6 highest scoring scenarios from all three groups (CCG Governing Body, Stakeholder Forum, Council of Members).

(ix) What services will be left and how will the hospitals be utilised once the MIUs and bed closures have taken place at Driffield, Hornsea and Withernsea? How viable are these buildings in the future and what would happen if they have to be closed? What would be percentage net loss by the underutilisation of these buildings?

The current provider of services, Humber NHS Foundation Trust, has published information regarding the full range of services provided at Driffield, Hornsea and Withernsea. MIUs and Community Bed provision are the only services directly affected by this urgent care consultation.

The aim is to improve the range and quality of urgent care services that are available to people across the East Riding area. The CCG’s plans may result in some space within existing hospitals not being used or used for the provision of a different service in future. However, any significant change to use of buildings would be subject to a separate consultation.

Detail regarding the current services that are provided at Alfred Bean Hospital are available here:


Detail regarding the current services that are provided at Hornsea Cottage Hospital are available here:


Detail regarding the current services that are provided at Withernsea Community Hospital are available here:

Copies of these documents are also enclosed (12 attachments) with this response (See Supporting Papers).

(x) Directing public to Bransholme MIU – is this not misleading to the public if there are no guarantees that this MIU will remain open if and when Hull CCG undertake a similar consultation exercise?

NHS Hull CCG has recently completed its formal public consultation on the future of urgent care in Hull. The consultation included proposals to create a 24/7 urgent care centre at Bransholme Health Centre. None of the Hull CCG options included the proposal to close urgent care services at Bransholme. In the very near future ERYCCG is expecting to receive formal notification from Hull CCG of the consultation outcome and will further consider any impact on the East Riding once the final decision is confirmed.

(xi) How confident are you that sufficient and competently trained staff will be available and in place to support the new systems?

The CCG is confident that the provider will be able to reallocate staff who already work in these roles and develop capacity, where required. Working as part of an integrated care system will help staff maintain and develop clinical competencies.
Proposed Options for Wrap-Around Patient Care

(i) The modelling used to inform the weighting criteria for all the 70 scenarios.

The modelling that has been used to inform the weighting criteria is enclosed. See attachment 6 (Supporting Papers) – Scoring Methodology – Community Beds.

(ii) Reduced bed capacity – what assurances/evidence can be given that there is capacity within the community to provide these beds?

The CCG’s proposals are centred around supporting more people in their own home. The CCG wants to invest in the local workforce to improve intensive rehabilitation services so more people can be supported back to independence sooner, in their own home.

The CCG has successfully piloted Time to Think beds and is confident that the capacity is available to deliver this model. The CCG would be working closely with the care home market to develop and implement this new model, following the outcome of the public consultation.

The CCG is also confident that these plans will offer more flexibility, especially during times of higher demand such as winter.

(iii) What services will remain following the closure of community beds at Withernsea or Bridlington? This was not made clear in the meeting as it was mentioned that conversations would be had with providers after the beds had been closed. Does forward planning not dictate that such arrangements should have already been determined?

Staff from provider organisations are always involved in discussions about service change and these discussions have informed the development of the proposals. As no decision has been made regarding the final outcome, it is right that no such arrangements have been determined.

However, as mentioned in the consultation document, it is recognised from early discussions that the proposals may have an impact on some people who currently receive palliative care in a community hospital setting. The CCG will be reviewing palliative care services, specifically focussing on improving ways to support people where there may be a greater need as a result of the consultation outcome, such as Bridlington and Withernsea.

In addition, Time to Think beds will be in a number of geographic areas across the East Riding of Yorkshire. The CCG would plan specifically to locate some Time to Think beds in the coastal areas of South Holderness and Bridlington if Option 1 is supported by the consultation.

(iv) How confident are you that sufficient and competently trained staff will be available and in place to support the new systems?

The CCG is confident that the provider will be able to re-deploy staff who already work in these roles and develop capacity, where required.

*See Supporting Papers for more information*
EAST RIDING OF YORKSHIRE COUNCIL

HEALTH, CARE AND WELLBEING
OVERVIEW AND SCRUTINY SUB-COMMITTEE

14 DECEMBER 2016

PRESENT: Councillors Aitken (in the Chair), Davison, Galbraith, Green, Jefferson, Kingston, Lisseter, Moore, Smith and Steel.

Officers present: Tracey Craggs - Assistant Director - Unplanned Care Transformation (East Riding of Yorkshire Clinical Commissioning Group), Quintina Davies - Head of Communications and Engagement (East Riding of Yorkshire Clinical Commissioning Group), Jane Hawkard - Chief Officer (East Riding of Yorkshire Clinical Commissioning Group), Andy Kingdom - Deputy Director of Public Health, Jezz Newton - Unplanned Care Operational Delivery Manager (East Riding of Yorkshire Clinical Commissioning Group), Rosy Pope - Head of Adult Services, Yvonne Rhodes - Head of Business Management and Commissioning, Gavin Robinson - Assistant Chief Finance Officer (East Riding of Yorkshire Clinical Commissioning Group), John Skidmore - Director of Corporate Strategy and Commissioning, Sally-Ann Spencer Grey - Lay Governing Body Member and Patient Champion (East Riding of Yorkshire Clinical Commissioning Group) and Gareth Naidoo - Senior Committee Manager.

Councillors R Burton (Portfolio Holder for Civic Wellbeing and Culture), Harrap (Portfolio Holder for Adult and Carer Services), Head, Healing, Owen (Deputy Leader), Strangeway and Wilkinson were in attendance as observers.

Also in attendance: Press - 1
Public - 2

The Sub-Committee met at County Hall, Beverley.

451 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS - No declarations of interest were made.

452 URGENT CARE SERVICES CONSULTATION - The Sub-Committee received a further verbal report on the Urgent Care Services consultation from East Riding of Yorkshire Clinical Commissioning Group (ERY CCG). Taking part in the consideration of this item was Jane Hawkard - Chief Officer, Tracey Craggs - Assistant Director (Unplanned Care Transformation), Quintina Davies – Head of Communications and Engagement, Jezz Newton - Unplanned Care Operational Delivery Manager, Gavin Robinson - Assistant Chief Finance Officer and Sally-Ann Spencer Grey - Lay Governing Body Member and Patient Champion.

The CCG had presented to the Sub-Committee on the consultation at its previous meeting of 15 November 2016. At that meeting the Sub-Committee felt that further information was required, particularly regarding the modelling process. The CCG was requested to return to the Sub-Committee with further information, much of which had been provided in the supporting papers, as deposited in Group Offices and public deposit points. The CCG also held a workshop prior to this extraordinary meeting to provide the Sub-Committee with an opportunity to be taken through the modelling process.

The Sub-Committee received an overview of the modelling process for both the community beds and Minor Injury Units (MIUs), including information on weightings criteria and assumptions.
The Sub-Committee also received a Mid-Consultation Review update. Over 1,000 people had attended the drop-in events across the East Riding.

1. The aim was to receive 663 responses spread across the East Riding geography. Currently the CCG had received 620 with about 200 more to input.

2. The aim was to receive a spread of responses across all age groups, but recognising that people were more likely to be over the age of 50 for community beds. Latest response figures breakdown were as follows:

- 35 and under: 8%
- 36 - 45: 12%
- 46 - 55: 20%
- 56 - 65: 20%
- 66 - 75: 32%
- Over 75: 8%

3. Healthwatch had supported the CCG approach to the consultation and had attended all drop-in events.

4. The League of Friends, Defence Leagues, Health Forums, etc had all been made aware of the consultation and attended drop-in events.

5. All local MPs were aware of the consultation and had been in touch with the Chief Officer and the Chair of the CCG.

6. All Town and Parish Councils had been made aware and responses had been received.

7. Ongoing media coverage continued locally.

The CCG was currently monitoring ongoing issues:

- Seven petitions received and reported to GB meeting in public on 13 December 2016.
- GPs – practices in Holderness written in to CCG raising concerns about the impact of the proposals on local residents, copied to local media.
- MP correspondence from Graham Stuart, Andrew Percy, Greg Knight:
  - Andrew Percy was keen to see a UCC remain at Goole Hospital.
  - Greg Knight had attended the Driffield drop-in event and discussed proposals with the Chief Officer and Chair of the CCG and had requested more information about impact on Bridlington.
  - Graham Stuart was keen to see a UCC remain at Beverley and had organised petition letters for Holderness, rallies and petitions.
- Full Council, by way of a motion, had raised concerns that the proposals did not contain options that would potentially give fair and equitable access to services for all residents. This was being raised through the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee which had also requested further information, including information on the modelling process, assumptions and weighting criteria.
- Public Health had requested information about how local health profiles had influenced the options being proposed.
- Standard petition letters received (as at 8 December):
  - Hornsea: 940,
  - Withernsea: 1,124,
  - Unaddressed: 405,
  - Driffield: 883,
  - Holiday makers: 70 (plus extra 171 with additional comments).
- Personal letters received, alongside letters for mayors and councillors: 46
During the consultation period, a query had been received from a member of the public highlighting a difference between the information presented in the consultation document and an activity report previously issued on the CCG website. The query has been answered (and was shared with the Sub-Committee). The CCG also promised to publish the information on their urgent care website www.eastridingofyorkshireccg.nhs.uk. In brief, the data used for consultation purposes included activity for East Riding population and its neighbouring CCGs within the Sustainability and Transformation Plan (STP) footprint (i.e. Scarborough & Ryedale CCG, Vale of York CCG, North Lincolnshire CCG, North East Lincolnshire CCG and Hull CCG). Provider reported activity included patients who were the responsibility of other CCGs outside the STP footprint, such as Doncaster CCG in relation to the Goole MIU. While total activity was important when providers were sizing the totality of their service provision, commissioners were responsible for their registered populations. For completeness the CCG had run the additional activity through the CCG’s modelling tool which had reconfirmed the four top ranked options remained as the top four.

The following actions were ongoing:
- Liaison with large businesses within the East Riding
- Drop-in event in the Brough area (ie library)
- Liaison with equality groups (review against equality analysis and consider further activity)
- Response types being received (review against geography and clinical/carer, etc. and consider further activity)
- Encouraging formal responses from key stakeholders/partners including the Sub-Committee, Healthwatch East Riding of Yorkshire, Hull and East Yorkshire Hospitals NHS Trust, Humber NHS Foundation Trust and Northern Lincolnshire and Goole NHS Foundation Trust etc.
- Publish additional information to website for consideration by public.

Members then discussed the following points:

- Modelling - whilst there was no one tried and tested model, the CCG believed that its bespoke model was robust, suitable and appropriate. A great detail of research and data had been applied in developing the model. In particular the CCG had considered the models of other NHS organisation that had developed similar services, particularly those of NHS Scotland who had comparable rurality issues with East Riding. The CCG had also worked with The Consultation Institute to quality check and assure its consultation process and modelling.

Whilst the level of detail and output made available through the model was to be welcomed, a Member raised concern that the model did not run based on current operational financial costs but rather on predicted operational costs. It was suggested that the CCG might wish to consider re-running its model based on current operational costs. The CCG agreed to look at whether re-running the model based on current operational costs was feasible and therefore possible.

- Implementation of consultation options - whatever the chosen consultation options, implementation would occur over a phased period (ie the MIUs would not be closed before UCCs (Urgent Care Centres) were fully functional, or community beds closed before arrangements and locations of Time to Think beds were in place). As was evident from the current level of feedback on the consultation so far, the CCG was acutely aware of the rurality and transport issues in the Holderness area and that some mitigating action in partnership with the Local Authority was required in this area, tailored to meet the needs of the model that was to be implemented when a decision about the consultation options was to be made in March 2017. The CCG
would therefore be looking to mitigate as much as possible in this area depending on which option was implemented.

- Changing public mind-set - whichever option was implemented the CCG recognised that it would need to undertake a detailed and sustained communications programme to change the way people viewed services and how they could access services. Whilst recognising that communicating to local populations about appropriate use of NHS urgent and emergency care services was a challenging and complex task, Members suggested considering methods used by the Council to change the way people recycled, which had been highlighted as a beacon of good practice. The CCG assured the Sub-Committee that this would be carefully considered and thanked Members for this suggestion.

- Wider Urgent Care Services - the introduction of UCCs was just one aspect that formed part of the wider urgent care service, other services being NHS111, ambulance service, seven day GP services and pharmacists. With regard to NHS111 this had just been upgraded to include clinical input. It was also confirmed that there were no plans to reduce pharmacy provision and it was noted that pharmacy provision came under the remit of Public Health. Regarding GPs, extended provision to seven day services was part of the General Practice Forward View and Five Year Forward View. The CCG was in the process of meeting individually with those general practices likely to be most affected by the proposals within the East Riding to discuss the consultation proposals and consider mitigation (particularly in light of the media release stating that the Holderness General Practices were against the consultation proposals). A conversation would also need to be had with GPs following the announcement of the new community services contract to understand how best community and GP services could better work together.

- Increased demand on ambulance services and GPs – ambulance services currently did not take patients to MIUs but when the new UCCs were operational, ambulance services would be expected to take patients there when appropriate. This way, ambulances would remain in the East Riding, rather than being detainted at Hull Royal Infirmary, and therefore more ambulances would be available within the East Riding. The UCC model was based on reducing demand on A&E and using NHS111 more effectively.

- Community beds - the Sub-Committee was concerned that there would be insufficient access across the East Riding to community beds, Time to Think beds and Home First beds. The proposal would clearly have an impact on the Council’s social care service and therefore the CCG would be working with the Council to ensure that service provision. The CCG stated that this change required a joint approach and that the whole health and care system, including the Council, would need to work together. The CCG was undertaking a market test for this type of bed with the nursing/care homes sector.

- Equipment at MIUs - the Sub-Committee was concerned if MIUs closed then equipment (such as X-ray machines), some of which had been specifically purchased through the League of Friends, would be removed. The CCG would carefully consider what equipment would need to be transferred as some equipment, such as X-ray facilities, were being used by other services and may need to be retained. It was confirmed all three potential UCCs currently had X-ray facilities.

- Liaison with large businesses - the Council’s Economic Development department and the Humber Local Enterprise Partnership (LEP) had excellent links to
businesses across the East Riding and it was suggested that the CCG liaise with them to ensure its consultation reached as many businesses and employers as possible.

**Recommended** — (a) That the CCG consider re-running its model based on current financial costings, if feasible, and share the outcome of this with the Sub-Committee;

(b) that the CCG consider liaising with the Council’s Economic Development department and the Humber Local Enterprise Partnership (LEP) to ensure the consultation reaches as many businesses and employers as possible, and

(c) that the CCG give due consideration to the Sub-Committee’s comments and concerns raised, and its response in due course, before making a decision.
Dear Jane

Consultation on Urgent Care Services — Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

I write on behalf of the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee following its extraordinary meeting of 14 December 2016 when further information and detail on the Urgent Care Services consultation was presented and discussed. Once again the Sub-Committee would like to thank you and your colleagues for your attendance at this meeting and the openness by which information was shared. In particular the Sub-Committee was extremely grateful for the opportunity to visit Health House on 12 December for a detailed session on the consultation modelling and the time given by your officers in preparing for this.

Following the extraordinary meeting of 14 December the Sub-Committee have just a few more questions set out below they would appreciate answers to in order for the Sub-Committee to make a truly informed response to the consultation.

1. Bed Modelling Summary

   (i) There does not appear to be the same level of detail/analysis as is evident with the UCC demand flow modelling for the bed modelling summary. Please could a more detailed explanation be provided on the three tabs (Audit Modelling, Population Sizes and Audited Ages) on the worksheet - in particular what do all the figures relate to on the second (Population Sizes) and third (Audited Ages) tabs?

2. UCC-demand-flow-tool-v11-2

   (i) The bed modelling is based on an audit carried out on the 23 and 24 June 2016. Has the UCC demand flow model been created using audit data from specific days as well? If so, over how many days was this audit carried out and when? Where has the data used in the model been extracted from?

   (ii) If people should not attend MIUs for more than one dressing, where would they be expected to go if the local surgery does not have the staff to undertake this task? Will they be commissioned to undertake this task?
(iii) Have the CCG’s Governing Body members visited the six hospitals prior to or will be doing so during the consultation period to experience first-hand service demand, staff feedback and the potential to utilise each site appropriately?

3. Recommendations for consideration during the consultation period

As stated in the minutes of the meeting of 14 December, the Sub-Committee made the following recommendations for the CCG to consider undertaking during the consultation period, these being:

(a) That the CCG consider re-running its model based on current financial costings, if feasible, and share the outcome of this with the Sub-Committee;

(b) that the CCG consider liaising with the Council’s Economic Development department and the Humber Local Enterprise Partnership (LEP) to ensure the consultation reaches as many businesses and employers as possible, and

(c) that the CCG give due consideration to the Sub-Committee’s comments and concerns raised, and its response in due course, before making a decision.

The next meeting of the Sub-Committee takes place on Tuesday 10 January 2017, 10am at County Hall, Beverley. Agenda item 5 is entitled ‘Urgent Care Services Consultation - Update’ and the Sub-Committee would like to invite the CCG to provide any further update on the consultation at this meeting and to report back on the above questions/recommendations.

I thank you for your cooperation in this matter and look forward to receiving your response in due course.

Yours sincerely

[Signature]

Gareth Naidoo – Senior Committee Manager
for the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee
Dear Gareth

Consultation on Urgent Care Services – Health Care and Wellbeing Overview and Scrutiny Sub-Committee additional questions

Thank you for your letter dated 21 December 2016 in which you requested responses to a few more questions in relation to the CCG’s Public Consultation on Improving Urgent Care Services which ends on 17 January 2017. A response is provided below:

1. **Bed Modelling Summary**
 Due to the smaller numbers of patients receiving care in a community hospital bed than visiting a Minor Injury Unit and the type of care needed, it was felt that the approach to modelling future community bed provision required more detailed analysis of clinical appropriateness as opposed to simply reviewing existing activity data and length of stay, etc. The bed audit provided an opportunity to review what care patients required and whether they could be appropriately supported in an alternative environment, ie with wrap-around support in the community. A copy of the Community Beds Utilisation Audit feedback report is enclosed for your information.

With regards to the community bed modelling summary (which you have a copy of) there are three tabs on the worksheet and the figures on each tab relate to the following:

**Tab 1 – Audit Modelling**
A total of 44 community beds were occupied. Column E contains the results of the audit that was carried out in June 2016 (34 patients). For the remaining 10 patients who were not audited, the same ratio of the audit results was applied (Column F).

The next stage was to apply the demographic growth expected in 2026 to these numbers (in columns I to K) and then an allocation of the 2026 expected numbers to actual bed types (in columns M to P). This tab also contains an explanation of the methodology used.

**Tab 2 – Population sizes**
This contains the East Riding of Yorkshire data extracted from the 2012-based Subnational Population Projections for Local Authorities in England By sex and 5 year age groups, all local authorities and higher administrative areas within England. The East Riding data was then summarised to the totals for those aged 70 and older (row 23) and a percentage growth was calculated for this age group to 2026 (cell R23) from 2016 (cell H23) giving a calculated percentage growth of 32.01% (cell S23). This percentage was then applied to the audited results on Tab 1. The population projection data used is available through the following link: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2
Please note that at the time of initiating the project, the 2014 based calculations were not available.
Tab 3 – Audited ages
This tab contains the ages of the patients audited in the community hospital beds. This shows that 85.29% of the patients audited were aged 70 or over and therefore provides the reasoning for using this age group (70+) to determine the demographic growth.

As mentioned in my letter to you dated 2 December 2016, as a further external assurance to the CCG the East Riding of Yorkshire Council Public Health function was asked to review the methodology for modelling bed numbers. This was subsequently conducted and agreed as entirely reasonable, given any unusual unpredictability of future demand. In addition, a further bed audit was undertaken in November 2016 and the findings broadly substantiated the results from the audit undertaken in June 2016 and the results of a previous audit undertaken by NHS England’s Emergency Care Improvement Programme (ECIP) Team in November 2015. The results of this audit are included as appendix 2 in the Pre Consultation Business Case.

2. Urgent Care Centre (UCC) demand flow tool v11-2

Question 2(i)
The UCC modelling was carried out using the accident and emergency patient level data for the 2015/16 financial year (1st of April 2015 to 31st March 2016 inclusive). This dataset included the Emergency Department and Minor Injury Unit Data and contained a wealth of patient level information regarding each attendance within that period including diagnosis, investigations and treatments carried out or not, patient age and registered GP practice, etc. The data was extracted from the Secondary Uses Service (SUS). The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services (http://content.digital.nhs.uk/sus). Because of the detailed data available, it was not felt that an audit would improve the approach to the modelling. However, during the consultation drop-in events we listened to what people have told us about how they use the Minor Injury Units and, in response to this, an audit is currently being undertaken across all the Minor Injury Units. Any additional intelligence received would help inform the CCG’s final decision.

Question 2(ii)
People who need to have follow up-treatment for wound dressings would be expected to attend the planned care services that are currently commissioned within primary and community services. We would not be seeking to commission any additional wound care services.

Question 2 (iii)
Members of the CCG’s Governing Body have visited the six hospitals referred to both prior to and during the consultation period. CCG members have experienced first-hand demand of services both in the community hospitals and Minor Injury Units. Many discussions have been held with staff during the consultation period and feedback received will be incorporated into the consultation analysis.

3. Recommendations for consideration during the consultation period

Question 3(a)
The CCG was asked to consider re-running its model for Urgent Care Centres, based on current Minor Injury Unit financial costings, in order to provide HOSC with additional assurance that the modelling is as robust as possible. Unfortunately, this is not possible as the model was created to address the requirements of delivering an Urgent Care Centre operating for 16 hour per day. Updating the model to allow for current activity/parameter modelling would require significant variation to the model and, therefore, would not provide the additional level of assurance that has been requested.

However, I can confirm that the CCG has met separately with Councillor Lisseter to discuss the reasons for this in more detail and has also validated the current model outputs against other available data:
• Comparison of the modelled costs in relation to Goole Urgent Care Centre with the current costs of Goole Minor Injury Unit (allowing for appropriate scaling) illustrates that costs are broadly in line with expectation.
• Comparison of the current modelled costs to the costs contained within the Community Services bids again provides a high level of correlation.

Question 3(b)
The CCG’s Communications Manager contacted the Council’s Economic Development Team in December 2016 and they have supported the CCG with sending messages out to businesses in the East Riding of Yorkshire area via agreed mechanisms.

Question 3(c)
The CCG looks forward to receiving the formal response from the Health Care and Wellbeing Overview and Scrutiny Sub-Committee which will be considered as part of the decision making process.

I hope you find the additional information provided above useful in helping the Sub-Committee to make an informed response to the consultation I look forward to discussing this further with Members on 10 January 2017.

Yours sincerely

Jane Hawkard
Chief Officer

Enc:
• Community Beds Utilisation Audit report
Community Beds Utilisation Audit
23rd/24th June 2016

Lead Clinician/Evaluators: Emma Owen, Unplanned Care Operational Lead Manager/Jeremy Newton, Unplanned Care Operational Delivery Manager, East Riding of Yorkshire Clinical Commissioning Group (CCG) supported by Sally-Ann Spencer Grey, Patient Champion, CCG Lay Member.
Community Beds Utilisation Audit

Situation:
The audit was conducted to identify the needs of the community bed inpatient population. This is required to inform the CCG’s Urgent Care Strategy Implementation.

Background:
East Riding of Yorkshire CCG is presently undertaking pre-consultation engagement and preparation for a potential public consultation linked to the implementation of its Urgent Care Strategy (appendix 1).

As part of the development of the case for change, evidence about the clinical case for change is being gathered. It has been identified that the CCG needs to identify the needs of the community bed inpatient population. This information is not readily available through contract or performance management systems and is not evidenced through previous audit.

The CCG therefore requested that an audit was undertaken to identify the needs of the community bed inpatient population.

Aims

The aims of the audit were to identify on two specific days what the needs are of the patients who are identified as being the inpatient population of the community beds commissioned by the ERYCCG.

Objectives

The objectives of the audit were:

a) To identify the numbers and percentage of patients in a community bed that do not need to receive their care in this setting

b) To identify the number and percentage of patients in a community bed who could be managed at home

c) To identify the number and percentage of patients who are in a community bed because they had sub-acute medical needs

d) To identify the number and percentage of patients who are in a community bed because they require nursing interventions that can only be delivered in a community bed

e) To identify the number and percentage of patients who are in a community bed because they require intensive therapy intervention/rehabilitation that can only be delivered in a community bed
f) To identify the number and percentage of patients who are in a community bed because they have had a stroke and require therapy/rehabilitation at specific intervals that can only be delivered in a community bed.

g) To identify the number and percentage of patients who are in a community bed because they have palliative care needs that can only be delivered in a community bed or the community bed has been identified as the patients preferred place of death.

h) To identify the number of red days each patient has experienced during their stay in the community bed.

i) To identify the number of patients who are in a community bed because they have social care needs and are waiting for a package of care or a placement.

j) To identify other interventions required that can only be delivered in a community hospital bed.

Assumptions

The audit made the following assumptions prior to being conducted:

a) The audit will be undertaken acknowledging that this provides a snap shot on a particular day.

b) The date of admission is identified as day zero for LOS purposes.

c) Patients and staff will not be interviewed as part of the audit.

d) Sub-acute medical care is defined as: ‘comprehensive goal-orientated inpatient care designed for a patient who has had an acute illness, injury or exacerbation of a disease process, it is rendered either immediately after or instead of acute care hospitalization to treat specific active or complex medical conditions or to administer any necessary technically complex treatment in the context of the persons underlying long term condition’

e) Nursing interventions is defined as: ‘nursing interventions that are delivered by a Registered General Nurse’

f) Intensive therapy/rehabilitation need is defined as: ‘requirement for at least 3 hours input per day from physiotherapy, occupational therapy or other allied health professional’

g) Red days are defined as:
During the conduct of the audit the following assumptions were made of the data presented:

a) Nursing interventions were defined as specific care provided by a registered nurse that could not have been provided by a non-registered professional. The following activities - Assistance with activities of daily living (such as toileting, washing/personal hygiene care, dressing, assistance in or out of bed or walking to toilet) were not nurse specific interventions, if these were the only things documented for the day this was not counted as ‘Green Days’ for the patient. The recording of these activities by the nursing staff was very lengthy but did not suggest they were undertaken as part of a rehabilitation/reablement planned activity.

b) The length of time given for any Intensive therapy/rehabilitation was not recorded in the notes audited, however, if there was an entry from a therapist or other allied health professional this was recorded as a ‘Green Day’.

c) We made an assumption that if the patient was in receipt of intensive therapy/rehabilitation (3 hours or more per day) this would have been recorded in the notes.

d) If there was no communications written in the notes from a therapist it was assumed that no rehabilitation/reablement was provided on that day. However, we are not sure if this is a true reflection of what the patients were receiving as no therapy plan was provided, there may have been therapeutic goals associated to the recorded activities of daily living in the nursing notes. We are unclear if there were separate therapy notes that we were not provided with.

e) The reason for requiring a community bed today in some cases was difficult to determine from the notes, therefore, an assumption was made that the reason remained the same as on admission, unless notes indicated a change.
f) If a medical review/ward round had been noted we assumed this was an intervention that supported the patient’s pathway of care through to discharge and therefore, counted these days as a Green Day.

g) Where there was no sub-acute medical intervention required or no obvious intensive rehabilitation/reablement we defined them as the intervention being able to be delivered at home. (not constrained by current service provision – so at this time the services may not be available to support care at home but this would be the aspiration)

**Assessment:**
The audit was conducted on two consecutive days in June 2016.

<table>
<thead>
<tr>
<th>Day</th>
<th>Hospital</th>
<th>Number Occupied Beds</th>
<th>Total Number Commissioned Beds</th>
<th>Number Patients Consented to Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>East Riding Community</td>
<td>25</td>
<td>30</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>Bridlington MacMillan Wolds</td>
<td>11</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>Withernsea Community</td>
<td>8</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Total:</td>
<td>44</td>
<td>54</td>
<td>34</td>
</tr>
</tbody>
</table>

Those individuals deemed by the clinical staff to be unable to give consent or without relatives who could give consent on their behalf were not included in the review.

The data fields collected were as follows –

<table>
<thead>
<tr>
<th>NHS Number</th>
<th>Age</th>
<th>Gender</th>
<th>Home Postcode</th>
<th>Date of Admission</th>
<th>Reason for admission on day of admission</th>
<th>LOS as of today</th>
<th>Reason for requiring community bed today</th>
<th>Sub-acute medical intervention required (Y/N)</th>
<th>What is the medical intervention required</th>
<th>Nursing Intervention required (Y/N)</th>
<th>What is the nursing intervention required</th>
<th>Therapy Intervention required (Y/N)</th>
<th>Social Care Intervention required (Y/N)</th>
<th>Other Intervention required (Y/N)</th>
<th>Detail what this is</th>
<th>Could the intervention required be delivered at home (Y/N)</th>
</tr>
</thead>
</table>
Findings:

The Demography of the patients occupying the beds during the audit were as follows - All beds (including those individuals not in the review)

(Just those reviewed – ages of all occupants were not made available)

The gender split in the East Riding total population is approximately 50% men and women. Whilst life expectancy continues to increase in the East Riding, there is still a gap between life expectancy of males (79.2) and females (82.5) with people living longer in some parts of the East Riding than others. Therefore, finding more females than males in the inpatient population is not unexpected.

Our total number of people in the East Riding of Yorkshire Area (including Pocklington) is 344,179. The average age split found in the inpatient population is also not unexpected as our population has an age split as follows -

16-34 = 62,988  
35-44 = 44,414  
45-54 = 49,994  
55-64 = 49,482  
65+ = 71,455
Also of note was the spread geographically of the patients in the units based on their postcodes of usual residency (see map below). The arrangements at Bridlington mean that for 6 of the beds the clinical cover is provided by the GP’s in the area, restricting access to their patients only, so finding such a small distribution is not unusual. The spread of patients who were in the ERCH and Withernsea facilities is wider as they accept any East Riding residents.

ERCH Pats = East Riding Community Hospital patients
Brid Pats = Bridlington Macmillan Wolds Hospital patients
With Pats = Withernsea Community Hospital patients
The patients requirements found on the day for the beds are summarised below. There were very few patients who required sub-acute care, and some needs could have been met by different type of beds as indicated.

<table>
<thead>
<tr>
<th>Overview</th>
<th>Bridlington and District Hospital</th>
<th>East Riding Community Hospital</th>
<th>Withernsea Community Hospital</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Beds Commissioned</td>
<td>12</td>
<td>30</td>
<td>12</td>
<td>54</td>
</tr>
<tr>
<td>Total Occupied</td>
<td>11</td>
<td>25</td>
<td>8</td>
<td>44</td>
</tr>
<tr>
<td>Occupancy on Audit Date</td>
<td>91.7%</td>
<td>83.3%</td>
<td>66.7%</td>
<td>81.5%</td>
</tr>
<tr>
<td>HFT Reported Occupancy 2015/16</td>
<td>71.9%</td>
<td>94.4%</td>
<td>78.7%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Total Unoccupied</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Total Unable to Audit</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Total Records Audited</td>
<td>8</td>
<td>19</td>
<td>7</td>
<td>34</td>
</tr>
<tr>
<td>Audit Rate</td>
<td>72.7%</td>
<td>76.0%</td>
<td>87.5%</td>
<td>77.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Audit Findings</th>
<th>Health Care Bed Requirements</th>
<th>Other Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Needing Sub-Acute Bed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total Needing Palliative Bed</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Total Needing Rehab Bed</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Total Needing D2A Bed</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total Health Care Bed Requirements</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Total Needing Non-Weight Bearing Bed</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total Needing D2A Home First Support</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total Needing Social Care Bed</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Total Needing No Bed</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total Other Requirements</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

1 Sub-Acute Bed - Beds needed to address a health need instead of, or following on from, an acute hospital admission - Medical input, nursing support and therapy input - Community hospital based
2 Palliative Bed - Beds needed to support palliative patients - Medical input, nursing support, limited therapy input - Some will be equivalent to sub-acute beds and therefore community hospital based, others could be provided in an alternative setting.
3 Rehab Bed - Beds needed to provide intensive rehab - Nursing support, Intensive therapy input. Could be provided in an alternative setting
4 D2A Bed - Bed needed to support patients before or during the assessment phase for ongoing care - Nursing support, therapy input - Could be provided in an alternative setting
5 Non-Weight Bearing Bed - Bed needed to support patients whilst non-weight bearing before rehab or discharge can take place - Limited nursing input, limited therapy input - Provided in care homes
6 D2A Home First Support - Service to support people at home before or during the assessment phase for ongoing care - Nursing support, therapy input - Provided in patients homes
7 Social Care Bed - Beds (or possibly other services) needed to support patients who no longer have health needs but cannot go home safely - Should be provided in an alternative setting
The split of patients who had been step-up from home/usual place of residence, or step-down from acute hospital were as follows:

Therapy Interventions:
There appeared to be no record of any ‘intensive therapy’ being delivered to any of the inpatients. There was one request for ‘aggressive therapy’, however, there was no plan to indicate how this was being delivered. There did appear in this case, however, there were more entries in the notes from therapists but no specific lengths of time indicated for delivery of therapy.

Nursing Interventions:
A summary of the nursing interventions that patients received is summarised in the chart below. There were 14 patients not receiving defined nursing interventions. Of the 26 recorded nursing interventions some patients were receiving more than one intervention so these are not individual patients, the recorded occasions describes the number of records that had this nursing intervention documented. The majority of these nursing interventions could be provided in other settings (by community nursing service ‘through the door’ in patients own home/usual place of residence). The pressure care/tissue viability could also be maintained by non-nursing staff after a nursing assessment of need.
Red/Green Days:
When assessing these it was difficult to determine these exactly even given the guidance. Therefore we counted red days as –
- when only activities of daily living were recorded in nursing notes as assisted,
- where there were no entries in medical notes or communication notes,
- or the patient was off the ward for ‘non-clinical reason’.

We counted green days as –
- Entries in nursing, communication or medical notes over and above activities of daily living noted (see above assumptions).

The results per unit and overall for Red and Green days identified are shown in table below:
Discharge Planning and Estimated Date Discharge:
There was no clear plan identified in most of the notes for what is to be progressed to achieve discharge. The estimated date of discharge seems to have multiple changes to it during the patients stay.

Advanced Care Plans/Palliative Care:
Choice regarding place of care or place of death was not evidently recorded in any of the patients notes reviewed.

Limitations:
- This was a snap shot in time over the two days.
- The numbers audited are small.
- There was no discussion with the patients or staff which may have filled in some gaps where assumptions were made.

The sample audited from the inpatient bed base was a good representative of a daily total population, but may not be representative of a whole year.

Recommendations:
It is our recommendation that the audit supports a case for change to develop a new model for community beds that will enable the CCG to deliver the type and number of beds that will deliver better outcomes for patients. The audit demonstrated that the type of beds required for most of these patients are the ‘Time to Think’ beds model with domiciliary care support and reablement/rehabilitation services input. Or Discharge to Assess (D2A) ‘home first’ model with input from community therapists and nursing teams who could deliver the reablement/rehabilitation in the patients’ homes in the majority of cases.

It would have been useful to have access to information for the audit regarding what therapy interventions were being received and how many times a day received. It also would have been useful to note in the audit findings on the patients admission how many days they had already had been an inpatient if they came from an Acute Hospital setting (this would be valuable to note for patients total length of stay in their pathway to discharge).

It is recommended that the audit is repeated in November to give a winter picture of the bed utilisation. It should also be noted that the audit team are clinicians however, they are not currently employed by the CCG in clinical roles and therefore, recommend a re-audit with representatives from CCG Nursing and Quality team participation. It may also be beneficial for the providers to also conduct the audit using the same tool as a comparison.

Action:
The information from this audit will be used to inform the Urgent Care Strategy case for change and consultation process.
PRESENT: Councilors Hall (in the Chair), Aitken, L Bayram, Davison, Galbraith, Green, Jefferson, Kingston, Lisseter, Moore, Smith and Steel.

Officers present: Teresa Cope - Chief Operating Officer (Humber NHS Foundation Trust), Linsay Cunningham - Delivery Manager (Healthwatch East Riding of Yorkshire), Quintina Davies - Head of Communications and Engagement (East Riding of Yorkshire Clinical Commissioning Group), Neil Griffiths - Assistant Director - Vulnerable People (East Riding of Yorkshire Clinical Commissioning Group), Jane Hawkard - Chief Officer (East Riding of Yorkshire Clinical Commissioning Group), Claire Holmes - Interim Care Group Director (Humber NHS Foundation Trust), Matthew Kay - Research Officer (Healthwatch East Riding of Yorkshire), Jeremy Newton - Commissioning Manager for Unplanned Care (East Riding of Yorkshire Clinical Commissioning Group), Rosy Pope - Head of Adult Services, Gavin Robinson - Assistant Chief Finance Officer (East Riding of Yorkshire Clinical Commissioning Group), Alex Seale - Director of Commissioning and Transformation (East Riding of Yorkshire Clinical Commissioning Group) and Gareth Naidoo - Senior Committee Manager.

Councillors Healing and Whittle were in attendance and spoke on Minute 458.

Councillors Owen (Deputy Leader) and Harrap (Portfolio Holder for Adult and Carer Services) were in attendance as observers.

Also in attendance: Press - 2 
Public - 1

The Sub-Committee met at County Hall, Beverley.

453 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS - Members made the following declarations:

(i) Councillor Hall declared a non-pecuniary interest in minutes 457, 458 and 459, insofar as she is a member of Driffield Hospital Defence League;
(ii) Councillor Jefferson declared a non-pecuniary interest in minutes 457, 458 and 459, insofar as she is a member of Hornsea and District Health Forum.

URGENT CARE SERVICES CONSULTATION - UPDATE

458 CCG UPDATE - The Sub-Committee received an update on the CCG consultation and response to its recommendations and queries following the previous meeting. Taking part in the discussion was Jane Hawkard - Chief Officer, Alex Seale - Director of Commissioning and Transformation, Jeremy Newton - Commissioning Manager for Unplanned Care, Gavin Robinson - Assistant Chief Finance Officer, and Quintina Davies - Head of Communications and Engagement from ERY CCG.

Following the extraordinary meeting of the Sub-Committee on 14 December, further questions and recommendations were made to the CCG. A response to these questions and recommendations was tabled and discussed.

Bed Modelling Summary
Due to the smaller numbers of patients receiving care in a community hospital bed than visiting a Minor Injury Unit and the type of care needed, it was felt that the approach to modelling future community bed provision required more detailed analysis of clinical appropriateness as opposed to simply reviewing existing activity data and length of stay, etc. The bed audit provided an opportunity to review what care patients required and whether they could be appropriately supported in an alternative environment, ie with wrap-around support in the community. With regards to the community bed modelling summary there were three tabs on the worksheet and the figures on each tab relate to the following:

Tab 1 - Audit Modelling

A total of 44 community beds were occupied. Column E contained the results of the audit that was carried out in June 2016 (34 patients). For the remaining 10 patients who were not audited, the same ratio of the audit results was applied (Column F). The next stage was to apply the demographic growth expected in 2026 to these numbers (in columns I to K) and then an allocation of the 2026 expected numbers to actual bed types (in columns M to P). This tab also contained an explanation of the methodology used.

Tab 2 - Population sizes

This contained the East Riding of Yorkshire data extracted from the 2012-based Sub-national Population Projections for Local Authorities in England by sex and 5 year age groups, all local authorities and higher administrative areas within England. The East Riding data was then summarised to the totals for those aged 70 and older (row 23) and a percentage growth was calculated for this age group to 2026 (cell R23) from 2016 (Cell H23) giving a calculated percentage growth of 32.01% (cell S23). This percentage was then applied to the audited results on Tab 1. At the time of initiating the project, the 2014 based calculations were not available. The population projection data used was available through the following link:

https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

Tab 3 - Audited ages

This tab contained the ages of the patients audited in the community hospital beds. This showed that 85.29% of the patients audited were aged 70 or over and therefore provided the reasoning for using this age group (70+) to determine the demographic growth.

As mentioned in the CCG’s letter to the Sub-Committee dated 2 December 2016, as a further external assurance to the CCG the Council’s Public Health team was asked to review the methodology for modelling bed numbers. This was subsequently conducted and agreed as entirely reasonable, given any unusual unpredictability of future demand. In addition, a further bed audit was undertaken in November 2016 and the findings broadly substantiated the results from the audit undertaken in June 2016 and the results of a previous audit undertaken by NHS England’s Emergency Care Improvement Programme (ECIP) Team in November 2015.

Urgent Care Centre (UCC) demand flow tool v11-2

Question 2(i)

The UCC modelling was carried out using the accident and emergency patient level data for the 2015/16 financial year (1st of April 2015 to 31st March 2016 inclusive). This dataset included the Emergency Department and Minor Injury Unit Data and contained a wealth of patient level information regarding each attendance within that period including diagnosis,
investigations and treatments carried out or not, patient age and registered GP practice, etc. The data was extracted from the Secondary Uses Service (SUS). The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services (http://content.digital.nhs.uk/sus). Because of the detailed data available, it was not felt that an audit would improve the approach to the modelling. However, during the consultation drop-in events the CCG listened to what people had told it about how they used the Minor Injury Units and, in response to this, an audit was currently being undertaken across all the Minor Injury Units. Any additional intelligence received would help inform the CCG’s final decision.

**Question 2(ii)**

People who needed to have follow up-treatment for wound dressings would be expected to attend the planned care services that were currently commissioned within primary and community services. The CCG would not be seeking to commission any additional wound care services.

**Question 2 (iii)**

Members of the CCG’s Governing Body had visited the six hospitals referred to both prior to and during the consultation period. CCG members had experienced first-hand demand of services both in the community hospitals and Minor Injury Units. Many discussions had been held with staff during the consultation period and feedback received would be incorporated into the consultation analysis.

**Recommendations for consideration during the consultation period**

**Question 3(a)**

The CCG was asked to consider re-running its model for Urgent Care Centres, based on current Minor Injury Unit financial costings, in order to provide the Sub-Committee with additional assurance that the modelling was as robust as possible. Unfortunately, this was not possible as the model was created to address the requirements of delivering an Urgent Care Centre operating for 16 hour per day. Updating the model to allow for current activity/parameter modelling would require significant variation to the model and, therefore, would not provide the additional level of assurance that has been requested. However, the CCG confirmed that it had met separately with Councillor Lisseter to discuss the reasons for this in more detail and has also validated the current model outputs against other available data:

- Comparison of the modelled costs in relation to Goole Urgent Care Centre with the current costs of Goole Minor Injury Unit (allowing for appropriate scaling) illustrates that costs were broadly in line with expectation.
- Comparison of the current modelled costs to the costs contained within the Community Services bids again provided a high level of correlation.

**Question 3(b)**

The CCG’s Communications Manager contacted the Council’s Economic Development Team in December 2016 and they had supported the CCG with sending messages out to businesses in the East Riding of Yorkshire area via agreed mechanisms.

Members then discussed the following points:

- Wound clinics - whilst services had evolved over time to undertake regular wound dressings at MIUs this was not deemed core MIU work. Even with the proposed closure of MIUs in Driffield, Hornsea and Withernsea, community services would
continue to support wound dressing as part of the planned care approach, whether this be through the numerous planned wound clinics delivered by the district nurse service across the East Riding.

- Modelling data - the Sub-Committee acknowledged the CCG’s response to it not being able to re-run the model for Urgent Care Centres based on current Minor Injury Unit financial costings. Whilst the Sub-Committee still had some differing of opinions to the CCG regarding the model, nevertheless the Sub-Committee was impressed by the quantity of data run through the model.

- Goole UCC operational hours - one of the options in the consultation was to upgrade Goole MIU to a UCC, however this would be operational for 16 hours a day, rather than the present 24 hour service. Councillor Moore was against the reduction in hours if Goole was upgraded to an UCC and believed this would increase the pressure on the ambulance service. The CCG responded that whilst the 16 hours proposed for the new UCCs was not mandated it was the best practice model nationally and that activity at night at Goole was extremely low. The proposed 16 hours was all about delivering best value and consistent services across the whole of the East Riding.

- Community beds - With current demand on beds at approximately 97 percent capacity in residential care the Sub-Committee expressed concern over the proposed closure of community beds at Bridlington and Withernsea and the need to have in place agreement with residential care homes. The CCG responded that 8 Time to Think beds had already been procured and that the proposed model would take time to be a reality as contracts and agreements would have to be in place first. The CCG would therefore ensure it worked with the care home market to have the necessary beds in place before moving to the proposed new model. The Head of Adult Services confirmed that the CCG was working closely with the Council to ensure a well-managed and planned provision and pathway for the expansion of Time to Think beds across the East Riding.

- Yorkshire Ambulance Service (YAS) - the CCG had met with YAS recently and the ambulance Trust was supportive of the UCC model being proposed by the CCG as the Trust believed this would help retain ambulances in the East Riding. This was because ambulances would be able to take patients to the nearest UCC rather than having to go to Hull Royal Infirmary and get held up there. The CCG would contract for this with YAS if one of the four options was approved.

Agreed - (a) That a detailed list of wound clinics across the East Riding be submitted to the Sub-Committee, and

(b) that the urgent care consultation update be received.

459 WARD COUNCILLOR REPRESENTATION - The Sub-Committee then received representations from Councillor Healing, ward councillor for South East Holderness, Councillor Whittle, ward councillor for North Holderness and Councillor Hall, ward councillor for Driffield and Rural on behalf of their residents over the proposed closure to their local Minor Injuries Unit (MIU).

Withernsea Hospital MIU

Councillor Healing, ward councillor for South East Holderness, made representation to the Sub-Committee regarding the proposed closure of Withernsea Hospital MIU.
A number of petitions from people across the Holderness area, of around 10,000 signatures had been submitted to the CCG in relation to the proposed closure of both Hornsea Cottage Hospital MIU and Withernsea Hospital MIU. In particular, South East Holderness residents believed that the closure of the Withernsea Hospital MIU would have an extreme impact on families and schools. If, during the school day, a child has a minor injury and the parent was not able to collect their child, then at least one member to staff would be required to accompany the child to Hull Royal Infirmary, rather than just going to Withernsea MIU. This was a time and cost resource that schools could not afford.

South East Holderness was a very rural area and had a largely elderly population and the community beds were often used as respite care. It was questioned what would be the human cost should the Withernsea MIU and the community beds be closed. Residents firmly believed that the MIU should be upgraded to a UCC and not closed.

**Hornsea Cottage Hospital MIU**

Councillor Whittle, ward councillor for North Holderness made representation to the Sub-Committee regarding the proposed closure of Hornsea Cottage Hospital MIU.

The omission of options for the Holderness coast was, in the residents’ eyes, a huge mistake by ERY CCG. It was felt that closing the MIU at Hornsea Cottage Hospital would deprive the local area of much needed and loved health care provision.

The proposed closure of the MIU would have an extremely negative impact on local residents and would place an increased time and financial cost on both schools and families. Public transport provision was not frequent from Hornsea to Beverley and would place an added financial burden on families and schools who would be expected to make a 24 mile round trip from Hornsea to Beverley and back.

It was stated that the GP surgery in Hornsea was not supportive of the proposal and was concerned over the expectation placed on the surgery to undertake treatment of minor injuries should Hornsea Cottage Hospital MIU be closed. The surgery believed it did not have the resource to deal with this stream of health care.

It was the residents’ belief that Hornsea Cottage Hospital MIU should not be closed.

**Alfred Bean Hospital MIU, Driffield**

Councillor Hall, ward councillor for Driffield and Rural Councillor made representation to the Sub-Committee regarding the proposed closure of Alfred Bean Hospital MIU.

Driffield Town Council had been working closely with East Riding of Yorkshire Council ward councillors, Greg Knight MP, local GPs, Alfred Bean Hospital League of Friends and the Alfred Bean Hospital Defence League in support of the MIU. An online campaign had been run in conjunction with the local paper Driffield and Wolds Weekly on Facebook, from which 976 emails have been sent to ERY CCG in opposition to the proposals.

In addition the Driffield Town Council had undertaken a campaign and mail out to all YO25 households (an extract of which was read out) which had resulted in 9,039 letters and coupons being returned to the Driffield Town Council via a freepost address.

The CCG’s drop-in consultation event in Driffield had been attended by over 250 people on 10 November 2016. Residents attending this event believed Alfred Bean Hospital to be very accessible for Driffield residents and the villages in the catchment area. It was within walking distance of the town and a bus passed the door every half hour. Residents believed that the CCG should maintain its MIU at Alfred Bean Hospital for the benefit of local residents.
Ward councillors were thanked for their representations. The Chief Officer of ERY CCG reiterated that the consultation was still open until 17 January 2017, that the CCG was continuing to listen to feedback raised and that all representations and responses would be carefully considered by the CCG in making its final decision in March 2017.

**Agreed** - That the views and representations of local residents be received and considered by the Sub-Committee when making its formal response to the consultation.

### 460 OVERVIEW AND SCRUTINY DRAFT RESPONSE TO URGENT CARE SERVICES CONSULTATION

- The Sub-Committee received a presentation from Gareth Naidoo, Senior Committee Manager.

The presentation outlined the draft response, as detailed at Appendix 1 of these minutes, for consideration in the Sub-Committee’s formal response to the ERY CCG’s Urgent Care Services consultation.

**Resolved** - (a) That the points outlined in the presentation be approved, and

(b) that the Chair and Vice-Chair be delegated to approve the final response to the consultation by the Sub-Committee, in consultation with the Director of Corporate Strategy and Commissioning.
Local people care passionately for and value their local NHS services and this has never been more so recognised than during this consultation. The consultation has provided a huge outcry of strong public feeling regarding the consultation options. Representations have been made by the public to this Sub-Committee, ward, town and parish councillors, MPs, the media and GPs. Strength of public opinion for their local services has been encapsulated by the sheer number of signatories to the many petitions established across the East Riding. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee can only but echo East Riding resident’s concerns and fears for their local NHS services and urge East Riding of Yorkshire Clinical Commissioning Group to give these due consideration when making its decision.

The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee do, however, understand the need for change across health and social care sector and recognise the financial challenges facing East Riding of Yorkshire Clinical Commissioning Group set against the context of the Humber, Coast and Vale Sustainability and Transformation Plan and the directive from NHS England for urgent care centres.

Proposed Options for Urgent Care Centres

Summary of Health, Care and Wellbeing Overview and Scrutiny Sub-Committee views

- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee agree there is a need to standardise service provision across the East Riding and support, in principle, the creation and development of Urgent Care Centres across the East Riding.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee believe that the Urgent Care Centre guidance issued by NHS England does not differentiate between very well populated urban settings and large rural areas such as the East Riding. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee believe the guidance issued has been too rigidly applied by East Riding of Yorkshire Clinical Commissioning Group and is not reflective of the East Riding geography, which covers almost 1,000 square miles, and population need.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee do not believe that the options consulted on provide East Riding residents with equal access to quality health and care services.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee do not feel the options consulted on meet all residents’ needs, particularly when taking into account rurality, highways network and transport provision.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee is extremely disappointed that the options consulted on were limited and, for example, did not provide any options for Driffield and the Holderness coast.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee believe that the list of 81 options used for shortlisting did not consider maintaining one Minor Injury Unit (for example in Driffield or along the Holderness coast), or some other form of placed based service, whilst creating two or three Urgent Care Centres. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee believe this to be a missed opportunity in the pre-consultation work and consultation options put forward.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee feel the bespoke model developed by East Riding of Yorkshire Clinical Commissioning Group has not been tested robustly based on current operations and due diligence applied to provide the necessary levels of assurance.
Alternative option proposed by the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

- That the East Riding of Yorkshire Clinical Commissioning Group maintain some place based services in the Driffield, Hornsea and Withernsea even if this means reduced hours - whether this be a Minor Injury Unit, a reduced Urgent Care Centre or something else to meet need, including seasonal variation.

This alternative provision could be funded by re-considering the way place based services are commissioned across the system, for example in the Driffield and Holderness area (ie how community services, ambulance services, patient transport services and primary care services etc. are provided).

Concerns of the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

- The opportunity provided to better understand the modelling process was welcomed by the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee but confidence is still lacking as the model used should have been tested on current financial costs, not on predicted operational costs, to ensure a truer picture. There is therefore a lack of due diligence in the model and the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee do not have the assurance that the options proposed are viable.
- Assumptions in the model are founded on changes being made to primary care but the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee heard that no firm proposals have been agreed by primary care providers. It is evident that some primary care providers are not supportive of the proposals, even though some of these are part of East Riding of Yorkshire Clinical Commissioning Group’s Council of Members, and the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee believe this to be a significant challenge for the East Riding of Yorkshire Clinical Commissioning Group to overcome.
- It would appear that the opportunity has not been taken to develop plans on the proposed options with providers given the changes on the horizon (ie new community services provider and the role of Yorkshire Ambulance Service). The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee is unconvinced that there will be the resources and skilled workforce necessary across the whole of the East Riding and that the opportunity has been missed to consider place based strategic solutions in the first instance before developing the options for consultation.
- Whilst acknowledging that rurality has been considered by East Riding of Yorkshire Clinical Commissioning Group the assumptions in the model show approximately 30 percent of patients will not present anywhere (due to the rural nature of the East Riding, its highways infrastructure and transport provision). This may result in their eventual presentation at Hull Royal Infirmary Accident & Emergency, something that goes against what the options are trying to avoid.

Recommendations:

(i) That East Riding of Yorkshire Clinical Commissioning Group maintains some place based services in the Driffield, Hornsea and Withernsea areas (even if this means reduced hours - whether this be a Minor Injury Unit, a reduced Urgent Care Centre or something else to meet need, including seasonal variation) by re-considering the way place based services are commissioned across the system.

(ii) Providing some place based services in the Driffield, Hornsea and Withernsea area are maintained then the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee would then support the creation of three Urgent Care Centres at Goole, Beverley and Bridlington.
Proposed Options for Wrap-Around Patient Care

Summary of Health, Care and Wellbeing Overview and Scrutiny Sub-Committee views

- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee understand that Option A is the preferred option and that Option B is more for future consideration.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee support, in principle, the further expansion of Time to Think beds across the East Riding but not at the detriment of the Holderness and Bridlington area.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee support, in principle, the development of Home First beds across the East Riding.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee feel that a greater level of understanding and comprehensive assurance over deliverability of the remodelled service is required by East Riding of Yorkshire Clinical Commissioning Group. For example, there has been very limited direct engagement with residential and nursing home providers and the community services workforce to make the vision a reality, particularly across the more rural parts of the East Riding. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee has great reservations that this can be achieved.
- It is felt by the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee that the proposals will have huge knock-on effects for adult social care and limited assurance has been provided that there will be sufficient overall bed capacity in residential care and the workforce needs have been fully considered and understood by East Riding of Yorkshire Clinical Commissioning Group.

Alternative option proposed by the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

- That East Riding of Yorkshire Clinical Commissioning Group reconsiders fully the population needs for community beds and residential and nursing care beds in totality to provide certainty of current and future need given that current demand on beds is very high.

Concerns of the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

- The model data used appears to be limited - a greater degree of sensitivity analysis needs to be undertaken to take into account seasonal variation, ie high and low demand.
- The NHS struggle to recruit and retain staff in the Holderness area. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee cannot envisage how by closing the Withernsea and Bridlington beds will ensure that there will still be adequate workforce and care provision to successfully provide Time to Think beds and Home First beds.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee feel that there has been a lack of meaningful communication and engagement with residential or nursing homes over whether the sector can provide the required number of Home First beds and Time to Think beds.
- It is felt that East Riding of Yorkshire Clinical Commissioning Group has not fully considered the new community services provider operational plan to ensure that there is a sufficiently skilled workforce to cover the Bridlington and Holderness areas should the beds in these locations be closed.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee remain to be convinced regarding bed capacity as the default will be that people will end up at Hull Royal Infirmary because they will be unwilling/unable to travel to Beverley or their nearest Time to Think bed. This will increase demand at Hull Royal Infirmary which goes against what the consultation options are trying to prevent.
- Adult social care will be affected by the proposals and this has not been clearly communicated or considered by East Riding of Yorkshire Clinical Commissioning Group.
Current demand on residential and nursing and community beds is around 97 percent. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee has huge concern that the closure of Bridlington and Withernsea community beds will only exacerbate this problem.

**Recommendations:**

(i) The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee support the principle of what is being proposed in Option A, but not the closure of beds at Bridlington and Withernsea.

(ii) That East Riding of Yorkshire Clinical Commissioning Group fully reconsiders the population needs for community beds and residential and nursing care beds in totality to provide certainty of current and future need, given that current demand on beds is very high.
Dear Jane

Consultation on Urgent Care Services - Health, Care and Wellbeing Overview and Scrutiny Sub-Committee Response

I write on behalf of the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee as a statutory consultee in the Urgent Care Services consultation. Please find enclosed the response to the consultation from the Sub-Committee.

May I take this opportunity to thank the CCG and all its officers that have participated in discussion with the Sub-Committee and provided it with all the relevant and necessary information over the course of the consultation. It has been much appreciated the openness with which the CCG has worked with the Sub-Committee on this matter and for all the support the CCG has provided the Sub-Committee with so that it can make a fully informed response to the consultation. The Sub-Committee thank the CCG for its co-operation and willingness to continue to listen to its concerns on this matter.

I do hope that the CCG, its Council of Members and its Governing Body seriously consider the views, concerns and recommendations of the Sub-Committee raised in the attached response when making its decision, and kindly request that this response is distributed to all Members for their consideration.

The Sub-Committee look forward to receiving the outcome of the consultation and the CCG’s decision in due course and hope to continue its close working relationship with the CCG in the future.

If you require any further information, please do not hesitate to contact me.

Yours sincerely

Gareth Naidoo - Senior Committee Manager
for the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee
Enc. Response of the East Riding of Yorkshire Council’s Health, Care and Wellbeing Overview and Scrutiny Sub-Committee Response to East Riding of Yorkshire Clinical Commissioning Group’s Urgent Care Services Consultation

cc. All East Riding of Yorkshire Clinical Commissioning Group Council of Members
All Members of East Riding of Yorkshire Clinical Commissioning Group Governing Body
Quintina Davies - Head of Communications and Engagement
Local people care passionately for and value their local NHS services and this has never been more so recognised than during this consultation. The consultation has provided a huge outcry of strong public feeling regarding the consultation options. Representations have been made by the public to this Sub-Committee, ward, town and parish councillors, MPs, the media and GPs. Strength of public opinion for their local services has been encapsulated by the sheer number of signatories to the many petitions established across the East Riding. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee can only but echo East Riding resident’s concerns and fears for their local NHS services and urge East Riding of Yorkshire Clinical Commissioning Group to give these due consideration when making its decision.

The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee do, however, understand the need for change across health and social care sector and recognise the financial challenges facing East Riding of Yorkshire Clinical Commissioning Group set against the context of the Humber, Coast and Vale Sustainability and Transformation Plan and the directive from NHS England for urgent care centres.

Proposed Options for Urgent Care Centres

Summary of Health, Care and Wellbeing Overview and Scrutiny Sub-Committee views

- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee agree there is a need to standardise service provision across the East Riding and support, in principle, the creation and development of Urgent Care Centres across the East Riding.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee believe that the Urgent Care Centre guidance issued by NHS England does not differentiate between very well populated urban settings and large rural areas such as the East Riding. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee believe the guidance issued has been too rigidly applied by East Riding of Yorkshire Clinical Commissioning Group and is not reflective of the East Riding geography, which covers almost 1,000 square miles, and population need.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee do not believe that the options consulted on provide East Riding residents with equal access to quality health and care services.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee do not feel the options consulted on meet all residents’ needs, particularly when taking into account rurality, highways network and transport provision.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee is extremely disappointed that the options consulted on were limited and, for example, did not provide any options for Driffield and the Holderness coast.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee believe that the list of 81 options used for shortlisting did not consider maintaining one Minor Injury Unit (for example in Driffield or along the Holderness coast), or some other form of placed based service, whilst creating two or three Urgent Care Centres. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee believe this to be a missed opportunity in the pre-consultation work and consultation options put forward.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee feel the bespoke model developed by East Riding of Yorkshire Clinical Commissioning Group has not been tested robustly based on current operations and due diligence applied to provide the necessary levels of assurance.
Alternative option proposed by the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

- That the East Riding of Yorkshire Clinical Commissioning Group maintain some place based services in the Driffield, Hornsea and Withernsea even if this means reduced hours - whether this be a Minor Injury Unit, a reduced Urgent Care Centre or something else to meet need, including seasonal variation.

This alternative provision could be funded by re-considering the way place based services are commissioned across the system, for example in the Driffield and Holderness area (ie how community services, ambulance services, patient transport services and primary care services etc. are provided).

Concerns of the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

- The opportunity provided to better understand the modelling process was welcomed by the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee but confidence is still lacking as the model used should have been tested on current financial costs, not on predicted operational costs, to ensure a truer picture. There is therefore a lack of due diligence in the model and the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee do not have the assurance that the options proposed are viable.

- Assumptions in the model are founded on changes being made to primary care but the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee heard that no firm proposals have been agreed by primary care providers. It is evident that some primary care providers are not supportive of the proposals, even though some of these are part of East Riding of Yorkshire Clinical Commissioning Group’s Council of Members, and the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee believe this to be a significant challenge for the East Riding of Yorkshire Clinical Commissioning Group to overcome.

- It would appear that the opportunity has not been taken to develop plans on the proposed options with providers given the changes on the horizon (ie new community services provider and the role of Yorkshire Ambulance Service). The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee is unconvinced that there will be the resources and skilled workforce necessary across the whole of the East Riding and that the opportunity has been missed to consider place based strategic solutions in the first instance before developing the options for consultation.

- Whilst acknowledging that rurality has been considered by East Riding of Yorkshire Clinical Commissioning Group the assumptions in the model show approximately 30 percent of patients will not present anywhere (due to the rural nature of the East Riding, its highways infrastructure and transport provision). This may result in their eventual presentation at Hull Royal Infirmary Accident & Emergency, something that goes against what the options are trying to avoid.

Recommendations:

(i) That East Riding of Yorkshire Clinical Commissioning Group maintains some place based services in the Driffield, Hornsea and Withernsea areas (even if this means reduced hours - whether this be a Minor Injury Unit, a reduced Urgent Care Centre or something else to meet need, including seasonal variation) by re-considering the way place based services are commissioned across the system.

(ii) Providing some place based services in the Driffield, Hornsea and Withernsea are maintained then the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee would then support the creation of three Urgent Care Centres at Goole, Beverley and Bridlington.
Proposed Options for Wrap-Around Patient Care

Summary of Health, Care and Wellbeing Overview and Scrutiny Sub-Committee views

- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee understand that Option A is the preferred option and that Option B is more for future consideration.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee support, in principle, the further expansion of Time to Think beds across the East Riding but not at the detriment of the Holderness and Bridlington area.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee support, in principle, the development of Home First beds across the East Riding.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee feel that a greater level of understanding and comprehensive assurance over deliverability of the remodelled service is required by East Riding of Yorkshire Clinical Commissioning Group. For example, there has been very limited direct engagement with residential and nursing home providers and the community services workforce to make the vision a reality, particularly across the more rural parts of the East Riding. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee has great reservations that this can be achieved.
- It is felt by the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee that the proposals will have huge knock-on effects for adult social care and limited assurance has been provided that there will be sufficient overall bed capacity in residential care and the workforce needs have been fully considered and understood by East Riding of Yorkshire Clinical Commissioning Group.

Alternative option proposed by the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

- That East Riding of Yorkshire Clinical Commissioning Group reconsiders fully the population needs for community beds and residential and nursing care beds in totality to provide certainty of current and future need given that current demand on beds is very high.

Concerns of the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

- The model data used appears to be limited - a greater degree of sensitivity analysis needs to be undertaken to take into account seasonal variation, ie high and low demand.
- The NHS struggle to recruit and retain staff in the Holderness area. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee cannot envisage how by closing the Withernsea and Bridlington beds will ensure that there will still be adequate workforce and care provision to successfully provide Time to Think beds and Home First beds.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee feel that there has been a lack of meaningful communication and engagement with residential or nursing homes over whether the sector can provide the required number of Home First beds and Time to Think beds.
- It is felt that East Riding of Yorkshire Clinical Commissioning Group has not fully considered the new community services provider operational plan to ensure that there is a sufficiently skilled workforce to cover the Bridlington and Holderness areas should the beds in these locations be closed.
- The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee remain to be convinced regarding bed capacity as the default will be that people will end up at Hull Royal Infirmary because they will be unwilling/unable to travel to Beverley or their nearest Time to Think bed. This will increase demand at Hull Royal Infirmary which goes against what the consultation options are trying to prevent.
- Adult social care will be affected by the proposals and this has not been clearly communicated or considered by East Riding of Yorkshire Clinical Commissioning Group.
Current demand on residential and nursing and community beds is around 97 percent. The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee has huge concern that the closure of Bridlington and Withernsea community beds will only exacerbate this problem.

**Recommendations:**

(i) The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee support the principle of what is being proposed in Option A, but not the closure of beds at Bridlington and Withernsea.

(ii) That East Riding of Yorkshire Clinical Commissioning Group fully reconsiders the population needs for community beds and residential and nursing care beds in totality to provide certainty of current and future need, given that current demand on beds is very high.
Dear Gareth

Consultation on Urgent Care Services – Health Care and Wellbeing Overview and Scrutiny Sub-Committee Response

Thank you for your letter dated 13 January 2017 in which you set out the formal response from the Health Care and Wellbeing Overview and Scrutiny Sub-Committee to our Consultation on Urgent Care Services. As requested, I can confirm that your response has been shared with Governing Body members as well as distributed to our Council of Members representatives. In addition, your comments will form part of the consultation feedback report and recommendations formally taken into consideration as part of the CCGs final decisions. We have already met with Sub-Committee members and responded to a number of queries during the consultation period and, hopefully, you will also find the supplementary information provided below useful.

Proposed options for Urgent Care Centres

Response to Sub-Committee Member Views and Concerns:

- **Standardisation** – I am pleased to note that the Sub-Committee agrees there is a need to standardise service provision across the East Riding and that you support, in principle, the creation of Urgent Care Centres.

- **National Guidance** – As we have publicly stated, we are not required to follow the national guidance. However, we are using this as a good practice guide and have already carefully considered the clinical impact of this in the context of the East Riding area when developing our proposals. The rural nature of the East Riding has been considered in terms of the provision of a number of Urgent Care Centres across the patch rather than a single Urgent Care Centre as may suit urban areas. In applying the national best practice on opening hours we believe that we can offer a much improved alternative to Accident & Emergency (A&E) for minors activity.

- **Access** – The clinical aspiration is to provide a safe, high quality and consistent walk-in urgent care offering for everyone across the East Riding. We are confident that the options presented provide improved services, over and above that which the MIUs can currently provide, and give improved access to urgent care services. The impact on some longer travel times has been considered during the development of our plans, alongside clinical risk and improved pathways from NHS 111. This has been externally reviewed by clinicians via the Yorkshire and Humber Clinical Senate.

- **Transport** – As you are no doubt aware, the CCG has a statutory duty to provide transport for patients with a clinical need and this is available for both emergency and planned patient journeys. There is a robust system in place for Yorkshire Ambulance Service (YAS) to clinically triage patients to decide what level of ambulance conveyance might be required. The NHS 111 service has been improved through a new specification which includes more clinical input to improve advice to callers in areas such as mental health and
dental as well as urgent care. Ambulance crews would be able, and YAS has confirmed their commitment, to take patients to Urgent Care Centres instead of A&E, if clinically appropriate, keeping the vehicles and crews in the East Riding area. This is not possible with the current MIU system due to lack of a consistent urgent care offer. The East Riding of Yorkshire Council is also a key stakeholder and is aware of the CCG’s proposed options so they can factor this into their future plans for public and community transport.

- **Options for consultation** – as mentioned to you in our letter dated 2 December 2016, we considered 81 potential scenarios for Urgent Care Centres. All the potential scenarios were tested and scored using the agreed, weighted criteria. Those that proved to be realistic potential options were then costed using the fifth and final test regarding value for money, which helped us to identify our options for formal consultation. Only when we had a list of the possible alternatives that would provide the best outcomes for patients did we consider what those services would cost. That left us with nine costed and scored alternatives, which we put through a value for money test as we are required to do. Our top 9 potential scenarios included the option of introducing an Urgent Care Centre at either Driffield, Hornsea or Withernsea, however, these do not feature in any of our four proposed options for public consultation, because they didn’t pass our value for money test.

- **Consider maintaining one Minor Injury Unit alongside Urgent Care Centres** – The clinical aspiration is to provide a safe, high quality and consistent walk-in urgent care offering for everyone across the East Riding. We believe that this scenario would lead to an inconsistent service, does not meet the tests in the criteria and would add to confusion about the most appropriate service to access.

- **Modelling tool** - The Urgent Care Centre modelling was carried out using the accident and emergency patient level data for the 2015/16 financial year (1st of April 2015 to 31st March 2016 inclusive). This dataset included the Emergency Department and Minor Injury Unit Data and contained a wealth of patient level information regarding each attendance within that period including diagnosis, investigations and treatments carried out or not, patient age and registered GP practice. We have discussed and demonstrated the modelling tool in detail to assure Sub-Committee members of its robustness. We have explained why the tool cannot be tested on current financial costs as it would require significant variation to the model but we confirmed that we have validated the current model outputs against other available financial data. We understood that the Sub-Committee Members fully appreciated this aspect of the modelling following very detailed analysis by Members, indeed the committee verbally acknowledged the detailed work that had been completed in developing the model and commended the CCG for this.

- **Impact on Primary Care** – I would like to reiterate the CCG’s commitment to work with primary care to mitigate impacts of any proposed changes and dialogue with GP practices has been on-going for some considerable time through the development of the urgent care strategy with representatives of the Council of Members. We acknowledged that there is an explicit need to consider mitigating actions that could be deployed to manage extra demand on the practices should the urgent care proposals become a reality. The CCG modelling of activity calculates a possible maximum increase of demand on primary care of around 4 extra patients for each practice (located near a current MIU) a day.

- **Impact on Accident and Emergency** – The CCG’s modelling data shows that ‘lost’ activity might actually be much greater than 30% since, when comparing current activity in areas within close proximity to a Minor Injury Unit to those areas not in close proximity to a Minor Injury Unit, the rates of A&E attendance are the same.

**Proposed options for Wrap-Around Patient Care**

Response to Sub-Committee Member Views and Concerns:

- **Time to Think Beds** – I am pleased to note that the Sub-Committee supports, in principle, the further expansion of Time to Think beds across the East Riding but note your concern regarding Holderness and Bridlington.

- **Home First approach** – I am also pleased to note that the Sub-Committee supports, in principle, the development of Home First beds across the East Riding.
• **Deliverability** – We have undertaken a market testing exercise with residential and nursing homes to assess availability of numbers and types of beds as well as capability to deliver the proposed service model. The CCG is both confident and assured that the proposed options for wrap-around patient care would be deliverable in 2017/18 should plans be approved. Representatives from residential and nursing homes and community services provider organisations were key members of the stakeholder forum and involved in developing the process.

• **Overall bed capacity** – We have been working closely with the Head of Adult Services at East Riding of Yorkshire Council in developing our proposals and are confident that our proposals could help to stimulate and sustain the residential care home market in the longer term. We are also testing the residential care home market in the East Riding to understand the viability of which care homes have the capacity and capability to deliver new models of wrap-around patient care, proposed as part of our Urgent Care consultation. Any implementation of our proposals will be subject to the outcomes of our consultation and a detailed mobilisation plan which will take into account the availability of beds and an appropriate phased approach. We are also committed to work together with the Local Authority to ultimately deliver a sustainable care home market with the right size capacity for East Riding.

• **Modelling tool** – As mentioned in our letter to you dated 6 January 2017, the approach to modelling future community bed provision required more detailed analysis of clinical appropriateness as opposed to simply reviewing existing activity data and length of stay, etc. The bed audit provided an opportunity to review what care patients required and whether they could be appropriately supported in an alternative environment, ie with wrap-around support in the community. As a further external assurance to the CCG the East Riding of Yorkshire Council Public Health function was asked to review the methodology for modelling bed numbers. This was subsequently conducted and agreed as entirely reasonable, given any unusual unpredictability of future demand. In addition, a further bed audit was undertaken in November 2016 and the findings broadly substantiated the results from the audit undertaken in June 2016 and the results of a previous audit undertaken by NHS England’s Emergency Care Improvement Programme (ECIP) Team in November 2015.

• **Workforce** – We want to invest in the local workforce to improve intensive rehabilitation services so more people can be supported back to independence sooner, in their own home. The CCG is confident that the provider will be able to re-deploy staff who already work in these roles and develop capacity, where required. Any implementation of our proposals will be subject to the outcomes of our consultation and a detailed mobilisation plan which will take into account the availability of workforce and an appropriate phased approach.

• **Bed Capacity** – We have successfully piloted Time to Think beds and are confident that the capacity is available to deliver this model. The CCG would be working closely with the care home market to develop and implement this new model, following the outcome of the public consultation. The CCG is also confident that these plans will offer more flexibility across the East Riding, especially during times of higher demand such as winter.

Finally, as you are aware, our Consultation formally closed on 17 January 2017 and we are now in the process of having all the feedback independently analysed. We are also examining all the alternative proposals we have received and taking the time to carefully consider everything we have heard before we make any final decisions. A report of the analysis will be shared with you in early March 2017 to provide Sub-Committee members with the opportunity to provide any additional comments, should you feel this further influences your views on our consultation proposals, prior to the CCG’s Governing Body making its final decisions in public on 21 March 2017.
Thank you for your ongoing support in scrutinising our proposals so that we can improve urgent care services for the whole of the East Riding.

Yours sincerely,

Jane Hawkard
Chief Officer
Dear Jane

Re: Consultation on Urgent Care Services - Health, Care and Wellbeing Overview and Scrutiny Sub-Committee Response

Thank you for your letter dated 7 March 2017 in response to the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee’s views and concerns raised in its formal response to the above consultation. The Sub-Committee appreciates the supplementary information you have provided and also thanks you for the opportunity to have sight of the Improving Urgent Care Services Consultation Report March 2017 prior to the Governing Body meeting on 21 March, although the Chairman would like me to express her concern regarding the short deadline the Sub-Committee have had to digest this report and respond accordingly.

That withstanding the Sub-Committee do not feel the information contained within the Improving Urgent Care Services Consultation Report March 2017 or your letter dated 7 March changes its views and therefore the recommendations, comments and concerns expressed in the formal response letter dated 13 January 2017 remain unaltered.

Having considered the Improving Urgent Care Services Consultation Report March 2017, the Sub-Committee would, however, like to make the following points:

**Urgent Care Centres**

**Transport**

In your letter dated 7 March, regarding ‘Transport’ you state “Ambulance crews would be able, and YAS has confirmed their commitment, to take patients to Urgent Care Centres instead of A&E, if clinically appropriate.” At its meeting of 7 March the Sub-Committee received a presentation from representatives of Yorkshire Ambulance Service NHS Trust who stated that emergency ambulances would not be used to take patients to Urgent Care Centres. There appears therefore to be difference in opinion regarding ambulances taking patients to urgent care centres. Also the Improving Urgent Care Services Consultation Report March 2017 does not appear to record or identify any submissions by Yorkshire Ambulance Service as it has done for other stakeholders.
Modelling tool

Whilst the Sub-Committee appreciates your response and explanation that the tool cannot be tested on current financial costs as it would require significant variation to the model, the Sub-Committee still believes that this is not actually a model but rather an estimating tool and should not be relied upon as a model for implementing the proposed changes.

Wrap-Around Patient Care

Overall bed capacity

With respect of the availability of bed spaces and provision for the new care proposals these do not appear to be supported by any submissions by residential care providers.

The Sub-Committee will follow the outcome of the Governing Body’s decision with much interest and look forward to welcoming you and your colleagues to Sub-Committee meeting of 4 April 2017 to receive the outcome report.

If you have any queries, please do not hesitate to contact me.

Yours sincerely

Gareth Naidoo - Senior Committee Manager
for the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee
Dear Gareth,

Consultation on Urgent Care Services – Health Care and Wellbeing Overview and Scrutiny Sub-Committee Response

Thank you for your letter dated 14 March 2017 in which you confirm that the Sub-Committee does not feel that the information contained within the *Improving Urgent Care Services Consultation Report March 2017* or our letter dated 7 March 2017 changes its views and therefore the recommendations previously sent to us remain unaltered. I have ensured that the further comments in your response are considered by the Governing Body before it meets in public on 21 March 2017.

I look forward to sharing the outcome of the Governing Body’s decisions relating to urgent care services with Sub-Committee members at the HOSC meeting on 4 April 2017.

If you have any queries, please do not hesitate to contact me.

Yours sincerely,

Jane Hawkard
Chief Officer
PRESENT: Councillors Hall (in the Chair), Aitken, L Bayram, Davison, Galbraith, Green, Jefferson, Kingston, Lisseter, Moore, Smith and Steel.

Officers present: Chris Clarke - Senior Commissioning Manager (NHS England), Tracey Craggs - Assistant Director - Unplanned Care Transformation (East Riding of Yorkshire Clinical Commissioning Group), Martin Dale - Strategic Project Manager (Tees, Esk and Wear Valleys NHS Foundation Trust) Quintina Davies - Head of Communications and Engagement (East Riding of Yorkshire Clinical Commissioning Group), Jane Hawkard - Chief Officer (East Riding of Yorkshire Clinical Commissioning Group), Paul Howatson - Head of Joint Programmes (Vale of York Clinical Commissioning Group), Caroline Maw - Practice Manager (Walkergate Surgery), Alex Seale - Director of Commissioning and Transformation, John Skidmore - Director of Corporate Strategy and Commissioning, Deborah Smithson - Cottingham Practice, Alison Finn - Senior Committee Manager and Gareth Naidoo - Senior Committee Manager.

Councillors Owen (Deputy Leader), Healing and Whittle were in attendance as observers.

Also in attendance: Press - 1
Public - 9

The Sub-Committee met at County Hall, Beverley.

476 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS -
Members made the following declarations:

(i) Councillor Hall declared a non-pecuniary interest in minute 478 insofar as she is a member of Driffield Hospital Defence League;

(ii) Councillor Jefferson declared a non-pecuniary interest in minute 478 insofar as she is a member of Hornsea & District Health Forum.

478 URGENT CARE SERVICES - CONSULTATION OUTCOME - The Sub-Committee received a report of the Chief Officer of East Riding of Yorkshire Clinical Commissioning Group, presented by Jane Hawkard, Chief Officer. Also taking part in the discussion of this item was Tracey Craggs, Assistant Director (Unplanned Care Transformation), Quintina Davies, Head of Communications and Engagement and Alex Seale, Director of Commissioning and Transformation.

A formal public consultation was undertaken on the future service options for urgent care in the East Riding of Yorkshire; specifically Urgent Care Centres and Community Beds/Wrap Around Patient Care to inform future commissioning arrangements to help meet the outcomes required by East Riding of Yorkshire Clinical Commissioning Group’s (CCG) Urgent Care Strategy.

The report (Part A) and appendices (Part B) considered by the CCG’s Governing Body when making its decisions on 21 March 2017, as deposited in group offices and public deposit points, included the wide range of evidence and views of patients, public and staff. The CCG had regularly consulted and met with the Sub-Committee before and during the consultation and considered its recommendations as part of its decision making.
After careful consideration of all the evidence presented and the views of patients, public and staff collected during the public consultation exercise, the following final decisions were made by the CCG’s Governing Body on 21 March 2017:

**Introducing urgent care centres**

The decision made by the CCG Governing Body was to:

Create Three Urgent Care Centres at East Riding Community Hospital in Beverley, at Bridlington Hospital and at Goole District Hospital.

Together with - providing urgent care appointments for low level minor injuries at 8-8 centres at Driffield and Withernsea to be booked into via NHS111/Single Point of Access and undertaking the actions set out in the CCG’s full responses by locality. These provisions are made because Governing Body has listened to the concerns of local people during the consultation process.

These would replace the current minor injury units across the region.

**Improving community beds/wrap-around patient care**

The decision made by the CCG Governing Body was to:

Create an integrated community and intensive rehabilitation centre in a single location, at Beverley supported by 15 Time to Think Beds.

Together with the following actions:

1. The location of time to think beds at Bridlington and South Holderness specifically.
2. The availability of an additional 10 time to think beds during the transition period.
4. The review of palliative care services to ensure the provision of service that meets the needs of individuals.

This meant that community hospital beds at Bridlington and Withernsea Hospitals would close and the CCG would be able to support more people in, or close to, their own home, refocusing resources into community teams.

The potential impacts of these changes on people with characteristics protected by the equality act were presented in full in the Equality Impact Assessment (EIA), which Governing Body members had considered.

The changes to urgent care services were expected to be implemented over the next six to nine months, in a managed way to minimise impact to patient care.

Through the implementation of the recommended service model the CCG felt it would be able to provide consistent and high quality urgent care services that best meet the health needs of the people of the East Riding.

The urgent care centres at Beverley, Bridlington and Goole the CCG believed would offer consistent opening for 16 hours a day, 365 days a year. There would be a consistent range of advice and treatment available, including access to x-ray for all minor injuries with no variation between centres. People would know that when they arrived at an urgent care centre it would be open and they would be seen.
The three urgent care centres would be supported by booked urgent care appointments for low level minor injuries, made available at Alfred Bean Hospital in Driffield and at Withernsea Community Hospital via NHS111.

The new model of community beds with wrap-around care would provide intensive rehabilitation and support for people with more complex nursing needs and would also provide Time to Think Beds to support earlier discharge from acute hospital care. Time to Think Beds would be based in residential homes and be used by people who were medically fit whilst they were waiting for complex care packages to be put into place to allow them to return home.

Tracey Craggs, Assistant Director (Unplanned Care Transformation) and Alex Seale, Director of Commissioning and Transformation of East Riding of Yorkshire Clinical Commissioning Group then tabled answers to specific questions raised in advance of the meeting by the Sub-Committee (as attached at Appendix 1).

Members then discussed the following points:

- Petitions and letters received by the CCG - Members queried why petitions and generic letters submitted to the CCG in response to the consultation were not given adequate weighting. Members felt that the CCG Governing Body, at its meeting on 21 March 2017, had not given due consideration to the 24,691 total signatures of petitions/letters submitted in response to the consultation proposals. The CCG advised that all petitions and generic letters were taken into account and had been included in the independent feedback analysis report. All these documents had been uploaded onto the CCG website for the public to view and were referenced in the Part A report submitted to the CCG Governing Body.

- Doctor provision at Goole Urgent Care Centre (UCC) - There was a discussion around staffing at Goole UCC. It was confirmed that a doctor would still be present in the UCC for the 16 hours the unit was open and then the GP’s out of hours service would be available and accessed through NHS111 (which was no change to the current out of hours service arrangements).

- Planned care at 8-8 centres at Driffield and Withernsea Hospitals - The new community services provider (City Health Care Partnership) contract had commenced on 1 April 2017. This now included the establishment of 8-8 centres at Alfred Bean Hospital and Withernsea Hospital from which planned and proactive community services (such as wound clinics, therapy services etc.) would continue to be provided, with the view to expanding this offer in the future.

- Unplanned care at 8-8 Centres in Driffield and Withernsea - In response to the consultation feedback, the CCG had discussed options with City Health Care Partnership and agreed to make appointments available at the 8-8 centres for people with low level minor injuries to access. Appointments could be booked via NHS111 and had been scheduled approximately one per hour (but these could be flexible and increased over peak times if necessary). 8-8 centres would not have a doctor on site but would be staffed by skilled nurse practitioners.

- Additional funding for GP services - There were no plans to provide additional funding to General Practices to support the 8-8 centres as this was not required (the current Minor Injury Units at Driffield and Withernsea were nurse-led). However, the CCG was making £20,000 transitional funding available to each of the General Practices in Driffield, Hornsea and Withernsea to support navigation and signposting to help public understand how to access the new system.
Consultation process and procurement of services - A member questioned why the CCG had procured services and awarded the community services contract prior to the outcome of the consultation and whether additional provision was included in the contracts to allow for extra services following the consultation outcome. The CCG advised that during the final stage of the procurement the bidding organisations were asked to submit bids on the basis of three urgent care centres. This was to ensure that the bidders had a level playing field in terms of considering staff and financial resource but the CCG made it clear that the proposals were subject to the outcome of the consultation and any changes to the proposed options would be addressed with the successful bidder following the consultation. Those tendering for the community services contract were not asked to bid on retaining services that were not included in the consultation options.

Yorkshire Ambulance Service (YAS) - At its meeting of 7 March 2017 the Sub-Committee received an update from YAS. At that meeting the Sub-Committee was advised that Trust ambulances were for triaged emergency incidents only and therefore would not deliver patients to UCCs as they did not deal with emergency cases. This seemingly went against what the CCG had stated throughout the consultation. The CCG reiterated that attendees of YAS at the Sub-Committee meeting of 7 March 2017 were very new in post at the time of attending, had not been suitably briefed on the latest position and that the CCG had agreement from the Chief Executive of the Ambulance Trust that ambulances would take patients to UCCs if appropriate. The CCG reiterated that the Trust had been consulted as part of the consultation process and had shown support to the proposals by participating in the video shown at the drop-in consultation events and available on the CCG’s website.

Hornsea Cottage Hospital Minor Injury Unit (MIU) - It was questioned why it had been determined to close the MIU at Hornsea Cottage Hospital and what would become of the X-ray facilities on site there. The CCG confirmed that X-ray facilities would not be affected by the MIU closure as the X-ray facilities would remain in place, as was the current arrangement at the hospital, to support the outpatient clinics. The CCG reiterated that the reason for the closure of the MIU at Hornsea was due to low patient footfall, numbers attending, many of whom could have been treated as part of planned care arrangements (such as wound dressing) or triaged over the telephone and provided with advice and guidance.

Holderness area - representations had been made to the Sub-Committee from Holderness Health Alliance, which represented the practices of Hedon, Hornsea Withernsea, that expressed extreme disappointment with the decision taken by the CCG and, together with Members of the Sub-Committee, felt that the CCG had failed to listen to the concerns raised by primary care providers and residents in the Holderness area (66 percent of respondents in the Holderness area did not support the proposals). It was felt that decision taken by the CCG substantially reduced services to nearly 50,000 patients in Holderness, whilst enhancing the service across the rest of the CCG area. In so doing, the patients with the highest health needs and lowest access to transport would lose out and therefore impact further on their health. The CCG responded that it had considered consultation feedback, health need and transport when making its decisions. The CCG had visited the GPs in Holderness and were specifically responding by introducing the urgent appointments at Withernsea 8-8, looking at a transport solution for Withernsea through the YorMed service because of low car ownership identified in Withernsea, as well as increasing advice and signposting. The CCG was making £20,000 transitional funding available to each of the General Practices in Driffield, Hornsea and Withernsea to support navigation and signposting to the new system but
acknowledged that the GPs would not receive any further financial support once the MIUs closed because this would not be required due to the units being nurse led.

The CCG stated that it had to consider changes that would provide a fair and equal service for the East Riding as a whole and believed that the decisions made were the best fit overall for everyone although it accepted that some residents would be displeased with having to travel further to access health services that had previously been closer to home.

Since the CCG Governing Body had made its decision, the Sub-Committee had received letters from the following individuals and organisations expressing extreme disappointment and disagreement with the decision:

- Letter from a disabled activist
- Letter from Driffield Hospital Defence League
- Letter from Driffield Town Council
- Letter from Graham Stuart MP & Sir Greg Knight MP
- Letter from Hornsea Cottage Hospital League of Friends
- Letter from Holderness Health Alliance
- Letter from Withernsea Town Council

After giving due consideration to the information provided and statements made by the CCG the Sub-Committee determined that the proposals were not in the best interest of East Riding residents as the new arrangements would create inequality of service across the CCG area, with residents in the Holderness area suffering the most. The Sub-Committee went on to further outline its concerns with the decision taken by the CCG’s Governing Body at its meeting of 21 March 2017:

**Predetermination**

It appeared to the Sub-Committee that the CCG had already effectively committed to the closure of MIUs at Driffield, Hornsea and Withernsea and the closure of community beds at Bridlington and Withernsea prior to the consultation had started as there was no provision within the new community services contract (that was out for tender at the same time as the urgent care services consultation) to retain MIU services or community bed provision in those areas. The Sub-Committee therefore believed the CCG had been predetermined in its decision from the start of the consultation.

**Modelling and financial planning**

The Sub-Committee acknowledged that a considerable amount of detailed work had been undertaken by the CCG in developing its prediction model and there had been engagement with the Sub-Committee and its members during the consultation. As stated previously, however, the Sub-Committee do not believe this to be a tried and tested model but rather an estimation tool which has not been tested on current financial costs but rather against predicted operational costs. There is therefore a lack of due diligence in the model and the Sub-Committee did not have the assurance that the model had produced to ensure a true picture of demand and need.

Assumptions had been made about number of patients and usage at the new UCCs yet these assumptions, which have some basis in theory, did not seem to be proven in similar situations elsewhere. Rather than the predicted reduction in minor injuries actually presenting at UCCs there could be a significant increase in the number of people presenting at A&E.
Topography

The Sub-Committee believed that the CCG had given inadequate consideration to topography of the East Riding and in particular the impact on residents having to travel further to access services. Travel time, deprivation and car ownership for those in the most eastern parts of Holderness meant that the decision taken by the CCG to close beds and MIUs in Holderness was denying access to services for residents in those areas.

Consultation with stakeholders

The CCG had placed great emphasis on the importance of stakeholder engagement throughout the consultation yet it was noted that both YAS and private residential care providers were conspicuous by their absence in the Urgent Care Consultation and Response Report for Consideration and Decision by the Governing Body (Part A) March 21st 2017. As previously stated, the Sub-Committee believed that there were no agreed protocols in place with YAS nor the residential care home sector. The Sub-Committee had not seen any documental evidence throughout and after the consultation process that confirmed arrangements or protocols had been agreed with YAS or residential care homes. The miscommunication/misunderstanding between YAS and the CCG regarding ambulances taking patients to UCCs highlighted to the Sub-Committee that verbal discussions fell far below an acceptable standard of engagement and assurance necessary to base proposals on.

The Council was in a position to know the availability of beds in the residential sector and had already advised the CCG of the very low level of the availability of such. The Sub-Committee believed there to be limited evidence to support the CCG’s case that there were the required number and standard of beds available across the East Riding to successfully implement Time to Think beds.

Mitigation

At the CCG Governing Body meeting of 21 March 2017, a report on the financial position and forward plan was presented. It was revealed that the CCG would be in deficit in the current year and was planning for to run at an increased deficit (in excess of £6 million) for the near future with a view to implementing changes further in the future that would recover this position. Members felt there were financial weakness in the modelling and combined with the future financial projections of the CCG, it would appear that the CCG has committed to a course of action for which there is no plan financial mitigation in place should the outcomes differ in reality from the estimates. The Sub-Committee has placed particular emphasis on the importance of having mitigation measures in place in case of such eventualities before the changes are implemented.

Agreed - That the Sub-Committee acknowledge that East Riding of Yorkshire Clinical Commissioning Group has attempted to act in the most part on its recommendations but believe the outcome is not in the best interest for East Riding residents as a whole.

Resolved - That the Sub-Committee does not support the decision taken by East Riding of Yorkshire Clinical Commissioning Group on the introduction of urgent care centres and improving community beds/wrap-around patient care following the consultation as it considers the proposals are not in the interests of the health service across the East Riding and therefore refer these decisions to the Secretary of State for Health.

Voting was by way of a recorded vote as follows:

For: Councillors Aitken, L Bayram, Davison, Galbraith, Green, Hall, Jefferson, Kingston, Lisseter, Moore, Smith and Steel.
Against: None.

Abstentions: None.

For - 12

Against - 0

Abstentions - 0

Following the resolution, the Chief Officer expressed her disappointment in the decision made by the Sub-Committee to refer to CCG’s decisions to the Secretary of State and reiterated that the CCG believed it had made its decision in the best interests of East Riding residents. The Chief Officer offered to arrange a future meeting with the Sub-Committee to discuss their concerns further along with and Chief Executive of Yorkshire Ambulance Service to provide evidence of the ambulance trust’s agreed working arrangements with the CCG with regard to taking patients to UCCs. The Sub-Committee accepted this offer but, notwithstanding the offer, the resolution still stood and the referral would still be made to the Secretary of State in the first instance because the Sub-Committee wished for the Secretary of State to put on hold the CCG’s implementation plans until he could make a decision; there was no indication from the CCG that it would be willing to place on hold its implementation plans whilst the Secretary of State considered the Sub-Committee’s referral.
Urgent Care

1. What is the 8-8 service and how does it work? What is the difference between Hessle and that being proposed at Driffield and Withernsea?

These are bases for community services teams and will include a range of clinics to support planned and proactive care management.
- Planned care / Wound clinics – changing dressings, removal of stiches
- Therapy services (podiatry, dietetics, speech and language, occupational therapy, reablement and rehabilitation, falls service
- Community link workers / social prescribing (help reduce social isolation by sign posting people to non-clinical activities in their local community
- Musculoskeletal services

For Driffield and Withernsea, there will be a number of urgent appointments made available for people with low level minor injuries and common minor ailments (i.e. patient suffers minor injury could ring NHS 111 and be triaged if clinically appropriate to an 8 to 8).

Hessle will be an 8-8 centre base for community services teams but will not have urgent appointments available for low level minor injuries due to its proximity to UCCs and A&E.

2. What exactly is low level minor injury and how does this differ from injuries dealt with by the minor injury units?

- Insect and animal bites
- Sprains and strains
- Minor burns and scalds
- Cuts and grazes
- Minor bumps and bruises

These will not deal with simple fractures.

3. How exactly will appointments for low level minor injury services/GP services be made via NHS111?

Patients will contact NHS111 who will follow a ‘pathways tool’ to identify appropriate course of action. The Directory of Service will identify the preferred option either directing to an Urgent Care Centre or the Care Co-ordination Centre which will book an urgent appointment at the 8-8 centre.

4. How will people be educated to call NHS111?

There will be a detailed communications plan and marketing campaign advertising the new Urgent Care system. This will include leaflets, social media and information to households, etc.

(i) How can the reputation and image of NHS111 be improved as some people have used the service in the past but will not anymore?

There are many people who successfully use NHS111 and report a good experience of this service. The consistent offering and opening hours at Urgent Care Centres, as well as the improved clinical support available through NHS111, will enhance the advice provided. We will work with NHS111
Appendix 1

to promote positive patient stories. Over time this will help build confidence in NHS111 for those people who may have had varied experience in the past.

5. **Seasonal visitors not registered with GPs, how will they know what to do? They may still present direct at the local hospital. What is the plan for signage for the community hospitals?**

In terms of seasonal variation, we have reviewed the total activity (STP plus non-STP area) per day at each of the six current Minor Injury Units (MIUs) over the 2015/16 financial year. The biggest influx of ERYCCG registered and non-ERY CGG registered patients occurs in Bridlington in the summer months, an increase of 350 more attendances for non-ERYCCG patients in August than in April, May, June and September. Bridlington will have an Urgent Care Centre for seasonal visitors to access 16 hours a day.

As part of the planned marketing campaign, we will target holiday resorts and caravan parks so they are aware of the services that are available to them. For those people who present direct at the local hospital, we will arrange for clear signposting information to be available. We are also making transitional funding available to support navigation and signposting via GP practices.

We will work with the local authority regarding any required changes to road signage.

6. **If 8-8 service provided at Driffield and Withernsea, why not also at Hornsea?**

This decision is based on patient demand, clinical need and taking into consideration levels of deprivation.

Our data shows that there are low numbers of people attending the MIU in Hornsea – less than 10 a day. Many of those could be seen within planned community services, such as repeat wound dressing (which would continue to be available in Hornsea) or advice and guidance which can be offered through NHS 111.

Our community services provider will be using Hornsea as a base for community services and they are working with the local medical practice to look at how they can continue to meet the need of the local population in that area and maximise the use of Hornsea Cottage Hospital as a community asset.

7. **How much additional funding/resource/support will GPs get to support the 8-8 service. What happens after a year, how will they be able to continue this service?**

None. The 8-8 service is part of the community services contract. We are making transitional funding available to support navigation and signposting via GP practices to educate people on accessing the changed services.

8. **What changes will happen at Goole - are they losing a GP?**

Goole will have an Urgent Care Centre that is open 16 hours a day. This will include access to medical input.

9. **Has consideration be given to providing transport to people in Driffield, Hornsea and Withernsea to take them to an UCC?**

Yes, consideration has given to transport arrangements, including availability of public transport and car ownership.
The CCG has a responsibility to ensure appropriate transportation for people who are in medical need of emergency and planned care and service provision for these areas is commissioned appropriately.

The CCG does not have responsibility to commission transport for people with minor injuries/minor illness however, in listening to the population we have considered what we could do to minimise the impact on local people in those areas where MIU’s and Community Beds are recommended to close. Where there is an urgent clinical need, we are specifically looking at a transport solution for Withernsea through the YorMed service because of low car ownership identified in Withernsea at 66.7% (average for ERY is 82.4%). We are also working with Humberside Fire and Rescue Service regarding potential solutions for people with an urgent need.

10. Name of ‘Urgent Care Centres’ not particularly intuitive to the public – can they not be renamed to something more easily understood?

In order to reduce confusion, the name of the Centres will be consistent with others that are in place across the country. The latest guidance suggests this is likely to be ‘Urgent Treatment Centres’.

Community beds/Wrap around patient care

1. Will East Riding Community Hospital in Beverley have increased bed capacity when creating an integrated community and intensive rehabilitation centre?

The modelling identifies a need for 29 beds to be available at East Riding Community Hospital in Beverley. This allows for changes in demographic growth up to 2026.

2. What will happen to palliative care beds at Beverley, Withernsea and Bridlington - are these being replaced by Time to Think beds?

Palliative care is when there is no longer a cure and the emphasis moves into achievement of the best quality of life for patients and their families for the time they have left. Many palliative care patients are already supported at home, with through the door nursing care.

Where appropriate, there will be access to palliative care beds at East Riding Community Hospital in Beverley. In addition, there will be a number of nursing or residential home beds with palliative wrap-around care, including Macmillan and Marie Curie support. We are looking to specifically introduce these in Holderness and Bridlington.

We will also be reviewing palliative care service provision in Bridlington and Withernsea.
Appendix 4

Letters received by the Sub-Committee expressing extreme disappointment and disagreement with the ERY CCG’s Governing Body decision

- Letter from Graham Stuart MP & Sir Greg Knight MP (page 95 - 96)
- Letter from Holderness Health Alliance (page 97)
- Letter from Driffield Town Council (page 98)
- Letter from Hornsea Town Council (page 99)
- Letter from Withernsea Town Council (page 100 - 101)
- Letter from Driffield Hospital Defence League (page 102 - 104)
- Letter from Hornsea Cottage Hospital League of Friends (page 105 - 106)
- Letter from a disabled activist (page 107)
Councillor Barbara Hall  
Chair, Health Overview and Scrutiny Committee  
East Riding of Yorkshire Council  
County Hall  
Beverley  
East Riding of Yorkshire  
HU17 9BA

21 March 2017

Dear Barbara,

East Riding Clinical Commissioning Group’s Urgent Care Strategy

Further to today’s board meeting of East Riding CCG and its adoption of the new urgent care strategy, we are writing to request that the Health Overview and Scrutiny Committee should exercise its right to refer the plans to the Secretary of State for Health.

The CCG’s decision lets down residents of both the Beverley and Holderness and East Yorkshire constituencies. Local people have been clear from the outset of this process that they do not want to see the Minor Injuries Units in Driffield, Hornsea and Withernsea close and to be forced to make long journeys on winding country roads to access treatment for things like cuts and sprains.

This is particularly the case because many of our constituents are elderly and have complex health needs. They are poorly equipped to travel from (for example) Withernsea to Hull, a round trip of some forty miles. We have also been contacted by the parents of young children who hold similar concerns – as well as by local schools who would regret the loss of their nearby MIUs bitterly. The problems with the centralisation of care envisaged by the CCG are compounded by the limited availability of public transport.

We continue to be concerned that the upshot of removing local minor injuries care will be greater pressure on both the already hard-pressed Accident and Emergency unit at Hull Royal Infirmary and Yorkshire Ambulance Service, which would not benefit anyone and could put lives at risk.

Separately, we are also opposed to the removal of community beds from both Bridlington and Withernsea Hospitals. These beds provide an important service to local people and allow patients to receive treatment close to home. People do not want to be stranded miles from their friends and relatives when they are in hospital. Whilst every effort should be made to encourage and support patients who can leave hospital to do so, “time to think” beds cannot be a substitute for good local hospital care.

Working hard for Beverley and Holderness  
Tel: 01482 679687  
Email: graham@grahamstuart.com Web: www.grahamstuart.com
The survey conducted by the CCG as part of its consultation found very limited public support for the package of proposals, despite a number of very leading questions. In Holderness, for instance, 90% of people did not agree with the question asking whether they would be prepared to travel further to visit an Urgent Care Centre.

Over ten thousand people have signed petitions opposing the reconfiguration proposed by the CCG. Hundreds of people have attended public rallies. Local GPs in Holderness have expressed their own opposition to the reorganisation, as have town and parish councils.

We are deeply disappointed that the CCG has ignored all these voices and decided to approve the plans today. The decision to withdraw minor injuries cover from Hornsea Hospital is widely regarded as a betrayal of the community. Having spoken to local people, the concessions that have been made regarding the availability of some reserved appointments for minor injuries at Withersea and Driffield Hospitals have not reassured the public there about the level of cover that will be available.

We hope your Committee will take the opportunity of its next meeting to refer the matter formally to the Health Secretary so that he can ask the Independent Reconfiguration Panel to review the proposals and assess whether they will deliver safe, sustainable and accessible services for local people.

Yours sincerely,

Graham Stuart

Graham Stuart MP

Right Honourable Sir Greg Knight MP
South Holderness Medical Practice: Hedon Group Practice:  
Church View Surgery:  
Eastgate Medical Group

Following the decision on urgent care in the East Riding we would like to make the following statement

Holderness Health Alliance who together represent the practices in Hedon, Hornsea and Withernsea remain extremely disappointed that the CCG has failed to listen to the concerns raised by Primary Care and our many patients. The decision taken by the CCG substantially reduces services to nearly 50,000 patients in Holderness, whilst enhancing the service across the rest of the CCG area. In so doing, the patients with the highest health needs and lowest access to transport will lose out. Our view is this will impact further on their health.

For many Holderness residents the only option for urgent care will be the Emergency Department at Hull Royal Infirmary. This department is already under immense pressure as is the Ambulance service which patients may well call upon to get there.

We do not feel that the proposed 8-8 centre at Withernsea will adequately cover patient need as it is very unclear what a "low level minor injury" is. Many patients with genuine need will have to travel long distances to access services in an area with very poor public transport.

We are unhappy about how the consultation was conducted and feel that residents of Holderness were not given any option to support services to be provided locally- 77% of Holderness Respondents’ did not support any of the options presented

The consultation document show that only 3% of Holderness respondents fully support the proposals for Urgent Care Centres and 61% do not support then at all.

On behalf of the GPs and Staff of the Holderness Practices

DR ROBERT BLACKBOURN (South Holderness Medical Practice, Withernsea)

DR PHILIP GEORGE (Eastgate Medical Group, Hornsea)

DR JANE STEPHENSON (Church View Surgery, Hedon)

DR JAMES RUSSELL (Hedon Group Practice, Hedon)
Cllr B Hall
Chair of the Health & Scrutiny Committee

Dear Cllr Hall

I write with reference to the recent consultation conducted by the East Riding CCG regarding the future of the MIU’s at Hornsea, Withernsea and Driffield and the subsequent decision to close Hornsea and provide some care for ‘low grade’ minor injury at Driffield and Withernsea.

While the Town Council are gratified to a certain point that there will be some level of provision at the Alfred Bean Hospital, the reality of this care is still to be ascertained. How it will work, and how effective it will be for our community remains a complete unknown at this stage. What is proposed is actually a far cry from the services we currently receive from the Driffield MIU.

With this in mind, we have to remember that over 10,000 people in Driffield and the surrounding villages made it clear to us and consequently the CCG that they wished the status quo to remain – a Minor Injury Unit at the Alfred Bean Hospital open 7 days a week 9am to 6pm and with the x-ray facilities intact. This is not what is being proposed so Driffield Town Council would like to formally request that the East Riding of Yorkshire Council Health and Scrutiny Committee refer this decision from the CCG to the Secretary of State for Health.

Yours sincerely

Claire Binnington
Town Clerk
30th March 2017

Councillor Barbara Hall
Chair, Health, Care and Wellbeing Overview and Scrutiny Sub-Committee
East Riding of Yorkshire Council
County Hall
Beverley
East Riding of Yorkshire
HU17 9BA

Dear Cllr Barbara Hall

We were very disappointed to hear the decision made by the board of the East Yorkshire CCG to approve plans that will result in the termination of the MIU service at the Hornsea Cottage Hospital.

As you will be well aware Hornsea is a rural town with many elderly residents and our public transport links to neighbouring towns are poor. This makes it very difficult for those without a car, or those unable to drive through injury or infirmity, to travel to one of the neighbouring towns to visit an A&E or Urgent Care Centre. In addition, the Town of Hornsea welcomes hundreds if not thousands of seasonal visitors and holiday makers each year who may or may not have access to transport. Any incident involving a visitor/holiday maker, as with residents, would necessitate a substantial journey to the closest A&E facility. This is unacceptable.

Consequently, Hornsea Town Council is extremely concerned that the removal of the MIU will lead to further calls to the ambulance service, which can only have a detrimental effect on response times and waiting times at A&E. As a result, this decision could lead to mortalities.

Hornsea Town Council does not think that the CCG has listened to the people of Hornsea, or the other towns of the East Riding that will be affected by this decision.

Furthermore, this decision does bring into question the long term viability of the Hornsea Memorial Cottage Hospital. The CCG has already taken beds away and are now removing MIU facilities. It is important to stress that the Hornsea Cottage Hospital was funded by the people of Hornsea and is a WW1 war memorial.

Would you please heed the plea of Hornsea residents and visitors and refer this matter to the Health Secretary and the Independent Reconfiguration Panel.

Yours sincerely
On behalf of Hornsea Town Council
22nd March 2017

Councillor Barbara Hall
Chair, Health, Care and Wellbeing Overview and Scrutiny Sub-Committee
East Riding of Yorkshire Council
County Hall
Beverley
East Riding of Yorkshire
HU17 9BA

Dear Councillor Hall

East Riding Clinical Commissioning Group’s Urgent Care Strategy

As a result of yesterday’s board meeting of East Riding CCG and its adoption of the new urgent care strategy, we are writing to request that the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee should exercise its right to refer the plans to the Secretary of State for Health as a matter of urgency.

We, on behalf of the people of Withernsea and South East Holderness are extremely disappointed that the CCG has failed to list local people who made it abundantly clear when consulted that MIU services need to be retained locally. The CCG consultation was flawed from the start – our local residents were not given any option to support services to be provided locally. We do not feel that the proposed ‘pre-bookable’ 8-6 centre at Withernsea will adequately cover patient need as it is very unclear what a “low level minor injury” is. Much more clarification is needed.

Many of the people here are elderly, low income families who are poorly equipped to make the long journey to enhanced services elsewhere. During a recent gas emergency in the town – 50% of our residents were flagged up as vulnerable, and in need of more urgent attention. This proportion of vulnerability had a direct influence on the severity of the immediate situation and special arrangements had to be put in place. This is a good example of the level of need there is here. Under these proposals, the people who have the highest needs and lowest access to transport will lose out to enhanced services elsewhere, where the demographic is different and there is less need. The closest access they will have will be at the Hull Royal Infirmary A & E Department, which is already at breaking point – a trip that takes at least 40 minutes in private transport on a good day – many of our residents do not have their own car. The public transport service is limited, this could take all day and is expensive. It would undoubtedly put extra pressure on the already compromised Ambulance Service as people may well have to take that option, which whilst unnecessary, they may have no other choice, whilst may ultimately put further lives at risk.

There are three schools and many care homes in the town who also rely on a local MIU.
We also oppose the removal of community beds from Withernsea Hospital. The nearest community beds would be in Beverley. These beds are a vital service to local people and allow patients to receive treatment close to home. People would be miles away from their families, in many cases too far away for anyone to visit them.

Thousands of people have responded to the consultation, attended rallies, signed the petition including local GP's and Town and Parish Councils and the CCG has not listened and has gone ahead regardless.

No one is re-assured about the level of local services that will be available under the new proposals and the decision to withdraw minor injuries cover from Hornsea Hospital is devastating blow for their community.

We would ask that your Committee to refer the matter formally to the Health Secretary so that he can ask the Independent Reconfiguration Panel to review the proposals and assess whether they will deliver safe, sustainable and accessible services for local people.

Yours sincerely

A.J. Moxon

Mrs. A.J. Moxon MILCM
Town Clerk
Dear East Riding Council,

As Vice Chairman of the Driffield Hospital Defence League, I wish to strongly voice our concerns as to the legality and credibility of the E.Y.C.C.G. Referring to their decisions concerning the E. Yorks Minor Injury Units, particularly the M.I.U at Alfred Bean, Driffield. Also the erosion of other services at the said hospital.

We feel that the E.Y.C.C.G's decisions should be more closely scrutinised by a more senior power. As facts on which they based their decisions have found to be incorrect. The consultation process is flawed and dishonest and figures have been manipulated.

It was a revelation to me that last Friday March 31st 2017, I as a patient attended the Alfred Bean Hospital.

At the M.I.U, one patient was in the treatment room, with two waiting. One mother with her nine year old son. She said this was a follow up visit. She was a non-driver with other children in school. No way would she have managed the time to have gone a further distance, she said it would have been very stressful, and would probably have had to use the ambulance service.
I asked a member of staff if the unit was busy. This person gave me the numbers for last week up to 11.30 on Friday 31st March.

March 27th Mon - 31
28th Tues - 28
29th Wed - 30
30th Thurs - 20
1st Fri - 13 Up to 11.30

+ I at 5.30pm a friend with some metal in his eye. That adds up to 120 patients in 4½ days. Averaging 24 per day, averaging 3 per hour. For a small unit that is busy. Where do 24 people go if not local? 24 is a much higher number than quoted at the consultations. Where did they get their figures from. These figures are fact. What is going on?

Also I was told that on 1st April the N.I.U. was being handed over to a private contractor. The public are also bewildered by this suggested new III appointment system (is it a sweetener?) Everyone is in agreement that it is common sense that if you incur an injury you need immediate attention, not waiting for an appointment, or trying to get to some Cave Centre miles away, particularly if this III system is restricted to 10 patients a day. What happens to the remaining 14?

Also are the ambulance services aware of this extra burden, 24 extra people a day, to medical centres will put this service under further intolerable pressure, have they even been consulted, has it been thought through?
I also had an X-ray, only to discover that the previous service had now been restricted to only 3 mornings per week, even though the department was very busy. I was told that in January 2017 the department was given notice that the X-ray service was to be terminated. Only due to the persuasion of the staff does this service continue. No public notification what is going on?

Also the ultrasound service has closed. The technician a Driffield person now travelling to York & Scarborough. No public notification what is going on. We are losing these services through stealth.

Physiotherapists are being down graded, so are leaving and going private. What is going on?

All these changes at the Alfred Bear are going on without consultation, without public knowledge and probably N.H.S knowledge. The staff are left in the dark.

We in the area have been served a raw deal. Thousands are being deprived and neglected. Having to travel for health care will only add to the health problems, the stress, strain and pressure, not forgetting the financial cost, will not improve the quality of life. It will not improve the health care, as the C.C.A's are quite keen to keep telling us.

Something must be done now to stop this recklessness.

Judy English (Vice Chair) D.H.D. L
Hornsea Cottage Hospital League of Friends and Community Care

28 March 2017
Councillor Mrs Barbara Hall
Chair
ERYC Overview & Scrutiny Committee
County Hall Beverley
East Yorkshire
HU17 9BA

Dear Councillor Hall

We, the Hornsea Cottage Hospital League of Friends, respectfully request that the recent decision made by the East Riding of Yorkshire Clinical Commissioning Group on the future of Urgent Care Services including the closure the Hornsea Minor Injury Unit be referred to the Secretary of State for Health, Rt. Hon. Mr Jeremy Hunt on the grounds that the consultation process was seriously flawed.

We are concerned that:-

- The list of options did not contain one which stated ‘no change’ or ‘maintain the status quo’ as we believe this is a necessary requirement in any list of options.
- The questions in the consultation document were biased and therefore misleading for the public. Many refused to complete the questionnaire for that reason.
- The figures released by the CCG regarding the responses received as being 1,359 are not a true representation of the population of the East Riding so should not give them a mandate to implement their plans. The 2011 Census shows the population as 354,179 and the estimated population in 2015 as 595,700 according to the ERYC website.
- Although the CCG acknowledge that they received over 13,000 letters/emails and 9 petitions (5,763 signatures from Hornsea & District alone), they then totally disregarded them when making their final decision.
- No good reason has been forthcoming as to why the overwhelming opinions of the public against these plans has been ignored.
- No regard was given to the impact of these plans on the rural population being able to access these Urgent Care Centres.
- These plans place too much reliance on other agencies to deliver what is required i.e. the Ambulance Service, Social Services, Residential Homes etc., and therefore have no firm foundation.

It was evident from the very first stakeholder meeting that the CCG were determined to push these plans through as all suggestions from the stakeholders were continually brushed aside. The whole process was not so much a consultation but more of an imposition.
The ERYC Overview & Scrutiny Committee have made some excellent recommendations regarding maintaining some place based services in Driffield, Hornsea and Withernsea which also appear to have been ignored.

The CCG have stated the changes would ‘improve services’ and whilst the Hornsea Cottage Hospital League of Friends, is not opposed to change per se, we feel these changes would definitely not ‘improve services’. Our hospital was refurbished four years ago costing £2.7 million with a promise from the CCG that it would house a multitude of services including a minor injury unit. Closure of this facility constitutes a waste of public money.

We therefore implore you to refer these plans to a higher authority for due and careful consideration.

Yours sincerely

J. Barton (Mrs)
Secretary/Publicity Officer

41 Clifford Street
Hornsea
East Yorkshire
HU18 1HZ

01964 534039

Email: jubri@uwclub.net
From a disabled activist

Observations and concerns about the process and decision.

1. The new 8 to 8 centres are likely to be underused for the following reasons:
   (a) 111 always tend to push things higher up than necessary - I've spoken to several people who have been directed to A&E rather than MIUs or out of hours services. My own experience of that was me ringing them for an out of hours appointment at the weekend and ending up being taken to A&E in an ambulance. Out of hours would have been more appropriate.
   (b) If someone has a minor injury and gets an appointment a few hours away they will end up going to A&E anyway and will not bother to try again in future.

2. The CCG seemed very sketchy on details when questioned about it and answered none of the questions properly. The way they railroaded the vote when one of their own members asked for further investigation was horrific. Hats off to that doctor - he said exactly what the public have said over the past few months.

3. They have not done anything to put transport plans into place and are only looking at Withernsea. When we analysed the returns from the Driffield consultation 28% were from people with no access to a car. Fuel poverty is higher in the YO25 area than Withernsea according to the last census. A person in poverty without transport in Driffield or the surrounding villages is as vulnerable as one in Withernsea. We had a lot of returns from people saying that they could get to Alfred Bean on a mobility scooter but couldn't get anywhere else as they can't get onto public transport.

4. Relating to the above point, I have huge concerns about the consultation with regards to disability. As I said at the meeting, they put the Disability Advisory Group (DAG) as a consultee but did not consult with us. As far as I am aware, none of the members of the previous Disability Access and Monitoring Group were invited to the Equality workshop and it is not clear whether any disabled person was in attendance as I have not been able to find any records of that workshop or any detailed Equality Impact Assessment. For them to say that the impact on disabled people is no different from that on everyone else is a complete nonsense from several angles:
   (a) Disabled people are less likely to be able to drive and own a car (especially now people are losing Motobility vehicles) and are several times more likely to live in poverty than non-disabled people.
   (b) Several people commented that busier A&E departments, waiting and travelling was extremely distressing for their relatives with dementia or autism.

   I am not happy that the CCG (and some of ERYC) are telling people that DAG has been consulted when no such consultation has taken place. I find it leaves a very bad taste in my mouth to be used in this way.

5. I cannot see the sense of opening Alfred Bean for longer and employing a nurse practitioner but watering down the service to the point where it will become unviable. If they are there it makes sense for them to deal with people who turn up. We will also lose x-ray if this goes ahead.

I sincerely hope that the Scrutiny committee takes the decision to petition the SoS to overturn these decisions.
Health Inequalities and Deprivation - WITHERNSEA (SOUTH EAST HOLDENNESS), HORNSEA (NORTH HOLDENNESS) AND DRIFFIELD (DRIFFIELD AND RURAL) AREAS

Deprivation using Indices of deprivation (IMD)

The IMD does not allocate wards themselves an IMD score. However, as IMD is linked to the LSOAs that uniformly sit within each ward, it is possible to calculate a population weighted deprivation score for each ward. Table 4.1 below displays the 26 East Riding wards ranked by deprivation, with the more deprived wards found at the top of the table. The three wards of South East Holderness, North Holderness and Driffield and Rural are highlighted.

*Table 4.1 IMD 2015 rank of East Riding wards, based on population weighted deprivation scores from LSOAs within them*

South East Holderness and North Holderness appear as the 4th and 5th most deprived wards of East Riding respectively, whilst Driffield and Rural is ranked the 10th most deprived.

On the following pages, map 4.1 shows the East Riding split into national deprivation deciles, zooming in on the East Riding towns by displaying them around the edge of the map. The deciles have been calculated by ranking every LSOA in the country by their deprivation score and then splitting them into deciles. The East Riding LSOAs that fall within the most deprived 10 percent of national LSOAs have been coloured red on the map. The darker the shading the more deprived the area. Similarly map 4.2 shows deprivation deciles for one of the domains (that makes up the whole IMD score) called Barriers to Housing and Services.
Appendix 5

Map 4.2 IMD 2015. Map of East Riding showing deprivation deciles and zoomed in areas of the ERY. Source ERY Data Observatory

Indices of Deprivation 2015 -
Indices of Multiple Deprivation

Source: Department for Communities and Local Government

Produced by Data Observatory
www.eastriding.gov.uk/dataobs

Deprivation Rank
- 10% most deprived
- 11-20% most deprived
- 21-30% most deprived
- 31-40% most deprived
- 41-50% most deprived
- 41-50% least deprived
- 31-40% least deprived
- 21-30% least deprived
- 11-20% least deprived
- 10% least deprived

Map 4.3 IMD 2015. Map of East Riding showing deprivation deciles and zoomed in areas of the ERY. Source ERY Data Observatory.