Health Outcome Impact Assessment: Proposed change in OOH location

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Position	Head of Urgent & Emergency Care	**Position**	Associate Director Clinical Outcomes, Population Health Strategy and Hosted Research
Date assessment completed	17/3/17	**Date assessment reviewed**	17/3/17
Signature	Ian Weller	**Signature**	

Step (1) Define the change and who will be affected

Title of project	Proposal to relocate the Chesterton Out of Hours (OOH) base from Chesterton Medical Centre to Clinic 9 on the Cambridge University Hospital (CUFHT) Site
Brief description	The Cambridge OOH base is a stand-alone facility currently located at the Chesterton Medical Centre (CMC) in Union Lane CB4 1PX. The service is operated as part of the Integrated Urgent Care (IUC) arrangements provided by Herts Urgent Care (HUC). The proposal is to relocate the base to Clinic 9 on the Addenbrookes site CB2 0QQ.
Change that the project will bring about What will be different in terms of structures and processes as a result of this project?	The GP OOH service operates between 1830 – 0800 and is accessed via patients calling NHS 111 and following triage via NHS pathways. If they receive a disposition "to contact a Primary Care service within 2,4,6,12 or 24 hours the patient, subject to their postcode are then offered a choice of OOH bases where they will be given an appointment slot or, if circumstances dictate, a home visit. The way in which patients access GP OOH will not change under this proposal however the co-location does offer a number of clinical benefits for patients, e.g:. • Economies of scale regarding GP shift fill (1830 – 0800) • Should a patient's condition deteriorate (5% need this) access to A&E is immediate • Access to diagnostics should this be needed (A&E conduct point of care testing) • Access to a specialist opinion if needed • Supports the CUHFT front of house streaming model • Supports the achievement of the national 4 hour target • Helps to reduce A&E overcrowding

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Local access to on site pharmacy
Single location that is well known by the general population with direct bus routes/access

</td></tr>
<tr><td>Project Lead</td><td>Ian Weller</td></tr>
<tr><td>Intended improvement:
Please be precise about the improvement that this project will bring about.

i.e. what are the results of the change described above?</td><td>As well as offering additional clinical quality, safety and access benefits to patients, co-location provides an opportunity to remove the isolation issue associated with a single site location.

There is a recognised shortage of GPs available to do work in OOHs including covering A&E streaming shifts at CUHFT and colocation will allow cross cover to take place

<table>
<tr><th colspan="6">Shift fill by base</th></tr>
<tr><td>Target 95%</td><td>Oct-16</td><td>Nov-16</td><td>Dec-16</td><td>Jan-17</td><td>Feb-17</td></tr>
<tr><td>Addenbrookes</td><td>43.40%</td><td>55.90%</td><td>58.70%</td><td>64.50%</td><td>69.90%</td></tr>
<tr><td>Chesterton</td><td>77.90%</td><td>82.60%</td><td>71.30%</td><td>84.70%</td><td>91.80%</td></tr>
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Source: HUC weekly shift fill analysis

Better flow between A&E and OOH (GP streaming model)

The CUFHT A&E has for a number of months been experiencing high levels of demand. The department regularly sees 300 patients per day and very often the number can be up to 330, resulting over 100,000 attendances per year, year on year increases have been at around 3% p.a., which is unsustainable.

Co-location will allow strengthening of the current arrangements where a GP service in A&E can stream patients identified as needing primary care direct to a primary care service.</td></tr>
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Step (2) Specify the people are affected by this change (patients)

How many people will be affected by this change?	Appendix Table 2 shows the use of the Chesterton Out of Hours Centre by postcode and Appendix Table 3 shows the use by practice. The change mainly affects Cambridge City and it is estimated that in a year about 7,600 face to face consultations

	of Cambridge City residents take place at the Chesterton Medical Centre (Appendix Table 2)
Where are they living? (locality or geographical area)	Appendix Table 2 shows the use of the Chesterton Out of Hours Centre by postcode and Appendix Table 3 shows the use by GP practice of the patients. Most face to face out of hours consultations amongst people in Cambridge City are for those living in CB4.
Any other features that help define the population who are affected by this change?	Appendix Figure 1 shows the distribution of face to face visits to Chesterton Out of Hours Centre by age. The largest age group attending face to face are for children aged 0-9 years old who make up 36% of face to face OOH consultations at the Chesterton base from all areas.
Are there any significant inequalities already **between** this group of people overall and other groups either within Cambridgeshire and Peterborough or elsewhere? *Please give reasons for thinking this is the case.*	The demographic inequalities between the wards in Cambridge are well understood, in particular higher levels of deprivation in the North of the city (see Appendix Figure 3). Appendix Figure 4 shows that there is a moderate increase in the rate of face to face out of hours consultations with deprivation of the GP practice.
Are there any significant inequalities already **within** this group of people? *Please give reasons for thinking this is the case.*	As above, the demographic inequalities between the wards in Cambridge are well understood, in particular higher levels of deprivation in the North of the city (see Appendix Figure 3). Appendix Figure 4 shows that there is a moderate increase in the rate of face to face out of hours consultations with deprivation of the GP practice.
Please describe the number and type of groups of people affected by the change who are either vulnerable or already subject to inequality.	This out of hours base is used by the travelling community. According to the Cambridge County Council Traveller JSNA 2010, Gypsies and Travellers make up almost 1% of the population in Cambridgeshire representing the largest ethnic minority in the county. In Cambridgeshire it is estimated that approximately 70% are Romany Gypsies, 20% are Irish Travellers and 10% are others including Scottish and Welsh Travellers and an increasing number of Eastern European Gypsies. There appears to be a demographic variation between North and South Cambridgeshire with a higher number of Irish Travellers in South Cambridgeshire.

	There are difficulties in accurately identifying the Gypsy and Traveller population should also be acknowledged.

Step (3) Please identify and list the individual the population health outcomes from the CCG Improvement and Assessment Framework that could be affected by this change (Health outcome impact assessment) https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/technical-annex.pdf

Having carried out a review of the above CCG improvement and assessment framework 2016/17 the proposed move (colocation) supports the achievement/compliance with a number of domains contained within the guidance, these are as follows

CCG Improvement and assessment framework outcome	Brief rationale for link between the change and the population outcome	Positive/ Negative/ Neutral Impact	Risk identified/mitigations
121 a,b,c. Use of high quality providers	Co-location provides the opportunity for Urgent and Emergency Care services to come together on a single site. This is could improve the ability to fill GP shifts and allow professionals to share skills and knowledge. Furthermore immediate access to diagnostics and specialist opinions is available more quickly for the minority of patients attending Out of Hours Primary Care who need this. 5% of all GP OOH contacts require transfer to A&E.	Positive	
105d. People with long term conditions feeling supported to manage their condition(s)	The clinical service offered is unchanged. Patients can still be assessed for a GP home visit or call 999 should their condition worsen.	Neutral	
127a - Achievement of milestones in the delivery of an integrated urgent care service	Progress in implementation of delivering functionally integrated, 24/7, Urgent Care Service accessed via NHS 111, in particular • There is joint governance across Urgent and Emergency Care This is one of the 8 mandated criteria for this domain.	Positive	
127c Percentage of patients admitted, transferred or discharged from A&E within 4	The increasing number of A&E attendances at CUHFT has made it difficult to achieve the	Positive	This depends on GP shift fill being maintained under the new

hours	national A&E 4 hour standard. Streaming patients who have a condition that is best treated in primary care to a dedicated GP in Clinic 9 could reduce the number of people being seen by A&E. This could enable better flow through the A&E unit.		arrangements.
128b Patient experience/access to GP services in Cambridge (GP patient survey (2015/16). **https://gp-patient.co.uk/**	The majority of out of hours contacts for urgent primary care needs are met through 111. For patients triaged by 111 as needing a face to face visit the same service will be provided in Clinic 9 at CUHFT as is currently provided at Chesterton. However for people who currently attend A&E on the CUHFT site whose needs would be better met by primary care there will now be a primary care option on site that is easy to access.	Positive	
128d Primary care workforce.	Recruiting GPs into working in OOH is extremely challenging. Co-location of GP streaming & OOHs services in a single location could help to improve shift fill and may attract new GPs into the service due to diversity of the role and the ability to work with A&E colleagues.	Neutral	Should GP streaming shifts/Clinic 9 OOH shifts fail to be filled at the capacity required, patients will default back to having to use the A&E this would have the reverse effect of what the scheme is trying to achieve.
164a. Effectiveness of working relationships in the local system	Co-location offers the possibility of closer working between the primary care Out of Hours service and A&E.	Positive	

Step (4) List any other population health outcomes that could be affected by this change

Population health outcome	Brief rationale for link between the change and the population outcome	Positive/ Negative/ Neutral Impact	Risk identified/mitigation

Health outcomes after a visit to A&E	At the moment it is not possible to predict whether co-location of primary care Out of Hours and A&E will lead to more patients who currently attend A&E and would be more appropriately seen by a primary care clinician having a primary care assessment or not. It is also not possible to predict the impact of colocation on the flows of patients into A&E.	Neutral	More appropriate use of primary care and streaming of patients from A&E into the OOH service reducing numbers in A&E could lead to improved outcomes. However there is a risk that more people attend A&E as a way of by-passing 111 and this might lead to increased flows which could have the opposite effect.
Transfers between OOH and A&E	On rare occasions (5%) patients attending OOH bases need urgent transfer to their local hospital due to a deterioration of symptoms associated with their presenting condition. Currently this would require a blue light ambulance/Medivac to CUHFT from Chesterton Medical Centre.	Positive	Nationally there is a circa 5% of GP home visits/base consultations require the patient to be transferred to A&E for further assessments.
Access to diagnostics	In addition at Chesterton Medical Centre there are no diagnostic facilities such as pathology/X-Ray/ultra sound etc. The full suite of diagnostic facilities exist at CUHFT which would be utilised if patients needs dictate.	Positive	
Increase in A&E Attendances	There is a risk that patients may bypass NHS111 and/or their GP practice and go directly to CUH in the knowledge of being able to access a GP directly/quickly. This may increase numbers at the A&E requiring triage thus making overcrowding worse and therefore impacting on the quality of care/outcomes for patients.	Negative	Evidence from GP streaming at Peterborough and Stamford Hospital was that this did not happen although the GP service there was weekends only.

Step (5) Assess where the impacts will fall

	Positive/ Negative/ Neutral Impact	**Brief rationale for link between the change and the population outcome**	**Risk identified/mitigation/comments**

Will the project impact on an individual's ability to improve their own health and wellbeing be positive/neutral or negative?	Neutral	The same service is transferring from one location to another.	
Will the impact on social, economic and environmental conditions that could affect health be positive/ neutral/ negative?	Neutral	Under this proposed change some travel times are longer but some are also shorter.	
Will the impact in the demand for or access to health and social services be positive/ neutral or negative?	Neutral	It is not possible to assess this as it depends on whether co-location acts to increase flows to A&E or decrease them.	Evidence from the GP streaming conducted at PSHFT over a 1 year (weekends only) timescale did not show any significant increase in A&E activity.
Will the proposal impact on global health be positive/ neutral or negative?	Neutral	No	

		Brief rationale for link between the change and the population outcome	Risk identified
Will the health impacts affect the whole population or will there be differential impacts within the population?	Yes	There is a direct impact (albeit small) on those who, if the change goes ahead, will have slight increases in travel time in getting to CUHFT as opposed to Chesterton Medical Centre • Increased financial cost of getting from CB4 to CUHFT associated with bus fare/taxi/parking/fuel • Anxiety associated with access to Clinic 9 from the CUHFT Car Park 1 • Anxiety associated with patients attending a large busy often confusing acute hospital site These changes are in access times (see Appendix Figure 6 and Appendix Figure 8 and are not expected to affect the outcome of the care that is received once the base is reached.	Where appropriate OOHs GP home visits can still take place. Drop off bays will be clearly marked out adjacent to Clinic 9 along with disabled parking. Clear signage will be introduced pointing patients to Clinic 9 for OOHs appointments as well as from the A&E for patients streamed. Further engagement with local community groups to discuss/listen to local issues. Integrated Urgent Care is now accessed via 111 and offers a range of options aimed at providing advice and guidance/signposting/referral

			other than GP OOH appointments.
Does each of the negative health impacts have a mitigation in place?	Yes	See risk log	See risk log below.
Will the health impacts be medium to long term?	No	Any health impacts are short term.	
Are the health impacts likely to generate public concern?	Yes	See End of Consultation Report. Public interest in the proposal has been primarily focused around access issues. In particular the added cost to people in the CB4 postcode area who live in a deprived area. Their concerns are related to travelling to CUHFT and the issue of CUHFT being a busy and confusing site to access.	These points are addressed in the Health Inequalities Impact Assessment.
Are the health impacts likely to generate cumulative or synergistic impacts?	No	No, this is just one step in a Urgent and Emergency care pathway.	
On balance will the health impacts have an overall positive or negative impact on the health of the population	Neutral	The impact on the overall health of the population is likely to neutral for the reasons outlined above.	

Step (6) Summary

Quantify or describe important health impacts	This is a direct location transfer for an established service. The main outcome benefits come from possible improved availability of GPs to staff the Out of Hours shifts and closer working with A&E. This could enable a primary care assessment if that is the best type of assessment for the patient. If there is an increase in attendance at A&E because of the co-location of primary care Out of Hours and A&E this could decrease any benefit. If co-location does not enable better shift fill for GPs then less clinical outcome benefit will be realised.
Recommendations to improve the project to maximise health of the population	The following recommendations have been made by the project team: • Raise awareness of the newly commissioned IUC service and the options available o GP OOH Home visits

	o First Response Service o Clinical Hub • Raise awareness of the newly launched (March 17) public MyHealth App • Raise awareness of local GP access times/services • Strongly consider extending local GP access until 2000 hours in the area affected by change i.e. CB4 postcode populations • Close monitoring of ED activity and GP shift fill in the IUC OOH service to ensure that the proposal does not make flow through A&E worse • Raise awareness of ways in which to access both health and social care

Stage 2 – Assessment of Risk
To be completed for any areas where a negative impact has been identified

Area of impact	Risk (as identified in stage 1)	Risk score	Mitigating actions	Mitigated risk score	Monitoring arrangements	Timescale for review	Responsibility for managing risk
IA	The above IA is an assessment based on the most accurate information. The actual behaviour of patients and their experience of the service in terms of access/clinical quality will need to be monitored over the coming weeks	5	Monthly monitoring meetings/data collections	2	Monthly	Monthly	CCG/HUC/CUH FT
A&E	GP shift fill remains challenging in OOHs as well as GP streaming. This would impact on the ability to stream patients from the A&E to Clinic 9, have the reverse effect of what the service is trying to achieve i.e. reduce overcrowding/increased flow through A&E	7	HUC have introduced a number of incentive schemes aimed at retaining and recruiting GPs into working in the IUC environment Smoothing capacity across Integrated Urgent Care bases to better meet demand	4	Daily monitoring of GP shift fill	Monthly	CCG/HUC
ED	Activity at A&E increases due to patient behaviour by passing local GPs & NHS 111 services and going straight to A&E to see a GP	5	Evidence from the GP in ED at PSHFT (1 year pilot) did not experience this Raising awareness of local GP	2	Daily	Monthly	CCG/HUC/CUH FT

			access/services including Integrated Urgent Care Use of Myhealth App				
Integrated Urgent Care Service	GP recruitment – GP recruitment is recognised nationally as an issue, this then impacts on the number of GP working in primary care and directly impacts on the number of GPs willing to work in OOHs There could be a risk that GPs currently working at Chesterton may not want to work at CUHFT (Clinic 9)	5	Explore the opportunity of recruiting overseas GPs to work in Integrated Urgent Care Working with emerging GP federations regarding how they may support OOH services across more GPs Exploring the use of cross cover from other Integrated Urgent Care/OOH providers/consortium	3	Monthly	Quarterly	CCG/HUC
IUC Staff	A formal consultation will need to be undertaken with staff – the risk is that some staff will not want to work in the proposed new location	5	Good HR process associated with staff consultation and providing support to staff affected by change	3	Weekly during consultation and after go live	Quarterly	HUC

Notes:

1. All areas of risk scoring greater than eight must be escalated in line with the CCG risk management process.
2. Monitoring arrangements can include review of complaints, incidents, and serious incidents, use of clinical audit, observation and patient feedback.