NHS
Greater Manchester, Lancashire and South Cumbria
Clinical Senate

Providing independent strategic clinical advice

Clinical Senate Review: Proposals for the Future Delivery of Urgent and Emergency Care Services in Wirral

Written for:
Wirral CCG by
Greater Manchester, Lancashire & South Cumbria Clinical Senate

December 2018

Chair's Foreword

Wirral Clinical Commissioning Group (CCG) commissioned Greater Manchester, Lancashire & South Cumbria (GMLSC) Clinical Senate to undertake an independent clinical review of the proposed plans for urgent and emergency care services delivered in Wirral.

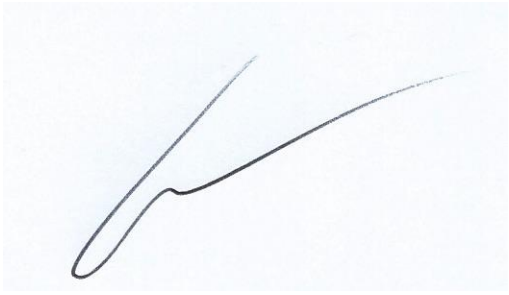
From the paperwork received and the conversations held during the review visit, it is clear that a lot of hard work has taken place, and is still taking place, to provide the best possible urgent and emergency care services for the population of Wirral. All partners are clearly united in the desire to achieve this, despite differences of opinion about how this can be achieved.

Colleagues across all parties should be congratulated on sowing the seeds of a cultural shift away from working in silos and towards collaborative working. However, as they themselves recognise, there is much work to be done to see this shift spread through all levels of the workforce.

The Clinical Senate gives its advice and recommendations with a caveat that there are interdependencies, out of scope of this review, that need to be urgently addressed if the proposals are to achieve the overall aims of providing the best possible emergency and urgent care in the area.

I would like to thank the clinicians and managers in Wirral who have contributed to this review. Also my sincere thanks to the review panel team who provided their time and advice freely.

This report sets out the methodology and findings of the review, and is presented with the offer of continued assistance should it be needed. The clinical advice and recommendations are given in good faith and with the intention of supporting commissioners.



Dr Gareth Wallis
Review Panel Chair
Greater Manchester, Lancashire & South Cumbria Senate

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1. Introduction

1.1. NHS Wirral Clinical Commissioning Group (CCG) is responsible for the planning and commissioning of health care services in Wirral and ensuring services deliver high standards of sustainable care and represent value for money.

1.2. This review of Urgent and Emergency Care (UEC) Services in Wirral is being conducted in partnership with Wirral Council, working closely with the members of "Healthy Wirral". Healthy Wirral is a partnership between organisations that deliver health and social care in Wirral, with the aim of transforming the way health and wellbeing services are designed and delivered in the area.

1.3. As with many health and care systems, Wirral is facing a number of significant challenges that affect the provision of UEC services, including:

- Changing population demographics
- Increasing emergency admissions
- Delayed discharges from hospital and transfers of care
- Health inequalities and conditions caused by unhealthy lifestyles
- Limited workforce
- Unwarranted variation in standards
- Confusion amongst the public about what service is the most appropriate when people need help
- Rising attendances at the Accident and Emergency department.

1.4. The aim of this review was to undertake an independent clinical review of the proposed plans for UEC services delivered in Wirral, in line with the NHS England Stage 2 assurance process.

1.5. The Terms of Reference for the review contain the following objectives:

1.5.1. Have all potential alternative options to the preferred model been considered (including co-operation and collaboration with other sites and/or organisations)?

1.5.2. Is this the optimal model for the Wirral population?

1.5.3. Does the preferred model's clinical case fit with national best practice?

1.5.4. Have innovations to practise been fully explored?

1.5.5. Have all the clinical interdependencies been considered?

1.5.6. Do the proposals make the most effective use of the workforce for service delivery?

1.5.7. Have future workforce implications been considered?

1.5.8. Have innovative workforce models been considered?

1.5.9. Have all stakeholders, including staff, third sector organisations, public and service users, been properly engaged in developing the proposed changes?

1.6. A copy of the full Terms of Reference can be seen in Appendix 1.

1.7. The Clinical Senate Review Team members were:

Clinical Senate Review Chair:

- Dr Gareth Wallis, Deputy Medical Director, NHS England North (Lancashire and South Cumbria) and GP

Citizen Representative:

- Ray Murphy, Cheshire & Merseyside Clinical Senate Council Member

Clinical Senate Review Team Members:

- Dr Mark Holland, Consultant in Acute Medicine at Salford Royal NHS FT
- Gill Johnson, Nurse Consultant, Central Manchester University NHS FT
- Dr Patrick Macdowall, Consultant Nephrologist, Lancs Teaching Hospital NHS FT
- Phil McEvoy, Managing Director, Six Degrees Social Enterprise
- Dr Andrew Simpson, Consultant in Emergency Medicine, North Tees and Hartlepool NHS FT

Clinical Senate Review Team Members (not in attendance at site visit):

- Damian Nolan, Divisional Manager at Halton Borough Council

Managerial and business support to the panel:

- Caroline Baines (Manager, NW Clinical Senates)
- Pamela Bailey (Project Manager, NW Clinical Senates)
- Becky Brown (Business Support, NW Clinical Senates)

2. Background

2.1 It is evident from the pressures facing Wirral, and many other areas (described in paragraph 1.3), that the NHS needs to review the current provision of UEC across the Emergency Department (ED) department and community locations.

2.2 In March 2018, the National Institute for Health and Care Excellence (NICE) published guidance titled *Emergency and acute medical care over 16s: service delivery and organisation in the community and in hospital*. This guidance aims to reduce the need for hospital admissions and providing community alternatives to hospital care. It also promotes good-quality care in hospital and joint working between health and social services.

2.3 A number of publications by NHS England set out guidance to support commissioners in undertaking this challenging, but vital, service transformation:

2.3.1 *General Practice Forward View (April 2016*)
This publication describes the requirements to ensure improvements in both 'in hours' and 'out of hours' access to Primary Care as part of a broader Integrated Urgent Care (IUC) offer.

2.3.2 *Next Steps on the NHS Five Year Forward View (March 2017)*
This publication sets out the mandate to standardise existing Walk in Centres (WIC) and Minor Injuries Units (MIU) through the implementation of Urgent Treatment Centres (UTC), open a minimum of 12 hours a day, seven days a week and integrated with local urgent care services. Within this publication is an expectation that 150 UTCs would be operational by December 2017 with any remaining transformational work, in respect of current WIC/MIU, being completed by December 2019.

2.3.3 *Integrated Urgent Care Service Specification (August 2017)*
This specification describes the requirement for CCGs to ensure delivery, by March 2019, of an IUC which includes a 24/7 Clinical Advice Service (CAS). This CAS must be fully integrated with NHS111 and be directly bookable both in, and out of, hours.

2.4 It is within this context, with increasing pressures and national strategic drivers for change, which Wirral CCG and partners are working to transform how UEC is delivered to the population of Wirral. The aim is to provide easily accessible, safe and effective services, as appropriate to clinical need.

2.5 UEC services in Wirral are currently commissioned across a number of footprints. NHS 111 and ambulance services are commissioned across the North West, primary care by NHS England's Cheshire & Merseyside team, whilst secondary care and community based services are commissioned locally by Wirral CCG.

2.6 Locally commissioned services currently include:

- Category 1 (major) ED department at Arrowe Park Hospital (APH), provided by Wirral University Teaching Hospital Trust (WUTH)
- Three WIC at Victoria Central Hospital (VCH), APH and Eastham Clinic
- Three MIUs at Moreton Health Clinic, Miriam Medical Centre and Parkfield Medical Centre
- NHS 111 provides triage services for the GP Out Of Hours (GPOOH) service which is provided by Wirral Community NHS Foundation Trust

2.7 Intelligence suggests a number of issues that commissioners of UEC services in Wirral must consider, in addition to the pressures and national strategic requirements already described. These include:

2.7.1 Confusion amongst the public about the range of UEC services available (other than A&E).

2.7.2 People from the most deprived areas are more than twice as likely to have emergency admissions for conditions which could have been managed in outpatient clinics/services.

2.7.3 In 2016/17, almost 50% of A&E patients presented at APH with low level ailments such as skin rash, cough, back pain and abdominal pain.

2.7.4 Over half (57%) of emergency admissions via A&E are admitted and discharged between 0-2 days.

2.7.5 A&E attendances peak amongst age groups 0-4 years, 20-24 years and 80+ years.

2.7.6 Attendance rates in those aged 90+ years are more than double those of 0-4 year olds.

2.7.7 WICs and MIUs see a high proportion of patients with infections and wound care needs, which could be dealt with in primary care.

2.8 Performance within the Wirral UEC system is generally poor compared to other areas in Cheshire & Merseyside, and is deteriorating across a number of operational, financial and clinical measures. Most notably this includes ongoing and consistent failure to achieve the A&E standard (95% of patients being seen and admitted or discharged within 4 hours) and delayed ambulance response times and handovers.

2.9 Commissioners proposed a draft model of care (Appendix 2), with a proposal to implement this via one of three short-listed options:

- **Option 1: 8-hour Community Offer**
  This option provides the maximum UTC offer of 24 hours 7 day a week care, with up to 8 hours per day community offer.
- **Option 2: 12-hour Community Offer**
  This option provides a 15 hours 7 day a week UTC offer, whilst increasing the community offer up to 12 hours per day.
- **Option 3: 15-hour Community Offer**
  This option provides the minimum mandated requirement of a 12 hour UTC offer, whilst increasing the community offer up to 15 hours per day.

2.10 The table in Appendix 3 summarises the offer under each of the options.

2.11 Option 3 was later discounted for a number of reasons, including failing to meet patient need by providing the mandated minimum service at APH UTC which would not provide consistent support to the APH ED as all minor injuries and ailments would need to present to the ED outside of the UTC hours.

2.12 This leaves two options that are being consulted on: Options 1 and 2.

3. Methodology

3.1 A number of teleconferences and meetings took place between the Clinical Senate and Wirral CCG from May 2018 to develop, iterate and agree the Terms of Reference for the review (Appendix 1).

3.2 Provisional review information was provided by Wirral CCG in the week beginning 22nd October 2018. Panel members reviewed these and discussed in a teleconference on 7th November 2018, and consequently made a number of requests for additional information.

3.3 This additional information was received on 23rd November 2018.

3.4 The review panel visited Wirral on 26th November 2018 (see Appendix 4 for full itinerary). The panel travelled to Arrowe Park Hospital, and during the day split into two groups: Group one visited Miriam MIU and APH WIC whilst Group 2 visited VCH MIU and WIC. Throughout the day, panel members met key colleagues to gain an in-depth understanding of the challenges faced, the opportunities for improving patient care and services, and to hear a range of views and thoughts.

3.5 The panel met with representatives from the commissioner and provider organisations at the end of the visit, and fed back their initial thoughts.

3.6 A draft report was sent to commissioners for accuracy checks on 12th December 2018 with feedback received by 16th December 2018. The final report was ratified at the GMLSC Senate Council on 17th December 2018 and sent to Wirral CCG on 18th December 2018.

4. Issues/Views expressed during review

4.1 This section is intended to highlight the significant issues/views expressed during the review. It is not intended to give an extensive record of the wide ranging and very helpful discussions which took place in each of the planned sessions. Further discussion of the panel's response to these views, and in line with the review's objectives, is contained within Section 5.

4.2 Key Issues/Views – NHS Wirral CCG

4.2.1 Wirral CCG commissioned this review because they were keen to gain independent clinical advice as to whether the proposed model for urgent care services within the area is safe and robust. The CCG's requirements are captured within the aims and objectives of the review, as detailed in Sections 1.4 and 1.5).

4.2.2 It was apparent that there is a genuine desire within the CCG to provide the best services possible, to listen to the public's views and to simplify the complex contracting and provider models of UEC in Wirral.

4.2.3 Commissioners articulated during the review visit that this is only part of a wider piece of work being undertaken through the Urgent Care Recovery Plan, which includes approaches across the spectrum of care from promoting self-care (e.g. pharmacies) to ensuring adequate access to community services (e.g. GP appointments), through to blockages within the patient flows into hospital beds and out (e.g. social care packages).

4.2.4 There was an acknowledgment from the CCG, which was reiterated by their partners, that Wirral has a culture of organisational silo working. A shift in that culture has started over the last 18 months but far more work is needed. It was recognised by Executive Teams across the organisations that there is a need for them to consistently model these behaviours, and to ensure they filter through all levels of all organisations.

4.2.5 There is a clear commitment amongst commissioners to work collaboratively across the commissioner and provider organisations to provide a single view of clinical governance and to enable the workforce to work together. A Memorandum of Understanding between the Healthy Wirral partners, has recently been signed, within which they agree to work collaboratively to deliver seamless services for patients and the public.

4.2.6 The CCG repeatedly stated that the current proposals are not finalised, that they are out to consultation, and that they are happy to hear any alternative models and ideas that could deliver the services needed. They have undertaken a broad range of patient and public engagement work to date over a number of years and continue to listen to the population through the current consultation exercise.

4.3 Key Issues/Views – Wirral University Teaching Hospital

WUTH are the lead providers for the APH A&E department.

4.3.1 Clinical Teams

4.3.1.1 Clinical teams at APH described a very complex, and confusing, system of UEC provision across community and hospital services in Wirral, and at the hospital "front door". The terms "fragmented" and "silos" were used on numerous occasions. The reasons for this were explained as being due to:

- Different services and systems being developed over time in a fragmented manner
- A large number of provider organisations
- A highly politicised environment.

4.3.1.2 There were clear frustrations expressed regarding the multiple front of hospital pathways. Streaming is provided by WCT colleagues who operate the WIC next door. Concerns were expressed regarding this current pathway for patients, which leads to some patients (6%) being inappropriately streamed to the WIC and diverted to A&E, at which point their "clock" starts again.

4.3.1.3 Hospital clinical teams expressed that they have had very little input to service design, and when they have been consulted, they do not feel as though their views have been listened to. For example: Their suggestion to locate the OOH GP in A&E was rejected. Additionally, the assertions from A&E colleagues that the main problems facing them and their team on a daily basis relate to the flow of sick patients into the hospital, and not the waiting room numbers, did not appear to be being heard on the day. These views seemed to be shared among other clinical specialties, and were compounded by the apparent lack of acute beds. Staffing issues, most notably a lack of middle grades and four consultant vacancies in the Acute Medical Unit (AMU) / Ambulatory Care Unit, are also compounding factors.

4.3.1.4 Lead clinicians made positive suggestions about what could and should be done to improve the services for patients and the workforce, summarising that the new model should meet the following criteria:

- Be seamless
- Have diagnostics for all
- Be one organisation
- Have one governance structure

4.3.1.5 There are three different IT systems across WUTH ED, WCT WIC/MIU and the GP Federation WIC/MIU. This further compounds communication and care co-ordination issues. Although results can be seen via the Health Information Exchange, clinicians are unable to see patients' notes, even of those being sent to APH A&E from APH WIC.

4.3.2 Executive Team

4.3.2.1 The WUTH Executive Team articulated a view that the proposals would help with the 4-hour A&E waiting time target as a significant number of breaches are amongst patients who do not need to be seen in A&E. They suggested that alterative pathways that enabled patients to be seen in different settings would ease the demands on A&E. This was somewhat at odds with the clinical teams who articulated that it was the poor patient flow through the hospital that led to the breaches.

4.3.2.2 Executive team members expressed optimism that system working across organisations was improving across Wirral, as evidenced by their winter planning being commended for its system approach. This view was echoed by executive team members in other organisations. As previously described, that view was not evident among the clinical teams.

4.4 Key Issues/Views – Wirral Community NHS Trust

4.4.1 WCT is the lead provider for the WIC/MIU at APH, VCH and Eastham Clinic.

4.4.2 A member of the WCT team working in VCH MIU/WIC expressed a view that "the CCG's intention is the right thing for patients". This was with respect to the proposal to have a UTC at APH plus four other community hubs. The view was that this would provide an optimum of accessibility to the public whilst concentrating the currently diluted spread of workforce. The current model provides a lot of choice to a relatively small population / geography. The variation in provision across sites leads to confusion about where to access services and when, and this has been evidenced through local engagement with patients. Consequently many patients default to ED as they know they will ultimately be seen there.

4.4.3 It was of interest to note that when the Eastham WIC was temporarily closed in 2017, the expected increased footfall at APH WIC and VCH WIC did not materialise. This demonstrates that these patients found alternative ways of dealing with their health concerns, although there was no evidence presented to identify what they were, and as such whether they were "appropriate" (e.g. pharmacy advice and support, GP appointment) or "inappropriate" (e.g. A&E, not seeking advice and support).

4.4.4 WCT colleagues echoed the views of CCG and WUTH colleagues that there has been some progress in organisations working together, e.g. through work looking at extended access and streaming, but there was still a long way to go.

4.4.5 There is strong support from the community for the WIC at VCH.

4.5 Key Issues / Views – GP Federations

4.5.1 Only one of the two Wirral GP Federations, GP Wirral (GPW), attended the Clinical Senate site visit, so it must be noted that the views heard can only be attributed to them. GPW represent approximately half of the GP practices in Wirral and are the lead providers for the Miriam and Parkfield MIUs.

4.5.2 GPW supports the proposal to have the Wirral UTC based at APH. However, there is a lack of consensus between them, the CCG and other partner organisations as to the best community service models. They expressed the view that any closures of existing community venues would lead to increased footfall at APH, which is already a struggling site / service. This contradicts the evidence from the temporary closure of Eastham Clinic when the anticipated increased attendances at other centres did not materialise.

4.5.3 Consequently, GPW colleagues articulated that community services should be strengthened rather than reduced, along with education for the public as to the right service to access for their particular health needs.

4.5.4 There is strong support from the community for the MIU at Miriam Medical Centre. They have instigated their own engagement exercise amongst their patients and fellow GP practices which demonstrates this, along with a live online petition against a closure.

5 Discussion

The sub-sections below contain analysis and discussion relating to the objectives described in the introduction and in the Terms of Reference (Appendix 1). Key recommendations are highlighted in bold and summarised in Section 6.

The panel is convinced that there is a very great and compelling need for the current model of care to change. The main drivers for change being:

- A large number of services across a number of providers, each with a differing offer and differing / varying opening times. This has caused confusion amongst the local population as to where to go and when for their pertinent health needs.
- A mandated requirement to implement a UTC in Wirral within the existing financial envelope.
- The APH A&E and WIC front door is currently confusing, illogical and lacks robust documentation at first contact.
- Numerous IT systems that necessitate patients having to rebook, even if they are referred to APH A&E from the APH WIC.
- Initial streaming is not currently controlled by the A&E department since 5th November 2018. This may well cause inefficiencies. The proposed UTC will address this system, but will not impact on hospital flow.
- Problems with patient flow within the hospital with patients waiting in A&E or AMU for beds in the hospital, with problems relating to monitoring or staffing. These areas will have a significant impact on the proposed UTC's functioning and need to be addressed but are outside the scope of this review.
- Confusing service landscape across Wirral for the public and patients which can lead to them defaulting to ED when it is not always the most appropriate option.
- Reconfiguration of the community WIC/MIU services. This will not have a significant impact on the hospital flow, 4 hour wait or admissions.

5.1 Have all potential alternative options to the preferred model been considered (including co-operation and collaboration with other sites and/or organisations)?

There is evidence of how seven original options were scored using weighted criteria including quality, sustainability and whether the option was deliverable within the available financial envelope. From this process the number of options was reduced to three. The CCG's Urgent Care Options Paper contains narrative regarding why the other options were discounted. This paper also describes how these three options were further reduced to two.

However, there is no evidence as to whether a longer list of options than the seven was considered. Consequently the panel are unable to comment on the process and its robustness.

The panel therefore recommends that other combinations of service be modelled. In particular there should be further exploration with regards to maintaining a walk-in facility

in at least one of the areas to the east of the M53 corridor serving populations of higher derivation, such as Wallasey or Birkenhead. The rationale for this being that there are high levels of deprivation in these areas, and the existing services appear to be well used and liked by patients. The panel were very impressed with the range and quality of service seen at VCH WIC with access to diagnostics, provision of a wide range of treatment options and lengthy opening hours. The panel is of the view that such a facility is definitely an asset to the community it serves which is, in part, one that experiences high levels of deprivation.

An option for consideration and modelling could be 24 hours UTC plus 12 hours (or even 15 hours) community in one of the most deprived areas with the other three centres opening for 8 hours a day. Whilst this may cost more, that may be outweighed by the advantages in the quality, access and deprivation criteria.

Whilst beyond the strict scope of this review, the panel wish to stress that they do not believe that either of the options being consulted on will resolve all of the problems currently being experienced in A&E.

5.2 Is this the optimal model for the Wirral population?

Wirral colleagues were aware of, and open in acknowledging, the currently convoluted approach to the commissioning and provision of services, the numerous issues that have arisen as a result (as previously documented) and the need to address them. Some of these issues would be resolved from the models presented, such as addressing the significant variation in what is provided across the different WICs/MIUs. The proposed model(s) would help to rationalise what is on offer, simplify service choices for patients, and ensure a consistent offer for the residents of Wirral.

Additionally **the panel agrees that co-siting the UTC with the ED at APH will have clear benefits** that cannot be attained by siting in any other location, due to the key clinical interdependencies, such as diagnostics and AMU. However, the **ED requires capital investment to reconfigure to make this model effective.**

Siting the UTC at APH will necessitate mitigation of the effects of bringing additional patient flow to an already busy hospital site. The panel understands that consideration is being made as to public transport provision and redesigning the site infrastructure at APH. This includes widening thoroughfares and building a multi-storey car park. However, many of the colleagues spoken with during the panel's visit did not seem aware of these plans. **Consequently the panel recommends effective communication of these plans to staff, partners and the public.**

To offset some of the increased flow to the APH site, and bring some services closer to people's homes, the panel recommends **consideration of the provision of services / clinics in the community hubs and/or neighbourhood centres as practicable.** These could include secondary care, extended hours primary care, dressings, and mental health services. It is acknowledged that this recommendation is strictly beyond the scope of this review.

The panel is very clear that the proposals will not solve all of the issues affecting the current system, such as flow through the A&E, multiple IT systems and a fragmented hospital front door. Again, whilst beyond the scope of this review, the success of the implementation of the models is inherently dependent upon these issues being addressed.

The panel is of the opinion that the future UTC and community provision ought to be tackled as part of a bigger plan, which is apparently in place but of which they were not sighted. It is not clear to the panel how primary care will support the future urgent care system in Wirral. There are some gaps in the knowledge base, which are explicitly acknowledged within the case for change, such as GP appointment capacity, that could be pivotal to the success of the implementation of the chosen model. Consequently, **if the workforce capacity allows it, the panel recommends a stepped approach to any changes rather than whole scale change at once.** This would avoid the UTC being overwhelmed at the point it opens and community walk-in services close, and allow evaluation of the impacts and outcomes of each change to be undertaken, with swift identification and mitigation of unforeseen consequences. It would be advantageous to consider the timing of this transition in line with the commencement of services at the nine neighbourhood centres.

Some of the evidence presented in the case for change is contradictory, and does not seem to support the proposed solution. For example, there is a suggestion that community WICs reduce ED attendances amongst their local population, but that the areas around some of the community WICs can have higher than average attendances at ED. It is recommended that more analysis is undertaken to look at which WICs are reducing ED attendances, and which are not, and looking to learn from that intelligence and apply it to the future model.

In conclusion, based on the information provided to the panel, they are not confident that the best model has yet been defined and offered as an option.

5.3 Does the preferred model's clinical case fit with national best practice?

The panel agree that a UTC with a full list of facilities and services as suggested in the preferred options document appears to fit with current best practice, including guidance from NHS England and the Five Year Forward View. Streaming from the front of the ED also fits. However, according to NHS England, NHS Improvement and the Royal College of Emergency Medicine (RCEM), **this should be managed by the Acute Trust[1].**

The panel were not clear as to whether national best practice fits with the population needs and health economy of Wirral, and noted that national best practice is an outline of what can be used to achieve the right goals. The meeting of best practice guidance should not be the reason to reconfigure services in a way that may be detrimental to patient care. **Clarity regarding the aims and objectives of the proposals, including modelled improvements of outcomes, are needed to identify whether this model is in fact the best one for Wirral.**

[1] Gateway 06842 July 2017 https://www.england.nhs.uk/wp-content/uploads/2017/07/principles-for-clinical-streaming-ae-department.pdf Accessed 18:15, 27/11/18

The panel's view was that some groups, particularly those opposing the proposals, may not accept compliance with national best practice as a valid rationale for change. It has been evidenced in numerous other areas that local people often want to retain the services they have regardless of whether or not it meets national standards. Robustly modelled outcomes may be a more compelling way to get people to see the benefits.

Mental health services are a national priority, and are highlighted as a local priority in both the case for change and during the panel's visit. The current model can result in patients waiting for some time for assessment/ admission in ED, GP practice and community, often in environments that are less than ideal. There was no evidence of how solutions to these issues have been explored within the new UEC proposals.

5.4 Have innovations to practise been fully explored?

Within individual organisations there appear to have been some innovations and solutions found by frontline staff. These include the DVT service providing Doppler scans in the community and a telemedicine service into nursing and care homes.

However, there does not appear to be sharing of innovation outside of organisational silos. Nor is there evidence of innovative solutions across organisational boundaries to find robust solutions to the problems a small and distinct population has in accessing appropriate urgent care. This has a direct effect on the ability of the acute trust to provide emergency care to the sickest patients. **The panel recommends an "innovations day" for clinical staff across the organisations might be a good starting point.**

In particular, there does not seem to be any evidence of innovative solutions for mental health patients presenting acutely out of hours at ED with a range of problems. It appears that the only option for these people is being brought to the ED but for many this is likely to be an unsuitable environment. **Engagement with Cheshire & Wirral Partnership Trust (CWP) is essential to find solutions** for this group of patients. Additionally **the panel recommends the provision of an acute assessment area, provided by CWP, in appropriate surroundings for patients presenting with acute mental health problems including detention on section 136.**

The panel were told that new innovations would not being considered until a final proposal was approved. The panel rejects this as a plausible rationale and feels it is illogical as innovative approaches and ideas can be an enabler to alternative solutions. This includes both clinical and workforce innovations as discussed in section 5.8.

Many innovations have been tried and tested in other areas, and so wholly unique innovations may not be a reasonable expectation. However, the panel was disappointed with the lack of evidence of utilising innovation from other areas. For example, an Emergency Village co-located in ED for acute admissions, is a model worth considering for Wirral.

5.5 Have all the clinical interdependencies been considered?

The panel is not convinced that all clinical interdependencies have been considered adequately. This is a complex UEC system with many multiple providers and interdependencies. Consequently it is confusing, difficult to understand, and as a result not optimised in terms of quality or cost.

The proposals address some key interdependencies at the frontline to some extent. However there is plenty of evidence to suggest that there is a considerable amount of work to be done to overcome the current silo working and lack of collaboration between organisations. **The partners need to work together to consider patient care pathways rather than just services and to allow pressured frontline staff to develop in as stress free an environment as possible.**

Interdependencies with primary care, patient streaming and flow within the hospital have already been discussed in this report. Although these services are beyond the scope of this review, the quality and effectiveness of them has a direct impact on the in-scope services and proposals, and **must therefore be considered and addressed**.

From a practical perspective, these proposals will only be successful if the **ED, UTC and any remaining WIC are managed under a single line of clinical governance.** This includes acute assessment facilities (e.g. acute admissions and surgical admissions). This may mean crossing historic and, in many cases, meaningless organisational boundaries, but could be regarded as being truly innovative in NHS terms.

The most important interdependency for the ED and the four hour target is the Acute Medical Unit (AMU). The proposals will remove some patients from the front of house to the UTC and whilst this may reduce attendances and have some impact on the four hour target, it will not reduce the stress and pressure on the ED staff. To do this the **AMU needs to be fully staffed as a priority**. In addition **a fully resourced expansion of the bed base is required** (it should be noted that this is not the same as increasing the number of beds with the same staff) and must be a priority for both the acute trust and the commissioners. At the time of writing, a Royal College of Physicians assessment of the ED and assessment areas was awaited.

The panel is particularly concerned about the lack of recognition of interdependencies with mental health services and social care provision. The interdependencies with mental health are covered in section 5.4. **Earlier access to Liaison Psychiatry for suitable mental health patients is an option for consideration.**

In terms of social care a strengths-based approach connected to a future UEC model may assist in reducing demand. This can be delivered through the independent and voluntary sectors as well as mainstream social care. The panel acknowledges that commissioners may envisage this being delivered through the community hubs,.

The lack of a shared IT system further compounds the problems. Whilst a single system would help, it is far from the main solution needed.

5.6 Do the proposals make the most effective use of the workforce for service delivery?

The panel does not feel that workforce issues have been adequately explored and consequently recommends that **a workforce review is needed to gain an accurate picture of the current workforce, their preferences for working across the system, and how this maps to the proposals.**

Whilst it is difficult, from the limited information available, to gauge how effectively the current resources are being use, there clearly must be some duplication at present. The panel note that there was no increased uptake in other WIC/MIU when the Eastham Clinic as temporarily closed. This indicates that it is highly likely that there is some inefficiency in the current workforce system. The proposals will certainly make more effective use of the workforce assuming silo working is removed. This is essential if high quality and efficient care is to be provided.

It is not clear whether the required workforce to deliver the proposed models is available. Wirral is highly fortunate to have a loyal workforce, particularly in nursing and other non-medical supporting professions. Partners all seemed confident that they would be able to recruit any staff needed to deliver the future model of care. However the panel did not see any evidence to support that confidence, particularly when they are carrying vacancies in AMU and middle grades, as an example.

The number of substantive vacancies in AMU is a concern and a risk for the proposals. The expansion of ambulatory activity without senior staff is not sustainable. Existing gaps in middle grade staff in other departments is a concern and has led to inefficiencies with consultants having to cover middle grade shifts.

The panel had concerns about the use of the term “Advanced Nurse Practitioner” (ANP) in the local workforce when they do not all have the Clinical MSc in Advanced Practice. There was evidence that local “ANPs” at APH and Miriam WIC have only undertaken modules in clinical examination skills an independent prescribing. This is not broadly recognised as an ANP qualification. Even with the MSc, ANPs would be expected to also have ongoing support and mentoring from experienced clinicians. The panel is concerned that a workforce is being assembled in numbers, but not in skills and experience, and this could jeopardise quality of care under future proposals.

The plethora of staff in some WIC, and services across Wirral, could be creating a demand culture in some areas where there is not an actual clinical need.

The plan to increase GP provision is welcomed.

5.7 Have future workforce implications been considered?

This has been discussed to some extent in the previous section. The panel does not think that the implications and impact of the proposals on the workforce have been fully understood or articulated.

There is very little information regarding relationships with training organisations including Health Education England and universities to ensure workforce sustainability over the coming years. **The aforementioned workforce review, which is required, needs to ensure a sustainable workforce both through an understanding of planned future retirements, and for developing a future workforce through training places. These need to be modelled against a clear workforce plan of what the proposed workforce structure needs to be to deliver the future model of care.**

The panel feels that not all staff are fully sighted on the proposals and/or did not understand the impact of the proposals upon themselves.

Whilst the proposals to increase GP and primary care provision are welcomed, there is no visible strategy regarding how this will happen.

5.8 Have innovative workforce models been considered?

The panel's view is that there is a very traditional model of health care in Wirral. The proposals do not clearly articulate if and how innovative models will be used to change this and deliver transformation of the UEC system as part of the proposals.

As discussed in section 5.4 of this report regarding clinical innovations, the panel were told that innovations (clinical and workforce) were not being considered until a final proposal was approved. The panel's view is that this is illogical, as innovative approaches and ideas can be an enabler to alternative solutions.

The panel feels that clinicians may be able to suggest innovative ways of working utilising the workforce effectively in the future. However this is stifled by organisational silo working.

5.9 Have all stakeholders, including staff, third sector organisations, public and service users, been properly engaged in developing the proposed changes?

Gunning Principles are the gold standard for public consultation and consist of four criteria that should be met by all public consultations, including NHS. CCG colleagues were convincing in their assertions that the current consultation is a genuine listening exercise and that no decisions have been made about the future plans for UEC services. They were also convincing in their assertions that they welcome alternative service model ideas and suggestions to those being consulted on, and those that have already been considered and discounted for the reasons specified.

The panel was satisfied that a great deal of work has gone into engaging the public and catering to a range of demography. They were provided with a very comprehensive "September 2018 Engagement Plan" and an "Engagement Strategy" spreadsheet which covered the dates, their audiences and attendees. Audiences included a wide range of individual stakeholders and organisations such as staff, the general public, GPs, MPs and Councillors. The CCG clearly anticipated challenges from some stakeholders and included within the plan comprehensive messages of mitigation.

The dedicated microsite includes animations and a translation service, and provided assurance that the CCG has invested time, effort and consideration in ensuring that the consultation is accessible to people for whom English is not their first language and for those with learning disabilities.

Evidence was apparent in the online presentation "*Review of Urgent and Emergency Care Services in Wirral"* as to how the considerable engagement had informed the plans to reach the proposals that were being consulted.

It was clear that there is passionate support for the current services in the community, and some work in the background to demonstrate this support (for example, Miriam MIU/WIC has an ongoing petition). Whilst there may never be a full agreement about the future of these services, full engagement amongst this population might have been expected to mollify matters somewhat.

The evidence to support effective staff engagement was less apparent to the panel than that for public engagement. Whilst the executive teams and most senior clinical leads talked about working together, our visit suggested staff working in the departments were less aware of this intention, or had not been engaged with to bring this to the fore.

Certainly the impression given by the clinical teams was that they did not appear or feel engaged and involved in the current service provision models, being seemingly unclear on what other parts of the service provide and how they function. A meaningful engagement of staff would have resulted in them having more understanding of the current state as well as the final proposed model. The people the panel met were mainly senior clinical staff, who might be expected to have been more engaged than their more junior colleagues. Consequently it is likely that lower grade staff have been even less engaged.

The panel recommends that opportunities for engagement and interactions between staff of different organisations are actively promoted and encouraged to help develop joint working, in order to work towards new models.

The panel found it difficult to find evidence regarding how proposals have been shaped via patient, carer, or staff engagement.

6. Conclusions

To summarise, the review panel concludes as follows:

6.1 There is a clear need for change in the UEC system in Wirral.

6.2 They do not believe that either of the options being consulted on will resolve the numerous problems currently being experienced, such as flow through the A&E, multiple IT systems and a fragmented hospital front door.

6.3 Co-siting the UTC with the ED at APH will have clear benefits that cannot be attained by siting in any other location.

6.4 Other service configurations should be modelled as alternatives to the recommended models.

6.5 There is scope for more innovation across clinical and workforce considerations.

6.6 Further consideration of clinical interdependencies is needed.

6.7 Workforce issues have not been adequately explored.

6.8 The current consultation is a genuine listening exercise and no decisions have been made about the future plans for UEC services

6.9 A great deal of work has gone into engaging the public and catering to a range of demography

6.10 The evidence to support effective staff engagement was less apparent to the panel than that for public engagement.

7 Recommendations

The panel makes the following recommendations (below), which are intended to be supportive and constructive:

7.1 Other combinations of service should be modelled. In particular there should be further exploration with regards to maintaining a walk-in facility in at least one of the areas to the east of the M53 corridor.

7.2 ED requires capital investment to reconfigure to make the proposed models effective.

7.3 Effective communication of plans to offset the effects of additional patient flow to APH is needed to staff, partners and the public.

7.4 Consider providing services / clinics in the community hubs and/or neighbourhood centres as practicable. These could include secondary care, extended hours primary care, dressings, and mental health services.

7.5 Future UTC and community provision ought to be tackled as part of a bigger plan.

7.6 If the workforce capacity allows it, undertake a stepped approach to any changes.

7.7 Streaming at the hospital front door should be managed by the Acute Trust.

7.8 Clarity is needed regarding the aims and objectives of the proposals, including modelled improvements of outcomes.

7.9 An “innovations day” for clinical staff across the organisations should be held to allow sharing of current innovations and ideas about future innovations.

7.10 Engagement with CWP is needed to find solutions for people presenting acutely out of hours with a range of mental health issues.

7.11 An acute assessment area in appropriate surroundings for patients presenting with acute mental health problems including detention on section 136, needs to be provided.

7.12 Partners need to work together to consider patient care pathways rather than just services and to allow pressured frontline staff to develop in as stress free an environment as possible.

7.13 Interdependencies with primary care, patient streaming and flow within the hospital must be considered and addressed.

7.14 ED, UTC and any remaining WIC must be managed under a single line of clinical governance.

7.15 AMU needs to be fully staffed as a priority.

7.16 A fully resourced expansion of the bed base is required.

7.17 Consider a model with earlier access to Liaison Psychiatry for suitable mental health patients.

7.18 A workforce review is needed to:

- Gain an accurate picture of the current workforce, their preferences for working across the system, and how this maps to the proposals.
- Ensure a sustainable workforce both through an understanding of planned future retirements, and for developing a future workforce through training places.
- Model a clear workforce plan of what the proposed workforce structure needs to be to deliver the future model of care.

7.19 Opportunities for engagement and interactions between staff of different organisations are actively promoted and encouraged to help develop joint working, in order to work towards new models.

Appendices

Appendix 1 - Terms of Reference

Independent Clinical Review: TERMS OF REFERENCE

1. STAKEHOLDERS

Title: Wirral Urgent Care Services

Sponsoring Commissioning Organisation: Wirral CCG

Lead Clinical Senate: GMLSC

Terms of reference agreed by: Prof Donal O'Donoghue (Chair, GMLSC Clinical Senate), Dr Paula Cowan (Medical Director, Wirral CCG) and Nesta Hawker (Director of Commissioning, Wirral CCG)

Date: **June 2018**

Clinical Senate Chair: Prof Donal O'Donoghue
Clinical Senate Review Chair: Dr Gareth Wallis
Citizen Representatives: Ray Murphy

Clinical Senate Review Team Members:

REVIEW PANEL MEMBER
Patrick MacDowall, Consultant Nephrologist, Lancashire Teaching Hospitals NHS Trust
Mamta Buch, Consultant Cardiologist, Manchester University Teaching Hospitals
Phil McEvoy, Managing Director, Six Degrees Social Enterprise
Mark Holland, Consultant in Acute Medicine, Salford Royal NHS Foundation Trust
Damian Nolan, Divisional Manager, Halton Borough Council
Gill Johnson, Nurse Consultant, Central Manchester University NHS Foundation Trust
Andrew Simpson, Consultant in Emergency Medicine, North Tees and Hartlepool NHS Foundation Trust

2. QUESTION & METHODOLOGY

Aim of Review: To undertake an independent clinical review of the proposed plans for urgent and emergency care services delivered in Wirral, in line with the NHS England Stage 2 assurance process.

Main objectives of the clinical review:

- Clinical Quality:
    - Have all potential alternative options to the preferred model been considered (including co-operation and collaboration with other sites and/or organisations)?
    - Is this the optimal model for the Wirral population?

    - Does the preferred model's clinical case fit with national best practice?
    - Have innovations to practise been fully explored?
    - Have all the clinical interdependencies been considered?
- Workforce:
    - Do the proposals make the most effective use of the workforce for service delivery?
    - Have future workforce implications been considered?
    - Have innovative workforce models been considered?
- Engagement
    - Have all stakeholders, including staff, third sector organisations, public and service users, been properly engaged in developing the proposed changes?

Scope of the review:
In scope: Urgent and emergency care services commissioned by Wirral CCG including A&E, walk-in centres, minor injuries centres and GP out of hours
Out of scope: Major trauma, dentistry
Out of scope but key Interdependencies: Pharmacy, NWAS, 111

Outline methodology:
Review panel visit

Timeline: **June - December 2018**

Reporting arrangements
The clinical review team will report to Dr Gareth Wallis, Panel Chair, on behalf of the North Region Clinical Senates, who will consider and agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the media handling of the report and subsequent publication of findings will be agreed within 3 months of delivery.

3. KEY PROCESS AND MILESTONES

a. Discussion with Clinical Senate Chair and Medical Director 22nd June (complete)
b. Discussion with Clinical Senate Chair, Commissioner and Review Team Lead to finalise Terms of Reference 22nd June (complete)
c. Information for review submitted by Commissioner and distributed to review team – 22nd October 2018 (complete)
d. Review Team WebEx/Teleconference - w/c 5th November 2018 (complete)
e. Requests for clarification and/or further information from Commissioners w/c 12th November 2018 (complete)
f. Review Panel Visit – 26th November 2018
g. Panel submit finding for report writing - 28th November 2018
h. Draft report back to panel for accuracy checks – 3rd December 2018 Return – 10th December 2018
i. Final report drafted & sent to commissioners for comment – 12th December 2018 Return 16th December 2018
j. Final report produced – 17th December 2018

k. Sign off of final report by Clinical Senate Council – 17th December 2018
l. Published to commissioner - 18th December 2018

4. REPORT HANDLING

A draft clinical senate report will be made to the sponsoring organisation for fact checking prior to publication on **18th December 2018**

Comments/ correction from Commissioners received by **16th December;** the final report will be submitted by the Clinical Senate to the sponsoring organisation by **18th December 2018.**

The report will be ratified by the Clinical Senate Council on the **17th December 2018.**

5. COMMUNICATION AND MEDIA HANDLING

The Clinical Senate aims to be open and transparent in the work that it does. The Clinical Senate would request that the sponsoring commissioning organisation publish any clinical advice and recommendations made. The Clinical Senate is aware of the sensitivities related to service change and reconfiguration and so an agreement will be reached in discussion with the sponsoring organisation in relation to the timing and process of publication.
Name of Communication Lead Sponsoring Commissioner:

6. RESOURCES

The clinical senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.
The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

7. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the North Region Clinical Senate accountability and governance structure.
The Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring commissioning organisation.
The sponsoring commissioning organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and

8. FUNCTIONS, RESPONSIBILITIES & ROLES

<u>The sponsoring organisation will:</u>

I. Provide the clinical review panel relevant information, this may include: with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance, service specifications. Background

information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions). The sponsoring organisation will provide any other additional background information requested by the clinical review team.

II. Respond within the agreed timescale to the draft report on matter of factual inaccuracy.

III. Undertake not to attempt to unduly influence any members of the clinical review team during the review.

IV. Submit the final report to NHS England for inclusion in its formal service change assurance process.

<u>Clinical senate council and the sponsoring organisation will:</u>

V. Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

<u>Clinical Senate council will:</u>

VI. Appoint a clinical review team; this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.

VII. Advise on and endorse the terms of reference, timetable and methodology for the review

VIII. Consider the review recommendations and report (and may wish to make further recommendations)

IX. Provide suitable support to the team and

X. Submit the final report to the sponsoring organisation

<u>Clinical review team will:</u>

XI. Undertake its review in line the methodology agreed in the terms of reference

XII. Follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.

XIII. Submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.

XIV. Keep accurate notes of meetings.

<u>Clinical review team members will undertake to:</u>

XV. Commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).

XVI. Contribute fully to the process and review report

XVII. Ensure that the report accurately represents the consensus of opinion of the clinical review team

XVIII. Comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it.

Appendix 2: Draft Model of Care

- Integrated Urgent Care Clinical Assessment Service (further described below) provides access to urgent care via NHS 111, either a free-to-call telephone number or online and will provide complete episode of care concluding with either: advice, a prescription, or an appointment for further assessment or treatment.
- The bottom layer is the Accident and Emergency Department located in Arrowe Park which will remain as a Category 1 (major) accident and emergency department.
- The next layer the model of care is the Urgent Treatment Centre (UTC) (further described below) which would provide a single front door for patients walking into A&E or the UTC and will triage and clinically assessed within 15minutes of arrival, and given an appointment slot within 2hrs of arrival. An urgent treatment centre will be created on the Arrowe Park Hospital site, open a minimum of 12 hours per day 7 days a week. The UTC will be GP led and treat minor illnesses and injuries and will include access to diagnostics (e.g. x-rays, bloods etc.) and will be integrated with A&E to enable consultant advice where required.
- The green layer of the model, (described further below) proposes; the Healthcare and Advice Centres would provide senior nurse appointments. These centres could also provide some intermediate care services such as a child and family offer and utilise technology to enable rapid access to diagnostics and advice from specialist e.g. such as Consultant Connect. They would have a wellbeing approach to the delivery utilizing a health coach model to promote self-care and access to other health and social care services such as voluntary sector & social care information, advice & guidance and a pharmacy onsite.
- The blue layer represents the Primary and Community Care offer; including GP practices, community nursing and other community services that much of the population access close to home. This proposal does not propose changes to this layer of care but does

acknowledge that there will be additional appointments available with extended opening hours in some GP Practices, meaning that GP appointments will be available 8am-8pm 7 days a week. This will likely to be provided in a cluster/hub basis across 9 localities. It is proposed that some of these hubs would be integrated and co-located with the Healthcare and Advice Centres and urgent treatment centre. The primary care offer will also include same day appointments booked via NHS 111 for urgent need and will manage urgent domiciliary visits at a time of day appropriate for patients to help to avoid unnecessary admissions to hospital and improve patient experience. There is also planned education programme to develop skills in health coaching to enable self-care which complements the approach within the Healthcare and Advice Centres.

- The wellbeing, education and community support layer includes access to schools, voluntary organisations, pharmacies and technology that can support prevention of ill health and promotion of self-care. This layer of support will be promoted throughout the model of care, technology will enable up to date signposting and tools for self-care.

<u>Urgent Treatment Centre based at APH</u>

It is proposed that one Urgent Treatment Centre will be required for Wirral. This centre will be on the Arrowe Park site for the following reasons:

- It meets population need: the Case for Change highlighted that due to the size of the population, geography of Wirral and demand for urgent care services one centre at this location would meet the population need.
- It meets NHS England standards: one of the National Standards includes having access to an A&E Consultant which would be achievable on the Arrowe park site; there is also the facility in A&E to treat patients who may deteriorate rapidly and require more acute intervention.
- It would provide a more streamlined pathway of care for patients: the Urgent Treatment Centre would provide a single front door at the Arrowe Park Site for patients with an urgent care need; this would be a more seamless pathway for patients, who would be seen by the most appropriate clinician in a timely manner. There is evidence base to show the benefits of urgent care services that are co-located within emergency departments for example co-located services can stream patients through one front door and thus reduce A&E attendances.

The Urgent Treatment Centre will meet the national standards along with the additional elements such as the triage of patients and direction to appropriate clinician including access to Psychiatric Liaison for mental health (building on development to meet core 24 standards by 2020/21) as appropriate. It would also offer a wellbeing offer such as voluntary sector, information and advice service and a pharmacy onsite and the ability to book appointments directly with some community services e.g. smoking cessation.

Implementation of an Urgent Treatment Centre will enhance patient experience through delivery of additional services, ensuring access to diagnostics to enable more patients to have their needs met without the need to go to A&E. We are also anticipating that fewer patients will require an admission. The integration with A&E will provide direct access to the A&E consultants to support decision making within the urgent treatment centre and

patients will be seen and treated within a maximum of 2 hours compared to 4 hour A&E standard.

Integrated NHS 111 and GPOOH service

Alongside the above, Wirral will be developing an Integrated Urgent Care Clinical Assessment Service (IUC CAS) with NHS 111 and GP Out of Hours to enable more needs to be met by NHS 111. The full details of this are specified within NHS England's 'Integrated Urgent Care Service Specification'

The introduction of an IUC CAS will fundamentally change the way patients access health services, the model for an IUC CAS requires the following offer for patients:

- Access to urgent care via NHS 111, either a free-to-call telephone number or online
- Triage by a Health Advisor
- Access to GP advice 24/7 with support from a multidisciplinary clinical team
- Consultation with a clinician using a Clinical Decision Support System (CDSS) or an agreed clinical protocol to complete the episode on the telephone where possible
- Direct booking post clinical assessment into a face-to-face service where necessary
- Electronic prescription
- Self-help information delivered to the patient
- As many clinically appropriate calls to NHS 111 as possible should be closed following consultation with an appropriate clinician, negating the need for onward secondary care referral or additional signposting.

Appendix 3 – Summary of Service Offer Under Three Options*

	Option 1 8 hour community offer	Option 2 12 hour community offer	Option 3 15 hour community offer	Urgent Treatment Centre
Bookable appointments	✓	✓	✓	✓
Walk in (dressings/wound care & non-urgent Paeds)	✓	✓	✓	✓
GP led (with MDT Team)	✓	✓	✓	✓
Access to A&E Consultants	X	X	X	✓
Access to same day X-Ray referral (at a designated X-Ray site)	✓	✓	✓	✓
Treatment of Minor Injuries	✓	✓	✓	✓
Treatment of minor Illnesses	✓	✓	✓	✓
Prescribing	✓	✓	✓	✓
Simple diagnostics (bloods, urinalysis, ECG)	✓	✓	✓	✓
Dressing service/wound Care	✓ (8 hrs)	✓ (10 hrs)	✓ (15 hrs)	✓
Routine phlebotomy	X	X	X	✓
Specialist Paediatric Service (walk in / GP referral)	✓ (8 hrs)	✓ (10 hrs)	✓ (15 hrs)	Paediatric A&E Dept.
MDT Offer	✓	✓	✓	✓

* Option 3 has been discounted.

Appendix 4 - Programme for visit on 26th November 2018

Time	Item	Details
9:00am – 9.45am	Arrival at : Arrowe Park Hospital	Review Panel meet for initial discussions prior to the start of the review Venue: Executive Room, Trust Headquarters, APH
9.45am – 10.15am	Meet & Greet	WUTH Clinical Team Representation
10.15am - 11.15am	Walking tour of Arrowe Park Hospital / Opportunity to speak to clinical teams / nursing staff / patients & carers etc	
11.15am – 12.15pm	**Group 1** tour of APH WIC & lunch	Tour of Arrowe Park Walk in Centre. Lunch at the centre at 12 noon
11.15am – 11.45am	**Group 2** travel to VCH WIC	Travel by car to Victoria Central Hospital (Walk in Centre and Minor Injury Unit)
11.45am – 12.45pm	**Group 2** Arrival at VCH Walk in Centre & lunch	Clinical Team Representation - Meet & Greet. Lunch at the centre at 12 noon.
12.45pm – 1.45pm	**Group 2** Walking tour of VCH Walk in Centre & MIU / Opportunity to speak to clinical teams / nursing staff /	
12.15pm - 12.45pm	**Group 1** travel to Miriam Minor Injury Unit	
12.45pm - 1.45pm	**Group 1** visit at Miriam MIU	Walking tour of MIU / Opportunity to speak to clinical teams / nursing staff
1.45pm - 2.15pm	**Group 1** travel back to WUTH (from Miriam)	
1.45pm - 2.15pm	**Group 2** travel back to WUTH (from VCH)	
2.15pm – 3.00pm	Review Panel Discussion and Reflections	Venue: Executive Room, Trust Headquarters, APH
3.00pm – 3.45pm	Discussion & QA Session	WCCG, WUTH & WCT Exec Teams
3.45pm – 4.15pm	Discussion & QA Session	WCCG, WUTH & WCT Clinical Teams