Northern England Clinical Senate

North Tyneside Urgent Care Review

June 2016

Contents

1. Introduction and Background

North Tyneside Clinical Commissioning Group (CCG) signed off its Urgent Care Strategy in March, 2015 and began a three month public consultation on a number of scenarios for implementation of the strategy in November, 2015. An approach was made by the CCG to the Northern England Clinical Senate during the summer of 2015 for the Senate to provide some constructive challenge and support to the CCG as it developed the detail behind the scenarios. The first of these informal support sessions was in November, 2015 and the second in January, 2016.

Given the considerable challenges being faced by the CCG, NHS England asked that the Northern England Clinical Senate be commissioned to provide clinical assurance as part of NHS England's formal assurance process. To this end an agreement was reached to convene a panel of clinical experts to undertake the review on behalf of the Clinical Senate. The three clinical members of the panel were

Member	**Role**
Dr Peter Weaving (Chair)	General Practitioner, Carlisle and member of Northern England Clinical Senate Council
Dr Nigel Rowell	General Practitioner, Teesside and Clinical Lead, Northern England Cardiovascular Clinical Network
Dr Mike Jones	Consultant Physician, County Durham and Darlington NHS Foundation Trust and member of Northern England Clinical Senate Council

Biographies for the panel members are included as Appendix A.

The panel was supported managerially by Roy McLachlan, Associate Director of Clinical Networks and Senate and by two members of his support team, Michelle Wren and Denise Preston.

Terms of Reference for the review were agreed with the CCG; an extract is given in section 2 below and the full Terms of Reference are given as Appendix B.

The date for the review was established as Thursday, 9th June 2016 and it was agreed it would take place at Newcastle Racecourse, Newcastle upon Tyne in the Brandling Suite. The date of the visit was also scheduled to fit in with the planned decision making processes of the CCG. This report was available in draft during week commencing 20th June 2016 for the final version of the report progress against gaps is noted in the relevant sections below.

2. Terms of Reference

An extract from the Terms of Reference is given below, summarising the main issues to be considered by the review panel.

North Tyneside CCG carried out a review of urgent care provision across the borough during 2015/16. The rationale for this was:

- *The opening of the Northumbria Specialist Emergency Care Hospital (NSECH) in June 2015 left North Tyneside with three overlapping services all providing walk-in access to urgent care.*
- *The public finds the current urgent care system confusing and difficult to navigate.*
- *The financial situation of the CCG makes the current configuration of urgent care services unaffordable.*

The outcomes of the review are set out in the Case for Change *document. The review formed the basis for a public consultation exercise which ran from October 2015 to January 2016, the results of which can be found in the* Right Care Time & Place *report. The outcomes of both these documents were used to inform the production of the* North Tyneside Urgent Care Business Case *which sets out the CCG's preferred option and next steps.*

The aim of the clinical review is to assess and assure the clinical model that will underpin the urgent care service that the CCG intends to commission from 2017/18 onwards. Issues relating to the consultation process, business planning and procurement strategy will be assured separately by NHS England and will fall outside the scope of the clinical review.

The full Terms of Reference are given as Appendix B to this report.
The following timeline was established for the production of this report

- First draft available to CCG for accuracy check in early week commencing 13th June 2016
- Final version available week commencing 4th July 2016

It was recognised by all concerned that this timeline was much tighter than usually expected for a Clinical Senate report.

3. Methodology

A range of documentation was made available to the Senate Review Team by the CCG in advance of the review visit and was presented via email over a period of weeks. A list of documents provided is detailed in Appendix C.

The agenda for the day was designed carefully to allow the CCG to present their plans to members of the review panel and to give plenty of opportunity for the panel to ask questions and enter discussion about the proposals.

The planned agenda for the day is included as Appendix D; it should be noted that it was decided, on the day, not to proceed with the second round of Q&A.

A list of attendees for each session is included as Appendix E.

The review panel had several opportunities to deliberate on discussions throughout the day and had a final session to discuss the possible contents of this report before the end.

4. Findings of the panel

The panel had an opportunity to seek clarification of issues covered in the formal presentation which lasted about 40 minutes. The panel then decided, in recess, which topics needed further exploration in a Q&A session with the CCG team. The panel used elements of an assurance grid prepared at an earlier stage of NHS England's assurance process, as the basis for the Q&A session. A copy of the grid used is given as Appendix F.

Each of the topics covered are set out below.

4.1 Clinical Support

Reference had been made during the formal presentation to there being high levels of support amongst GP practices for the proposed scenarios from the public consultation, and to the preferred location of the Urgent Care Centre. It was pointed out that in the Appendix to the draft Business Case, where details of the Pre Consultation Stakeholder Engagement are set out, there are only a few GPs listed. The suggestion was made that the CCG needed to provide substantially more evidence of GP support for the proposals as part of the Business Case given that such support is one of the four tests NHS England would be applying in considering approval for the planned changes.

Early July progress
The panel has noted that in version 5.6 of the Business Case that extensive evidence has been provided of GP involvement and engagement in developing the clinical model.

4.2 Care Pathway and Interdependencies

Section 2.2.3 of the draft Business Case was noted to be work in progress. The panel asked that they be sent a copy of the finalised section of the Business Case to ensure it addresses all the relevant issues set out in the assurance grid.

Early August progress
The panel has noted that in version 5.12 of the Business Case section 5.3.10 that more detail is available on the Care Pathway and Interdependencies. This includes escalation pathways for frequent attendees and patients experiencing a mental health crisis. Further, in appendix 4 two detailed pathways are provided for children. There appeared to be no escalation pathways detailed for frail elderly but this work could be finalised during the implementation of the proposed new service.

4.3 Specific Measurable Outcomes

As with 4.2 above, section 7 of the draft Business Case was also noted to be work in progress. The CCG team were able to reassure the review panel that there was every intention to include measurable outcomes that can be audited.

The panel asked that they be sent a copy of the finalised section of the Business Case to ensure it addresses all the relevant issues set out in the assurance grid.

Early July progress
The panel has noted that in version 5.6 of the Business Case section 9 does include a range of specific measurable outcomes.

4.4 Workforce

Specific questions were raised by the panel regarding relative responsibilities for TUPE and any redundancy payments. The CCG team felt that both elements would be for the provider of a decommissioned service to consider rather than the CCG as commissioner. The panel believed it would be important to clarify this and to include evidence in the final Business Case that the CCG had considered the issues fully and identified responsibility accordingly.

Further, the panel asked about paediatric expertise being available in the Urgent Care Centre; the CCG assured the panel it would be available and it was suggested that this be written into the final Business Case and the Service Specification.

Early August progress
The panel has noted that in version 5.12 of the Business Case section 5.2.14 and appendix 8 there is more, and sufficient, detail than previously about workforce.

4.5 Impact on other providers

The review panel asked about the modelling that had been undertaken to assess the impact on other providers. The CCG indicated that modelling had been undertaken and made reference to, for example, the situation in South Tyneside post the closure of the Jarrow Walk In Centre where only three practices were not able to offer a same day appointment due to increased demand. It was suggested that more detail be included on the modelling that had been undertaken in the final Business Case, particularly around primary care.

Early August progress
The panel has noted that in version 5.12 of the Business Case further detail has been provided on the impact on other providers. Further analysis has been provided including details of schemes intended to mitigate A/E increases.

4.6 Activity

This element of risk generated significant discussion.

It was noted that activity for urgent care had increased substantially between 2014/15 and 2015/16 (chart 1 in the draft Business Case refers). It was also noted that the plan was to decrease overall urgent care activity by 20 – 26% depending on location of the centre with potential financial savings of £800,000. It was further noted that the opening of NSECH in June 2015 appeared to have generated increased demand for urgent care. With all three of these features the panel pointed out the risk the CCG was carrying to realising the planned decrease in activity. The CCG team acknowledged that this was a risk the CCG would have to bear if the plans did not come to fruition.

It was also suggested that the CCG might want to include activity modelling which took into account figures including quarter 4 in 2015/16 and to undertake a sensitivity analysis of the impact of potential increases as well as reductions in predicted activity levels.

Early August progress
The panel has noted that in version 5.12 of the Business Case further detail has been provided on activity modelling including appropriate sensitivity analysis.

4.7 Information Technology

The panel encouraged the CCG to specify the use of web based technology by the new provider to access medical records, and indeed, to consider stipulating the use of the same IT system as GPs in the CCG.

4.8 Members of Parliament (MPs) and Local Authority support

The CCG team gave assurances that they were confident the two local MPs and the councillors from the Local Authority, all appeared supportive of the proposals to date. The panel highlighted the risks around not having explicit support.

5. Summary

Overall the panel was very impressed with the progress made by the CCG in bringing a complex set of proposals to the implementation stage.

There were eight specific areas of risk (see above) for the CCG to address, some of which require more evidence to be provided in the final Business Case. The panel would also want to encourage the CCG team to address all the relevant issues detailed in the assurance grid (Appendix F) for NHS England.

The panel was confident the CCG understood all its risk areas especially those financial risks associated with activity levels.

Biographies

Dr Peter Weaving, North Cumbria University Hospitals

Peter Weaving is a GP partner in Carlisle and emergency department doctor with North Cumbria University Hospitals Trust working at Whitehaven. Previously Clinical Director for Urgent Care and a GP Clinical Director for the same trust he has also spent a number of years on the commissioning side in Cumbria from Primary Care Groups, as the chair of Eden Valley PCG and was then the Professional Executive Committee Chair of the Eden Valley Primary Care Trust before moving back to the primary care side as the clinical chair of a Practice Based Commissioning group. He then joined the newly formed Cumbria Primary Care Trust which became Cumbria Clinical Commissioning Group and in 2011 he became its clinical chair in a shared role until moving into secondary care in 2013. He has represented Cumbria on the Northern Clinical Senate since then.

Dr Michael Jones, Consultant in Acute Medicine, County Durham and Darlington NHS FT

Current Posts:
Consultant and Clinical Lead in Acute Medicine
University Hospital of North Durham
Senior Lecturer University of Durham
Chair of Specialty Advisory Committee for Acute Internal Medicine
Member of Specialty Advisory Committee for General Internal Medicine
Member of Internal Medicine Board of JRCPTB
Director of Standards for Royal College of Physicians of Edinburgh
Education lead for Society for Acute Medicine
National Education Lead for Think Kidneys campaign in England
National lead for the Broad Based Training Programme in UK

Previous Posts in the NHS:
Consultant Physician and Clinical Lead in Acute Medicine Lothian Universities Health Division
National Clinical Lead for Medicine in Unscheduled Care Project in Scotland
Adviser in General Internal Medicine to Chief Medical Officer for Scotland
Deputy Medical Director Tayside Health Board
E-health Director Tayside Health Board
Project Lead for Unscheduled Care in Tayside
Clinical Group Director for Medicine and Cardiovascular Group 2001-2004
Associate Medical Director 1998-2001
Consultant Nephrologist 1992-1999
Lecturer in Medicine Aberdeen University 1985 –1992

Roles outside of NHS:
Dean and Director for Higher Specialist Training in the Royal College of Physicians of Edinburgh
Vice President of the Royal College of Physicians of Edinburgh
Secretary, Vice President and President of the Society for Acute Medicine (UK)

Chair of Specialist Training Committee of Academy of Medical Royal Colleges UK
Chair of Curriculum group for Acute and Internal Medicine in UK
Member of Education Committee of Academy of Medical Royal Colleges UK
Secretary of General Internal Medicine (G(I)M) Specialty Advisory Committee
Chair of the Joint Committee for Basic Medical training
Member of the Joint Committee for Higher Medical Training,
Member of Transitional Executive of Joint Royal Colleges Physicians Training Board
Assessor for Registrar Training for Royal College of Physicians in Ireland
External Examiner for International MRCP examinations
Reviewer for Scottish Medical Journal, Clinical Science and Nephrology, Dialysis and Transplantation.
Reviewer of book proposals for Blackwell Scientific
Reviewer of grant applications for the Medical Research Council and National Kidney Research Fund.
Member of the editorial board for the CPD journal for Acute Medicine and British Journal for Hospital Medicine

Dr Nigel Rowell
GP at the Endeavour Practice Middlesbrough, TS1 2NX

Current Roles:
Board and Governing Body Member South Tees CCG with a role as Executive sponsor for the System Resilience Group (SRG) 2013 -

GPSI in Heart Function South Tees Hospitals FT

Primary Care Lead for CVD, Northern Strategic Clinical Network

Past Roles
South Tees Practice Based Commissioning Group Chair 2010 – 2013

Vice Chairman, Tees Health Authority 1999 – 2002

Commissioning Lead, South Tees GP cluster 1992 – 2002

Fundholding Lead Cleveland Centre Consortium 1995 – 2001

Secretary South Tees BMA

Founder South Tees Practitioners Group 1990 – 2016

PCT Professional Executive Committee and Chair Funding panel 2005 – 2008

Member Cleveland LMC 1995 -2014

Appendix B

Northern England Clinical Senate

SENATE CLINICAL REVIEW

TERMS OF REFERENCE

Title: North Tyneside Urgent Care Strategy

Sponsoring Organisation: North Tyneside Clinical Commissioning Group (CCG)

Clinical Senate: Northern

NHS England regional or area team: NHS Cumbria and the North East

Terms of reference agreed by:

Roy McLachlan

on behalf Northern England Clinical Senate and

(Name)

on behalf of North Tyneside CCG

Date: 9 June 2016

Senate Clinical Review Team Members

Chair: Dr Peter Weaving, General Practitioner, Carlisle and member of Northern England Clinical Senate Council

Dr Nigel Rowell, General Practitioner, Teesside and Clinical Lead, Northern England Cardiovascular Clinical Network

Dr Mike Jones, Consultant Physician, County Durham and Darlington NHS Foundation Trust and member of Northern England Clinical Senate Council

Aims and Objectives of the Clinical Review

To review the clinical model that has been developed for the new urgent care service in North Tyneside and provide independent assurance to NHS England and the CCG Executive.

Scope of the Review

North Tyneside CCG carried out a review of urgent care provision across the borough during 2015/16. The rationale for this was:

- The opening of the Northumbria Specialist Emergency Care Hospital (NSECH) in June 2015 left North Tyneside with three overlapping services all providing walk-in access to urgent care.
- The public finds the current urgent care system confusing and difficult to navigate.
- The financial situation of the CCG makes the current configuration of urgent care services unaffordable.

The outcomes of the review are set out in the *Case for Change* document. The review formed the basis for a public consultation exercise which ran from October 2015 to January 2016, the results of which can be found in the *Right Care Time & Place* report. The outcomes of both these documents were used to inform the production of the *North Tyneside Urgent Care Business Case* which sets out the CCG's preferred option and next steps.

The aim of the clinical review is to assess and assure the clinical model that will underpin the urgent care service that the CCG intends to commission from 2017/18 onwards. Issues relating to the consultation process, business planning and procurement strategy will be assured separately by NHS England and will fall outside the scope of the clinical review.

Timeline

June 2016

Reporting Arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report. Clinical senate council will submit the report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

The review team will look over the proposal/data/ information provided by the CCG (This can be circulated via secure email) then the review team will come together for a one day face to face meeting to discuss the information received as a group and meet with the CCG clinicians and managers to clinically test out the proposal. The timeframe would be for CCG information to be circulated in May 2016 with the face to face meeting on Thursday 9 June 2016.

Report

A draft clinical senate assurance report will be circulated within ten working days from the face to face meeting by the review team to the sponsoring organisation for factual accuracy.

Comments/correction must be received within five working days.

The final report will be submitted to the sponsoring organisation following the Northern England Senate Council meeting in July 2016.

Communication and Media Handling

The arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation.

Resources

The Northern England 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.

Accountability and Governance

The clinical review team is part of the Northern England Clinical Senate accountability and governance structure.

The Northern England Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring 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 address before progressing their proposals.

Functions, Responsibilities and Roles

The **sponsoring organisation** will

i. provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. 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.

Clinical Senate Council and the sponsoring organisation will

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

Clinical Senate Council will

i. 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.
ii. endorse the terms of reference, timetable and methodology for the review.
iii. consider the review recommendations and report (and may wish to make further recommendations).
iv. provide suitable support to the team.

v. submit the final report to the sponsoring organisation.

Clinical Review team will

i. undertake its review in line with the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. 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.
iv. keep accurate notes of meetings.

Clinical Review team members will undertake to

i. commit fully to the review and attend all briefings, meetings, interviews, panels etc, that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Documentation provided by CCG in advance of review panel meeting

- Terms of Reference.
- Urgent Care: Case for Change - NHS North Tyneside CCG.
- North Tyneside CCG Urgent Care Assurance Letter.
- Right care time and place – Consultation on urgent care in North Tyneside – NHS North Tyneside CCG.
- J Harvey Independent Researcher - Right care time and place: North Tyneside Urgent Care Consultation Final Report.
- Urgent Care: Equalities Analysis – NHS North Tyneside CCG.
- Urgent Care Centre Clinical Executive Briefing.
- NHS North Tyneside CCG Urgent Care Assurance Key Line of Enquiry (KLOE's).
- Business Case.
- NHS North Tyneside CCG Urgent Care Service Model Principles.
- Activity Modelling.
- Modelling – Forecast Activity Distributions and Five Year Forecast.

North Tyneside Urgent Care Strategy Review
Agenda

Date:	Thursday 9 June 2016	**Time:**	09:30 – 15:00
Location:	Newcastle Racecourse, High Gosforth Park, Newcastle upon Tyne NE3 5HP Brandling Suite		
Chair:	Dr Peter Weaving		
Panel Members:	Dr Mike Jones, Dr Nigel Rowell, Roy McLachlan		

Time:	Items	Lead
	Meeting – Part 1 – Review Panel Only	
09:30	Welcome, Introductions and Objectives of the Review	Peter Weaving
09:40	Confidentiality Agreement/Code of Conduct	Roy McLachlan
09:45	Discussion on the Papers Submitted	All
	Meeting – Part 2 – CCG Members Join the Panel	
10:15	Overview of Proposal by CCG	All
	Meeting – Part 3 – Review Panel Only	
11:15	Panel Discussion and Identification of Key Issues	All
	Meeting – Part 4 – Q & A Session and Working Lunch	
12:15	Q & A with CCG Members	All
	Meeting – Part 5 – Q&A Session	
13:15	Q & A with CCG Chair	All
	Meeting – Part 6 – Panel Discussion	All
14:00	Panel Deliberations	All
15:00	Meeting Closes	

Appendix E

Attendees at each session

Panel Meeting

9.30am	Peter Weaving Mike Jones Nigel Rowell Roy McLachlan	Michelle Wren Denise Preston

Overview of Proposal by CCG

10.15am	Peter Weaving Mike Jones Nigel Rowell Roy McLachlan Michelle Wren Denise Preston	Mathew Crowther John Mathews Ruth Evans John Wicks

Q & A with CCG Members

12.00pm	Peter Weaving Mike Jones Nigel Rowell Roy McLachlan Michelle Wren Denise Preston	Mathew Crowther John Mathews Ruth Evans John Wicks Charlotte Brand

Appendix F

Assurance Grid

North Tyneside Proposed Urgent Care Service Change (Final pre-decision making assurance expectations)	
Assurance gap	**KLOEs to facilitate full assurance**
Service change process	
Production of a risk log with clear understanding of risks and action to address these	- What process has been followed for highlighting, recording and mitigating risks associated both with the service change process and the proposals themselves? - Please share a copy of the project risk log. - What are the major risks relating to the proposed changes and process and what actions have been taken or are planned to mitigate these?
Clinical support (GP support one of four tests)	- What level of wider practice engagement has there been to retain GP support of the proposed future model as it has evolved, particularly given the anticipated decision to procure an integrated/single site urgent care service at a non-site specific location? - What further wider clinical engagement has there been to support the development of the clinical model i.e. through SRG, with frontline staff, PTS/ambulance providers etc?
Communications and engagement	- How have the views of patients, carers and a wider range of local stakeholders been sought and considered as part of the formal consultation process? - How has this feedback influenced the evolution of your change proposals? If feedback has or will not be actioned, is there a clear rationale for not doing so?
Full equality analyses required for both consultation process scenarios as part of final	- What considerations has the equality analysis of your options highlighted, how have these informed the evolution of your scenarios and selection of your preferred option and what action

decision making process	has or will be taken to mitigate any risks to protected characteristics groups? - Please share the equality analysis undertaken for your consultation process, demonstrating the impact on protected characteristics groups and steps taken to fulfil the Public Sector Equality duty.
Clinical model	
Some work required to clearly articulate projected clinical outcomes, patient experience improvements and metrics Clinical senate review of preferred clinical model required to provide full clinical assurance Risk assessment of patient safety risks associated with model	- What are the anticipated outcomes from the service change from both a clinical and patient experience perspective? Can these be quantified? What is the evidence base behind these predictions? What metrics will be used to measure anticipated outcomes? - How does the prefered option support delivery of the urgent and emergency care review and the integrated urgent care commissioning standards at a local level? - What quality standards are relevant to the proposed change? What scenario modelling has been undertaken to assess the impact of the new model on such standards and are you assured that such standards will be achieved? - How will the various components of the proposed new model integrate with one another and with the wider urgent and emergency care system i.e. links with 111/GP OOH/ED etc? (hand offs/hand ons, escalation procedures etc?) - How will you ensure an integrated urgent care service across a number of different sites/provider types and how will technological and data sharing barriers be overcome to support this? - How will capacity within general practice be created/protected to facilite the provision of 'bookable approintments'?

	- What part will the existing community pharmacy minor ailments service play in the new model? - What consideration has been given to the integration of social care and mental health into the new model? - What part will self-care, patient education and prevention play in the new model? - What work has been undertaken to plan pathways within the new model i.e. triage, diagnostics, pharmacy? - What considerations have been given to both ambulance and patient transport services and how will they be appropriately integrated into the new service design? - What will triage processes look like for 111 and walk-in patients and how will patients be supported to navigate their way through the new service? - What clinical governance/patient safety considerations have informed the model's developed and how they been addressed to reduce patient risk? (referral prpocess in and out of the service, DNA processes, safeguarding processes, ability to deal with more acute urgent cases in p/care, increased infection risk etc?) - Has the casemix of patients and required competencies and time been considered when undertaking activity modelling? - What is the impact on EPRR and what action has or is being taken to mitigate any risks? - How will the CCG ensure that the clinical model is implemented as anticipated and benefits fully derived?

Workforce model	
A workforce skills and capacity assessment aligned to proposed model(s) and associated costs (TUPE, training, redundancies) , linked to financial planning and implementation timescales.	- What is the proposed staffing model for the new service and how does this differ to current configurations? What additional numbers, roles, competencies and skills may be required? What TUPE, training, redundancy issues are there and how will these be addressed? - How will you specifically ensure that future services are sufficiently skilled to accommodate paediatric patients, specifically given the potential closure of the paediatric walk in service? - If a hub and spoke model of care is to be pursued, how will ensure that general practice is sufficiently skilled to deal with potential higher acuity (both mental health and acute) consultations? - What analysis of workforce supply and skill has been undertaken to support further development of the proposed new service model and how will the procurement approach support a mutually sustainable urgent care workforce? - What assurances were obtained from potential future providers as part of market testing process around the delivery of the proposed workforce model? - How will you ensure that potential providers are able to fully assess workforce implications and service deliverability at procurement stage?
System impact and strategic alignment	
Full impact assessment of proposals on other providers, including primary care capacity and general practice specifically	- What scenario modelling work has been undertaken to assess the impact of the proposed new model/scenarios on wider care system delivery i.e. constitutional standard and KPI delivery across acute, OOH, primary care, mental health and NEAS services?

	- What assurances are there of NEAS capacity, workforce and skills to manage a 111-centric model of accessing urgent care? - What criteria and/or evidence has or will inform the final location selection and what scenario modelling has been undertaken to support this? Has this modelling work considered the quality and performance of existing services, estates and travel constraints together with need (rather than purely demand) and deprivation levels? - What work has been undertaken to full assess and minimise the impact of the new model on general practice, given current capacity challenges, considering all? - What work has been undertaken with neighbouring CCGs to understand impact on services in other CCG areas and to ensure that urgent care service provision continues to be accessible for patients on the periphery of the CCG's boundaries i.e. Newcastle-Gateshead and Northumberland? What assurances do you have that such patients can continue to access relevant services and that sufficient capacity is available? What is the potential financial impact of the proposals ? How will you will together to ensure those patients are sufficiently informed about any new arrangements? - How do your implementation proposals align with the future arrangements for the registered GP list at Battle Hill and what joint working and/or communications is planned to co-ordinate messages for patients, if and as appropriate? - What impact, if any, will there be on core pharmaceutical dispensing services; is additional/alternative capacity required and how will any additional services be established and funded? - How does the final service model align with the work emerging from the North East Urgent and Emergency Care Vanguard and/or regional work to deliver Integrated Urgent Care Standards?

Activity and financial planning	
Further work required to enhance accuracy of activity assumptions to align activity modelling with finance and workforce planning	- Are the activity assumptions within the scenario modelling reasonable and are patient flows fully understood and accurately represented? Have flows to the new Cramlington site and also into Newcastle been fully considered? Has the scenario modelling reflected the unexpected higher demand at the new emergency specialist care hospital?
More detailed financial planning required around preferred service delivery model, prior to final decision making, particularly in articulating efficiencies to be achieved, future costs and financial tolerance for activity risks and informed by more detailed activity modelling and workforce planning	- How are your activity assumptions informed by anticipated self-care and preventive interventions and/or initiatives to redirect and reduce activity (such as to community pharmacy) through the North East Urgent and Emergency Care Vanguard? - What learning has been applied from similar service changes elsewhere to inform your planning and modelling? - What is your evidence base for your final proposed number of sites and service configuration?
Further financial modelling based on more reliable activity assumptions (including breakdown of financial sources).	- Do the financial flows mirror the assumed activity models and are expected activity changes reasonable? What tolerances have been built into the activity and financial planning? - Is the model affordable and does it demonstrate value for money when compared to the 'do nothing' scenario? - What was the outcome of the premises analysis and what are the financial implications of this? - Are the set up and on-going revenue costs of all options fully understood and appropriately included in the models, including IT, site reconfiguration, project management , set up costs etc. BC should outline a clear financial plan encompassing each service element, including: - clear, costed staffing model - capital cost requirements

	- diagnostics costs - premises costs (including any void costs) - IT costs - any additional pharmacy costs - transition, double-running, disruption costs -impact on funded patient travel costs? - What is the process for releasing any efficiencies identified and are there any barriers to this?
Transport and travel analysis to underpin site-specific scenarios	- What were the results of the planned travel analysis? Has this covered car ownership, public transport routes, road capacity, travel times, costs etc? - How has this informed your final options appraisal to reach your preferred option?
Implementation, monitoring and evaluation	
A clear procurement plan including impact assessment on choice and competition	- What is your procurement plan? - How will you use the procurement process to both achieve a truly integrated urgent care system while protecting/enhancing choice and competition? - If choice will be reduced, what is the trade off in terms of increased clinical outcomes and what is the evidence base for such predictions?
High-level plan to be developed prior to decision making with more detail post-decision	- What are the outcome metrics you plan to measure your new service model against and how will these promote integrated, right place, first time urgent care? - What quality, constitutional standards and KPIs have been used to inform the development of the outcome metrics for the proposed new service model and what work has been undertaken to model the impact on these?

	- What monitoring mechanisms will you have in place to assess the performance of the new model? - Please share your outline evaluation framework for the final model and demonstrate how this links with your initial strategic objectives. - How will your implementation planning ensure targeted communications for specific regular urgent care service user groups in order to change health seeking behaviour and off-set risks of increased A&E attendances etc? What work has been undertaken to understand patient health choices to attend A&E over and above primary care services to support with such targeted implementation communications? - How will implementation of your service overcome data sharing challenges, has a privacy impact assessment been undertaken to support this and how will patient confidentiality and data protection be upheld? -