Bath and North East Somerset
Clinical Commissioning Group

Proposed Changes to Urgent Care Services in Bath & North East Somerset

A Report on the Public Engagement Process

25th September 2012 to 31st October 2012

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Executive Summary

Introduction

From April 2013, Clinical Commissioning Groups (CCGs) will become the statutory bodies responsible for commissioning local health services in England. In preparation for this, Bath & North East Somerset (B&NES) CCG is currently working in shadow form and is taking on a greater degree of accountability for managing NHS budgets and developing commissioning plans.

Since forming last year, the CCG has been working with neighbouring CCGs who use the Royal United Hospital (RUH) in Bath, to review urgent care services and how they all work together in light of four main reasons:

- Ensuring patients are clear about where to get the best treatment
- Needing to balance the affordability of the different services offered
- Knowing that the number of patients who use urgent care services is growing and will continue to grow
- The contracts for the GP-led Health Centre based at Riverside in Bath and the GP out-of-hours service end in March 2014.

The review has focussed on a preferred option which would see the bringing together of GPs and nurses currently provided by the GP-led Health Centre and the GP out-of-hours service with the Emergency Department at the RUH to create an Urgent Care Centre. This preferred option also includes improving the ability of GP practices to see urgent care patients.

The CCG believes this is the best model of care for the future as it not only addresses the reasons above, but creates a model which is financially sustainable. The CCG also believes having GPs based at the Emergency Department will improve the care of older people and people with long term conditions, which will become an increasingly important role for primary care.

Public Engagement Process

The CCG wanted to hear the views of the public about its proposals to relocate the GP-led Health Centre to the RUH. As a result a public engagement process was undertaken by the PCT and CCG from 25th September 2012 to 31st October 2012 to ascertain those views.

A printed engagement document and questionnaire was produced. Around 1,300 documents and questionnaires were circulated together with stamped addressed envelopes to encourage people to respond. It was also made available on-line at the CCG's website with the ability for people to complete the questionnaire on-line. The document was made available in easy read hard copy format as well as on the CCG's website.

The public and stakeholders were invited to attend a series of public meetings at which the CCG set out the rationale for the proposed relocation of the GP-led Health Centre.

Media

A proactive media release was circulated on 25th September 2012 to seek their support in asking local people to put forward their views about how urgent care is delivered in B&NES. The release set out where and when the public meetings would be held and included details about how to access the engagement document and questionnaire.

The local press published articles as well as letters from people who opposed the proposal for the relocation. The chair of the CCG also did a couple of radio interviews about the engagement. A follow up media releases was circulated on 2nd October 2012.

Local Political Engagement
The CCG wrote to the two MPs representing Bath & North East Somerset to inform them of the proposed relocation of the GP-led Health and sent them details of the engagement process.

Staff Engagement
Members of the CCG and PCT met with the nursing and administrative staff of the GP-led Health Centre on 24th October. The purpose of the meeting was to give the staff an opportunity to ask questions and gain further clarification on the potential relocation of the service.

Wellbeing Policy Development & Scrutiny Panel
A paper was presented to the scrutiny panel on 21st September 2012 setting out the proposal and proposed engagement process as well as the draft public engagement document and questionnaire.

B&NES LINk
LINk supported the engagement process and helped organise the stakeholder session to complete the health impact assessment and equality impact assessment.

Public Engagement Results
A total of 208 people responded to the questionnaire - 51 people completed it on-line and 151 people returned the questionnaire in the post. The overall figures for people's preferences on the GP-led Health Centre move were:

- 84 people (40.4%) said it was a good idea
- 98 people (47.1%) said it wasn't a good idea
- 26 people (12.5%) said they weren't sure

A petition was launched by the Bath Constituency Labour Party Action Team opposing the proposal to relocate the GP-led Health Centre. At the time of submitting this report, it had been signed by 1,028 people.

What the CCG Heard
Throughout this extensive engagement process, many views and comments have been made by members of the public, staff, councillors and stakeholders. Having reviewed all the feedback, the following were the main objections and concerns expressed regarding the relocation of the GP-led Health Centre:

- Inadequate GP access – in particular, respondents cited difficulties booking a short notice appointment that fits around work and family commitments, getting a same day appointment and being able to get through on the phone.
- Insufficient car parking at the RUH
- Car parking charges at the RUH
- Public transport (including the associated cost) and getting to the RUH

- Comments that the RUH can be an unpleasant and stressful environment with long waits in the Emergency Department
- The GP-led Health Centre is convenient and easy to access, particularly for students and people working in the city
- Provision of services for vulnerable people, particularly the homeless
- The GP-led Health Centre is high quality and customer focussed and some respondents were concerned that this would not be replicated by the Urgent Care Centre
- Concerns that the new model would result in more pressure on both GP practices and the Emergency Department resulting in increased difficulty accessing GP appointments and longer wait times at the RUH
- The savings assumptions were not clear
- Access for visitors and tourists to the city

Conclusion

This report has been made available on the CCG's website and will be circulated to those members of the public who requested a copy. It will also be shared with the local providers of urgent care services via the Bath Health Community Urgent Care Network in order to jointly consider and reflect on what other improvements and changes could be made to services in light of the feedback received.

B&NES CCG would like to take this opportunity to thank everyone who has taken part in this public engagement process. The feedback has been invaluable and will be considered at length in developing the model for urgent care services.

Recommendation

This report along with the health & equalities impact assessment will be presented to the Wellbeing Policy Development & Scrutiny Panel on 16th November 2012 with a recommendation that the proposal to relocate the GP-led Health Centre to the RUH to create an Urgent Care Centre can proceed.

Introduction

From April 2013, Clinical Commissioning Groups (CCGs) will become the statutory bodies responsible for commissioning local health services in England. In preparation for this, Bath & North East Somerset (B&NES) CCG is currently working in shadow form and is taking on a greater degree of accountability for managing NHS budgets and developing commissioning plans.

B&NES CCG consists of 28 member practices (27 general practices and the GP-led Health Centre) . The CCG covers the city of Bath, the towns of Radstock, Midsomer Norton, Paulton, Keynsham and the Chew Valley area and has a registered population of approximately 195,000. The CCG covers the full geographic area of NHS Bath & North East Somerset PCT and its geographic boundaries are co-terminous with B&NES Local Authority.

1.1 Demographic Change

The Office of National Statistics (ONS) projects that the population of B&NES will increase to 198,800 by 2026. This increase is expected to be mainly in the older age groups; in particular the 80+ population is projected to increase by 40% from 9,900 in 2010 to 13,900 in 2026. The age profile of B&NES is similar to the national average and growing older:

- In 1981, 5,600 people were 80 years or older
- In 2010, 9,900 people were 80 years or older

1.2 Mortality & Life Expectancy

The health of people in B&NES is generally better than the England average. Over the last ten years, annual mortality rates for all causes have fallen, with all-cause mortality decreasing from 731 per 100,000 in 1993 to 495 per 100,000 in 2010, a 32% reduction. This downward trend is reflected in England and similar authorities. Female life expectancy is three years longer than men and women experience lower mortality rates.

Mortality from treatable conditions is also significantly lower than the England average. In addition, all-cause mortality has decreased in the under 75s, and the current rate for the area is lower than national, regional and comparator areas. Infant mortality rates are similar to the England average (however numbers are very small) and child mortality rates are lower.

1.3 CCG's Strategic Objectives

The above information together with the CCGs experience as clinicians working in the local health system has enabled them to identify six key strategic objectives:

- Responding to the challenges of an ageing population
- Improving quality and patient safety
- Promoting healthy lifestyles and wellbeing
- Improving the mental health and wellbeing of the population
- Improving access and consistency of care
- Reducing inequalities and social exclusion

In developing these strategic objectives, the CCG has identified four key service priorities as follows:

- Redesign of urgent care
- Services for people with long term conditions
- End of life care
- Dementia care

1.4 Redesign of Urgent Care

Since forming last year, the CCG has been working with neighbouring CCGs who use the Royal United Hospital (RUH) in Bath, to review urgent care services and how they all work together in light of four main reasons:

- Ensuring patients are clear about where to get the best treatment
- Needing to balance the affordability of the different services offered
- The growing number of patients using urgent care services which will carry on growing in the future
- The ending of the contracts for the GP-led Health Centre based at Riverside in Bath and the GP out-of-hours in March 2014.

1.5 The Current Services

There are a number of urgent care services who see patients in different locations in B&NES including:

- Bath & North East Somerset Emergency Medical Service (GP out-of-hours) – when your GP surgery is closed at night and over the weekends, a GP is available to provide advice, arrange to see you at one of two locations or visit you at home
- The Minor Injury Unit at Paulton Hospital
- GP-led Health Centre at Riverside in Bath
- The Emergency Department at the RUH in Bath
- Great Western Ambulance Service

1.6 Strategy Background

In 2006 B&NES Primary Care Trust (PCT) published an Emergency & Urgent Care Strategy which had seven key objectives, one of which was about ensuring patients are assessed and treated by the right professional with access to the right interventions first time. At the time the aim was to establish an integrated face to face (walk-in) service to provide that assessment and treatment on the basis that patients didn't always know which service to use and when.

1.7 Service Background

In April 1999, the Department of Health announced the first nurse-led walk-in clinics to improve access to health care and in 2001 the PCT opened such a facility in Henry Street. In 2008 PCTs were required to commission GP-led Health Centres as part of the Department of Health's strategy to improve access to primary care. The nurse-led walk-in service was integrated to create the GP-led Health Centre which opened in April 2009. This unfortunately meant the PCT had to deviate from its strategy outlined above.

In 2004 the PCT commissioned GP out-of-hours services (evenings, overnight, weekends and Bank Holidays) from Bath & North East Somerset Emergency Medical Services (BEMS), a non-profit making organisation made up of mainly B&NES GPs. When it was first launched the GP out-of-hours service was based at the RUH. It then moved to Riverside with the GP-led Health Centre and other services. The service moved back to

the RUH site in October 2010 as the benefits of being on the RUH site outweighed being based at Riverside.

1.8 The Proposed New Model

The PCT and CCG is progressing work with local GP practices to improve their ability to see urgent care patients. The aim is to ensure that telephones are answered promptly between the hours of 8 am and 6.00 pm with no closure during lunch time periods. The aim is also to improve the time taken for GPs to visit patients at home who are unwell instead of waiting to do the traditional home visits at the end of the morning or afternoon surgery.

The proposed new model would see the bringing together of GPs and nurses currently provided by the GP-led Health Centre and the GP out-of-hours service with the Emergency Department at the RUH to create an Urgent Care Centre.

The CCG believes this is the best model of care for the future as it not only addresses the reasons for change, but creates a model which is financially sustainable. We also believe having GPs based at the Emergency Department will improve the care of older people, which we know will become an increasingly important role for primary care.

Currently, the GP-led Health Centre provides a walk-in service at Riverside in James Street in Bath. The services are high quality and delivered by dedicated and skilled staff. They include general health advice, treatment for urgent health needs and information about the NHS and social services. However, many of the patients who attend the GP-led health centre are attending for routine primary care needs, that could be managed by GP practices in B&NES. This is supported by the fact that on average only 10 patients per week have to be re-directed to the RUH.

The RUH is situated at Combe Park, approximately a mile away from the GP-led Health Centre. The RUH provides a suite of medical and surgical services to a population of 500,000, dispersed across West Wiltshire, Bath, North East Somerset and Somerset.

The Trust offers a range of acute medical and surgical services including accident and emergency and trauma & orthopaedics, as well as paediatrics, clinical support services and hosting maternity services on site for the Great Western Hospital NHS Trust.

The development of the Urgent Care Centre would lead to improved access to x-rays; extended access to blood tests; and easy access to other diagnostic tests such as ultrasound scans. A further advantage to relocating the service would be the availability of observation beds. This would make further onsite monitoring possible, for example, following a head injury or asthmatic episode. Currently, these patients would need to be transferred from the GP-led Health Centre which can be distressing.

As there are clinicians already working at the hospital there is also the potential to access their expertise on site. For example, doctors who specialise in the care of older people (geriatricians) run clinics at the hospital. Also, there are regular out-patient fracture clinics in operation. There is potential for clinical staff already on duty at the hospital to provide support to the staff working with urgent care patients.

Therefore, B&NES CCG believe that urgent care services in B&NES could be significantly improved by relocating it to the RUH and after careful consideration propose to create a 24/7 GP-led Urgent Care Centre at the hospital.

1. The Engagement Process

2.1 Developing the Process

In April 2012 the PCT and CCG held an event with stakeholders, patients and public where the proposals to redesign the urgent care system were presented. Attendees were asked to consider how people use urgent care services along with the NHS financial changes. The following was considered:

- The demand for services
- Clinical quality and patient safety
- The size and needs of the population served including the demographic changes
- The health needs of the population
- The clinical evidence base and best practice
- Access to GP appointments
- When, why and where patients attend from

Attendees were then posed three questions to consider:

- What are the most important patient experience issues for people when using the urgent care system?
- What are the key principles to hold on to when planning any changes?
- How can we help people understand the different parts of the urgent care system and how best to use it?

The key messages from these questions were as follows:

- Good accessibility and waiting times for all services, including car parking and transport
- Customer and quality focussed
- Need for joined up and integrated services
- Good triage systems
- Maximising the use of technology
- Communication and education

Subsequent to this, the Bath Health Community Urgent Care Network held a specific event at the end of April 2012 to consider in more detail the potential options for redesigning the services which looked at:

- The demand for services
- The size and needs of the population served
- Options of the type and location of urgent care services
- The costs of providing the current services
- The fact that patients should be seen safely in the most suitable environment for their needs, whilst ensuring that public money is spent wisely

All the above, together with previous patient survey results, helped shaped the proposals further and resulted in the CCG and PCT deciding to proceed to a full public engagement process, which began on 25th September 2012 and concluded on 31st October 2012.

2.2 Who the CCG Engaged With

The CCG wanted the engagement to be as wide and inclusive as possible. To support this printed engagement documents and questionnaires were produced which were also made available on-line at the CCG's website. Around 1,300 documents and questionnaires were circulated together with stamped addressed envelopes to encourage people to respond. People could complete the questionnaire on-line as well.

Your Say Advocacy an independent advocacy service working primarily with people with a learning disability converted the engagement document into easy read format which was made available on the CCG's website.

2.3 Public Meetings

In the first instance the CCG organised four public evening meetings to inform people and stakeholders of the proposed relocation of the GP-led Health Centre, to answer questions and concerns and gather feedback.

Members of the Wellbeing Policy Development & Scrutiny Panel expressed concern that evening meetings were not convenient for older people and as a result two further daytime events were organised. They were as follows:

Evening of 2nd October at the Centurion Hotel in Midsomer Norton
Evening of 4th October at the Hilton Hotel in Bath
Evening of 9th October at Fry's Conference Centre in Keynsham
Evening of 10th October at Bath Royal Literary & Scientific Institute in Bath
Afternoon of 25th October at the Methodist Church Hall in Radstock
Morning of 26th October at St Luke's Church Hall, Bath

An impromptu additional evening meeting on 15th October at the Methodist Church Hall in Radstock was organised by a B&NES Labour Councillor.

At each meeting a presentation was made by the CCG explaining the national changes to commissioning and the development of CCGs. The presentation went on to explain the urgent care redesign proposals which was followed by a question and answer session. Attendees were also provided with a set of frequently asked questions as well as the engagement document and questionnaire.

2.4 Publicity

A number of organisations as well as the media were asked to publicise the public meetings and promote the document and completion of the questionnaire as follows:

- All B&NES GP practices
- The GP-led Health Centre
- Paulton Minor Injury Unit
- Bath & North East Somerset Emergency Medical Service (the GP out-of-hours service)
- The Care Forum via their e-bulletin to the health and social care voluntary sector network forum in B&NES
- Bath Tourism's e-newsletter circulated to nearly 500 tourism businesses
- B&NES Age UK
- The Carers Centre via Facebook and Twitter
- Bath Spa University via Facebook, Twitter and the students union website

- Your Say Advocacy supported service users at a network event to complete the questionnaires

2.5 Media

The first press release outlining the plans went out on 13th September 2012, the day the plans were presented to full Council. The following week, on 19th September 2012, this was re-issued with the dates of the first four public meetings organised.

On 25th September 2012 another full release with additional information about the engagement process, including a link to the online questionnaire, was issued. On 2nd October 2012 dates were issued about the extra two daytime meetings to the media.

During this period a number of queries were answered from the Bath Chronicle, Somerset Guardian, Chew Valley Gazette, Midsomer Norton and Radstock Journal and The Breeze FM. Interested journalists were also provided with copies of the Frequently Asked Questions.

A journalist from the Somerset Guardian attended the first meeting in Midsomer Norton on 2nd October, as did a photographer from the Midsomer Norton and Radstock Journal. A reporter from the Bath Chronicle attended the meeting at the Bath Royal Literary & Scientific Institute in Bath on 10th October.

The media coverage all helped draw attention to the engagement work, including the meetings and the online questionnaire. There were also a number of letters and two commentary / editorials in local newspapers.

Media coverage included:

15th September:

- Bath Chronicle story online

20th September:

- Bath Chronicle story and comment piece
- Somerset Guardian story
- Midsomer Norton & Radstock Journal story

25th September:

- The Breeze FM – interview with Dr Orpen

27th September:

- Bath Chronicle letter
- Somerset Guardian – story promoting local meeting

October:

- Chew Valley Gazette covered the story

4th October:

- Bath Chronicle comment from columnist

11th October:

- Bath Chronicle article and two letters
- Somerset Guardian report on meeting and letter

- Midsomer Norton & Radstock Journal story and photograph

18th October:

- Bath Chronicle report on meeting and two letters

25th October

- Bath Chronicle article and two letters
- Midsomer Norton & Radstock Journal article about meeting with Radstock Councillors

2. What People Said

This section looks at all feedback received during the engagement and includes:

- feedback from staff
- feedback from the public meetings
- feedback from B&NES Local Involvement Network (LINk)
- questionnaire analysis

3.1 Staff Feedback

Members of the CCG and PCT met with the nursing and administrative staff of the GP-led Health Centre on the evening of 24th October 2012. The purpose of the meeting was to give the staff an opportunity to ask questions and gain further clarification on the potential relocation of the service. All questions asked were answered and a report of this meeting can be found at annex 1.

3.2 Feedback from the Public Meetings

These meetings were attended by varying numbers of people, including members of the public, staff, councillors and representatives from the voluntary and statutory sector. Table 1 below provides a breakdown of the attendees at the public meetings. A summary of the questions and answers from each meeting can be found at annex 2. The notes of these meetings are not verbatim, but capture the key points raised.

Table 1

Date of Meeting	Numbers Attending	Breakdown of Attendees
02.10.12	16	11 Members of the Public 1 Town Councillor 1 B&NES Councillor 1 GP Out-of-Hours Staff 1 Dorothy House Hospice Staff 1 Nursing Home Staff
04.10.12	43	31 Members of the Public 6 GP-led Health Centre Staff 1 Sirona Staff 1 GP Out-of-Hours Staff 1 DHI Staff 1 Boots Staff 2 Members of Bath Labour Party
09.10.12	10	3 Members of the Public 1 GP Out-of-Hours Staff 1 B&NES People First Staff 2 Mental Health Reablement Staff 1 B&NES Councillor 2 Members of Bath Labour Party
10.10.12	29	19 Members of the Public 2 CAB Staff 1 GP-led Health Centre Staff 1 Age UK B&NES Staff

		1 Sirona Staff 1 Red Cross Staff 1 Bath Chronicle Staff 1 B&NES Councillor 2 Members of Bath Labour Party
15.10.12	10	2 Members of the Public 6 Radstock Town Councillors 1 B&NES Councillor 1 Radstock Action Group
25.10.12	4	2 Members of the Public 1 B&NES Councillor 1 Nursing Home Staff
26.10.12	8	7 Members of the Public 1 Care Provider Staff
Total	**120**	

3.3 B&NES LINk Feedback

B&NES LINk provided feedback on the proposals as follows:

- Concerns that the practices, particularly those in the city centre have signed up to the new model of care and will step up to improve their access.
- Access at the RUH and to the RUH from central Bath for tourists, those who work and live centrally and for those who have mobility problems.
- The provision of more statistical information about the use of the GP-led Health Centre and the Emergency Department at the RUH looking at who, when and where people come from.

3.4 Questionnaire Analysis

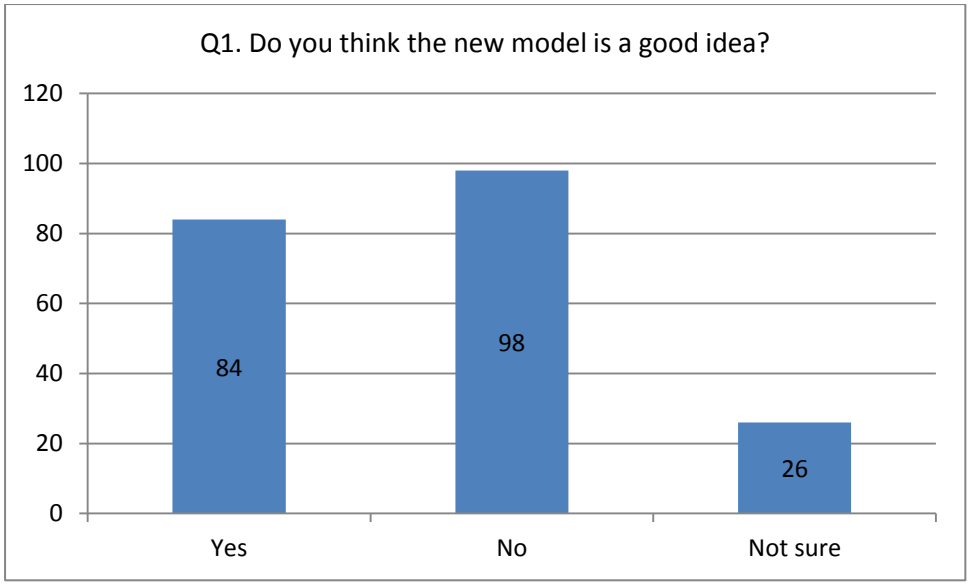
A total of 208 people responded to the questionnaire and this section looks at the feedback received via the questionnaires during the engagement period. Demographic data is also included along with the respondents reported use of the GP-led Health Centre as well as the Emergency Department at the RUH.

3.4.1 Respondents Feedback

Q1 Do you think the new model proposed is a good idea?

Of the 208 questionnaire responses received, 40.4% of respondents thought that the proposed new model was a good idea and 47.1% thought it wasn't a good idea. 12.5% respondents were not sure. Figure 1 shows the breakdown of responses received.

Figure 1



86 of the 98 people who were not in favour of the new model made a comment explaining why they did not support the changes. Comments included:

"The centre sees 30,000 people who as a result do not see their GPs. 9,000 are not registered with GPs. Getting these people seen by a different practice doesn't make a saving - it just moves cost onto GPs at the RUH"

"Until GP surgeries are open longer hours and at weekends, they will continue to provide inadequate services to the communities they should be serving. GPs are better place to treat older patients and those with chronic long term conditions who are likely to be able to get to them from their home and to see GPs and nurses who they can build up relationships with/ continuity. Younger working persons continue to need more central access with parking and where it is less essential to know the Dr or nurse they are seeing."

"Because this service helps workers who commute to the city to attend medical appointments, without having to take sick time off work. My surgery is only open working hours - useless for working people."

"GP services need to be accessible to all in various places and not centralised which makes it difficult for some to access"

"Loss of walk in centre in Bath to the RUH defeats the object, will increase demand elsewhere."

"More confusing - who is going to educate patients re 'prompt care'. I don't know what it means. Poor location - out of town, encouraging minor illness to attend hospital setting. Are we not trying to prevent this?"

"RUH more difficult to get too. Parking limited and expensive. It will confuse people even more. In recent years they have been told not to go to the emergency department."

"The RUH isn't as accessible as the Riverside centre - or as convenient for those who live/work in Bath

The model proposed, with the walk in centre being co-located at the RUH, promises a poorer service for users used to the existing service. The CCG cannot force GPs to extend their hours, therefore most users will have to go to RUH and share triage with A&E. Leading to long delays, more difficult travel, parking difficulty and increased costs and time lost. Additionally, GPs provide no cover at weekends. Savings forecasts appear to be 'guesstimates' and included savings to be made from costs of out of hours provision. I can see the loss of service, I can't see any cost reduction or increased efficiencies happening."

"RUH is very difficult to access if you have no transport and are disabled in any way. Riverside is accessible for people to the east of Bath as well and for people working in the city."

"I'm sceptical that I will be able to access a weekend/out of hours service via my GP easily. I struggle to get through on the phone now. 'Walk-in' element and weekend access is essential."

Only 5 of the 84 respondents who thought that the proposed new model was a good idea made a comment and all but one of these centred around introducing a more cost effective model and eliminating duplication.

14 of the 26 people who weren't sure whether or not the proposed new model was a good idea made a comment. Comments included:

"Centralisation may be essential to save costs but does not necessarily prove to be customer friendly or indeed cost effective"

"Of the 4 options none had been costed and there do appear to be other options not explored like Bristol's SPA [Single Point of Access]"

"There are a lot of GP surgeries who do not cater for drop in sessions. For example, Oldfield Park surgery offers drop in sessions twice a day, five days a week. However, there are too many surgeries which offer appointments only and these patients may prefer the GP led health centre as they have a better chance of being seen."

"GP surgery hours do not work for those in work. Evening surgery needs to be until 10pm."

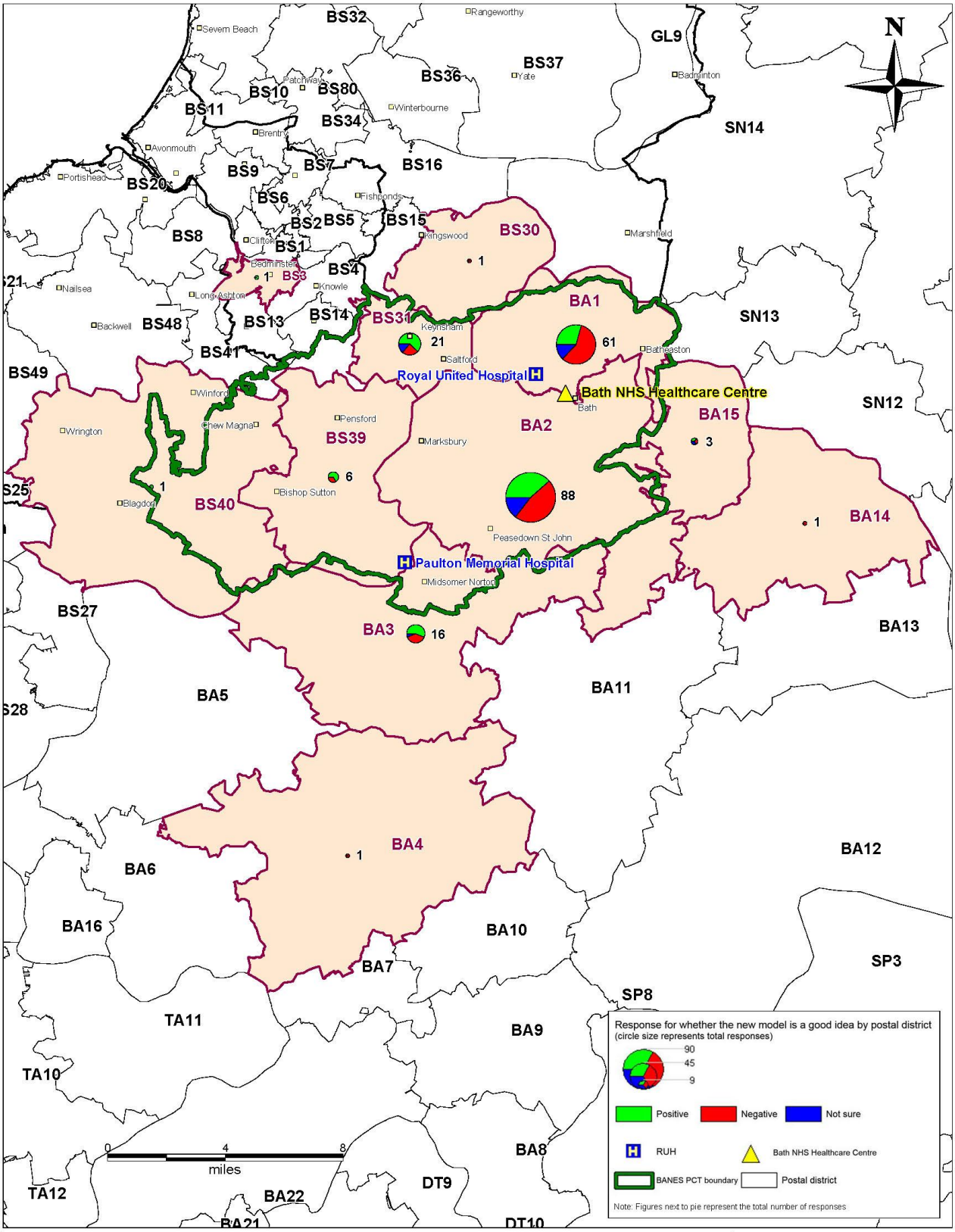
"Can see it's a way to save money but at the expense of the care and availability and ease of getting to it"

"RUH have more work to do. They won't have enough staff."

Map A (overleaf) indicates whether the respondents think that the proposed new model is a good idea by postcode area. It shows that approximately half of the respondents giving BA1 and BA2 postcodes were opposed to the proposed new model but in contrast, over half of the respondents giving BA3, BS39 and BS31 postcodes were in favour of the new model. This split can at least be partly attributed to the proximity to the RUH and the GP-led Health Centre. People living in BA3, BS39 and BS31 postcodes would be highly unlikely to walk to either the GP-led Health Centre or the RUH and for some it would be easier to get to the RUH and would avoid going through Bath city centre. On the other hand, many people from BA1 and BA2 postcodes can easily walk to the GP-led Health Centre, but not

the RUH, and for many people in these areas, the GP-led Health Centre is closer than the RUH too.

Map A



NHS Bath & North Somerset

Urgent Care Redesign Patient Feedback (October 2012)

Avon IM&T Consortium NHS

Jurong Zheng - 1 November 2012

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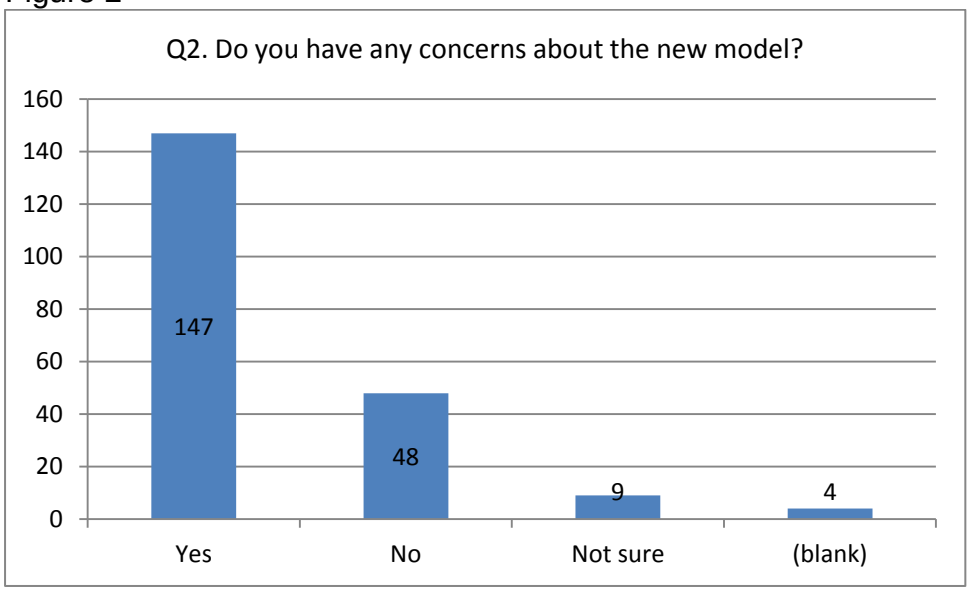
Q2 Do you have any concerns about the new model?

As shown in Figure 2, the majority (70.7%) of respondents expressed concerns about the proposed new model. Concerns were raised by nearly all of the respondents who opposed the change and also 26 of the 58 people who thought the proposed new model was a good idea.

Figure 2



The main concerns about the relocation of the GP-led Health Centre were:

- Inadequate GP access – in particular, respondents cited difficulties booking a short notice appointment that fits around work and family commitments, getting a same day appointment and being able to get through on the phone.
- Insufficient car parking at the RUH and the car parking charges
- Public transport (including the associated cost) and getting to the RUH
- Comments that the RUH is an unpleasant and stressful environment with long waits in the Emergency Department
- The GP-led Health Centre is convenient and easy to access, particularly for students and people working in the city
- Provision of services for vulnerable people, particularly the homeless
- The GP-led Health Centre is high quality and customer focussed and some respondents were concerned that this would not be replicated by the Urgent Care Centre
- Concerns that the new model would result in more pressure on GP practices and the Emergency Department resulting in increased difficulty accessing GP appointments and longer wait times at the RUH
- The savings assumptions were not clear
- Access for visitors and tourists to the city

Comments included:

"GPs are always busy and often you have to wait a couple of days for an appointment. Walk in centres are great because it means you don't have to wait or go to hospital."

"Until we get better access to GP appts this [new model] will only lead to greater frustration amongst users (out of town, no parking, parking charges, over medicalisation of simple general health conditions i.e. a hospital setting)."

"Access is difficult because of lack of parking in and around the hospital. High cost of parking for people on low incomes (who have more health problems) and no hospital buses at weekends."

"There needs to be a frequent bus service from city centre to RUH to compensate for loss of walk in centre in town."

"The walk in centre has a friendly and calming ambience, the A&E department by its very nature does not."

"You would have to wait longer at the RUH emergency department if they shut Riverside."

"My experience of emergency care has been long delays - first a wait for triage and then an even longer wait for treatment. Those in pain and discomfort are continually finding themselves pushed to the back of the queue because of the need to treat those with apparently more likely life-threatening conditions."

"Long waits in a hospital rather than health care environment. Stressful experience."

"I feel the RUH at present could not cope with more patients or staff attending there, the parking for both is currently not sufficient. Also GP practices are working very hard but still have their patients attending the Health Care Centre in town due to difficultly getting appointments."

"There would still be the same amount of people working there, the same outgoings like electricity etc and there will be a huge cost in relocation and setting up the facilities."

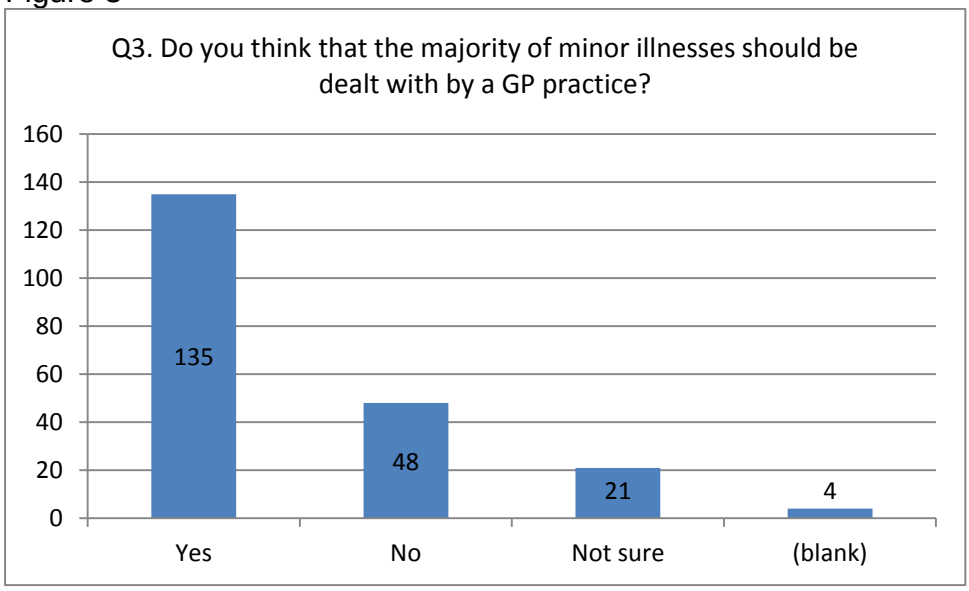
"I have been grateful in the past to walk in surgeries in Bath. Visitors staying with me have also used that service: where would visitors needing treatment go in the future planning?"

"Why change what works for the sake of the cost? No price can be put on a person's health."

Q3 Do you agree that the majority of minor illnesses should be dealt with by a GP practice to avoid duplication?

Figure 3 shows that 64.9% of respondents agreed that the majority of minor illnesses should be dealt with by a GP practice.

Figure 3



Comments made by respondents who disagreed that the majority of minor illnesses should be dealt with by a GP practice included:

"It's very inconvenient for people working to get to their GP surgeries if they fall ill in the day it is difficult to get an appointment there and then. The GP's are full anyway seeing to the local patients who are able to make appointment. There is no duplication as more people are seen."

"Although the majority could in theory be dealt with by a GP practice, the sad fact is that people find it impossible to get appointments at their GP when they need to."

"You cannot always get an appointment with your GP and you have this [walk-in centre] arrangement handy."

"Because it is not always possible to get to your GP. For a general appointment, I will have to wait a week at least. This is a terrible service, at least a walk in centre empowers people to make their own decisions about when they want to see a doctor, not when it suits the doctor!"

"In an ideal world you would get an appointment for a minor illness that was at the scheduled appointment time and with the option of facilitating employment commitments. The reality is that all GPs run offensively behind and it is not possible to arrange an appointment without having to first arrange time off work. Having more staff available through extra centres at peak demand times and at geographically convenient locations does facilitate this to some degree. A walk in centre close to the centre of town respects workers and residents timetables as well as overcoming the nightmare of providing enough affordable parking."

The respondents who agreed that the majority of minor illnesses should be dealt with by a GP practice also made comments about the accessibility of GP services and these included:

"[Yes,] But these plans take no account of people who are employed or study miles away from home and cannot always take time off in the middle of the day."

"I do not see the duplication of the service but I think that you are referring to duplication of payment? GPs appear to being paid a per capita payment and some of their patients are not able to get a convenient service and therefore choose the walk in centre. The GPs whose patients choose to use the walk in centre are being paid for a service that they don't provide on that occasion? Surely some transfer payment system could be arranged to cope with this?"

"Change things only when GPs and practice nurses agree to work more flexible hours to fit in with people using the services...evenings and weekends. GPs currently do not want to do this they want the option to continue to earn large amounts of extra money for doing locum shifts in OOH services."

Comments made by respondents who were not sure whether the majority of minor illnesses should be dealt with by a GP practice included:

"Only if the GP opening hours are extended otherwise people are left with nothing. People who work for example can't usually make GP opening hours."

"Yes for registered patients but access would need to be improved. Access at the time when it is convenient to the patient, an appointment at "11am or not at all" is of no use to a working professional with a minor illness. It is also no use to get put on hold for 30mins in a first come first served same day appt system. Temporary residents are another group who would suffer here."

"I agree that where possible, minor illnesses should be dealt with ones GP. If, as happened to me on several occasions, my GP has not been able to provide an appointment within a week then the walk-in centre provides a back up. This is not duplication."

"They should not be dealt with by the hospital. But this seems to be the effective proposal!"

"Yes, IF GPs are available and easy to get to, which they're not. If you're worried about double paying, re-jig GP contracts or make deductions."

Q4 Would you like to make any other comments about access to GP services in Bath and North East Somerset?

The majority of responses to this question suggested that current opening hours and appointment systems were not adequate and access to GP services needed improvement. Some of the comments received included:

"My GP practice is huge and the service is very poor when it comes to care that is needed the same day."

"Not always able to get appointment on same day. Attitude of reception staff. Lack of communication."

"From observation of the years and from the discussions at the [public] meeting, GPs are overwhelmed by the ageing population and there appears to be a focus on the most 'at risk' groups. The people who lose out and find it most difficult to get convenient treatment are

those working and trying to get an appointment at short notice at a time convenient to their work or childcare appointments."

"No true evening service, although can book online which is good, I can never get an appointment to fit around work commitments in a reasonable time."

"It's very hard for students to find GPs and near impossible to get an appointment to the one available on campus so the walk in centre is extremely beneficial to many of us"

"Very difficult to navigate the maze of 'same day appointments versus appointment on a later day when you are able to make the appointment'. At times, difficult to get past receptionists."

"To sign on with a GP you require two proofs of identity and address. Too bureaucratic and it excludes the vulnerable"

"I am a carer and my mother felt ill when it was 5.30pm. I had to persuade the GP to see my mother as they wanted me to call 999 when there was no need. All they were worried about was they were closing at 6pm and I was only a 5minute drive away. They eventually stayed on to see my mother who needed antibiotics."

"A prompter service should be available and GPs should be prepared to work longer hours for the money they now earn."

"Appointments released on the day are invariably gone within minutes and the telephone is constantly engaged unless you are very lucky."

"More frequent access to surgeries for walk in problems would help, even if it entailed waiting."

Of the 208 responses received, 134 respondents commented that the current service offered by their registered GP practice is not satisfactory. Nevertheless, 20 people said that access to their registered practice was good. However, four of these people stated that they were retired and a further six people stated that they were aged over 65 years so it can be assumed that these people are less likely to be in full time employment and therefore may find it easier to access GP services during their standard opening hours.

Q5 Would you like to make any other comments about access to the GP out-of-hours service in Bath and North East Somerset?

Less than half of the respondents commented on this service, 18 people said that they had never used the service and the remaining respondents left this question blank or wrote about the GP-led Health Centre suggesting that there is a lack of awareness of the BEMS GP out-of-hours service. However, of the comments received about BEMS, 31 were negative and mostly related to the telephone and triage system. 12 positive comments were received. Comments included:

"These are for emergency appointments and they are not very convenient as they are remotely located. Therefore people without transport or disability/vulnerable do not have easy access because of location."

"They are only for emergencies; minor injuries and dressing are not done there."

"I checked at our Pulteney Street surgery and was told about the 0800 out of hours service. I think more publicity is needed about that availability."

"All locums must be vetted by the authority and qualifications checked as fit to practice - with excellent understanding of the English language and up to date skills."

"Often patient waiting hours for a call back from triage call centre to even make an appointment in which time the patients have either attended A&E or Bath Health Care Centre."

"I recently had to use the BEMS service for my one year old son who had breathing difficulty. I found the telephone triage service poor - after taking details of his symptoms, I was told a clinician would phone me back within 1 hour (which seemed an inappropriately long time). After 30 mins of further deterioration in his condition, and still awaiting a call back, I had to ring again and was told that the call back would be upgraded to more urgent but I still had to wait another 10 mins for a clinician to phone. In this time we had decided to put him in the car and drive to the RUH. In the end we were given an appointment straight away at BEMS but we were very close to having to go to A&E because of the failure of the telephone assessment service to recognise the severity of his symptoms and triage him in a timely fashion. Having appointments rather than a walk-in service for BEMS works only if the quality of the telephone assessment is good. This is very important if we are going to divert people away from A&E."

"Go back to having GPs do it within existing salary, terms and conditions. Most other services are getting staff to take pay cuts or do more work for no extra funding and GPs and other NHS staff do have much better T's and C's than the rest of this country's employees."

"A bit long winded having to speak to a receptionist, then wait for a nurse to call back before being able to arrange to see a doctor. In the past calls were triaged by nurses who either gave immediate advise or booked appointments to see a doctor or nurse. I worked as a triage nurse within a nurse-led casualty and feel the old system was better. System at Paulton good, apart from initial contact."

"There are time lapses between the GP's surgeries and the out of hours so what does the patient do then? I often use the out of hours service as my mother has more problems but instead of a GP coming out they call an ambulance when they could deal with it."

"It always takes quite a long time before someone picks up the phone and then you won't get an appointment unless it is a serious health issue."

"In emergency, found phone responses stressful and requires repeating problems as calls are redirected."

"My mum died less than 48 hours after an on-call GP refused to visit her at home. He treated her by phone via carers. Need I say more?"

"You ring and speak to someone who promises a GP will call back within a time and it's a couple of hours later. Then someone else will ring to give you an appointment and the person you eventually see is not the GP you spoke to initially!"

"You have to ensure that as far as humanly possible the visits are covered by local GPs, not by exhausted/poor English speaking/insufficiently qualified or motivated hacks just doing it for the money."

"Our experience as a carer of a 90 year old was complicated, time consuming and difficult."

"Would like to talk to someone rather than to a machine or listening to options I don't understand."

Q6 Would you like to make any other comments about access to the GP-led Health Centre in Bath?

The majority of comments received in response to this question were positive about the service available at the GP-led Health Centre. Many of the respondents who had used the GP-led Health Centre indicate that a high quality and accessible service is offered and comments include:

"Wonderful, efficient, friendly, professional caring service."

"Good reception and information plus less pressure on consultation time."

"In many ways I prefer the service at Riverside to that provided by my GP."

"If the health centre was closed I would have serious concerns about accessing urgent care."

"Excellent staff, good system, does much needed job. Please don't get rid of it. I have found it better than GP at times - a more holistic approach."

"The Bath walk in clinic has always provided accessible, convenient, timely medical care."

"If the centre is moved to the RUH, there must be proper publicity, not just for local people but also, perhaps via the tourist information office for visitors to the city"

"Never used the service - have heard waiting times are long and patients are turned away."

"It is like a comfort blanket to so many people who know they will be expertly treated shortly. Most people can get there reasonably easily and Sainsbury's car park is close. Perhaps it could be nurse led?"

"My experience has been that the walk in centre fulfils a need and provides a good service."

"I'm not convinced that the walk in centre did not reduced demand at casualty - it must have."

"Suitable for minor illness or injury but not appropriate for on-going complaints which they are unable to refer if [the] patient [is] registered with [a] local GP."

"It is convenient for some but it is an unnecessary duplication of services and therefore cost."

"If GP surgery hours are extended then don't see a need for this [the GP-led Health Centre]."

"I have nothing but praise for the superior service they offer."

"GPs frequently direct their patients to this service when overloaded - especially small practices."

"I dread the prospect of hours spent waiting in A&E. How will this be speeded up?"

Q7 Would you like to make any other comments about access to Emergency Department services at the Royal United Hospital?

The majority of comments received in response to this question related to long waits to see a doctor in the Emergency Department and difficulty in accessing the hospital due to insufficient parking or inadequate public transport and the associated cost. Comments included:

"Recently I experienced a 3-4 hour delay when my wife was taken there with a suspected arm fracture. Also parking is a problem especially for out of town patients and night time."

"A new patients car park with reasonable charges for short stays. Also car park should be multi-level to maximise use of available building space."

"Parking and transport are always difficult / expensive"

"First class people but long waits between each service: reception - triage - specialist – treatment"

"Lack of parking near the A&E department. Cost of parking. No bus service during the night."

"Think they are already overstretched, often hours waiting, not triaged effectively enough so patients seen here that could be managed elsewhere more appropriately. No parking for patients or staff."

"It is important that it exists but it does need to be staffed properly. The experience of my family and friends is that it is to be avoided if at all possible, unless for example one has a broken leg. There are very lengthy waits and the medics are usually foreign with a poor grasp of the English language and certainly do not inspire confidence."

"Very inaccessible and impractical to those with minor health complaints."

"Not good. Very long waiting times and rather scary."

"Direct access by public transport is not available unless you are coming from city centre or the south side Park and Ride and even then not available during the night and infrequently on Sundays. It can be intimidating for the elderly at times when particularly busy."

"You would have to wait longer at the RUH emergency department if they shut Riverside"

"Poor. A multi-storey car park is required but use should be chargeable."

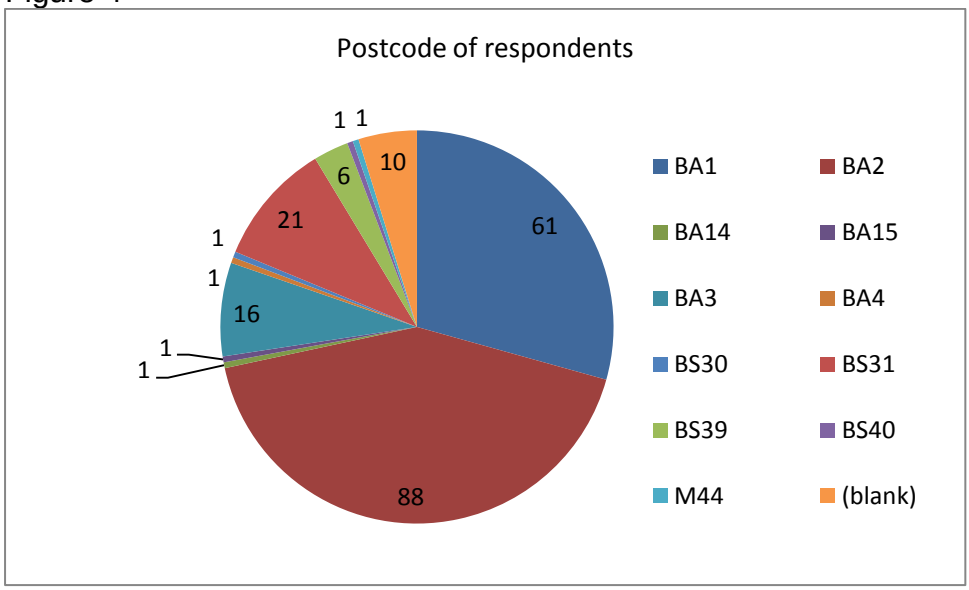
"Already stretched and difficulty in parking, even for disabled."

3.4.2 About the Respondents

Postcode
Respondents were asked to provide the first four letters/numbers of their postcode. Only the first half of the postcode was requested in order to preserve anonymity.

The postcodes below show that the respondents predominantly lived within the B&NES Council boundary with the majority (71.6%) living within BA1 or BA2 postcode areas. Those who didn't live within B&NES, lived in adjacent postcode areas with the exception of one respondent in the BS3 postcode area and another who was from Manchester but visiting family members in Bath. The breakdown of respondents' postcodes is shown in Figure 4 below.

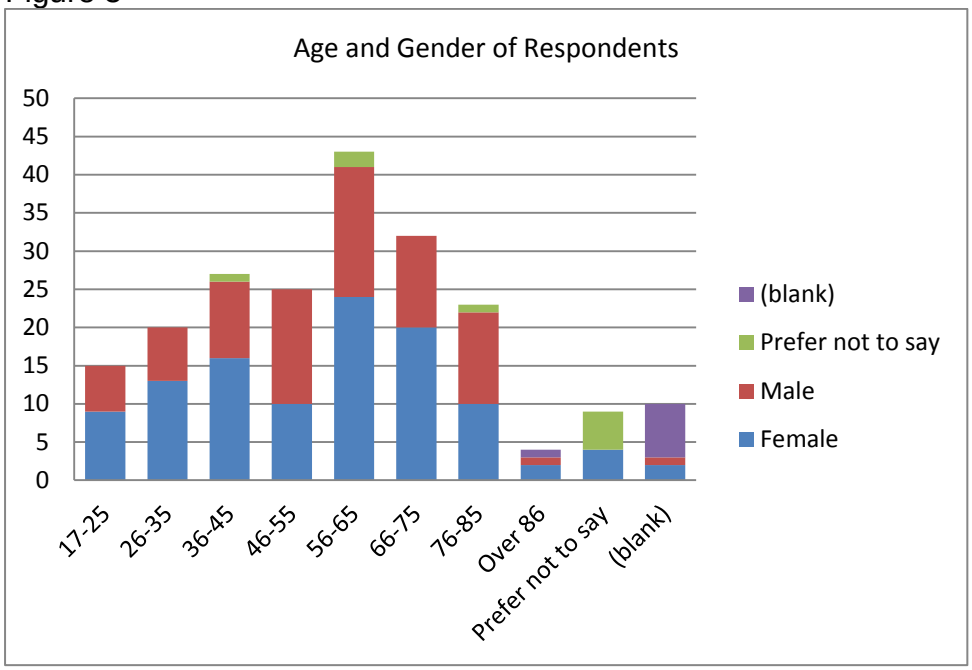
Figure 4



It is not surprising that the majority of respondents were from BA1 and BA2 postcode areas for two reasons. Firstly, Bath is more densely populated than North East Somerset and secondly, many City of Bath residents are likely to find that the GP-led Health Centre is closer and easier to access than the RUH so are therefore more likely to have stronger views on changes to the existing model and complete a questionnaire.

Age & Gender
Respondents were asked to provide their age and gender and the responses are shown in Figure 5 below.

Figure 5



53% of respondents were female and this is roughly representative of the B&NES population. However, with the exception of the 36-45 age band, the age of respondents is not representative. The number of respondents aged between 17 and 25 years is lower and a disproportionately high number of people aged between 55 and 84 years completed questionnaires.

Ethnicity

Respondents were asked to provide their ethnicity and the majority (83%) indicated that they class themselves as 'White British' as shown in Figure 6 below.

Figure 6

Ethnic Group	Number of respondents
White British	173
Czech (White)	1
European (White)	1
Indian	3
Irish	1
Mixed white and Asian	1
Mixed white and Asian (Pakistani)	1
Other mixed background	1
Other White background (English)	2
Other White background (Jew)	1
Other White Background (Northern Irish)	1
Polish (White)	2
Polish/German (White)	1
Slavic (White)	1
Prefer not to say	10
But why - what does it matter?	1
(blank)	7

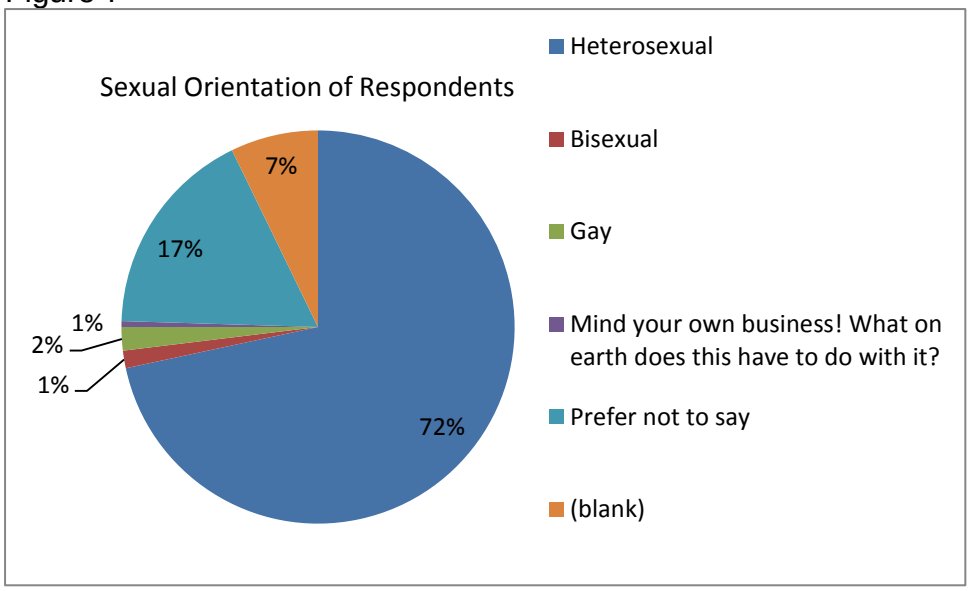
Grand Total	208

It is estimated that 88% of the B&NES population would describe themselves as 'White British' so the respondents are representative of the total population in terms of ethnicity.

Sexual orientation

Respondents were asked to provide their sexual orientation and the majority (72%) indicated that they are heterosexual as shown in Figure 7 below.

Figure 7

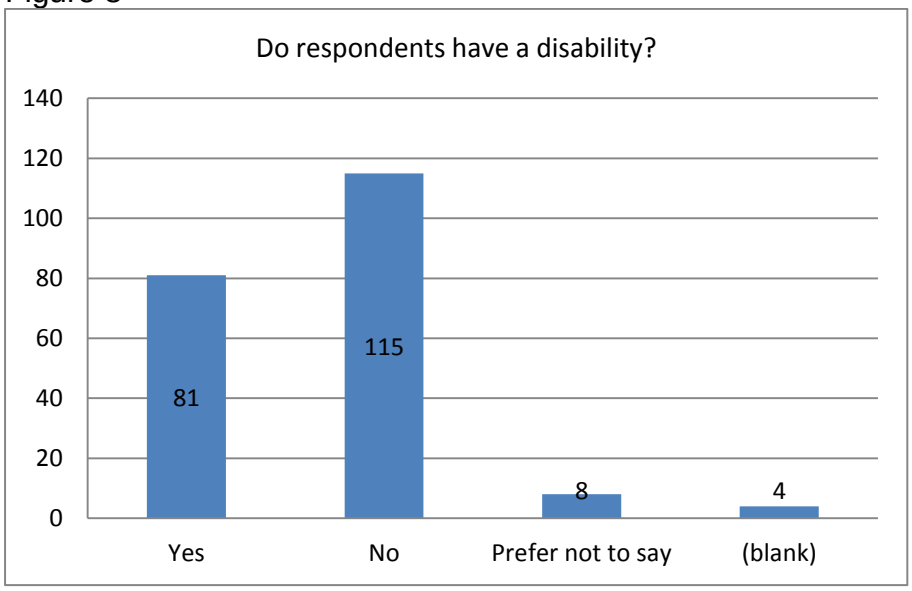


There is currently no data which indicates the proportion of people in B&NES who are gay or bisexual and as one quarter of respondents did not give their sexuality, it is not known whether the respondents are representative of the general population in terms of their sexual orientation.

Disability

Figure 8 shows that 81 of the 208 respondents (39%) indicated that they have a disability and 29 of these respondents were supported to complete the questionnaire by the Your Say advocacy group.

Figure 8

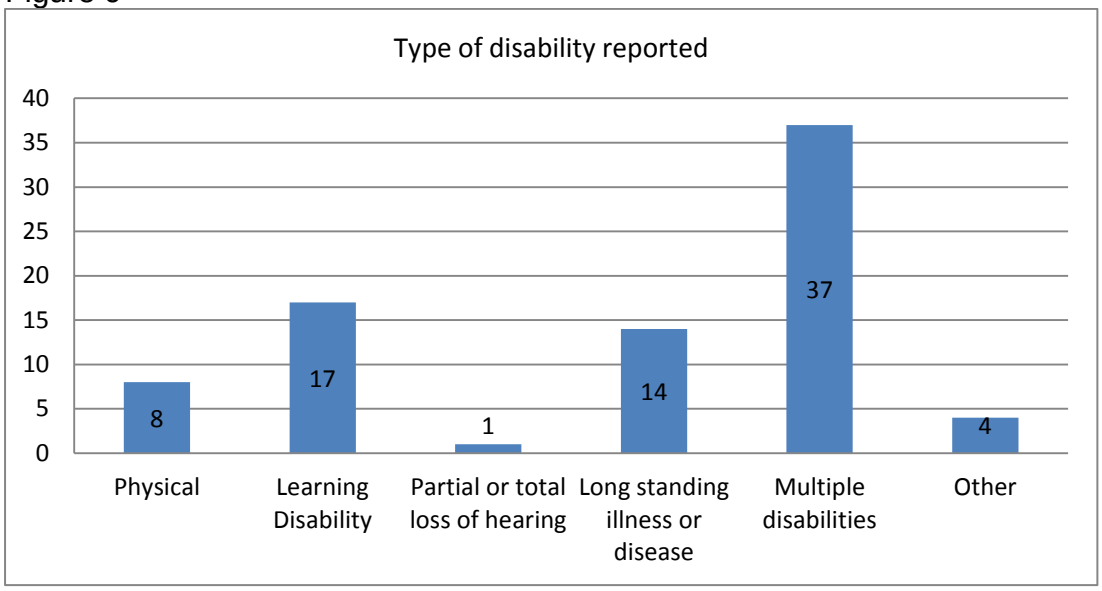


It is estimated that 18% of the total UK population have a long standing illness or disability and have significant difficulty with day-to-day activities. It appears that more respondents reported having a disability than would be expected in B&NES. This may be due to some respondents indicating that they do have a disability but in reality they are not experiencing significant difficulty with daily activities so a fair comparison isn't being made. It may also be affected by the disproportionately high number of respondents over the age of 55 because the likelihood of developing a disability increases with age. However, people with long term conditions are much higher users of health and social care services than average so it is important to ensure their views are captured.

Of the 81 people who reported to have a disability or long term health condition, 46 people were in favour of the proposed new model, 23 opposed the change and 12 people were not sure whether the new model was a good idea or not.

Figure 9 shows the type of disability that people reported. Where respondents, indicate that they had more than one disability, these have been recorded in the graph under 'multiple disabilities'.

Figure 9

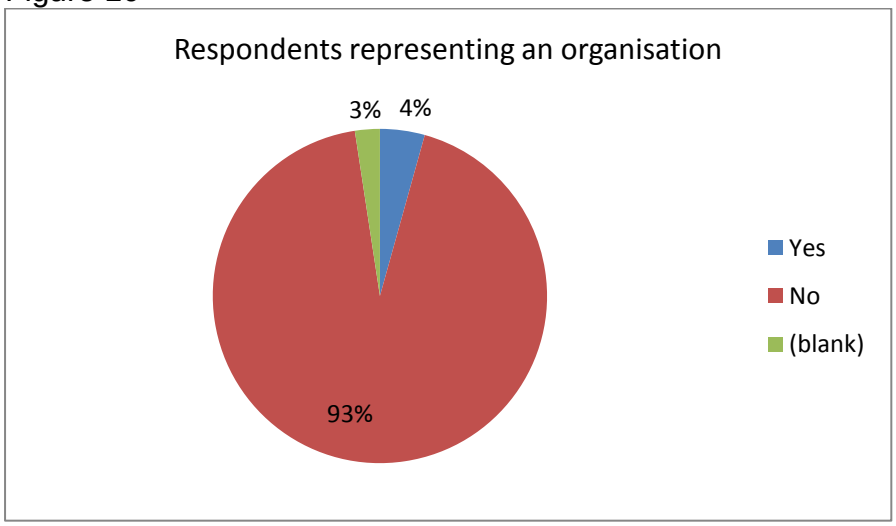


It appears that no respondents reported only having partial or total loss of vision, a speech impediment or a mental health condition or disorder. However, four people reported a partial or total loss of vision and other disabilities so for reporting purposes have been classed as having 'multiple disabilities.' Similarly, five people reported a speech impediment alongside other disabilities and 14 people reported having a mental health condition or disorder alongside other disabilities.

3.4.3 Organisation Representatives

Respondents were asked to indicate whether they were completing the questionnaire on behalf of an organisation. As Figure 10 shows, the majority (93%) of people were not representing an organisation.

Figure 10



The organisations represented via the questionnaires were:

- Friends of St Chad's and Chilcompton Surgeries
- London Road and Snow Hill Partnership
- St Michaels and Beehive Patient Group
- The Batheaston Neighbourhood Group

- The patient group at Batheaston Medical Centre
- Bath Labour Party
- Communication Workers Union

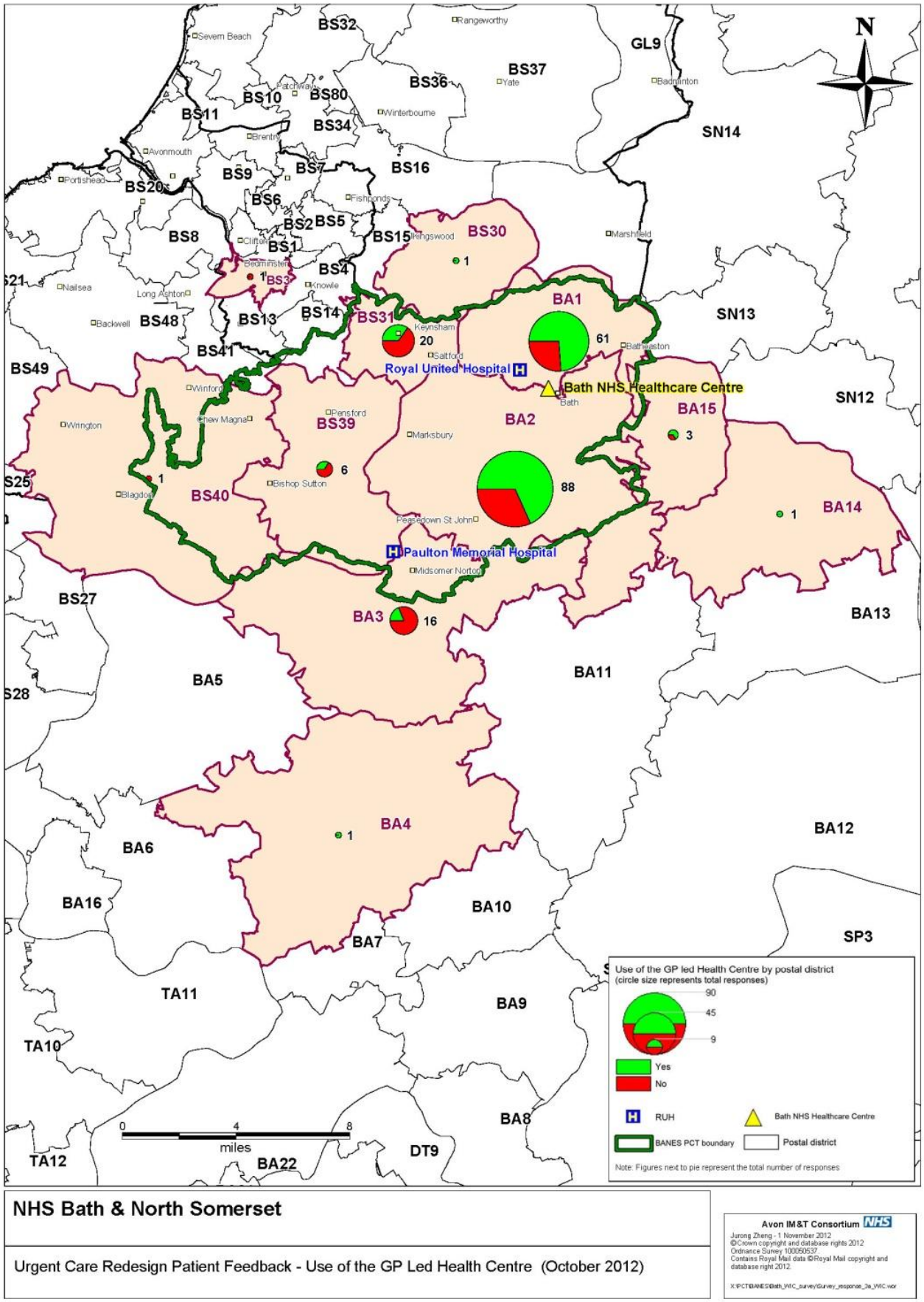
There were 14 respondents who stated that they were representing either the Your Say Advocacy service or B&NES Networks. However, these respondents were completing the questionnaire as individuals with support from these groups and so have not been counted as representing an organisation.

3.4.4 Respondents' Use of the GP-led Health Centre & Emergency Department by Postcode Area

Use of the GP-led Health Centre

61.5% of respondents had used the GP-led Health Centre and map B (overleaf) shows whether or not the respondents had used the GP-led Health Centre at Riverside by postcode area. Approximately three quarters of people living in BA3, BS39 and BS31 have not used the centre whilst a much higher percentage of people living in BA1, BA2 and BA14 postcode areas have used this service. This is not surprising considering the location of the GP-led Health Centre but there is a strong correlation between respondents favouring the proposed new model and not using the GP-led Health Centre.

Map B

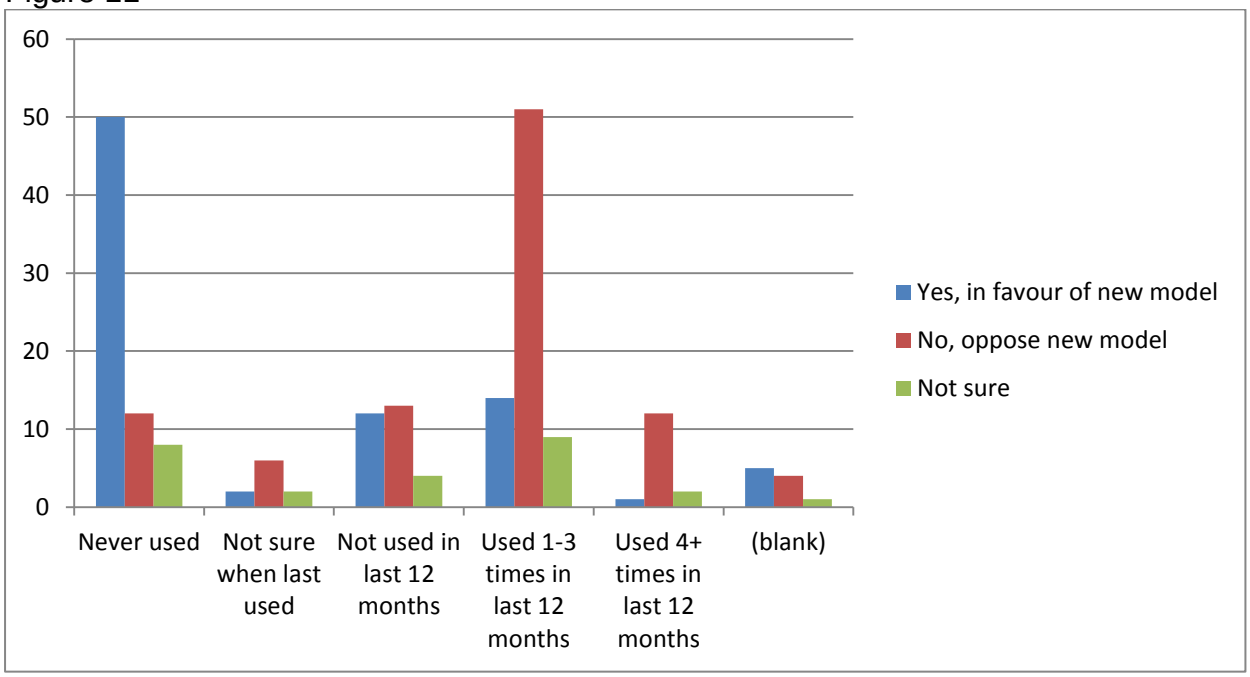


NHS Bath & North Somerset

Urgent Care Redesign Patient Feedback - Use of the GP Led Health Centre (October 2012)

Figure 11 shows the respondents usage of the GP-led Health Centre and whether or not they are in favour of the proposed new model. There is a strong correlation between respondents who support the change and who have never used the GP-led Health Centre. Similarly, there is a correlation between respondents who have used the service in the last 12 months and oppose the new model. Interestingly, the respondents who have not used the centre in the last 12 months are split equally about whether the new model is a good idea or not.

Figure 11

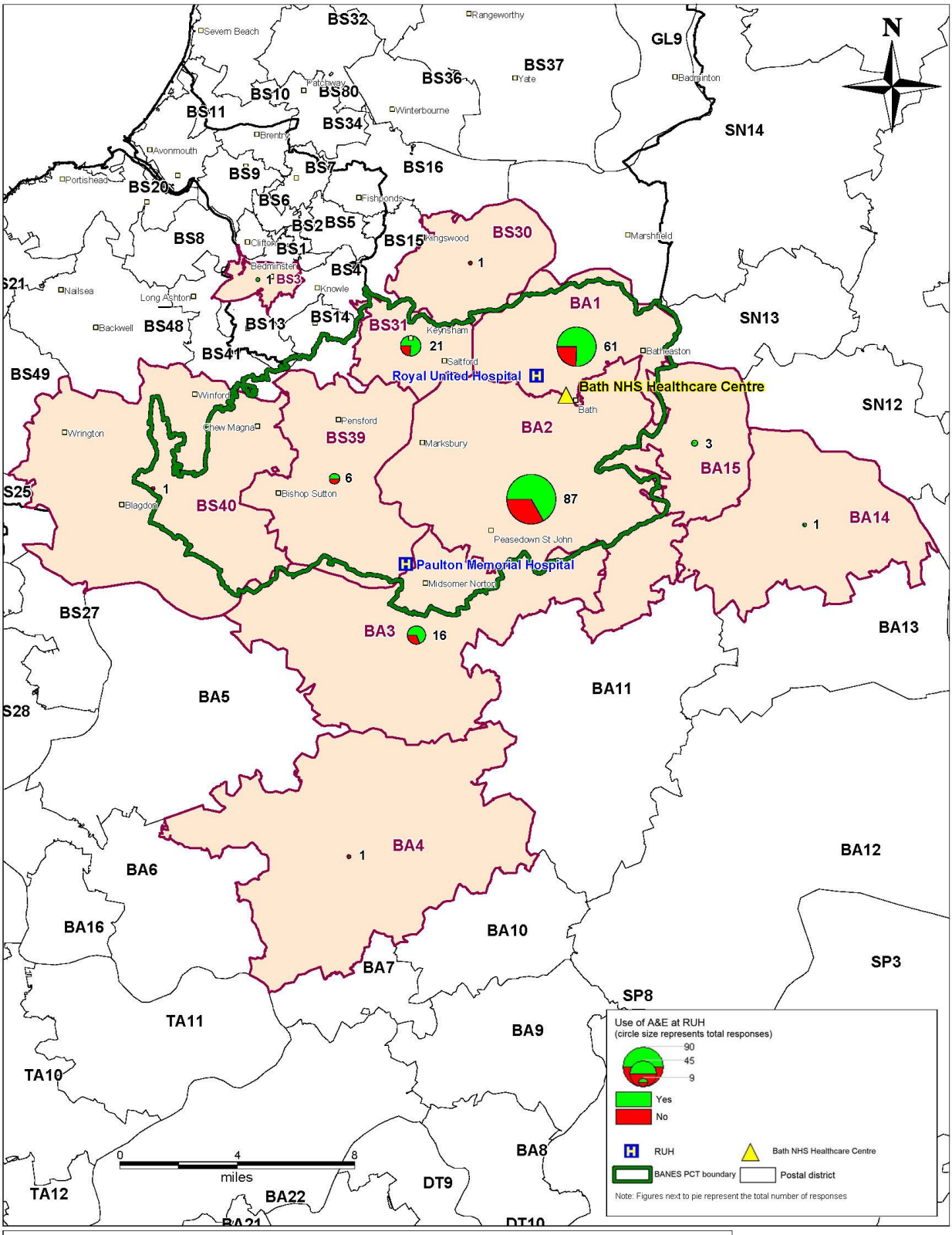


Use of the Emergency Department

68.3% of respondents had used the Emergency Department at the RUH and map C (overleaf) shows whether or not the respondents had used the Emergency Department by postcode area. In the BA1 and BA2 postcode areas, a similar number of respondents had used the Emergency Department as had used the GP-led Health Centre. In BA3 and BS31 postcode areas, approximately three quarters of respondents had used the Emergency Department, but only around a quarter of respondents had used the GP-led Health Centre.

Assuming that there isn't a greater proportion of people in BA3 and BS31 requiring emergency care than people living in BA1 or BA2 postcode areas, this indicates that despite the RUH and the GP-led Health Centre being only a mile apart, people choose to attend the service that is closest and/or easiest for them to access. This is also reflected in Map A where the majority of respondents living in BA3, BS39 and BS31 postcode areas were in favour of a new model located at the RUH.

Map C



NHS Bath & North Somerset

Urgent Care Redesign Patient Feedback - Use of A&E at RUH (October 2012)

Avon IM&T Consortium NHS

Jurong Zheng - 1 November 2012

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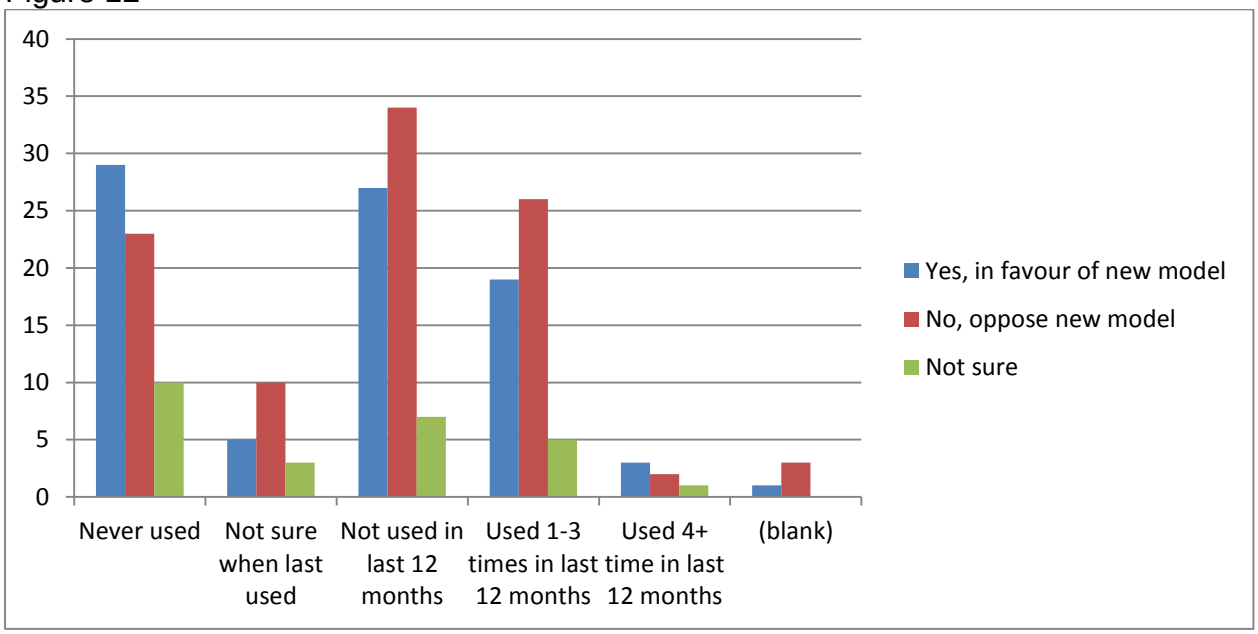
Figure 12 shows the respondents usage of the Emergency Department and whether or not they are in favour of the proposed new model.

Figure 12



Unlike Figure 11 which shows a strong correlation between use of the GP-led Health Centre and support for the proposed new model, there does not appear to be any strong correlation between usage of the Emergency Department and the respondents' opinion on the changes to urgent care services.

3. Conclusion

The majority of people who responded to the public engagement questionnaires disagree that urgent care services currently provided at the GP-led Health Centre at Riverside should be moved to the RUH (47.1% oppose the change). Although 40.4% of respondents support the proposed changes, 70.7% of respondents expressed concerns about the new model.

The concerns raised through the questionnaires as well as the public meetings can be summarised as:

- Inadequate GP access – in particular, respondents cited difficulties booking a short notice appointment that fits around work and family commitments, getting a same day appointment and being able to get through on the phone.
- Insufficient car parking at the RUH
- Car parking charges at the RUH
- Public transport (including the associated cost) and getting to the RUH
- Comments that the RUH is an unpleasant and stressful environment with long waits in the Emergency Department
- The GP-led Health Centre is convenient and easy to access, particularly for students and people working in the city
- Provision of services for vulnerable people, particularly the homeless
- The GP-led Health Centre is high quality and customer focussed and some respondents were concerned that this would not be replicated by the Urgent Care Centre
- Concerns that the new model would result in more pressure on GP practices and the Emergency Department resulting in increased difficulty accessing GP appointments and longer wait times at the RUH
- The savings assumptions were not clear
- Access for visitors and tourists to the city

The majority of respondents (64%) commented that access to GP services was poor stating that same day appointments were hard to access, short notice appointments that fit around work commitments are not available, opening hours are limited, problems getting through on the phone and difficulty accessing out of hours services. Despite this however, 64.9% agreed that the majority of minor illnesses should be dealt with by a GP practice where possible.

Despite wide communication and engagement, only 208 people responded to the questionnaire which equates to 0.1% of the 197,000 registered population of B&NES. However, concerns around the move came through strongly.

Finally, B&NES CCG would like to take this opportunity to thank everyone who has taken part in this public engagement process. The feedback has been invaluable and will be considered at length in developing the model for urgent care services.

GP-led Health Centre Staff Meeting on Urgent Care Proposals
Riverside, James Street West
Wednesday 24th October 2012, 7 pm to 8.30 pm

Present: Dr Ian Orpen, Chair, B&NES CCG
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES

Attended an open meeting with staff from the GP-led Health Centre to continue their engagement process in relation to the urgent care proposals.

10 staff from the GP-led Health Centre – predominantly qualified nursing practitioners but with administrative/reception staff also present. Jenny Theed and Amanda Phillips, Sirona Senior Leadership Team Directors present.

The majority of individuals attending the meeting had also attended the wider public engagement forums and were therefore well informed about the nature and scope of the proposals.

Members of the CCG briefly outlined the redesign proposals

- Escalation – pressure on acute hospitals throughout the year
- Need to streamline services and target resources to those with the greatest need
- the savings assumptions
- Role of the Urgent Care Network and how the proposal has been developed supported by them
- Option 3 has been an aspiration for quite some time.

The meeting was then open for a question and answer session.

Q: Aren't there walk-in centres that have been co-located with emergency departments that have not worked well and have subsequently moved out?

A: Yes there have been examples where the model hasn't worked well, but generally not the case and has been due to the way they have been set up. This is where the specification becomes so critical. Getting the relationships and governance model right will be important. Maidstone was cited as an early implementer of the model and at the time of visiting the service in 2005, it was working well.

Q: How do you envisage it working? We want to avoid wasting money. We currently see 30,000 patients a year and it is not clear what will happen to these patients.

A: Currently funding the GP-led Health Centre to be open at weekends as well as funding the out-of-hours service to provide GPs at weekends. We will want to involve the Urgent Care Network and staff in the development of the specification. Links back to the need to involve key practitioners in the design to make sure it is right. Getting relationships and risks right is important – as are clinicians being signed up to the model.

Q: Will the relocation of the GP-led Health Centre to the RUH not only serve to blur and confuse patients even more?

A: We are aiming to simplify what is available between the GP practice and the Emergency Department. We believe developing an urgent care centre at the front door will help do this as patients do know that ED is one of only two services that is always available 24/7, the other being the ambulance service. We want to ensure that patients with primary care needs visit their practice so we do not expect all the patients currently using the GP-led Heath Centre to go to the urgent care centre. We do need to signpost and change behaviours about attendance and shift patient flows away into primary care and educating the public is going to be important. We will need highly qualified practitioners in the new model who can help individuals understand the pathway.

Comment: People that come to the GP led health centre aren't confused.

A: No we are not saying they are, but it is about getting the pathway right and systems to ensure that we have an affordable model for the future given the pressures we are facing with no additional resources.

Comment: GPs are part of the system that is failing and they can't accommodate their patients that is why they come to us. When Monmouth was based here they regularly redirected their patients to us as they didn't have any appointments. They will need to employ more GPs and nurses and this will cost lots of money.

A: We are very aware that from what we have heard so far that this is a real concern. Work is being done to extend improve access and looking to tackle the number of DNAs which is clearly wasted capacity that is paid for. Overall the system isn't working too badly and they are still seen as handy and convenient to a number of patients – but we do recognize there are issues around access as well as perception and we need to continue to work to change this around.

Comment: Access to GP's is part of the problem. We haven't seen a drop in activity since the GP hours were extended. Patients are still telling us that it is difficult and they appreciate our accessibility and that we are convenient.

A: This has been a consistent message from all the public meetings which we need to listen to and recognize. We are working with practices through an incentive scheme to improve access over the next 18 months which includes ensuring that telephones are always answered between the hours of 8 am and 6.00 pm and not closed over lunch time periods. Also want to ensure practices have their doors open between the hours of 8 am and 6.30 pm so that patients can walk in and make appointments. We are aware that the do not attend rate (DNA) is quite significant in some practices so again we want to work with practices to address this as this is clearly wasted funded capacity.

Q: How is the money going to work? The facts about money aren't readily available and we can't see how you have come up with your savings assumptions without impacting on service or jobs.

A: Option 4, ie close the GP-led Health Centre with no re-provision would release £1.3m to reinvest locally into priority services. Did not want to do this as we recognized the need for some re-provision and know that the skilled work being done is making a valuable contribution. The GP out-of-hours service costs £1.6 m a year - totaling £2.9 million expenditure. We believe the urgent care centre will cost

approximately £2.4 million to operate, therefore releasing approximately £500,000. This is based on streamlining overhead costs (assumption is about 7% given the number of existing providers – BEMS, Sirona and Assura) and skill mix, reducing duplication, but also wider system savings such as preventing unnecessary emergency admissions. We believe the benefits of having primary care at the front door will potentially save for B&NES around three admissions per week. It is this wider 'whole system' approach that will generate the overall savings across the health community. This therefore does not mean that the savings would solely be released from two providers or through a reduction in trained staff at the WiC – who's skills and expertise we need to make the model work well.

Q: What about the costs of creating the urgent care centre and will it be a separate building or in the Emergency Department?

A: Currently the assumption is that there is the potential to use space within the existing emergency department albeit there will need to be changes to the building. This would come from one off capital funding and would not be recurring in future years.

Comment: Patients have concerns about the relocation to the RUH as they can't afford to travel, parking is problematic – with disabled parking being a particular concern.

A: This has also been a consistent message at the public meetings. Parking has improved at the RUH and there are now a greater number of disabled parking spaces. However, we do need to consider this further in terms of drop off points and disabled access. Linkages with the local authority are strong and their responsibilities for transport is helpful in providing alternative solutions around bus routes etc. We do know that for some people they would have to get two buses. We are not necessarily expecting all of the patients currently being seen at the GP-led Health Centre to go to the RUH and that people will increasingly go to their practice. However we do need to keep looking at this because we know it is a concern.

Q: Isn't there a risk that the urgent care centre would just become part of the Emergency Department?

A: We are absolutely clear that the urgent care centre needs to be structurally and philosophically different to the Emergency Department. The ED will continue to work separately. The Centre needs to have consulting rooms rather than ED cubicles and needs to feel like the atmosphere that has been created by your team. The specification needs to be very clear about this delineation. .

Q: How do you see the future role of the community hospitals such as St Martin's developing in terms of rehabilitation and community admissions?

A: Continue to have a crucial role. With the appointment of a consultant geriatrician the aim is to provide 10 step up beds at Paulton Hospital to enable GPs to admit directly rather than to the RUH. Have already appointed two extended nurse practitioners to support the development of both hospitals. Plans to pilot by end of December the relocation of the access team at the front door of the RUH will help inform the specification for the urgent care centre.

Q: How do you see the reception operating at the front door?

A: This still need to be worked through, but essentially it will be important to ensure that it is adequately resourced through some sort of joint reception arrangements and

that we have senior nurse streaming at the front door to ensure that patients are directed into the right service. Input into the specification would be welcomed.

Q: Are there areas where they have this model?

A: Croydon have a similar model. A joint visit to see how it works could be useful.

Q: Why don't you do more to educate the public?

A: This is very difficult and the evidence suggests that general education about how to use services has limited impact but we will continue to do whatever we can and initiatives such as the new 111 number should help. Evidence suggests that opening new services such as walk-in centres, GP-led Health Centres and NHS Direct has created new demand but only some of it is for urgent care and a high percentage should be redirected to primary care. This wont happen overnight and we need practitioners across a range of disciplines to talk to people about how best to access services appropriate to their needs. Staff like district nurses, reablement workers, practice nurses etc also play a key role in letting people know how best to get the service that they need.

Comment: Is there going to be a job I want? Need to consider whether the role would be what I would want to do in the future and what it means for me and others in the team. Are our skills going to be transferable? Will the shift patterns suit?

A: Understand this represents a change for all staff working at the current GP led health centre. We do need the specialist skills that are within this team in the future. There will be variety in the same way as now by the very nature of the 'drop in' nature of the service. But it is hard to predict exactly what the changes will be in terms of patients who present for treatment. There will be an opportunity to interface with acute setting and learn new skills. We recognize that inevitably things will be different – but hopefully in ways that also provide opportunity as well as change. We will be working with the new provider(s) to do as much as we can to maintain stability and skills – but it will be different and it will affect individual staff in different ways.

Q: Who will be the provider? We have concerns about private service tenders.

A: We will need to go through a procurement process so we cannot say who the provider will be. There are national rules about competition and choice and private providers cannot be excluded from the process. The detailed ways of working will be part of the provider bid (within the constraints determined by the commissioners of the service). We recognize that the team does a good job; we want to work with you to provide a model that builds on this – albeit in another location/setting.

Q: What are the next steps?

A: A report including the outcome of the public engagement process as well as the health impact assessment and equality impact assessment will be presented to the Wellbeing Policy Development & Scrutiny Panel on 16th November 2012. The report has to be submitted by 6th November. Depending on the outcome of the Scrutiny Panel, the aim would be to present a paper recommending to proceed with the proposal to the Clinical Commissioning Committee and to the next Public Board meeting where the decision will be made in January 2013 – with a view to the service going 'live' in 2014

Jenny Theed agreed to attend the next team meeting for a major item on new service model. Experiences and understanding of existing team really important and valued – need to get the specification right and have people who understand how things work on the ground.

Ian, Simon and Corinne thanked for their attendance. Through the bespoke session staff had greater understanding. Inevitably concerns about impact of organization change on individual members of staff – but discussions strongly focused on needs of users/patients and staff were open to new ideas and ways of working in support of these aims.

Staff at the meeting agreed that the notes of the meeting could be included within the final engagement report.

Annex 2

Urgent Care Public Engagement Event
Centurion Hotel, Midsomer Norton
Tuesday 2nd October 2012, 6.30 pm to 8.00 pm

Present:
Dr Ian Orpen, Chair, B&NES CCG
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Dr Elizabeth Hersch, Urgent Care Lead, B&NES CCG
Dr William Hubbard, Consultant Cardiologist & Head of Medical Division, RUH
Tracey Cox, Chief Operating Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES

Q: Is the ambulance service involved?
A: Yes, Great Western Ambulance Service (GWAS) is a member of the Bath Health Community Urgent Care Network.

Q: How is the ambulance service funded?
A: The PCT funds the service and has a contract with GWAS.

Q: How is Sirona funded?
A: The PCT and Council have a tripartite contract with Sirona who were established when PCTs had to 'divest' themselves of provider services.

Comment: Sirona can prevent people going into hospital?
A: Agree. They provide a range of community services as well as having knowledge of other services available in the community so are able to signpost. Equally clinicians need support with signposting too.

Q: What about the administration/management costs of the CCG?
A: Given the size of the NHS budget overall management costs are low and some would say too low and it is undermanaged. The CCG budgets will be less than the PCTs partly due to reduced responsibilities, but the CCG needs good managers and we are fortunate to have skilled and dedicated managers. However, the CCG team will be smaller and will have £24 per head of population to spend on its running costs.

Comment: Years ago matrons and doctors ran the RUH now it's administrators.
A: Evidence shows management costs are lower than other business sectors. Also, years ago there were significant waiting list problems and lengthy waits in the Emergency Department. Without good managers these would not have improved so we absolutely need them.

Comment: My wife had a poor experience at the RUH.
A: The hospital has developed systems for talking to patients, staff and relatives to get feedback. Complaints are scrutinised in detail to identify lessons that can be learnt and where the hospital can improve.

Q: Why the increase in diabetes?

A: The increase is associated with type 2 diabetes. It used to be known as maturity onset diabetes, but is no longer a later life problem. One of the reasons for the increase has come about as a result of the increase in obesity levels. This is not just an issue for the UK and is a world-wide problem with India seeing a massive increase in type 2 diabetes.

Q: With the RUH becoming a Foundation Trust what will the relationship be with the CCG?

A: Although FTs are independent organisations they still need to work in partnership with other organisations as no one organisation can do things on their own. The NHS was more homogenous, but divided between primary and secondary care. However, as a result of the changes there are better links and integration between primary, community and secondary care.

Q: Do you buy services from the RUH?

A: Yes, B&NES is about 45% of the RUH's business, Wiltshire is about the same and the other 10% is Somerset and South Gloucestershire.

Q: What is the cost/price of RUH services to the CCG?

A: For most secondary care services, there is a national tariff, eg out-patient appointments and in-patient episodes of care. The in-patient tariff reflects different conditions and complexity of conditions. As a result of the ageing population and complexity of needs, the costs of secondary care are rising. It is therefore really important that services work well together and benefit from the expertise at the RUH.

Q: Do Bristol hospitals provide some services?

A: Yes they do and they also provide some of the regional specialist services which are not provided by the RUH for example neurosurgery and burns.

Q: Parking is a real problem at the RUH so what will be done about this?

A: The CCG is aware that this is a real issue and concern for people so will work with the RUH to explore potential solutions as the plans progress.

Comment: Member of the public at the meeting stated that he had attended the RUH's AGM where it was announced that a new car park would be built on the site of the old path labs as a new path lab is being built.

A: RUH's Director of Estates has also done a lot of work to improve parking as well as transport services to the RUH, including the Odd Down Park & Ride service which now goes to the RUH and the Wiltshire Hopper service. More disabled spaces and drop off points have been provided at the hospital.

Q: Sometimes during out of hours we know we don't need to be hospitalised but need some specific help?

A: NHS 111 is the new national number for people to ring 24/7 and they will be able to signpost into the appropriate service and if it is life threatening the service will be able to transfer the request to the ambulance service. NHS 111 will also have access to something called 'special patient notes' which provide patient specific

information about needs or end of life wishes. This will enable services to be more joined up and improve the patient experience.

Q: The Health Centre has other services what will happen to these?

A: The contraception & sexual health service, dental access service and the specialist drug & alcohol services will remain. There are no changes to these services.

Urgent Care Public Engagement Event
Hilton Hotel, Bath
Thursday 4th October 2012, 6.30pm to 8.30pm

Present:
Dr Ian Orpen, Chair, B&NES CCG
Dr Ruth Grabham, Clinical Director, B&NES CCG
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Dr Jim Hampton, Planned Care Lead, B&NES CCG
Dr William Hubbard, Consultant Cardiologist & Head of Medical Division, RUH
Tracey Cox, Chief Operating Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES
Joel Hirst, Associate Director of Medicines Management, NHS B&NES

Q: Who appoints lay members?
A: The CCG is responsible for appointing the lay members based on national guidance.

Q: Who was on the panel for these appointments?
A: Dr Ian Orpen was on panel that made the appointments.

Q: ***Why are there no Local Authority members on the CCG?***
A: The Governing Body has very well developed joint working arrangements at a strategic level through the Health & Wellbeing Board and at operational level. There has been a partnership with the Local Authority for four years and recently a joint partnership framework has been agreed and fully endorsed by the Council. Ian Orpen also attends the Wellbeing Policy Development & Scrutiny Panel meetings every two months.

There are also several joint posts with the Local Authority. A Health & Wellbeing Partnership Board has been up and running in B&NES for a while, but the new policy requires Health & Wellbeing Boards.

Q: How do we, as members of the public, contact the PPI Lay Member?
A: The post has only just been appointed and not currently in post. However, details will be made directly via the CCG's website.

Q: Is this a paid post and local?
A: It is a paid post and is a local resident who previously worked in Plymouth Council.

Q: Please can you provide more details about the Governance and Audit structures?
A: The Audit and Assurance Committee is chaired by a lay member. There will be a process of external audit to ensure that there is robust governance. The CCG is currently going through its authorisation process which will also involve a process of ensuring that the governance structures and processes are robust. The formal assessment is on 9th November 2012.

Q: What will happen to the homeless service at Julian House?
A: This service will not be affected by these proposals.

Q: Is the service seven days per week and if not, what will happen at weekends?

A: No the service isn't available at weekends and we will need to review the impact of the proposals for the homeless.

Q: How much will you save?

A: A full business case still needs to be developed, but we have made some high level savings assumptions on the basis of bringing the services together.

Q: Have you made the decision to close the service?

A: The service is not closing, but relocating and the redesign of services is using the resources we have more efficiently. We need to invest to support the most vulnerable – shift resources to support people with the greatest need. If we take no action the graph will get worse in terms of the gap.

Q: How will you improve GP services?

A: We are working with all practices to improve access to same day appointments through an incentive scheme.

Q: Will they be open longer including Saturday morning?

A: Practices have extended their opening hours, ie earlier in the mornings or later in the evenings as well as Saturday mornings, but this is variable.

Q: My surgery does not offer Saturday morning appointments?

A: Practices already open extended hours, but this is variable. We want to improve the answering of telephones and ensuring practices do not close at lunchtimes.

Q: So, are you working efficiently?

A: There is always scope for improvement and a number of practices are involved in an initiative called Productive Practice in order to become more efficient.

Q: I agree that we should do all we can to prevent older people being unnecessarily admitted to hospital and would strongly support more community support. The proposal suggests moving services to the RUH rather than the community, why?

A: This is a very interesting point and we do want to support the frail elderly as much as possible in the community. However, the majority of patients who use the GP-led Health services are between 20 and 29 years of age. We want to use resources released to reinvest in community services. All agencies that provide urgent care work together and with the voluntary sector. This provides comprehensive services to patients. We need to make sure resources are in place for people in need and we need money directed to the right place for the future.

Q: I understand the increasing demand, but how will you increase GP appointments?

A: We need to understand how best we can work in primary care and this is what the incentive scheme is all about. Some GPs take calls from patients and can get to the root of the problem quickly and others operate a walk-in and wait service.

Q: What happens if you close the service before you are sure?

A: The service would not relocate until March 2014.

Q: Will there be the same number of GPs?

A: Yes.

Q: What do you mean by duplication of services?

A: The GP out-of-hours service presently operates from the RUH on Saturdays and Sundays which duplicates with GP-Led Health Centre also open at weekends. The GP-led Health Centre also duplicates what practices provide and are already funded to provide.

Comment: I have to wait three weeks for an appointment at my own GP practice. Am I supposed to be psychic when I will next get sick? I get same day treatment at the Walk-In centre.

A: I'm sorry one of my patients had to wait a long time for an appointment. My practice is one of the closest to the GP-led health Centre and demand and activity need to be better managed. There is a need to have primary care stepping up to improve access.

Q: It sounds like it is a done deal and based on cost. People come to us who cannot get appointments elsewhere. You seem to have made your mind up. Who makes the decision? Is the public involvement now over?

A: There are further public meetings, as well as the questionnaire for people to give their views. Following this a report on the findings as well as an impact assessment will be presented to the Wellbeing Policy Development & Scrutiny Panel.

Q: What is the date of this meeting?

A: The Scrutiny Panel is taking place on 16th November 2012.

Q: What about parking at the RUH?

A: Parking has improved. There is now a direct Park & Ride service to the RUH. With regard to the cost of parking, this is in line with other Trusts in the South West. Parking for disabled and renal patients is free. Volunteers pay £1 per day. The area where the pathology block is located will become a car park.

Q: What about the frail and elderly?

A: Yes, this is an issue and there are local transport schemes as well as the non-emergency patient transport service.

Q: Should we convert more GP surgeries into Walk-in Centres?

A: The CCG cannot make practices do this. However, some practices do offer a walk in and wait service, but locally we do hope the incentive scheme will influence practices approach to offering same day appointments and improved telephone access.

Q: What about people visiting Bath?

A: Visitors and tourists can temporarily register with any practice in B&NES as the practices are already funded to do this. There are a number within one mile of the GP-led Health Centre. Prior to the GP-led Health Centre, people were directed to local practices for any medical treatment so we would expect this to happen.

Comment: My surgery is Grosvenor. I am a shift worker and cannot fit an appointment into my day. The bus service is not frequent enough. There is better access in a central location.

A: There is a very clear message regarding access to GPs, but we need to use the resources we have effectively given there will no additional money for the foreseeable future. We need to prioritise those with the greatest need.

Q: Will this increase the pressure on the RUH?

A: No we do not believe it will as our aim is that most of the people who visit the GP-Led Health Centre will go back to their practice.

Q: Why don't you educate people?

A: Evidence suggests that general education about how to use services has no impact. For most people, using the urgent care system is a rare occurrence – on average once every six years for the out-of-hours service and once every three years for the Emergency Department.

Q: What is the cost of someone attending the GP-led Health Centre versus a GP versus the RUH?

A: The pricing structures are different. The A&E tariff is an average of £100. There is no national tariff for GPs visits. However, it works out at approximately £16 per GP consultation. Nationally, walk-in centres are three to four times more expensive than visiting a GP.

Comment: We are being asked to take a lot of this on trust and I'm not convinced.

A: Demand is increasing for example there has been a 5% increase in ambulance activity. Of the 30,000 contacts at the GP-led Health Centre around 10,000 are from outside the area.

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Q: Have you considered another hybrid model such as having a GP service in A&E and keep the Walk-In service in the city centre?

A: Difficult choices have to be made. There is a risk of continuing to pay twice and therefore not being affordable. However, there have been some very good points made about finance and the savings assumptions.

Q: What about the RUH?

A: The out-of-hours service is already based at the RUH. If you were starting with a blank canvas the obvious choice would be to locate this at the RUH. The view seems to be that the GP-led Health Centre is a safety valve for poor GP access.

Q: I work for an organisation where people visit us in Bath – people would have to go to the RUH?

A: Prior to the opening of the Centre, practices had an arrangement to accept temporary registrations and we want to promote this.

Q: The service works now so why change it?

A: Yes, we don't disagree the service is high quality and very valued, but we do have to allocate resources based on need.

Q: Why not try the new model before you close the Walk-in Centre?

A: We have 18 months before the changes would happen.

Q: The Walk-In Centre was determined as being the best way forward when it was set up. What has happened to change this?

A: The Darzi review led to the development of GP Led Health Centres and the PCT was required to commission such a centre. We are now in a very different financial climate and so we need to consider how we use our resources given that we will not receive any increase.

Q: It is popular – why get rid of it? Is it a done deal?

A: We would ask that people complete the questionnaire either tonight or later or on-line so that we take account of comments and views. A final report will be produced setting out what we have heard.

Q: I would feel more comfortable if I could send my questionnaire directly to the Scrutiny Panel as I don't feel I can trust you?

A: All questionnaires do need to come back to Corinne Edwards as it is not appropriate to send them to the Scrutiny Panel. A full report setting out the findings of the questionnaire will be made publically available and presented to the Panel. Members of the public have to make a request to the Council if they wish to make a statement in advance of the Panel meeting.

Urgent Care Public Engagement Event
The Carter Room, Fry's Keynsham
Tuesday 9th October 2012, 6.30 pm to 8.30 pm

Present:
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Dr Shanil Mantri, Learning Disabilities Lead, B&NES CCG
Dr Jim Hampton, Planned Care Lead, B&NES CCG
Dr William Hubbard, Consultant Cardiologist & Head of Medical Division, RUH
Tracey Cox, Chief Operating Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES
Joel Hirst, Associate Director Medicines Management, NHS B&NES
Andrea Morland, Associate Director for Mental Health Services, NHS B&NES

Comment: The CCG has no local Keynsham GP membership.
A: The GP Cluster Lead, Dr Shanil Mantri, was introduced.

Comment: Bristol CCG is not currently involved in the redesign process even though many Keynsham residents use Bristol based services.
A: Agreed that longer term engagement with Bristol would take place. A representative from Bristol PCT had attended the Urgent Care Network and the proposal had been shared.

Comment: BEMS had reduced the pressure on the Emergency Department
A: Agreed, which is why we would like to strengthen the GP presence at the front door of the RUH.

Q: How do you know that the GP Led Health Centre has not reduced pressure on the ED? Is there a case that actually the early intervention prevents escalation of a condition in the longer term and therefore attendance at ED?
A: There is national data to which suggests that activity has not reduced at Emergency Departments despite the development of walk-in services. A report produced by the Primary Care Foundation called "Breaking the Mould without Breaking the System," provides evidence and information that has been used to help inform local thinking.

Q: Is there is a revolving door with the GP-led Health Centre for people with long term conditions.
A: The main reasons for attending the GP-led Heath Centre include tonsillitis, earache, viral illnesses, etc which are routinely seen in primary care.

Q: What was the history of the set-up of the Walk-in Centre?
A: The evolution of the Nurse-Led Walk-In Centre to the GP-Led Health Centre was explained. It was noted that the PCT was required to commission it, although did not have a local need in terms of GP access. We are now in a position to do something different as a result of the GP-led Health Centre and GP out-of-hours contracts ending in March 2014.

Q: What is the reason for the DNA rate?

A: There are various reasons for people not attending their appointments and this is an area that needs to improve as this wasted capacity which is paid for.

Comment: Aren't we actually pushing people up to the RUH and therefore increasing the risk of high cost interventions? Isn't the Walk-In Centre saving this? If not and the issue is to actually get people accessing their GP and that is what they are using the Walk-In Centre for, we need to be clear about what GPs will offer and that variability in response needs to be addressed.

Comment: The psychology of the local population needs to be taken into account - the Walk-In Centre provides people with security.

Q: In the new model, will you still be able to walk-in?

A: Yes.

Comment: It should be made clearer that Paulton MIU will still exist as well as above. It is not clear enough.

Q: Walk in services don't exist for the people of Keynsham? Do they use Hengrove?

A: The use of Bristol hospitals was explained and also the role of the Urgent Care network.

Q: An attendee expressed concern about the 9,000 non-B&NES patients who use the GP-Led Health Centre including visitors and people working in Bath. Is there the capacity in the Bath practices to do this?

A: GPs will need to be flexible and get access working better. There will still be a Walk-in facility at the RUH. We are working with practices on an incentive scheme to improve access.

Q: What patient involvement is there for the CCG?

A: There will be a Patient and Public Involvement Group and we want to try to find a way to better engage with the public. The current confusion regarding redesign etc was acknowledged and also the need to get positive outcomes being key.

Comment: It was noted that the physical accessibility of the RUH is not great for people with disabilities or mental health problems. They often use other facilities because they feel safer. Therefore this move may not meet people's needs. William Hubbard noted that A&E are the part of the health service that never says no - if we had GPs in that location it might greatly improve the quality of service.

Q: Could the Mineral Hospital be used? Another attendee noted access to the Min was very difficult so this wouldn't make sense.

Comment: Parking at the RUH is an issue for people.

A: Parking had improved over the past few years. Charging was introduced some years ago, partly as it was believed that some people were parking at the RUH for and working/shopping in Bath). Also moved staff parking to an outlying area and

now charge them too. A new car park will be built on the area where the pathology labs are based as they are being re-built.

Q: Why not charge for DNAs?

A: This is a difficult one not only as it would involve a huge administrative infrastructure to implement it. Even the administrative burden of ringing people is huge. Texting does not work for everyone and sometimes does not work. However, we need to think about how we do reduce the DNA rate.

Q: If there are some people that are known to be non-attenders could GPs enter into a relationship with Dial-a-ride to ensure they get there?

A: This is an interesting idea so thank you raising.

Q: What weekend cover is provided by the GP-led Health Centre and will this be replicated?

A: There is some duplication currently with the GP out-of-hours service (BEMS) based at the RUH at weekends as well as GPs based at the GP-led Health Centre at weekends. The proposal would mean that there will not be a central location. However, the cover provided by BEMS is all day each day either at the patient's home or at the RUH.

Q: Who answers the phone out-of-hours?

A: Currently this is Wiltshire Medical Services, but from April this will be replaced by NHS 111 the new national number.

Q: Is BEMS good value for money?

A: It is slightly above the national average cost, but its works well as its strength is that it is provided by local GPs.

Q: Will the new Centre be delivered by the RUH?

A: We cannot say who will be the provider of the service as it will be subject to a procurement process.

Urgent Care Public Engagement Event
The Elwin Room, Bath Royal Literary & Scientific Institute
Wednesday 10th October 2012, 6.30 pm to 8.30 pm

Present:
Dr Ian Orpen, Chair, B&NES CCG
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Dr Ruth Grabham, Clinical Director, B&NES CCG
Dr Jim Hampton, Planned Care Lead, B&NES CCG
Dr William Hubbard, Consultant Cardiologist & Head of Medical Division, RUH
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES

Comment: We need adjacent disabled parking for urgent care at the RUH. The disabled car park at RUH is often full. The door spring to the Diabetic Centre is impossible to push. Parking is expensive.

A: Agreed. When reconfiguring parking at the RUH, emphasis is being put on disabled places being close to the different centres. Parking costs are less than other acute hospitals in the South West. WH will take comments back to the RUH.

Comment: The RUH may be cheap compared with other hospitals, but it is currently free to park in the centre of Bath for the GP-led Health Centre.

Q: How much is parking?

A: Many patients do not pay or have reduced charges e.g. cancer patients pay £1 per day, parking is free for the first 20 minutes and two hours is £2.60. Parking issues will be taken into account as part of this review.

Q: Could the RUH Park & Ride bus run at weekends?

A: Not sure, but may be this can be considered for the future.

Q: How much do both the GP Out-of-Hours and the GP-led Health Centre cost?

A: The GP Out-of-Hours service costs £1.6m per year. The GP-led Health Centre costs £1.3m per year.

Comment: I have used the Walk-In Centre twice. When I rang my GP surgery I was referred by NHS Direct on a Sunday morning. The idea of trekking to the RUH for mild conditions is a concern. Riverside is central and accessible to visitors, those not registered with a B&NES GP and those who will not go to the RUH. The costs are minimal.

A: GPs are working hard and are committed to providing appointments for patients. Practices need to balance patients' needs and preferences for same day appointments versus their preference for longer, booked appointments. We are working with practices to improve access for patients. It is recognised that primary care will need to step up and ensure good urgent access.

Q: When will this happen?

A: We are currently working on this and recognise that this is a difficult situation which we need to approach in different ways. Times are changing and GPs need to face the challenge of ill health and what we are doing to prepare for increasing numbers

of people with very ill health. There may be some inconvenience from these proposals, however, there are several GP practices within one mile of the GP-led Health Centre for patients to go to and we need to focus on using resources to deal with the greatest need.

Comment: When ringing for the Out-of-Hours service the practice answerphone gives the BEMS number for patients to ring. I have never had a problem accessing BEMS. The BEMS service is good with quick access to a GP.

A: That is what BEMS is there for. If patients need a GP out of hours it is also possible that, if appropriate, they receive a home visit by a GP.

Q: I endorse the idea of a Walk-in Centre that is central and friendly, as it is now, with low waiting times. Under the plan who would triage at the RUH front door, a receptionist?

A: No, triage would not be made by a receptionist. It would be by a trained nurse. One of the benefits of the proposed option is that it allows access to specialist resources. If all these resources are in the same place it will simplify the system. As commissioners we will set standards about how quickly patients need to be seen and waiting times. BEMS is a very good service and we would expect the provider of a new service to have the appropriate resources.

Q: Will it put pressure on already pressured staff at the RUH? A patient had a 4 hour wait for a planned appointment (cancer unit).

A: The aim of the urgent care centre would be to help reduce the pressure on the Emergency Department given there has been an 8% increase in attendance. Some patients come to ED who would be better seen in a GP practice.

Comment: The plan is to relocate the service. Patients will still be faced with seven choices for urgent care so the system is not being simplified very much.

A: There would be six choices as one choice would be Emergency Department for Urgent Care.

Q: Will the triage service mean more waiting?

A: Waiting times will be part of the standards set and it is not expected to add a step for patients. It is very important to have an experienced nurse triaging patients.

Q: Will the 30,000 contacts be expected to go up to the Urgent Care Centre?

A: No. We hope that many of these can be diverted back to see their GPs rather than going to the Urgent Care Centre. Some people who currently go to the GP-led Health Centre or Emergency Department (ED) could actually see their GP instead. 30% of the 30,000 Walk-In Centre attendances are not B&NES residents, so we need to work with Somerset and Wiltshire CCGs on how to help these patients access their own GPs. We are working with colleagues in Wiltshire who are facing similar pressures. We need to make the system more sustainable. The proposals for Urgent Care Redesign are a small part of this work.

Q: The current contract runs out in 2014. Does the building lease run out then too?

A: No the lease on the building does not run out then. Other services will stay in Riverside. In terms of space, there is potential to use it for other services, however, we have not fully worked this through at this time. Earlier today the GPs were

discussing the future of diabetic services and that is one possible example of a service where we would want to commission a range of community support closer to patients homes. This is a good example of how we might want to use resources in the future.

Q: Do you have to pay the RUH rent for space for both BEMS and the GP-Led Health Centre?

A: There is currently no rental charge for BEMS who are currently on the RUH site. As we go forward rental charges will need to be reviewed.

Q: In terms of projected savings, what about including the costs of appointments that patients do not turn up to? Could there be a clear message to patients that if you don't turn up you are eroding the budget?

A: Yes we need to think best how to do this as this is a very good point.

Q: How will the public be advised of the outcome of the Engagement?

A: If anyone would like to see the report they can let Corinne Edwards know. We will also be doing an impact assessment and a report will be presented to the Scrutiny Panel. All documents will be available to the public.

A: If the service does change it is very important to get the message through, especially to the hard to reach groups. It would be good to get feedback from members of the public on the best way to do this.

Comment: Older people are being presented as a looming burden. We can do prevention work with GPs in order that older people have healthier older lives. We need to ensure older people don't fear going to GPs in case they are perceived as a burden.

A: This is a good point and we need to be sensitive. Prevention is important and it is a community responsibility so we are working closely with the local authority. We need to help people to have meaningful lives whatever their age. This is what we can consider using the savings for example psychological support for people with long term conditions which would have a great impact on their quality of life.

Q: I am concerned about the perception that older people are a burden. A&E does need to respond to older people and is actually also full of the results of binge drinking in younger people.

A: We are not saying that older people are a burden, however, we need to be realistic about the areas of greatest need and we need to use money as best we can. We recognise the concerns about alcohol licensing and the impact this has had.

A: We are passionate about using NHS capacity the best way and not wasting it. 10% of appointments at St Michael's surgery are DNAs and it is a waste of resources. We need to move patients back to the setting they should be treated in. Examples of using the GP-led Health Centre from my practice (Dr Jim Hampton) today are: i) 1 patient was offered an appointment in the morning, lunchtime, in the afternoon, but declined and said she would go to the GP-led Health Centre; ii) GP-led Health Centre referred a patient back for a dressing and the practice booked a 20 minute appointment that the patient did not attend.

Comment: £650,000 is only 0.2% of the CCGs £220 million budget and is not a large amount of money.

A: Although this is a public meeting, I disagree with you; £650,000 is a large amount of money and worth saving. We also need to note that the cost of a consultation at the GP-led Health Centre is double the cost of a consultation in a GP practice. Other areas in the country are reviewing the need for similar services.

Q: Will the additional work for GP practices affect availability for other patients?

A: No. In terms of numbers, even if doing hotel visits for visitors, it will be just one of many visits in a day, for example if doing 10 home visits a day one additional visit is manageable.

Q: Estimates are forecasts and this is only a small percentage of the overall spend and a small amount of money. There is a need for these patients and the Walk-In Centre acts as a safety value for practices. Where will this need be met?

A: We feel that £650,000 is a considerable amount of money. The redesign can offer huge benefits in quality of care, not just in terms of savings. Savings may actually be higher than £650,000, however, it is about the quality of care.

A: There were 28 unused appointments in my practice (Fairfield Park) this week = 280 minutes in just one practice per week. We need to let people know about this. Yes there is a need to provide care for those 30,000 attendances, but the GP-led Health Centre may not be the right place. The right place is often the GP practice and there is capacity there. We are working to make sure appointments are available in GP practices for urgent care.

Q: From Ian Orpen – Who feels that their GP practice does a good job? Show of hands

A: Majority agreed.

Comment: Cllr Katie Hall, Vice-Chair of the Wellbeing Policy Development & Scrutiny Panel explained that the Panel will scrutinise this proposal. I have taken notes of the discussions and have already asked numerous questions of Corinne Edwards and Ian Orpen. We are taking the proposal seriously. The Scrutiny Panel is also holding an Alcohol Reduction Scrutiny Day.

A: The CCG has regular meetings with the Leader of the Council and the Director of Peoples Services and had a recent session on alcohol. It is a very complex issue, the Council has some role, but we also believe that shops and supermarkets have a responsibility to their community. The CCG has a good working relationship with the Council.

Comment: Need to be mindful of not penalising responsible drinkers.

Q: All GPs are working hard. You cannot get capacity from DNAs because you cannot use it unless you know who is not going to attend their appointment. Where will GPs find capacity to see these patients from the Walk-In Centre?

A: This is why we need to work with practices to understand why people DNA to try and reduce the numbers.

Q: I cannot understand the argument that resources are being duplicated. What is the difference between the costs of the Walk-In Centre and a GP practice?

A: It is double because capacity in GP practices for these patients has already been paid for. Therefore we are paying additionally when the GP-led Health Centre is

used for GP practice work. The average cost of a GP appointment is £19/£20 per appointment.

Comment: There is a trend between the rise of GP commissioning and getting rid of Walk-In Centres. GPs do appear to be defending them.

A: This is not GP money, this is health community money. The history of GP-led Health Centres is that PCTs were required to commission them to ensure all communities had the same service to avoid variations. At the time the PCT did not believe it needed such a service as it had no problems with GP access, ie no closed lists or problems recruiting GPs. Such centres had more value in inner city areas where there were problems with GP access. If B&NES had been asked at the time how to spend the money to improve local access this would not have been the way we would have chosen to spend it.

Q: Is there a pot of money for these engagement events and writing the reports?

A: We have to pay for room rental, but the benefits are worth it. PCTs were seen as distant from people and CCGs need to engage with the public so we need to ensure we do this well.

Comment: Savings should not equal a poorer service.

A: This is about improving quality. The experience of co-locating primary and secondary care is good and we have already seen benefits from BEMS being on site at the RUH.

Urgent Care Public Engagement Event
Radstock Methodist Church Hall
Monday 15th October 2012, 7.00 pm to 8.30pm

Present:
Dr Ian Orpen, Chair, B&NES CCG
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES
Menna Davies, Communications, NHS B&NES

The meeting had been called by Cllr Eleanor Jackson, in her capacity as B&NES Champion for Adult Health Care.

Q: What about the local area teams that sit beneath the NCB?
A: The diagram had been simplified, but the local area teams are the outposts of the National Commissioning Board.

Comment: I have concerns about the process for the appointment of the Lay member to the CCG. I had asked about it at the meeting at the Centurion in July and was told the details hadn't been agreed, then went on holiday and when I came back it was advertised on 16th August with a closing date of 23rd August, with interviews on 7th September. This left no time for me to apply and I question the validity of this because the process was so quick / short notice. Also I called HR and someone put the phone down on me.
A: The CCG was under tight time pressures but had received 14 applications with three high calibre candidates interviewed.

Q: Are all these paid posts?
A: Yes all posts are remunerated and local rates of pay had been agreed by the PCT in line with national guidance.

Q How do running costs stack up compared to the PCT?
A: PCT £37 per head of population, CCG will be £24 so significantly less. The CCG will receive circa £1,800 per head to spend so it's a relatively small percentage of that spent on health services.

Q: The red line shown on the 'uncomfortable truth' graph isn't real and is just a projection so why use it?
A: This reflects the funding the funding that the PCT would have expected to receive if things had continued before the changes to public sector funding. The NHS has to deliver QIPP efficiency savings to reinvest in services.

Q: How many practices in our area, what about a salary cut for GPs?
A: There are 27 practices plus the GP-led Health Centre which makes the 28. Primary care is also experiencing tough times and is earning the same as seven or eight years ago.

Comment: Will look at this as I don't believe it.

Comment: Radstock has a below average age population and an early death rate in males and high female cancer rates, plus exploding birth rate. Radstock faces particular issues including high incidence of childhood obesity.

Q: Are there national policies and health messages to help take the pressure off health services?

A Yes there are and the messages are very important. Smoking rates locally have dropped from 25 – 19% in last six years.

Q: Given the socio economic aspect what is the CCG going to do locally for Radstock which is a poorer area of B&NES. What are you going to do to make sure we get the right sort of money for the needs of our local population?

A: The CCG is working closely with the Council and that it was recognised that Radstock was an area in need of support. It will be important to work with public health colleagues, who will be moving to the Council, to consider health improvement and healthy lifestyles for areas such as Radstock.

Comment: Pleased to hear that the CCG recognised Radstock as a poorer area.

A: As a GP working in the area for the last 20 years I know absolutely the problems and I have seen a definite improvement in health and longevity locally.

Comment: Obesity and poverty are closely linked.

A: Yes and the CCG's aim is to narrow the gaps in life expectancy and deprivation.

Q: The JSNA is very thin in parts, particularly regarding mental health. Very little in there about Radstock apart from the fact it's the second highest area for people claiming benefits. How much will the CCG be involved in influencing that? Is it your role as commissioners or is it Public Health as part of the local authority?

A: The mental health commissioning role is a joint appointment between the Council and the CCG. The CCG and the Council will continue to work very closely together building on the partnership between the PCT and the Council. This is a major benefit and quite unusual nationally. The JSNA is not a static document and continues to develop. Comments are very welcome.

Q: What are your plans to deal with diabetes, specifically with regard to the BME population, which has a higher incidence?

A: Specific work has and continues to been done with the BME population.

Q: How is moving the GP-Led Health Centre to the RUH making it more accessible?

A: Although the middle of Bath is accessible for people living in Bath, it is not necessarily that accessible for people who live in North East Somerset. We believe there are wider benefits of bringing the GP-led Health Centre together with the RUH.

Q: How will it affect the Out-of-Hours service at Paulton?

A: It will not affect this service.

Q: Where will this centre be in relation to A&E?

A: It would be in the same place - at the front door of the RUH. You will be able to go to one place to get all you need.

Q: What about access to a consultant at the weekends? They don't work at weekends.

A: Yes they do and all new consultants appointed at the RUH have 7 day week contracts.

Q: Would it affect the hours that GP practices offer now out of hours?

A: No, but we are working with GPs through an incentive scheme to improve access and we would expect to see improvements from next April.

Q: What is happening to the Mineral Hospital?

A: It is a matter of public record that the hospital is in breach of its foundation trust status (one of the smallest foundation trusts). Linkage with the RUH isn't a new idea and is being discussed. The RUH is one of very few hospitals in the country without a rheumatology department.

Q: The FAQs are muddled because there is no detail of where the numbers come from eg numbers of people going to ED increasing. Where do these figures come from?

A: The data comes from the providers. The PCT monitors activity at the RUH and the GP-Led Health Centre as part of the contracts.

Q: What does 30,000 patient contacts mean?

A: Contacts do not mean 30,000 different patients. These are the number of times people visit the GP-Led Health Centre, one patient could visit 10 times which equates to 10 contacts.

Q: What has been done to engage with people who use the Centre?

A: Seeking feedback from those who use the centre through all the public meetings as well as via the questionnaires which have made available at the centre.

Comment: Cllr Jackson said she had seen all the data at the Scrutiny panel but it didn't stack up with her first-hand experience when she attended the centre recently with a sprained shoulder. Only had to wait an hour and observed that everyone there except her was under 40 and included two homeless people, two who looked like they had drug problems, two teenage girls (she thought one might have thought she was pregnant), some Chinese tourists and students. Said that we have a very high teenage pregnancy rate and also a lot of concern about people not registered with a GP. She was told that the centre shuts the door one and a half hours before closing time because it is so busy. Said that sometimes stats don't tell the whole story. In many cases it's for people who may drop-out. Said she was dealt with very well there.

Q: What is the CCG's overall budget?

A: Approximately £220 million.

Comment: £500,000 potential savings is therefore "peanuts".

A: Disagree £500,000 is an awful lot of money and would go a long way to help improve services for people with dementia, diabetes as examples.

Comment: Concerned about accessibility as a lot of people who use the centre would find it hard to get to the RUH. The 20-29 age group are the ones who are likely not to have the bus fare. Said that a lot of homeless people have nothing to do with Julian House at all.

Comment: A weakness of the centre is that it doesn't have access to services like X-rays.

A: This is one of the reasons for wanting to relocate the centre to the RUH as there would be better links and access to other hospital services.

Comment: Of all the NHS reorganisations this has been the most complicated of the lot. Not all treatments cost more; many are simpler and cheaper than in the past. The problem is change in expectations of patients and the treatments being delivered. NHS designed for life-threatening and lifestyle harming conditions but there has been a move in emphasis to stuff that should be done outside the NHS – cosmetic procedures. A lot of expense can be got around by better education to stop people getting into this position. Vast amounts of expense could be saved. Talked about 1/5 of NHS budget 20 years ago spent on homeless people and that today there are millions of empty homes. Said it's a problem of bad governance not money.

A: Agree that although certain treatments are now cheaper there are lot of new treatments and procedures that are expensive which are enabling people to live longer. There have been significant improvements in cancer treatments but they are very costly. There does need to be a much more open debate about funding and the pressures. Getting clinicians more involved and more accountable for the decisions made is one of the key aims of the new policy.

Comment: Have a very dim view of the changes because it means it's not possible to get to see your own doctor.

Urgent Care Public Engagement Event
Radstock Methodist Church Hall
Thursday 25th October 2012, 2.00 pm to 3.30pm

Present:
Dr Ian Orpen, Chair, B&NES CCG
Tracey Cox, Chief Operating Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES
Menna Davies, Communications, NHS B&NES

Q: How did the elections for CCG appointments happen without public involvement?

A: The Department of Health (DoH) set up a rigorous election process which included a meeting of 150 GPs and Practice Managers (90% turnout in B&NES) who elected an interim group to go forward. This election also included sessional GPs who work in surgeries, hospitals and for the Out of Hours service and make up one third of the B&NES GP workforce. A further election took place in May 2011 when a 98% vote of confidence was achieved for the CCG members with no new nominations being made.

Comment: This is not a true democratic process.

A: This is the process that we have been required to follow by the DoH who, together with the new National Commissioning Board, will continue to check and monitor all CCGs.

Q: What is the Individual Patient Panel?

A: This panel deals with requests for treatments that are not usually covered by NHS funding and are outside the PCT's existing policy. An example of this would be for infertility treatment.

Q: What about conflicts of interest?

A: This is covered in the CCG's constitution and this, together with the CCG's Business Conduct Policy and Register of Interests is available at public meetings and also on the website. Apologies were made regarding the length of the website address which was recognised as being unnecessarily cumbersome due to the requirement for B&NES to be written in full. All at the meeting agreed.

Q: Seeing a GP on the same day is not always possible, what are you going to do to improve access?

A: This concern has been a consistent theme at all these public meetings. Work is on-going with GP practices to address this problem. An incentive scheme is being introduced for the practices in order that they can improve access by answering the phones promptly, staying open at lunchtimes and responding to patients who have 'same day' needs. Another area that requires attention is patients who miss their appointments (DNAs). The DNA rate ranges from 3% - 10%. It was noted that this is time that the GPs are paid for, but is then wasted. All avenues to improve this will be investigated such as texting and phoning patients to remind them of their appointments.

Q: Why pay GPs an Incentive Payment when they are already paid to do the job? The contract with the GPs needs to be changed to make them work more efficiently – we are now in a 24/7 world and they need to adapt.

A: The GPs have a national mandated contract, however, this is currently being reviewed and consultation with the BMA has just commenced.

Q: When monitoring effectiveness, who will monitor the CCGs?

A: The National Commissioning Board will have Local Area Teams (LATs) who will be constantly monitoring CCGs as they continue to develop. GPs are already monitored and this includes both prescribing and referral patterns.

Q: Are these figures available to the public?

A: Yes, via Public Board Reports and Freedom of Information requests.

Q: As a Manager of a Nursing Home I would like to suggest another potential saving. Currently patients are admitted to the RUH if they require intravenous (IV) antibiotics. This could be carried out by qualified nurses in the nursing home and thereby saving an average of three to four days as a hospital in-patient.

A: A new Intravenous service had been commissioned from Sirona Care & Health for District Nurses to be trained to give IV antibiotics to patients in their own homes. There is potential to link this service to support nursing homes.

Q: The loss of the GP-Led Health Centre could be detrimental to the community – my experience of the Out of Hours service was not good, although I acknowledge I should have telephoned in advance. First line of contact with Out of Hours staff at the RUH needs to be improved.

A: The service offered to patients and staff training will be addressed as part of the procurement process. At this time we do not know who will be the provider of the service.

Q: Do GPs have a regular appraisal?

A: Yes, there is currently an appraisal which GPs have to undergo every 5-6 years. A new revalidation system is being implemented from April 2013 which will include both patient and colleague feedback.

It was agreed to ask the PCT's Medical Director, who currently oversees GP appraisals, for a synopsis of the process to be made available on the CCG's website.

Q: Have you considered advising patients of proposed changes to services via videos in waiting rooms? This could also be used to make patients aware of which services they should use for different situations and also of the DNA problems and costs associated with it?

A: Thank you for this suggestion which we will take forward as part of our discussions with practices.

Urgent Care Public Engagement Event
St Luke's Church Hall, Bath
Friday 26th October 2012, 10.00 am to 12.00 pm

Present:
Dr Ian Orpen, Chair, B&NES Clinical Commissioning Group
Dr William Hubbard, Consultant Cardiologist and Head of Medical Division, RUH)
Corinne Edwards, Associate Director of Unplanned Care and Long Term Conditions, NHS B&NES
Joel Hirst, Associate Director of Medicines Management, NHS B&NES
Menna Davies, Communications, NHS B&NES

Q: Where will the CCG operate from?
A: The expectation is that it will operate out of the old PCT offices at St Martin's Hospital, Bath. However, this is a changing situation and may alter in the future as the NHS reforms work through.

Q: How do members of the public express an interest in being involved with the CCG Patient Involvement Group?
A: Please let us know if you are interested. We are looking into the idea of having a promotional leaflet in GP practices. The CCG are really keen to reach out and get people involved in building on the work of the Healthy Conversation events that the PCT ran.

Q: Is there any academic input into the decision making processes in the new design of the NHS?
A: There are 14 clinical networks offering Best Practice being formed e.g. Cardiovascular Disease, Cancer and others. There is also an Academic Science Network promoting innovation and the LETBEs Local Education and Training Boards.

Q: When was the Riverside facility established?
A: In 2001 a Nurse Led Walk-In Centre was opened in Henry Street. In 2004 this relocated to the facility at Riverside. In April 2009 the GP-Led Health Centre was opened at Riverside.

Q: Can we learn things from dental colleagues about reducing missed appointments?
A: GP practices have looked at a number of options. Some practices text patients to remind them about appointments. There is a scheme looking at improving access in GP practices which is being run over the next 18 months and some of these issues will be picked up as part of this scheme.

Q: Is the cost benefit of moving going to be offset to the public who will then have to pay for the additional travel costs to get up to the RUH site?
A: The expectation is that a significant number of the current 30,000 contacts at the GP-Led Health Centre will not go to RUH. It is anticipated that many will go back to their own GP practices. There are lots of Out of Area patients and it is anticipated that they will be redirected to local GP practices, several of which are within one mile of the GP-Led Health Centre, as temporary registered patients.

Q: In a previous era it used to be possible to "sit and wait" for an appointment at the GP surgeries. Why can't we go back to this?

A: Some practices do already offer this service. There is a need for practices to try out different models. The right solution will vary depending on the location of the GP practice, however, we are encouraging GP practices to innovate.

Q: By moving work back to GP surgeries, will this not lead to a cost pressure to GP practices for more nurses and other staff?

A: No extra funding will be available for GP practices. The practices are already funded for this activity. Practices are currently engaging in a programme to review their productivity through reviewing their systems. This may lead to skill mix adjustments in GP practices. There is a large proportion of 20-29 year old users of the GP-Led Health Centre. There is work on-going with the universities to look at supporting the student population to be able to understand how to use the urgent care system including an app for smart phones.

Q: Currently it is easy to get a prescription dispensed after going to the Riverside Centre due to the proximity of the local pharmacy. Moving the Urgent Care Centre would lose good access to medicines.

A: This is an issue which needs to be looked at and considered. Across B&NES there are already 100 hour pharmacies. There are options that could be included in the service specification e.g. having a pharmacy on the RUH site.

Q: Currently there is a strong message to avoid bringing "infected" people onto the RUH site to reduce infection control outbreaks e.g. Norovirus. Surely the move of the Urgent Care Centre onto the RUH site will increase this risk?

A: The issue is about keeping carers and visitors who have symptoms of stomach virus away from the site. The policy has never been to keep "ill" people who need treatment away from the service. Norovirus is a community problem which is not fully understood, but much has been done to minimise its impact.

Q: How will the saving be achieved if other services are going to continue to be run in the Riverside premises?

A: The savings identified are purely related to the benefits of moving the GP-Led Health Centre out. There have not been other savings identified related to the premises. The premises will still be viable for the services staying e.g. Contraception and Sexual Health service, Dental Access services and Specialist Drug and Alcohol Misuse services.

Q: Why not just take the GPs out and leave the nurse-led Walk-In service? Would this give you the savings?

A: The proposed model is assuming that most people can access their GPs. The team believes that the synergies of co-location of the Urgent Care Centre on the RUH site will lead to additional benefits to prevent admissions through access to on-site diagnostics not available at the Riverside.

Q: As a patient it can be very frustrating to get into see the GPs and sometimes GPs clearly are under pressure – we are concerned that this change will put more pressure on the GP system?

A: The reality is that there are significant pressures for the whole health system and the proposed changes are about prioritising patients with the greatest need. The growing

demand from Diabetes, Dementia and changing demographic mean we need to make some difficult decisions now.

Comment: The concerns raised can be summarised into two issues (a) People like the city centre location and find it convenient and (b) There is a fear that the high quality service we get at Riverside will be watered down to a less good service when it moves, due to the diversion of staff into the Emergency Department.

A: The new proposed service will have a clear and separate contract and service specification including key performance indicators that the service will have to deliver. The commissioners are clear that for the model to work there has to be a very different feel to the service at the RUH “front door” and that it is a “primary care” service with all that goes with it. From the work recently seen since the GP out-of-hours service has relocated already demonstrates that there are clear benefits in having a GP-Led service at the front door of the hospital.