Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Urgent Care in Primary Care

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Primary Care Commissioning Committee meeting

20 September 2018

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Purpose of Paper

This paper brings together the work done to consider the feedback from the consultation on changes to urgent care services and other information required to decide whether to proceed with the proposed changes.

Taking into account all the information set out in the paper, it recommends to PCCC members that the CCG reconsider the proposed changes and develops alternative options for the reconfiguration of minor illness and minor injury services.

Key Issues

- The CCG has considered the consultation feedback, including the response from the scrutiny committee, and identified a number of actions to mitigate the issues raised.
- It has also completed a review of all the alternative suggestions made during the consultation to identify any potential benefits.
- The review of information relating to the public sector equality duty concludes that there is no specific impact for any protected group and that the CCG has met its statutory requirements.
- The feedback relating to the proposed siting of the urgent treatment centres has raised some questions around whether there might be benefits in other approaches that would outweigh the benefits of co-location with A&E.
- While it was concluded that any potential exacerbation of health inequalities could be mitigated, it was also noted that there could be opportunities to do more to reduce these.
- The opportunity to work as a system to address the challenges facing urgent care is also recognised.
- The recommendation to reconsider the options for the reconfiguration of minor illness and minor injury services would mean reviewing the proposed changes to increase urgent GP appointments as these were dependent on the funding released from changes to the minor injuries and walk-in services.
- The CCG will work with partners and the public to develop a new set of options, taking into account the feedback and information from the consultation.
- The recommendation also has a number of other implications which are set out in the paper
- Work with eye care providers to review the feedback and alternative suggestions has led to the recommendation that the changes to urgent eye care services are not progressed but instead providers will work together to improve signposting to the most appropriate service.

Is your report for Approval / Consideration / Noting
Approval
Recommendations / Action Required by Primary Care Commissioning Committee
The Primary Care Commissioning Committee is asked to: i. Reconsider urgent care proposals for minor illness and minor injuries ii. Agree not to progress the proposed changes to urgent eye care iii. Receive a revised pre-consultation business case in summer 2019 If PCCC approves the above three recommendations, Members are then asked to: iv. Approve a 2 year contract extension for the walk-in centre v. Approve the re-procurement of extended access (hub) services with a 2 year contract term vi. Agree to receive proposals to maintain development of primary care as part of 2019/20 planning
Governing Body Assurance Framework
Which of the CCG's objectives does this paper support? To improve patient experience and access to care To ensure there is a sustainable affordable healthcare system in Sheffield
Are there any Resource Implications (including Financial, Staffing etc)?
Existing resources will need to be reviewed in order to ensure the relevant deadlines are achieved.
Have you carried out an Equality Impact Assessment and is it attached?
EIAs have been completed for the proposals that are the subject of the consultation and previously presented to the Committee
Have you involved patients, carers and the public in the preparation of the report?
The subject of this report is the feedback from consulting patients, carers and the Public

Recommendations for Urgent Primary Care

Primary Care Commissioning Committee meeting

20 September 2018

1. Introduction

1.1 The CCG held a public consultation on proposals to redesign the urgent care system in Sheffield between September 2017 and January 2018. The analysis of the feedback received was presented to Primary Care Commissioning Committee (PCCC) on 22nd March 2018, who noted the need for detailed consideration of the issues raised and alternative suggestions put forward. Further updates were brought to PCCC in May and August 2018 which described the work being undertaken to consider the feedback and progress made and it was agreed that a final report and recommendations would be brought to PCCC in September.

1.2 The decision required for any consultation is whether to:

- Proceed with one of the options consulted on, with suitable mitigations if required;
- Abandon proposals and continue with the status quo; or
- Reconsider the approach and develop alternative options.

1.3 This paper sets out the results of the work carried out to consider the consultation feedback and other information to enable PCCC to decide which course of action to take, including the implications of the recommended approach.

2. Background

2.1 The urgent care review was undertaken to meet a number of objectives including reducing duplication and simplifying access to urgent care services; improving access to urgent care in GP practices; and reducing the pressure on A&E. (For full details see Appendix 1).

2.2 The CCG's proposals to redesign urgent care services were informed by an extensive period of public engagement and were primarily designed to ensure that:

- Patients are signposted to the most appropriate service.
- Patients who need an urgent appointment receive one within 24 hours – and mostly the same day.
- Most of the time care is provided closer to home so that fewer people have to travel outside their local area to receive urgent care.

2.3 The changes proposed were to:

- Improve the way people access services so that they are assessed over the phone by their practice or NHS 111 and booked an appointment or signposted to the right place for the care they need.
- Change the way people get urgent GP appointments, with groups of GP practices (neighbourhoods) working together to offer urgent appointments within 24 hours.

- Change where people go for minor illness and injuries – creating two urgent treatment centres at the Northern General Hospital (adults) and Sheffield Children's Hospital (for children). These would offer both booked and walk-in appointments and would replace the current walk-in centre (WIC) and minor injuries unit (MIU).

- Change where people go for urgent eye care, offering urgent appointments at locations across the city instead of the Emergency Eye Clinic at the Hallamshire, which would be for emergency (sight-threatening) conditions only.

- The improvements to signposting and access would be achieved by reinvesting the savings made from the changes to minor injuries and illness services into primary care services to create additional capacity.

2.4 A public consultation was held between 26 September and 31 January 2018. All the feedback was independently analysed and reports submitted to PCCC in March 2018. (These are available at www.sheffieldccg.nhs.uk/get-involved/urgent-care-consultation.htm)

2.5 As set out in reports to PCCC in May and August, the feedback has been fully considered by the CCG over the past few months, working with providers and members of the public through the Urgent Care Public Reference Group. In summary, work has focused on three main areas: reviewing the vision and objectives, considering the feedback in detail and exploring whether the issues raised in relation to the proposals can be mitigated and reviewing the alternative suggestions put forward through the consultation.

3. Information for consideration

3.1 Consultation feedback – key themes

3.1.1 As set out in previous reports to PCCC, there were significant differences in responses between the self-selecting responses to the consultation survey and those from the demographically representative telephone survey, with a more positive response overall from telephone survey participants.

3.1.2 Overall, the feedback indicated support for the CCG's vision to ensure 'the most appropriate response in the most appropriate setting that is easy to understand and access' and the objectives of the programme. However, many did not agree with the way we were proposing to achieve them and some felt that they had not been communicated clearly enough. The majority of people were supportive of the principle of providing more urgent care in GP practices and there was also support for creating a children's urgent treatment centre at Sheffield Children's Hospital.

3.1.3 However, there was also considerable strength of feeling expressed against the proposals to replace the minor injuries unit and walk-in centre with an UTC for adults at the Northern General Hospital (NGH). This included six petitions submitted during the consultation period and two further petitions presented at subsequent PCCC meetings.

3.1.4 Across all sources of feedback there were a number of common concerns about the proposals. These have been reviewed by a variety of stakeholders to consider the issues raised in detail and potential mitigations. A summary of the actions identified to mitigate concerns is included at Appendix 2.

3.1.5 The table below details the main issues raised during the consultation and the CCG's response to these.

Issue raised in consultation	NHS Sheffield CCG Response
Parking and Travelling. • Lack of parking at the Northern General Hospital (NGH) • Difficulty in travelling to NGH from the city centre and from areas in the south/south west of the city. • Travel to other practices within neighbourhoods	• The improved availability of urgent appointments in primary care would mean that far fewer people need to travel outside their local area to get the care they need. • However, we acknowledge the level of concern expressed regarding access to the NGH site and the need to look at how this could be improved. • The CCG has already committed to working with providers, South Yorkshire Transport Executive and community transport providers to consider how transport to the NGH site could be improved and would also work with Sheffield Teaching Hospitals to consider how parking could be improved. We recognise that any costs would need to be considered as part of the final business case. • We have undertaken work to identify travel times between practices in every neighbourhood by car and bus and will support neighbourhoods to take these into account in their planning.
Potential exacerbation of health inequalities • Detrimental impact on vulnerable groups from moving the walk-in-centre • Siting the Urgent Treatment Centre at the NGH, particularly for the homeless.	• One of our main aims is to work with our partners to continue to reduce health inequalities and we have committed to tailoring services to support this. This aim is also a key principle of the neighbourhood approach, with GP practices working together to address inequalities and develop services to meet the needs of their communities. • Vulnerable groups such as the homeless, those affected by substance misuse or asylum seekers have more complex health needs, which are best supported by continuity of care from their GP. There are a number of practices that offer services tailored to the needs of specific vulnerable groups and increasing the availability of appointments at practices would benefit these groups and help make sure they are seen at the most appropriate place for their needs. • We recognise that access by telephone could be an issue for some of these groups and that different approaches would be required, as they are now, to ensure they were not disadvantaged.

	• We carried out extensive engagement with a range of vulnerable groups to inform the development of options for urgent care and ensure these did not exacerbate inequalities. However, the consultation feedback has raised some different views to those we heard in the engagement and issues that would need to be mitigated.
Loss of services in city centre	• We acknowledge the strength of feeling expressed in the consultation about wanting to retain some form of urgent care service in the city centre and the concerns raised that not having this could have a negative impact on certain groups. • For those living in the city centre, access to urgent care for minor illness would be improved with appointments within 24 hours guaranteed at the practices in the city centre. This would include the student communities who are served by a number of practices in the city centre. Similarly, more people would be able to get care closer to home and not need to come into the city centre for treatment. • The proposed increased investment in primary care would help to strengthen all practices, including those in the city centre, and improve services for patients where this is needed. • We recognise that for some people using public transport it may be easier to access services if they are based in the city centre. However, increasing the care available at GP practices would enable more people to get care without having to travel out of their local area. The majority of people with minor injuries access services by car or taxi but we recognise the need to consider measures to mitigate the issues raised for those using public transport.
Do-ability re neighbourhoods/ primary care • Resourcing (staff and financial) • Lack of detail around their design	• We understand that many people were not aware of the neighbourhood approach, where groups of practices work together to coordinate health and social care, and deliver services to support the specific health and social needs of their area. However, this has been in place for the past two years and is already delivering a variety of improvements, including developing additional services to meet the needs of local communities. • We are continuing to invest in developing neighbourhoods and last year also embarked on a

	large scale programme to support primary care resilience and sustainability. This has included investing in creating a more diverse workforce, schemes to improve access and quality, and developing a primary care estates strategy. • Further assurance has been sought that practices would be able to manage the expected increase in patients. Discussions have also been held with the practices with the highest number of patients using the walk-in centre who are likely to be most affected to ascertain any support they would need to do this. • We are therefore confident that with the additional investment from the changes to minor illness and injuries services, primary care would be able to deliver the changes proposed. • We understand that people would have liked to have specific details of how each neighbourhood would work together to provide appointments within 24 hours. However, the basis of neighbourhood working is that practices determine appropriate solutions for their local communities so each neighbourhood would need to develop its own approach to urgent care appointments.

3.2 Consultation feedback - alternative suggestions

3.2.1 The consultation feedback also included a total of 17 alternative suggestions for how services could be configured. Full details of the approach taken to consider these was set out in the report to PCCC in August, along with six of the suggestions which initial assessment had shown would not be viable.

3.2.2 Work has continued to explore the feasibility of the remaining suggestions and any potential benefits or negative consequences. A summary of the conclusions reached is included at Appendix 3.

3.3 Response from Scrutiny Committee

3.3.1 As well as the duty to involve the public and consult on changes to services, CCGs have a legal duty to consult the local authority on any major changes to services and take account of its response when making a decision.

3.3.2 NHS Sheffield CCG has attended meetings of the Healthier Communities & Adult Social Care Scrutiny Committee to explain the proposals and share the findings of the public consultation, as well as providing updates during the consultation process. The Committee submitted its formal response to the CCG on 21 August, which is attached as Appendix 4. While the Committee said it was supportive of the ambition to provide

more urgent care in GP practices, it felt it needed more detail to be confident this was achievable and raised a number of other issues, namely concerns regarding:

- the similarity of the three options for the urgent treatment centre
- siting the adult UTC at NGH, as was felt to be difficult to access by public transport for those in the south of the city, including students
- closing the walk-in centre and minor injuries unit may affect people in the city disproportionately and exacerbate health inequalities
- the impact on vulnerable groups who use the walk-in centre, particularly those who may find it difficult to access appointments via a telephone triage system

The Committee also highlighted a number of areas where they felt they needed further information, including data on patient flow and traffic modelling, evidence that siting UTC at NGH is viable, clarity of the national guidance requirements and details of how neighbourhoods would work together.

3.3.3 These points reflect some of those raised in the consultation feedback, as set out in section 3.1. They have been reviewed by the Urgent Care Programme Board and taken into account in reaching the conclusions set out in section 4.

3.4 Equality

3.4.1 The Public Sector Equality Duty (PSED) set out in the Equality Act 2010 requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between people with and without protected characteristics.

3.4.2 In order to understand any specific impact on these groups, the analysis of the consultation feedback and telephone surveys included a breakdown by protected characteristics. The demographics of people responding to the consultation survey was broadly consistent with the overall population demographics although those aged 16-21, Asian and Black ethnic groups, and gypsy and travellers were under-represented. 15% of respondents identified as disabled (cf 18% of the overall Sheffield population), and 24% identified themselves as carers, although there are no Sheffield-wide figures available for comparison. Additional meetings and focus groups were held to get views from the under-represented groups and their feedback, which is included in the qualitative analysis.

3.4.3 The report on the consultation feedback showed there were very few significant differences in responses from people with protected characteristics from the responses overall. The only significant differences were that those between 16-30 and over 80 were more likely to agree that providing more care in communities would make it easier to access urgent care, and that women were more likely to be happy to be seen at a different practice, while carers were less likely to want this. In terms of the options for the UTCs, respondents from Asian or Asian British Chinese backgrounds were more likely to pick option 3 and Asian British Pakistani respondents were more likely to select option 2.

3.4.4 The city-wide telephone survey was demographically representative of the Sheffield population and again showed very few differences in responses from people with protected characteristics. The only significant differences were that people under 31 and over 72 were more likely to be happy to be seen at a different practice compared

to those over 72 (70% compared to 42%), and disabled people with an older profile were 19% less likely to say yes. Those aged 62-71 were more likely to want to go to a GP practice than a UTC – 76% compared to 61% overall.

3.4.5 In addition, the consultation survey included a specific question to draw out any issues for different groups (Q7: Is there anything about the proposal that you feel would have a more positive or negative impact on you and if so why?). The analysis found that there were no significant differences to responses between those with and without protected characteristics, although carers were slightly more likely to refer to desire for central-based services.

3.4.6 To provide additional assurance, the CCG has looked at the how services are used by different groups to identify any potential impact on specific groups. This has predominantly focused on ethnicity, as services do not all collect data on other protected characteristics. The breakdown is attached at Appendix 5 and shows there are no specific groups that are more likely to be disproportionately affected based on their current use of services. However, it should be noted that there was a significant number of walk-in centre patients for whom this information was not recorded. Similarly, it is recognised that the walk-in centre has a high proportion of users from the student population. This is thought to be due to many students not registering with a local GP so addressing this issue would mitigate the potential impact on this group. This view is supported when services were analysed by age band (see Appendix 10).

3.4.7 The Strategic Patient Experience, Engagement and Equality Committee has delegated responsibility for ensuring the CCG meets its statutory equality duties. The Committee has received details of the information to be provided to PCCC and is assured that consideration of this will enable the CCG to meet its duties.

3.4.8 Taking all this information into account, we have concluded that there is no specific impact for any protected group that needs to be considered and that the issues raised reflect the main themes addressed elsewhere in this report.

3.5 Health inequalities

3.5.1 The analysis of the consultation feedback included a breakdown of feedback by vulnerable groups to support consideration of the potential impact on inequalities. A number of concerns were raised regarding the potential impact on the homeless and people with substance misuse concerns of moving services out of the city centre and siting the adult UTC at NGH. These included views that the distance and cost of travel could deter people from seeking help for health problems or increase inappropriate use of ambulance service. Concerns were also raised about barriers to accessing telephone triage, how people would get home from NGH, and having to walk through areas frequently used by drug dealers. This was different to the views heard in the engagement undertaken with vulnerable groups prior to the consultation, which indicated that these groups tended to go to A&E rather than the WIC and would rather see a GP if possible.

3.5.2 There were mixed responses from people for whom English is a second language, including refugees and asylum seekers. Many welcomed the idea of a UTC and felt the changes would improve how quickly people are seen and ensure they get an appropriate response. However, concerns were again expressed regarding the adult

UTC being sited at NGH and about the potential impact of losing the WIC on the vulnerable and elderly. There were also comments about the need to improve telephone triage and the need for interpretation services at GP.

3.5.3 Responses were also analysed by postcode, which has enabled consideration of the views from people living in areas of deprivation. This did not show any significant differences between those in the most deprived areas (including postcode areas S2, S3, S5, S9, S14) and the responses overall. There were lots of comments about needing better access to GPs and a positive response to making it easier to get urgent appointments at practices. Concerns related to the accessibility of NGH and closing the WIC but there were also some comments that NGH is more accessible and 'caters for more people than Hallamshire'.

3.5.4 Health inequalities was a key focus of discussions at the public reference group workshop that was held to discuss the consultation feedback and was rated as the most important of the options appraisal criteria. It was recognised that a lot of the concerns raised regarding access to NGH had come from people living in the south of the city, where there are fewer areas of deprivation and high levels of car ownership. However, the group highlighted the importance of considering and prioritising those in more deprived areas and the need to target services on areas of greatest need. The east of the city was mentioned specifically, where it was felt there are higher levels of deprivation and a greater concentration of carers.

3.5.5 To further understand the potential impact on health inequalities and explore the concerns raised regarding this, a wide variety of data has been considered, including information on car ownership, travel times to services from deprived areas and the methods of transport used to access current services.

3.5.6 Data on vehicle ownership (see Appendix 6) shows that the majority of areas of poor access to a vehicle are in the centre and east of the city, with a further pocket of low access in the far south. When mapped to the postcodes of attendees, the services most likely to be attended by people with poor access to a vehicle were A&E departments at NGH and Sheffield Children's Hospital, but there is also a small cohort of WIC attendees with low access to a vehicle. Access to a private vehicle for MIU attendees was high.

3.5.7 Data on journey times indicates that fewer people would potentially be able to access NGH within half an hour by public transport than could access the MIU/WIC sites. (See maps at Appendix 7). However, there is a higher proportion of people from deprived areas who are within 30 minutes of NGH by public transport. Similarly, more people from the most deprived areas in Sheffield can access NGH within 30 minutes by public transport compared to those who can get to the MIU within this time

3.5.8 Attendance data shows that more people live within a 30 minute journey to the WIC or MIU than NGH. However, this would be offset by the increased capacity in GP practices, which would reduce the number of people who would need to travel to NGH. Similarly, only 14% of people attending the MIU had used public transport and attendees tend to be from areas identified as having good access to a vehicle.

3.5.9 The correlation of the postcodes of attendees (where available) with deprivation data shows that the services used most frequently by people in the 3 areas of greatest deprivation are the A&E departments at SCH and NGH, with 40-45% of all attendances coming from this cohort. This indicates that the locations are accessible

for people in these areas and that the proposed changes would not exacerbate inequalities. 35% of attendances at the walk-in centre also come from these areas but the impact would be negated by improved primary care access for minor illness closer to home. These three areas account for approximately 20% of attendances at the MIU, while almost 40% are from the areas with least deprivation, suggesting that changes to this service would not have a disproportionate impact on health inequalities.

3.5.10 In addition, we have reviewed the data on which practice attendees are registered with to identify the practices that would potentially be most affected if the walk-in centre was closed (attached as Appendix 8). Previous assumptions that students were high users of the WIC due to geographical convenience were supported by the number of attendees from practices with high numbers of students on their lists. These practices have been actively engaged during the consultation and beyond to ensure the potential impact is understood and could be mitigated. A considerable number of attendees (6000) are registered outside of Sheffield, which again indicates a high proportion of student service users.

3.5.11 Taking all this into account, the conclusion reached is that the proposed changes would support a reduction in health inequalities as they will improve access to minor illness care and offer greater continuity of care for vulnerable groups. People in the most deprived areas of Sheffield are more likely to use A&E than the MIU and WIC, potentially reflecting their closer proximity to NGH, so siting the adult UTC at NGH should not deter them from accessing healthcare. However, it is recognised that there could be a detrimental impact on vulnerable groups in the city centre in terms of minor injury services, which would need to be addressed. Mitigations include the actions proposed in relation to travel and transport, as well as those specifically to address concerns regarding health inequalities, as outlined in Appendix 2. It is also recognised that there could be opportunities to reduce health inequalities further if alternative approaches are explored

3.6 GP views

3.6.1 GP views on the proposals and whether they are deliverable have been sought through a number of different mechanisms, both during the consultation and subsequently through follow up discussions with practices, neighbourhoods, localities and the Local Medical Committee. There were a limited number of formal responses to the consultation but a large number of discussions have taken place, both with individual practices and groups. Throughout conversations, there was consensus supporting the principle of investing in primary care to make it sustainable and improve access.

3.6.2 Discussions since the consultation have shown that while some practices want or need to work together as neighbourhoods to deliver the improvements, other practices feel that with additional investment they could meet the standards as individual practices and some said that they are already meeting them.

3.6.3 While some concerns have been raised over logistical issues, overall members are supportive of the proposed approach to invest in primary care to improve capacity for minor illness. However, it is clear that there is no single model that would be suitable for all practices or their patient populations and a more flexible approach is required.

3.7 System views

3.7.1 While work was undertaken to engage partners in the development of the urgent care proposals, some of the issues raised in the consultation underline the need for engagement at all levels within partner organisations to ensure a shared understanding and approach.

3.7.2 Discussions have taken place with providers regarding concerns raised and further work undertaken to provide assurance about the activity modelling and assumptions made. Providers have been very willing to work with the CCG to consider the feedback and determine the best approach for Sheffield, which has ensured input from a wide range of clinical and operational experts.

3.7.2 It is important to note that the environment in which the programme has operated has changed considerably since it started. The development of the CCG's Urgent Care Strategy and the resulting Urgent Care in Primary Care programme commenced prior to the establishment of the accountable care partnership for Sheffield, which is seeing providers and commissioners take a shared approach to planning and delivering all health, care and wellbeing services and outcomes for the city.

3.7.2 There is a willingness from all parties to work together as a system to address the challenges faced by the city. This therefore brings greater opportunities to work collectively to improve urgent care services and ensure the best solution for Sheffield.

3.8 National guidance

3.8.1 National guidance was published in April 2017 setting out the requirement for places to implement "standardised new Urgent Treatment Centres" by December 2019. These have to treat both minor illness and minor injuries and offer both pre-bookable and walk-in appointments. This was followed in July 2017 by a set of national principles and standards which CCGs are required to deliver (available at www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf) These were factored into the development of the options included within the consultation.

3.8.2 The guidance refers to the advantages of co-locating urgent treatment centres alongside A&E departments but does not mandate this. The proposals put forward were based on co-locating UTCs with A&E because of the benefits this offers for patients and to help reduce the pressure on Sheffield's A&E departments by making it as easy as possible to divert patients attending with non-emergency conditions to the UTC. These benefits need to be considered along with those from other approaches to determine the best solution for people in Sheffield.

3.8.2 The CCG has recently been advised that the national timescales for implementation of the UTCs will now be applied less stringently so the CCG can work to a local rather than national timescales for implementation of a revised configuration of services.

4. Conclusions

To decide on which course of action should be taken, each of the four elements of the proposals has been reviewed both individually and collectively, recognising that they are interdependent. The key points are set out below, along with the overall recommendations

4.1 Improve the way people access services

4.1.1 Consultation feedback included some concerns about the effectiveness of the current NHS 111 service and the difficulties some patients experienced contacting practices but there was also recognition of the need for and benefits of effective signposting, often achieved through clinical triage.

4.1.2 Most practices in Sheffield now have non-clinical signposting in place in the form of 'care navigation' and a number of practices have clinical models of triage or other systems which meet the needs of their population. Making this a requirement – as proposed - would ensure that all patients have equitable and consistent access to signposting services in the future.

4.1.3 The effectiveness of the NHS 111 service will improve in 2019 due to the implementation of a revised regional service specification which will significantly increase the number of patients who are clinically triaged. This is expected to increase the accuracy of signposting and thereby the confidence of patients to adhere to signposting advice.

4.1.4 The review of the feedback therefore concluded that there is no evidence to suggest that introducing an improved system where patients contact their practice or NHS 111 and are assessed over the phone would not be in the best interests of patients in Sheffield. It was, however, acknowledged that for some patient groups phone access was not appropriate and adaptations would be required to meet their needs.

4.2 Change the way people get urgent GP appointments

4.2.1 The consultation feedback identified widespread support for improving access to urgent same day GP appointments and the number of comments received about the current difficulties some patients encounter trying to obtain urgent appointments also suggests this is something people would like to see improved. It also showed that the majority of people were happy to be seen at a different practice if it meant they would be seen quicker and that people would rather be seen at a local practice than one of the proposed UTCs.

4.2.2 In addition, creating additional appointments in practices has clear benefits for those requiring continuity of care, including those in vulnerable groups.

4.2.3 However, as was highlighted in the response from the scrutiny committee, there have been a number of concerns raised about whether this could be delivered and people wanted more detail about exactly how it would work in each neighbourhood.

4.2.4 Further discussions have been held with practices to provide additional assurance about delivery. As set out in section 3.6, this has shown that some are confident that (with additional investment) they could deliver urgent appointments within 24 hours without needing to work with other practices, which suggests a more flexible approach may be beneficial.

4.2.5 In conclusion, the approach of increasing capacity for urgent appointments in practices would be beneficial for Sheffield. However, a more flexible approach is required to respond to the different positions of practices so that they are free to achieve the target of providing urgent appointments within 24 hours without working in neighbourhoods if they choose. Increasing capacity can only be achieved with additional investment so this would need to be reconsidered if the changes to the minor injuries unit and walk in centre are not progressed.

4.3 Change where people would go for minor illness and injuries

4.3.1 The review of feedback has concluded that there is no evidence to suggest that establishing a UTC would not be in the best interests of people in Sheffield and there was general support for establishing a separate UTC for children at Sheffield Children's Hospital.

4.3.2 The consultation feedback showed mixed views with those taking part in the representative telephone survey responding more positively to the proposals regarding the UTC than those who responded directly.

4.3.3 However, the CCG is very conscious of the strength of feeling from some members of the public and stakeholders about the adult UTC being sited at Northern General Hospital and the loss of the urgent care services for adults in the city centre.

4.3.4 One of the main drivers for proposing Northern General and Sheffield Children's Hospital as the sites for the UTCs was to co-locate them with A&E departments, which evidence shows provides significant benefits. The strength of feedback regarding access and our review of the alternative suggestions has indicated that there could be benefits from other approaches that should be understood fully to determine if they would outweigh those of co-location with A&E, including the potential to reduce health inequalities further. The CCG has also taken on board that people felt that the options consulted on for this element of the proposals were too similar.

4.3.5 Not proceeding with closing the minor injuries unit and walk-in centre would however impact on the proposed changes to increase urgent GP appointments, as this was to be achieved by re-investing the money saved into primary care.

4.4 Change where people go for urgent eye care

4.4.1 The consultation feedback showed mixed views about this proposal. Some people raised strong concerns about their desire for urgent eye treatment to continue to be provided at the Royal Hallamshire Hospital and/or the ability of optometrists to provide the same level of treatment as the hospital ophthalmology team. Other people indicated their preference to access urgent eye care in the community

4.4.2 No evidence was found to suggest that providing urgent eye care in community settings would not be beneficial. However, the providers have recently collectively suggested that they could work together over time to ensure that more patients are appropriately signposted into existing urgent or emergency services without the need to undertake the proposed service redesign.

4.5 In Summary

4.5.1 Taking into account all the information set out above, it is recommended that the CCG **reconsider the options for the reconfiguration of minor illness and minor injury services**.

4.5.2 This does not mean that we are recommending any of the alternative suggestions made in the consultation feedback as options at this time. We would work with partners and the public to develop a new set of options, taking into account the feedback and information from the consultation.

4.5.3 Although there was support for a children's UTC at Sheffield Children's Hospital this could not be progressed in isolation and will need to be considered as part of the overall approach to minor illness and minor injury services.

4.5.4 It would also mean reviewing the proposed changes to increase urgent GP appointments as these were dependent on the funding released from changes to the minor injuries and walk-in services. However, it is recommended that we still work towards providing appointments within 24 hours for all patients that need them.

4.5.5 The proposals regarding urgent eye care were not dependent on the other elements of the proposal. However, it is recommended that these are not progressed and instead providers will work together to improve signposting to the most appropriate service.

5. Practical implications if PCCC approves recommendations

5.1 Revised Programme Timescales

5.1.1 The recommendations above will result in significantly revised timescales for the mobilisation of any changes. This is to allow for the development of revised options in collaboration with partners and the public, the production of a new business case and the NHS England service change assurance process, which has to be completed before proceeding to consultation. A full timetable will be developed if the recommendation to reconsider is supported but it is unlikely that any agreed changes would be implemented before April 2020.

5.2 Contracts for current services

5.2.1 PCCC approved a nine month extension to both the walk-in centre and extended access (hub) services in December 2017 and unless existing contracts are extended or the services re-procured the services would cease on 31st March 2019.

5.2.2 **Walk-in Centre:** It is now unclear whether a walk-in centre service will continue to be required post winter 19/20 or whether the service offer would change to that of a UTC specification. It is therefore recommended that the contract for the walk-in centre is extended by a further 2 years to 31st March 2021.

5.2.5 The CCG will issue a Prior Information Notice (PIN) to explain to the market our reasons for the walk-in centre contract extension to mitigate any risk of challenge from bidders who previously missed out on the contract.

5.2.2 **Extended Access (hubs) Service:** There is a separate paper being presented to PCCC concerning the next steps that the CCG needs to take to ensure delivery of extended access in line with NHS England requirements. To align with this paper, it

will be recommending that the Extended Access (Hub) service is re-procured over the next six months with the successful provider commencing service provision from 1st April 2019. It is proposed that the contract runs for 2 years to tie in with any potential changes to the other services that may emerge post reconsideration and further consultation.

5.2.6 At this stage, it is anticipated that the existing rolling contracts for the Minor Injuries Unit and the GP Collaborative would continue to 31st March 2021 to enable a full revised configuration of services, if necessary, at the same time.

5.3 Primary Care

5.3.1 The CCG's Primary Care Strategy sets out the need to invest differentially in order to improve health outcomes and that successful delivery of its ambitions depends upon the level of investment achieved. As part of the GP Five Year Forward View national strategy, non-recurrent funding is available to invest in primary care to deliver improvements during 2018/19 but further investment will be necessary to sustain improvements in access in the longer term.

5.3.2 The options proposed in the consultation would have provided additional recurrent resources to invest in primary care. Until the approach to urgent care is determined, the CCG will need to look at how to maintain momentum in improvements in primary care as part of 2019/20 planning process.

5.4 Public involvement and consultation

5.4.1 In line with our legal duties, we will work with our partners and the public to develop revised options. This will also involve reviewing the criteria used to assess how options meet the agreed objectives, which again will be done in collaboration with our stakeholders. A formal consultation will be held on the revised options in 2019.

6. Recommendations

The Primary Care Commissioning Committee is asked to:

i. Reconsider urgent care proposals for minor illness and minor injuries
ii. Agree not to progress the proposed changes to urgent eye care
iii. Receive a revised pre-consultation business case in summer 2019

If PCCC approves the above 3 recommendations, Members are then asked to:

iv. Approve a 2 year contract extension for the walk-in centre
v. Approve the re-procurement of extended access (hub) services with a 2 year contract term
vi. Agree to receive proposals to maintain development of primary care as part of 2019/20 planning

Paper prepared by: Kate Gleave, Rachel Dillon and Eleanor Nossiter
On behalf of: Brian Hughes, Director of Commissioning & Performance
13 September 2018

Appendices

Contents

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Vision for urgent care

Our new model of urgent care will provide the most appropriate response where needed in the most appropriate setting that is easy to understand and to access for both patients and clinicians

Pre-consultation Objective	Rationale
Reduce Duplication and simplify access	Patient feedback from Urgent Care Strategy and Vulnerable Groups engagement said this was key as current system is confusing and hard to navigate
Reduce inequalities	Patients are not accessing the current services based on levels of need. Some groups of patients are encountering barriers to access e.g. cost of public transport, access to a phone, interpreter requirements
Improve access to Primary Care services	Several primary care services are currently provided within secondary care. The range of primary care services also creates confusion and duplication. The improvement in access includes ensuring patients are signposted to most appropriate service and that all primary care services have access to the patient's record (if consent given)
Improve access to urgent care provided by GP practices (without detrimentally affecting waiting times for planned care)	Access to urgent appointments within practices varies significantly across Sheffield, as does the length of wait for a planned appointment. This creates further inequalities across the city. Signposting included as part of improving access will reduce inappropriate demand and help to manage patients' expectations
Support a sustainably resourced primary care	Primary Care within Sheffield needs further investment in order to provide a sustained service. This involves sustaining both the workforce and financial investment into practices
Encourage and support self care	Empowering patients to self care where appropriate encourages them to take responsibility and positive action for their health and wellbeing and reduces unnecessary interactions with urgent care services. It will include patient education and will help to reduce inappropriate demand and manage patients' expectations
Provide value for money	The CCG has a duty to ensure that it commissions services which provide value for money (spending less, spending well and spending wisely)
Deliver care locally and appropriately	Patient feedback had indicated that being able to access care locally is important but this has to be balanced to ensure that care is also appropriate for the population
Reduce pressure in Emergency Departments	Over the last year, STHFT have struggled to achieve the four hour A&E target. This is in part because of the volume of attendances, a proportion of which could have been managed within primary care
Contribute to or enable delivery of the national requirements	As stated in section 4 above, the system has to incorporate a number of national requirements into the services provided within Sheffield. The health and social care organisations within Sheffield have agreed to work in partnership as an ACP. The final model must enable partnership working.

Appendix 2: Summary of actions identified to mitigate key issues fro the consultation

Issue	Actions to mitigate
Parking and travel to NGH	Considerations • Increased availability of urgent appointments in primary care will mean fewer people need to travel • Majority travel by car Actions • Explore ideas for providing transport for those without easy access to transport and factor costs into business case (eg shuttle bus between city centre and NGH, park and ride facility) • Explore potential for using technology to reduce need for face-to-face appointments • Provide information on travel to NGH site (bus routes /frequency) • Discuss parking capacity at NGH with STH • Discuss how could improve transport to NGH site with providers, South Yorkshire Transport Executive and community transport providers (NB – already
Potential exacerbation of health inequalities	• Disproportionately invest our effort and resources into those communities with most need • Address registration issues for homeless and other vulnerable groups • Maintain approaches being used successfully for non-English speaking patients and share best practice with all practices in Sheffield • Link in with the ongoing work on digital literacy taking place in city to address digital exclusion. • Run targeted education / awareness campaigns to increase understanding of services available and how to access, including signposting and self-care • Consider skill mix of workforce, including mental health, in the UTC and extended access hubs
Loss of services in city centre	• Redistribution of resources and investment into primary care to allow access through local services • Improved signposting/triage to local services

	• Ongoing support in place to support practices, including those in city centre, to ensure sustainability and resilience • Review GP services for homeless to ensure sufficient capacity • Review the extended access (hub) provision • Work with city centre practices to encourage more students to register with a GP in Sheffield.
Do-ability re neighbourhoods/ primary care	• Ongoing use of non-recurrent funding to develop practices, increase sustainability and resilience and improve access • Share work already taking place to improve access, quality and sustainability to increase general awareness and confidence • Explore different contractual mechanisms to support practices to deliver our commissioning intentions • Invest in estate development in line with the CCG's primary care estates strategy • Continue work with practices to support signposting and increase awareness of local services to help reduce demand on practices • Continue work re workforce development and skill mix in practices/neighbourhoods • Continue to support neighbourhoods to introduce governance frameworks • Continue work to deploy new technologies to support practices, including city-wide Wi-Fi and e-consultations

Appendix 3: Alternative Suggestions

The following summaries detail the outputs of the work done to review the alternative suggestions made in the consultation, including workshops held with providers and commissioners and the urgent care public reference group.

For the provider and commissioner workshops the suggestions were grouped under common themes, as several of the suggestions were similar and likely to have the same advantages and disadvantages. A summary has been produced for each group and details of which suggestions the group includes are included in the heading. As no details were provided for any of the suggestions, the summaries also set out how the CCG interpreted the way each suggestion would work.

Although consideration has been given to whether these could potentially be viable approaches, the main focus has been on understanding the potential benefits and consequences and whether these should be explored further. The conclusions for six of the 17 suggestions were presented to PCCC in August and these are the summaries for the remaining suggestions, which detail the conclusions reached under the following categories:

- Sustainable activity levels - whether numbers of patients will mean services are to be too small to be economically viable or too large to be delivered safely
- Right Thing First Time – whether the approach would enable patients to get the care they need at the first place they go
- Logistical Feasibility – including staffing requirements, compliance with national guidance, and building capacity
- Benefits
- Disadvantages
- View – the conclusion reached by the CCG about each suggestion

UTC at Northern General, plus additional service in city centre

Suggestion 1 - Keep the Walk In Centre open (and shut the Minor Injuries Unit)
Suggestion 2 - Keep the Minor Injuries Unit open (and shut the Walk In Centre)

This is based on having an adult UTC at NGH, children being seen at SC(NHS)FT and **the continuation of one of the centrally located minor illness or injury services in its current form.**

The GP Collaborative service would be decommissioned and the functions incorporated into or co-located with the NGH UTC in line with the Integrated Urgent Care specification.

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen in a practice within their locality. A minority of adults and children with minor illness symptoms and all those with minor injuries would be seen at their respective UTC during core hours, evenings and weekends. Overnight, adults and children with minor illness symptoms would only be seen via an appointment booked through 111 at the NGH Urgent Treatment Centre. Any patients requiring treatment for minor injuries overnight would be seen in the relevant ED.

<table>
<tr><th colspan="5">Future State System Summary</th></tr>
<tr><th>Weekdays
08:00 – 18:30</th><th>Weekends
08:00 – 18:30</th><th>Twilight
18:30 – 22:00
(7 Days)</th><th>Overnight
22:00 – 08:00
(7 Days)</th></tr>
<tr><td>Patients who need continuity of care seen within practice
Patients who do not need continuity of care seen within their practice or neighbourhood</td><td>Patients seen in a practice within their locality (service also provides planned care)</td><td>Patients seen in a practice within their locality (service also provides planned care)</td><td rowspan="3">Adults and children with illness symptoms seen within NGH Urgent Treatment Centre booked appointments only)</td></tr>
<tr><td>Adults at NGH UTC (illness symptoms and minor injuries)</td><td>Adults at NGH UTC (illness symptoms and minor injuries)</td><td>Adults at NGH UTC (illness symptoms and minor injuries)</td></tr>
<tr><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td></tr>
<tr><td>Adult minor injury service in a central location OR
Adult minor illness service in a central location</td><td>Adult minor injury service in a central location OR
Adult minor illness service in a central location</td><td>Adult minor injury service in a central location OR
Adult minor illness service in a central location</td><td>Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td>Key</td><td colspan="3">Minor Illness Service Minor Injury Service Minor Illness & Injury Service</td></tr>
</table>

Option Viability Assessment	
Sustainable Activity Levels	• Initial indication is that that activity levels sustainable for a UTC and one of the current services, however full feasibility modelling required
Right Thing First Time	• UTC and co-location with A&E allows patients to receive the most appropriate care expediently. • However, would not eliminate confusion over which service to use
Logistical Feasibility	• Complies with national UTC guidance
Benefits	• Provides a secondary point of access in city centre negating some concerns about access to NGH site • Retains a city centre service, which was highlighted as desirable in consultation feedback
Disadvantages	• Concerns raised re access to both Broad Lane (transport) and RHH sites (parking) • Duplication of services/resource, especially for minor illness • Could present with emergency complaint that requires transfer to A&E • Will not release (as much) money to reinvest in primary care • Lose opportunity to encourage continuity of care through GP
View	Could be benefits in retaining a service for injuries – less benefit in retaining illness service as preferable to provide in practices

UTC at Northern General, plus additional service in city centre

Suggestion 12 Provide an enhanced minor ailments Walk In Centre staffed by prescribing nurses and prescribing pharmacists at the Wicker Pharmacy and Mobility shop

This consists of an adult UTC at NGH **plus a minor ailments service somewhere central**. The ailments service would be staffed by prescribing pharmacists and prescribing nurses but would not include GPs and would not have any diagnostic facilities. Children would be seen at SC(NHS)FT.

The GP Collaborative service would be decommissioned and the functions incorporated into or co-located with the NGH UTC in line with the Integrated Urgent Care specification.

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen in a practice within their locality. A minority of adults and children with minor illness symptoms and all those with minor injuries would be seen at their respective UTC during core hours, evenings and weekends. Overnight, adults and children with minor illness symptoms would only be seen via an appointment booked through 111 at the NGH Urgent Treatment Centre. Any patients requiring treatment for minor injuries overnight would be seen in the relevant ED.

<table>
<tr><th colspan="4">Future State System Summary</th></tr>
<tr><th>Weekdays
08:00 – 18:30</th><th>Weekends
08:00 – 18:30</th><th>Twilight
18:30 – 22:00
(7 Days)</th><th>Overnight
22:00 – 08:00
(7 Days)</th></tr>
<tr><td>Patients who need continuity of care seen within practice</td><td rowspan="2">Patients seen in a practice within their locality (service also provides planned care)</td><td rowspan="2">Patients seen in a practice within their locality (service also provides planned care)</td><td rowspan="3">Adults and children with illness symptoms seen within NGH Urgent Treatment Centre (booked appointments only)</td></tr>
<tr><td>Patients who do not need continuity of care seen within their practice or neighbourhood</td></tr>
<tr><td>Adults at NGH UTC (illness symptoms and minor injuries)</td><td>Adults at NGH UTC (illness symptoms and minor injuries)</td><td>Adults at NGH UTC (illness symptoms and minor injuries)</td></tr>
<tr><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td><td>Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td>Adult minor ailments service somewhere central</td><td>Adult minor ailments service somewhere central</td><td>Adult minor ailments service somewhere central</td><td></td></tr>
<tr><td>Key</td><td colspan="3">Minor Illness Service ■ Minor Injury Service ■ Minor Illness & Injury Service ■</td></tr>
<tr><th colspan="4">Option Viability Assessment</th></tr>
<tr><td>Sustainable Activity Levels</td><td colspan="3">• Further work required to assess whether minor ailment activity levels sustainable</td></tr>
<tr><td>Right Thing First Time</td><td colspan="3">• UTC treating both minor illness and minor injury, plus co-location with A&E, allows most patients to receive the most appropriate care expediently
• However, likely to create confusion over which service to use / when to use minor ailments service</td></tr>
<tr><td>Logistical Feasibility</td><td colspan="3">• Complies with national UTC guidance</td></tr>
<tr><td>Benefits</td><td colspan="3">• Provides a secondary point of access in city centre negating some concerns about access to NGH site
• Use knowledge and skills of pharmacists</td></tr>
<tr><td>Disadvantages</td><td colspan="3">• Not able to cover all minor illness and minor injuries
• Unlikely to be seen as an alternative to WIC or MIU by public
• Poor parking</td></tr>
<tr><td>View</td><td colspan="3">Unlikely to add sufficient value to justify cost. Work already taking place to consider development of minor ailments services in city so may be progressed through that if there is found to be a need.</td></tr>
</table>

One Central UTC

Suggestion 5 Site the UTC at the Walk In Centre (instead of NGH)
Suggestion 7 Site the UTC at the Royal Hallamshire Hospital (instead of NGH)

This proposes commissioning 1 adult UTC for the city **somewhere central** that would provide a minor illness and injury service to adults. Children would be seen at SC(NHS)FT.

The GP Collaborative service would be decommissioned and would either be combined into any UTC service specification (minor illness service overnight) based in the central location. Otherwise a new service would be commissioned and based in the current location at NGH.

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen in a practice within their locality. A minority of adults and children with minor illness symptoms and all those with minor injuries would be seen at their respective UTC during core hours, evenings and weekends. Overnight, adults and children with minor illness symptoms would only be seen via an appointment booked through 111 at the overnight illness service. **Further consideration would be needed to decide whether to keep this service sited at the NGH or move it to the central UTC** Any patients requiring treatment for minor injuries overnight would be seen in the relevant ED.

<table>
<tr><th colspan="4">Future State System Summary</th></tr>
<tr><th>Weekdays
08:00 – 18:30</th><th>Weekends
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<tr><td>Patients who need continuity of care seen within practice
Patients who do not need continuity of care seen within their practice or neighbourhood</td><td>Patients seen in a practice within their locality (service also provides planned care)</td><td>Patients seen in a practice within their locality (service also provides planned care)</td><td>Adults and children at central Urgent Treatment Centre (illness symptoms and booked appointments only) OR Leave location at NGH</td></tr>
<tr><td>Adults at centrally located UTC (illness symptoms and minor injuries)
Children at SC(NHS)FT</td><td>Adults at centrally located UTC (illness symptoms and minor injuries
Children at SC(NHS)FT</td><td>Adults at centrally located UTC (illness symptoms and minor injuries
Children at SC(NHS)FT</td><td>Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td colspan="4">Key | Minor Illness Service | Minor Injury Service | Minor Illness & Injury Service</td></tr>
<tr><th colspan="4">Option Viability Assessment</th></tr>
<tr><td>Sustainable Activity Levels</td><td colspan="3">• Activity levels sustainable (based on pre-consultation modelling)</td></tr>
<tr><td>Right Thing First Time</td><td colspan="3">• Combines minor injuries and illness so more people will get right care first time.
• However not co-located with A&E so risk of needing to travel if more complex care required.</td></tr>
<tr><td>Logistical Feasibility</td><td colspan="3">• Complies with national UTC guidance
• Would require further assessment to determine whether there is sufficient space to create a UTC in current MIU area</td></tr>
<tr><td>Benefits</td><td colspan="3">• More central location allows for easier access by public transport
• Would be more accessible for people libing in the south of the city</td></tr>
<tr><td>Disadvantages</td><td colspan="3">• Not co-located with A&E so people presenting with emergency needs will have to be transferred
• Concerns raised re access to both Broad Lane (public transport) and RHH sites (partking)
• Limits the no of staff that could be redeployed into primary care/ED
• Splits urgent and emergency care expertise across 2 sites
• Negative imact on ability to staff other primary care services
• May encourage duplication re minor illness
• Loss of opportunity to encourage continuity of care through GP</td></tr>
<tr><td>View</td><td colspan="3">Needs to be fully modelled to determine costs and workforce implications. Need to determine potential impact on reducing health inequalities and if this and other benefits outweigh the benefits of co-location with A&E.</td></tr>
</table>

2 UTCs 1 at NGH plus 1 somewhere central

Suggestion 6 Have a UTC in the south as well as one in the north
Suggestion 8 Option 1 plus a second UTC at the RHH

This would require the CCG to commission 2 adults UTCs, one at the Northern General site and one somewhere central. Both services would see adults with minor illness and injury symptoms. Children would be seen at SC(NHS)FT.

The GP Collaborative service would be decommissioned and the functions incorporated into or co-located with one of the adult UTCs in line with the Integrated Urgent Care specification

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen within their locality. Overnight, adults and children with minor illness symptoms would only be seen via an appointment booked through 111. **Further consideration would be needed to decide whether to keep this service sited at the NGH UTC or move it the central Urgent Treatment Centre service.** Insufficient staff are likely to be available to staff the overnight service at 2 UTC locations within the city.

<table>
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(7 Days)</th></tr>
<tr><td>Patients who need continuity of care seen within practice
Patients who do not need continuity of care seen within their practice or neighbourhood</td><td>Patients seen in a practice within their locality (service also provides planned care)</td><td>Patients seen in a practice within their locality (service also provides planned care)</td><td>Adults and children at NGH Urgent Treatment Centre or at the central UTC location (illness symptoms and booked appointments only)</td></tr>
<tr><td>Adults at NGH UTC OR centrally located UTC (illness symptoms and minor injuries)
Children at SC(NHS)FT</td><td>Adults at NGH UTC OR centrally located UTC (illness symptoms and minor injuries)
Children at SC(NHS)FT</td><td>Adults at NGH UTC OR centrally located UTC (illness symptoms and minor injuries)
Children at SC(NHS)FT</td><td>Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td>Key</td><td colspan="3">Minor Illness Service Minor Injury Service Minor Illness & Injury Service</td></tr>
<tr><th colspan="4">Option Viability Assessment</th></tr>
<tr><td>Sustainable Activity Levels</td><td colspan="3">• Initial indication that activity levels sustainable, requires full feasibility modelling to confirm</td></tr>
<tr><td>Right Thing First Time</td><td colspan="3">• Combining minor illness and minor injury in both services, plus co-location of 1 UTC with A&E, allows more patients to receive the most appropriate care expediently</td></tr>
<tr><td>Logistical Feasibility</td><td colspan="3">• Complies with national UTC guidance
• Query over workforce sustainability and implications on wider system - need to fully model
• Would require further assessment to determine whether there is sufficient space to create a UTC in current MIU area</td></tr>
<tr><td>Benefits</td><td colspan="3">• More central location allows for easier access by public transport
• Improved acces for people in South
• Consistent approach – combines minor illness and minor injury</td></tr>
<tr><td>Disadvantages</td><td colspan="3">• Not support best use of resources
• Will incur capital costs
• The south is not the area with the greatest health needs
• Does not promote GP access / continuity of care</td></tr>
<tr><td>View</td><td colspan="3">Needs to be fully modelled to determine costs and workforce implications. Could be opportunity for greater reduction in health inequalities if second UTC sited to support greatest need. Could have implications re investment in primary care / other areas.</td></tr>
</table>

Urgent Eye Care No Change

Suggestion 15 Keep the Emergency Eye Clinic open

This would see no changes to the current system with both urgent and emergency eye care being seen via a combination of EEC/ED and PEARs. Eye care overnight would be provided solely within ED.

Future State System Summary			
Weekdays 08:00 – 18:30	**Weekends 08:00 – 18:30**	**Twilight 18:30 – 22:00 (7 Days)**	**Overnight 22:00 – 08:00 (7 Days)**
Urgent eye care seen at EEC/ED/PEARs*	Urgent eye care seen at EEC/ED/PEARs*	Urgent eye care seen at EEC/ED/PEARs*	Urgent eye care seen at ED

Option Viability Assessment	
Sustainable Activity Levels	• Current service has sustainable activity volumes
Right Thing First Time	• No secondary referrals required as all conditions (including sight-threatening) can be treated
Logistical Feasibility	• Current service is feasible
Benefits	• Only requires high cost equipment at one site • No variation in quality of care • Good links to central public transport • Is recognised/trusted service
Disadvantages	• Access inequitable – depends on where people live • Does not use resources to best effect • Does not decrease geographical inequalities • Does not offer care closer to home • Poor parking at RHH
View	No change would not deliver the objectives of making more care available closer to home and making best use of resources. However, since the consultation providers have indicated they could now work together to meet these objectives through improved signposting rather than reconfiguring services.

Urgent Eye Care provided in 'Optometry Cluster Locations'

Suggestion 16 Scale up the existing PEARs service (to accommodate urgent eye conditions)
Suggestion 17 Use optometrists working in clusters similar to neighbourhoods

This is similar to the CCG's proposed community-based option but would instead see optometrists operating in clusters similar to primary care neighbourhoods.

Future State System Summary			
Weekdays 08:00 – 18:30	**Weekends 08:00 – 18:30**	**Twilight 18:30 – 22:00 (7 Days)**	**Overnight 22:00 – 08:00 (7 Days)**
Urgent eye care is undertaken in the community across a number of sites			Urgent eye care seen at ED

Option Viability Assessment	
Sustainable Activity Levels	Based on the modelling for the proposed option, activity levels could be sustainable
Right Thing First Time	This would be the case for those sent by NHS 111. However, patients self-referring would need to be able to determine whether their condition needed urgent or emergency care which could delay treatment if judgement is incorrect.
Logistical Feasibility	• This is very similar to the proposed option so assumption is that this would be feasible • Potential capital costs for equipment required to set up
Benefits	• Providing in local areas / closer to home improves ease of access (which is particularly important given age profile and nature of conditions) • Able to influence geographical spread of locations across city to ensure equity of access • Integration of optometry and ophthalmology – city-wide solution • Longer opening hours
Disadvantages	• Cluster approach is less close to home than proposed dispersed model • Potential risk of service variation
View	This is very similar to the option proposed, however offers fewer benefits as would mean services not as close to home if in clusters and would be more complicated to implement

Appendix 4: Response from Scrutiny Committee

Tel: (0114) 27 35065

Email: patricia.midgley@councillor.sheffield.gov.uk

Ref: PM/ECSS

Date: 21st August 2018

Pat Midgley
Chair, Healthier Communities & Adult Social Care Scrutiny Committee
Sheffield City Council
Town Hall
Pinstone Street
Sheffield, S1 2HH

Tim Moorhead
Chair, NHS Sheffield Clinical Commissioning Group
SENT BY EMAIL ONLY

Dear Tim

Re: Urgent Primary Care Proposals

I am writing to you as Chair of Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee, to give you our formal response to your proposals for changing Urgent Primary Care Services in Sheffield.

1 Consultation Process

From the start of the consultation process, we were disappointed that the three options presented were very similar, all involving the closure of the Broad Lane Walk in Centre and the Minor Injuries Unit. For many, this was frustrating, and gave the impression that the consultation was a paper exercise. We were also disappointed at the lack of early public engagement in drawing up the proposals for consultation, and echo HealthWatch's concern that the public and statutory stakeholders were involved at a late stage and with limited opportunities to share their views.

We feel that it's really important that big changes to health services are done with people, not 'to' people – the overwhelmingly negative tone of the responses to the consultation suggest that on this occasion, the engagement process hasn't been effective in bringing the public on board with the proposals. We understand that during the public consultation, alternative options were suggested. We are keen to

understand how the CCG has considered these alternatives, and whether any of them, or elements of them are feasible.

Key Issues

Do any of the suggestions raised through the consultation process provide feasible alternatives to the proposals that were consulted on, and how are they being considered by the CCG?

2 Proposed siting of the Urgent Treatment Centre at the Northern General

Concerns about access and capacity at the Northern General Campus are well known. Parking is a long-standing problem, and air quality has been highlighted as an issue. It is expensive and difficult to access by public transport for those in the south of the City, including our significant student population – and for many in the city would require 2 bus rides and a journey time of over an hour. The site is difficult to navigate once you are there, and Councillors have heard concerns from people who feel unsafe in the areas surrounding the Northern General, particularly at night.

We fear that this will deter people from seeking medical treatment at the appropriate time, which could lead to worse outcomes for patients, and higher costs for the health and social care system.

We also have concerns that the impact of these proposals may cross over into other health service areas –for example, people in the south of the City may choose to use services outside of Sheffield rather than face a difficult journey to the Northern General.

Whilst we recognise that the aim of the proposal is to create more capacity within urgent primary care so people who currently use the Walk in Centre will not need to travel to the UTC (our concerns about this part of the proposal are set out in the next section), current users of the Minor Injuries Unit – 18,000 per year, will in all likelihood need to be treated at the UTC. We have not yet seen any information about expected patient flow or traffic modelling to demonstrate the likely impact of the proposals on the Northern General site and surrounding area, or what might be done to mitigate this.

We were alarmed to see in the consultation report that senior managers at the Northern General raised concerns about their ability to accommodate the service. Overall, this leaves us unconvinced that siting a UTC at the Northern General is a viable proposal.

We recognise that there are national expectations around establishing Urgent Treatment Centres, but we are not clear how much these guidelines are driving the proposals. We would be interested to understand what would happen if Sheffield chose not to set up an Urgent Treatment Centre, or if current arrangements could satisfy the UTC guidelines. We'd also be interesting in any learning from other areas who have gone through similar changes – what has been the impact in other areas where walk in centres and minor injuries units have been closed.

Key Issues

Is there evidence available to demonstrate that siting a UTC at the Northern General is viable in terms of capacity and appropriateness of the site?

What would the impact of siting the UTC at the NGH be – in terms of patient flow, increased number of journeys, traffic modelling etc

How can access to services be improved for people in the south of the city, and those who would find it difficult to get to the NGH?

Are there repercussions to not following the national guidelines on Urgent Treatment Centres? Can the guidelines be met by retaining current arrangements? What have other areas done?

3 Increasing capacity within Urgent Primary Care

We know from talking to our residents that access to GP services is a really important issue in the city. We support the ambition to provide more urgent care in GP practices, however without any detail available about additional investment or how practices will work together in neighbourhoods to provide these additional appointments, we don't have confidence that the proposals will work.

For us, the detail of how far residents might have to travel to get to a GP practice in their 'local area' is incredibly important. It can be easier to travel all the way into the city by public transport than across a neighbourhood. We know that neighbourhoods vary in size, population, number of practices and how well developed they are in terms of working together – which leaves us with concerns that residents in some neighbourhoods might find it harder to access the additional appointments made available –resulting in a greater number of trips to the Northern General, with all the difficulties that entails, or not getting treatment. That the impact of closing the Walk-in Centre and Minor Injuries Unit may affect people in the city disproportionately is of great concern to us – we want to be sure that any changes to health services reduce health inequalities, not make them worse.

We understand that of the 60,000 walk-in centre appointments per year, users tend to come disproportionately from certain postcodes and certain practices – but we have not seen any projected patient flow analysis, and it has not been made clear to us how many additional appointments need to be created through these proposals, and in which parts of the city they need to be.

We understand that students are frequent users of the walk-in centre – and we would like to know if any specific work is being done to encourage students to register with GP practices, and whether there is enough capacity within the primary care system to accommodate them if they do.

We are concerned that some groups of vulnerable people who currently use the Walk in Centre – for example, people with mental illness, people with English as a second language, homeless people, will find it difficult to access the additional appointments via a telephone triage system – and we would like to understand the potential impact of the proposals on these groups, and any mitigations that are being considered.

The minutes from the Health and Wellbeing Board's consideration of Urgent Care in July 2017 supported proportionate re-investment into the areas of greatest need, but we have not been given any information about how the financial side of the proposals will work. We've been informed that the provision of additional urgent appointments in primary care is dependent upon investment that would come from closing the Walk in Centre and Minor Injuries Unit, however we would like to understand this in more detail. How much money will closing the Walk in Centre and Minor Injuries Unit free up? How much will it cost to establish the UTC? How much will be invested in primary care in the city, and in which parts of the city?

We are concerned about the capacity of the Primary Care system to make these proposals work. We are aware that practices find it difficult to recruit enough GPs, and whilst the CCG seemed confident that increasing the use of prescribing pharmacists and nurse practitioners will deliver the required number of additional appointments, we have not seen any workforce analysis to demonstrate what the workforce requirements of the proposals are, and whether that workforce is available in Sheffield.

We were also concerned to note that the consultation responses from primary care providers were not positive, leading us to question whether there is the willingness within the primary care system to make these proposals work.

Key Issues

How will the Neighbourhoods work together to provide additional appointments, is there evidence to demonstrate that this approach will work?

How many additional appointments are needed and in which parts of the city? Which groups and communities will be most affected by the proposals and what are the mitigations?

What are the workforce requirements and is the workforce available in Sheffield?

Is there evidence available to demonstrate that the primary care system is willing and able to make these proposals work?

How will the finances work? How much will it cost to create an Urgent Treatment Centre? How much will be invested in Primary Care, and in which areas/practices in the city?

Through our work as a Scrutiny Committee, we want to support and improve the NHS in Sheffield, and our aim has been to engage constructively with the CCG on these proposals. Overall however, we don't feel that we have seen sufficient evidence to assure us that the proposals are in the best interests of Sheffield people. We look forward to receiving your response to the issues we have raised, and trust that you will seriously consider our concerns as part of your decision making process.

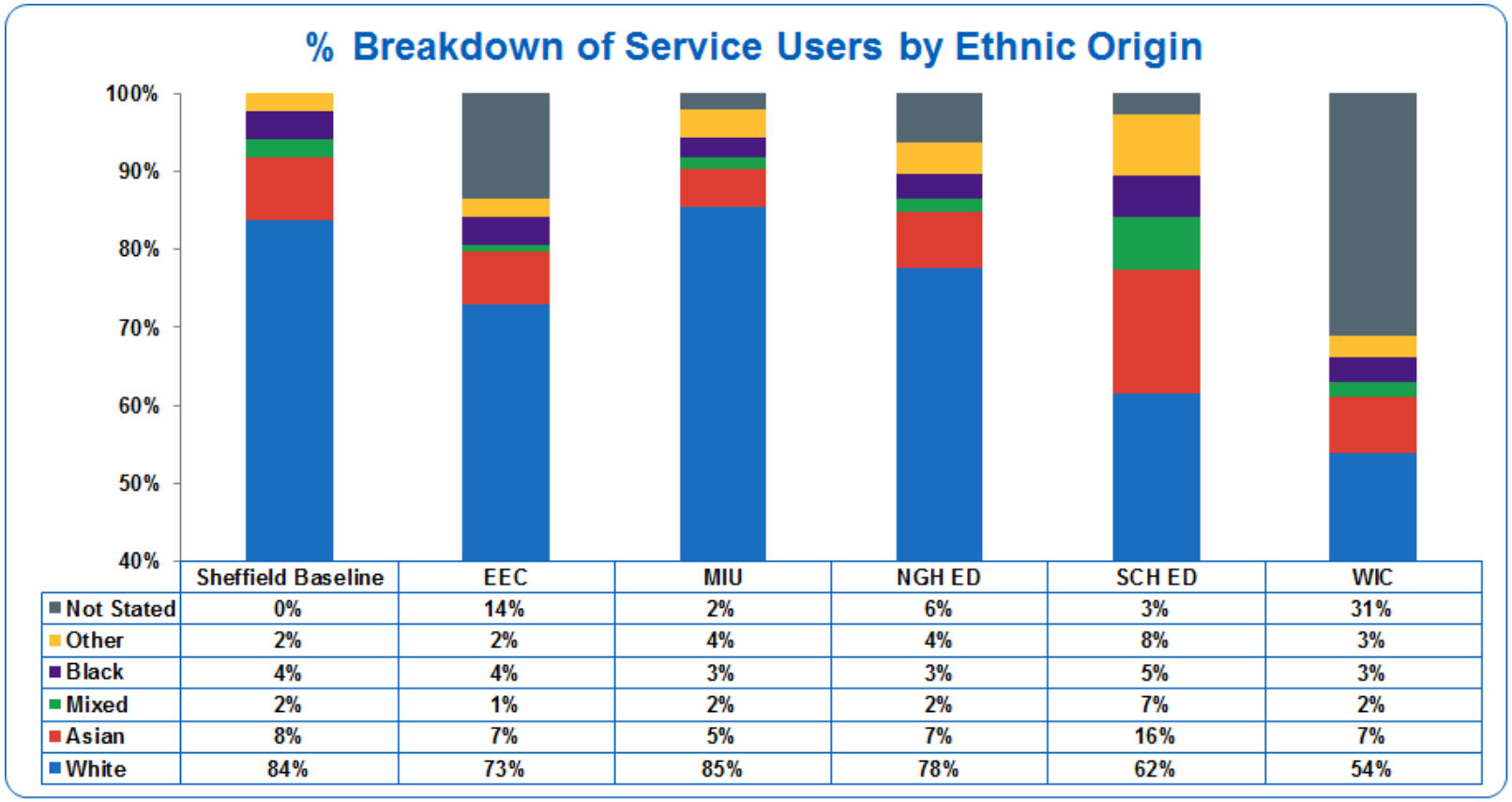
Yours sincerely

Pat Midgley

Chair, Healthier Communities and Adult Social Care Scrutiny Committee.

Appendix 5: Ethnic Origin of Attendees by Service

Figure 5-1



	Sheffield Baseline	EEC	MIU	NGH ED	SCH ED	WIC
Not Stated	0%	14%	2%	6%	3%	31%
Other	2%	2%	4%	4%	8%	3%
Black	4%	4%	3%	3%	5%	3%
Mixed	2%	1%	2%	2%	7%	2%
Asian	8%	7%	5%	7%	16%	7%
White	84%	73%	85%	78%	62%	54%

Figure 5-1 above shows a graphical representation of the ethnic origin recorded for services attendees compared to the breakdown of the entire Sheffield population. The only service that showed a substantially different demographic to the Sheffield population was SCH's ED which showed a much higher proportion of attendees from Asian/Mixed/Other ethnic origins. However as there is no proposed change to this service there should be no impact. It should also be noted that 31% of WIC attendees did not have their ethnic origin recorded.

Appendix 6: Vehicle Ownership

Figure 6-1

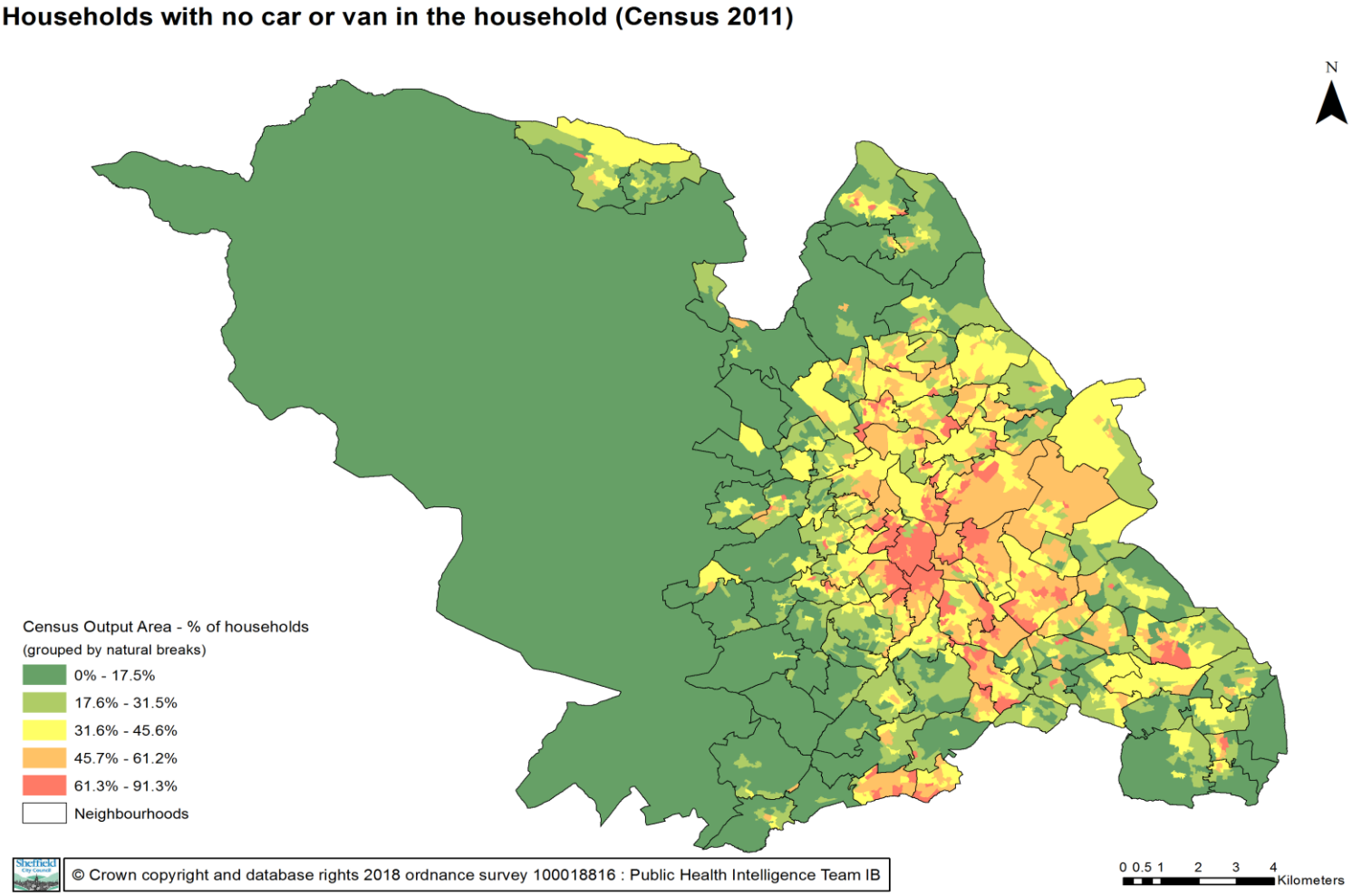


Figure 6-1 above shows a geographical heat map of areas of the % of households without access to a car/van in a Lower Super Output Area (LSOA). A higher percentage indicates lower access to a private vehicle in that area.

Figure 6-2

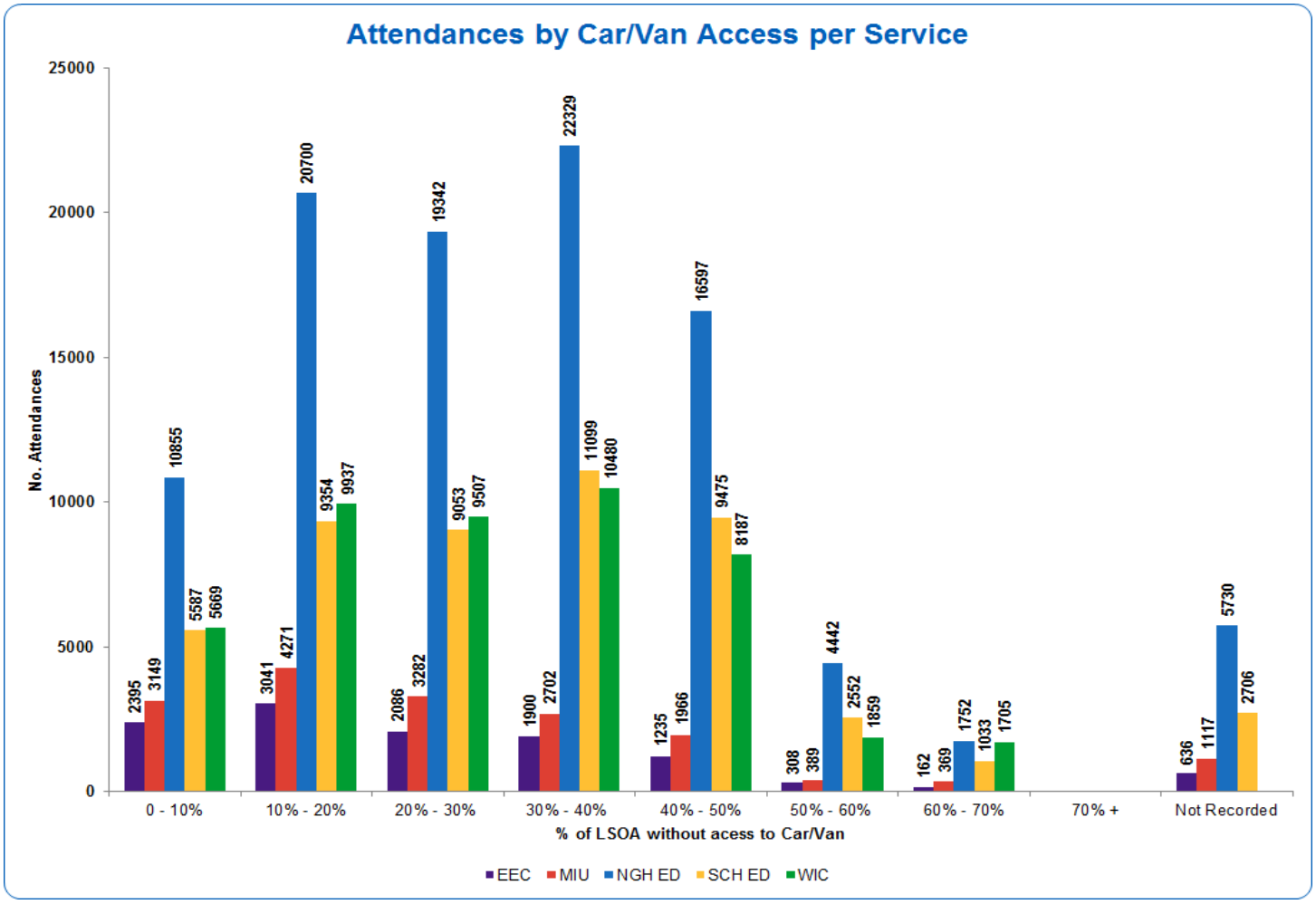


Figure 6-2 above shows the breakdown of the volume of attendances per service split into percentage bands of not having access to a private vehicle based on the attendees' LSOA. Access to a private vehicle tended to be good for all services with the majority of attendees coming from areas where 70% or greater of the population had access to a private vehicle. This was especially true of MIU where 62% of attendees were from such areas.

Appendix 7: Travel Times

Figure 7-1

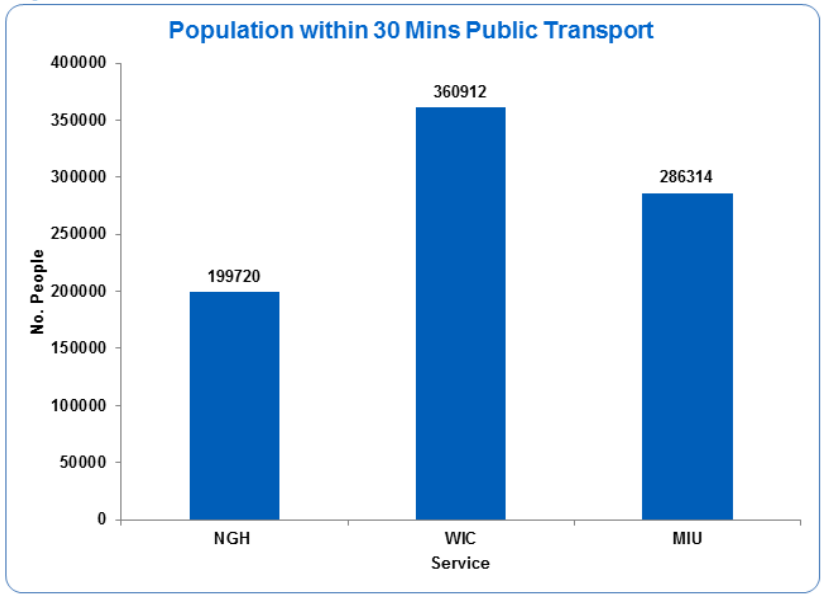


Figure 7-2

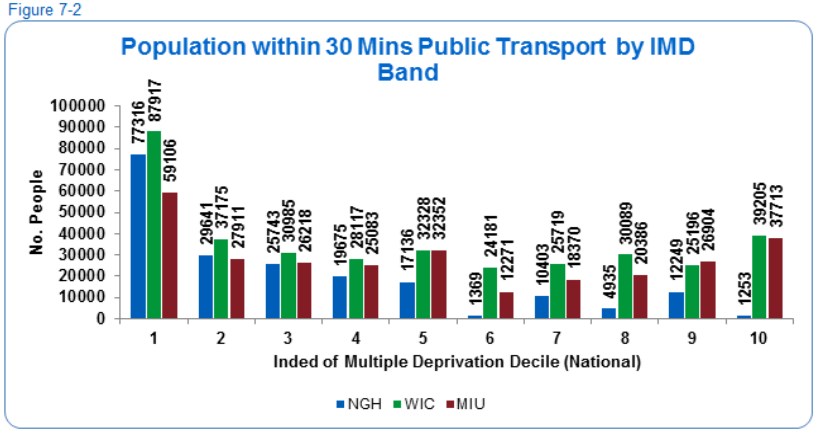


Figure 7-3

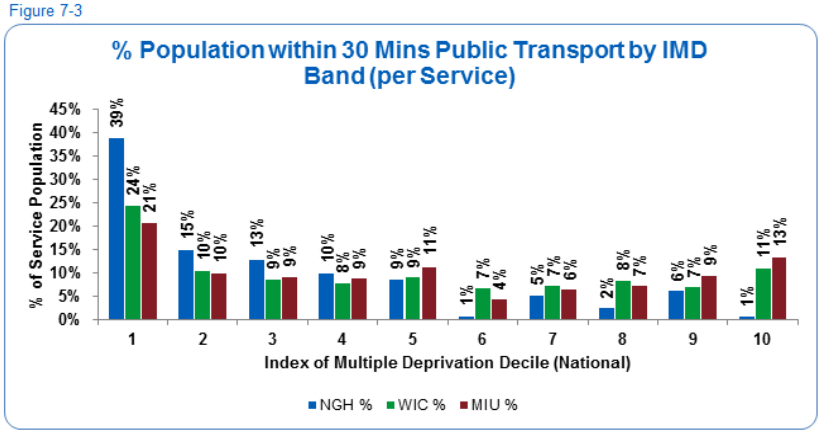


Figure 7-1 shows a graph detailing the volume of population within 30 minutes of the NGH/MIU/WIC sites via public transport, i.e. the volume of the population who could potentially travel to these sites via public transport. The data has been taken from Public Health's "SHAPE" tool. Figure 8-1 shows the raw total volume demonstrating that less people have access to the NGH site via public transport. However figures 7-2/7-3 to right show the data broken down by the Index of Multiple Depravation (IMD) showing that those who do have access to NGH tend to be from more deprived backgrounds compared to the other two services.

Figure 7-4

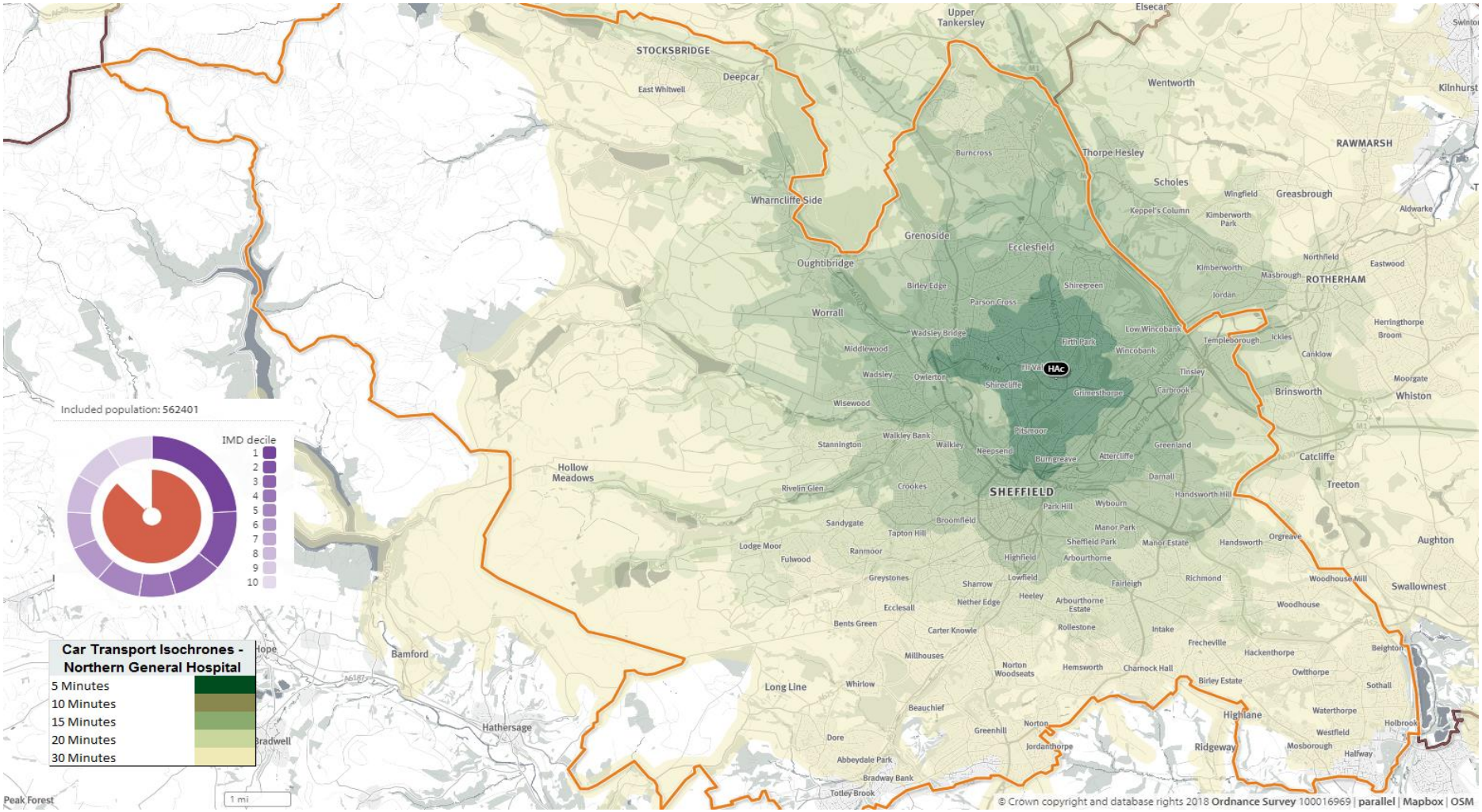


Figure 7-4 shows the areas of Sheffield that are within 5/10/15/20/30 minutes travel by car from the Northern General Hospital and details the total population (within the Sheffield LA Boundary) living in those areas (purple pie chart).

Figure 7-5

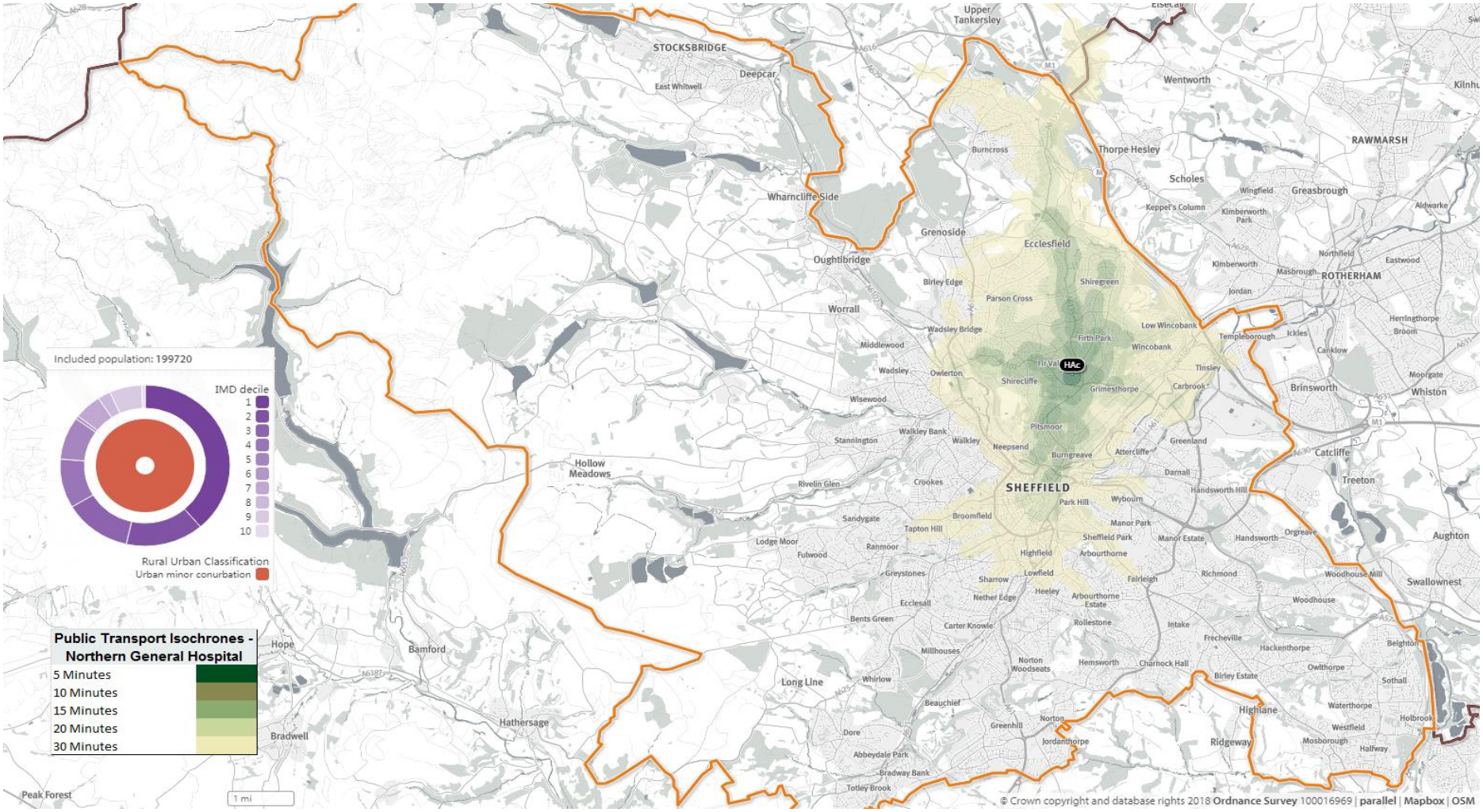


Figure 7-5 shows the areas of Sheffield that are within 5/10/15/20/30 minutes travel by public transport from the Northern General Hospital and details the total population (within the Sheffield LA Boundary) living in those areas (purple pie chart).

Figure 7-6

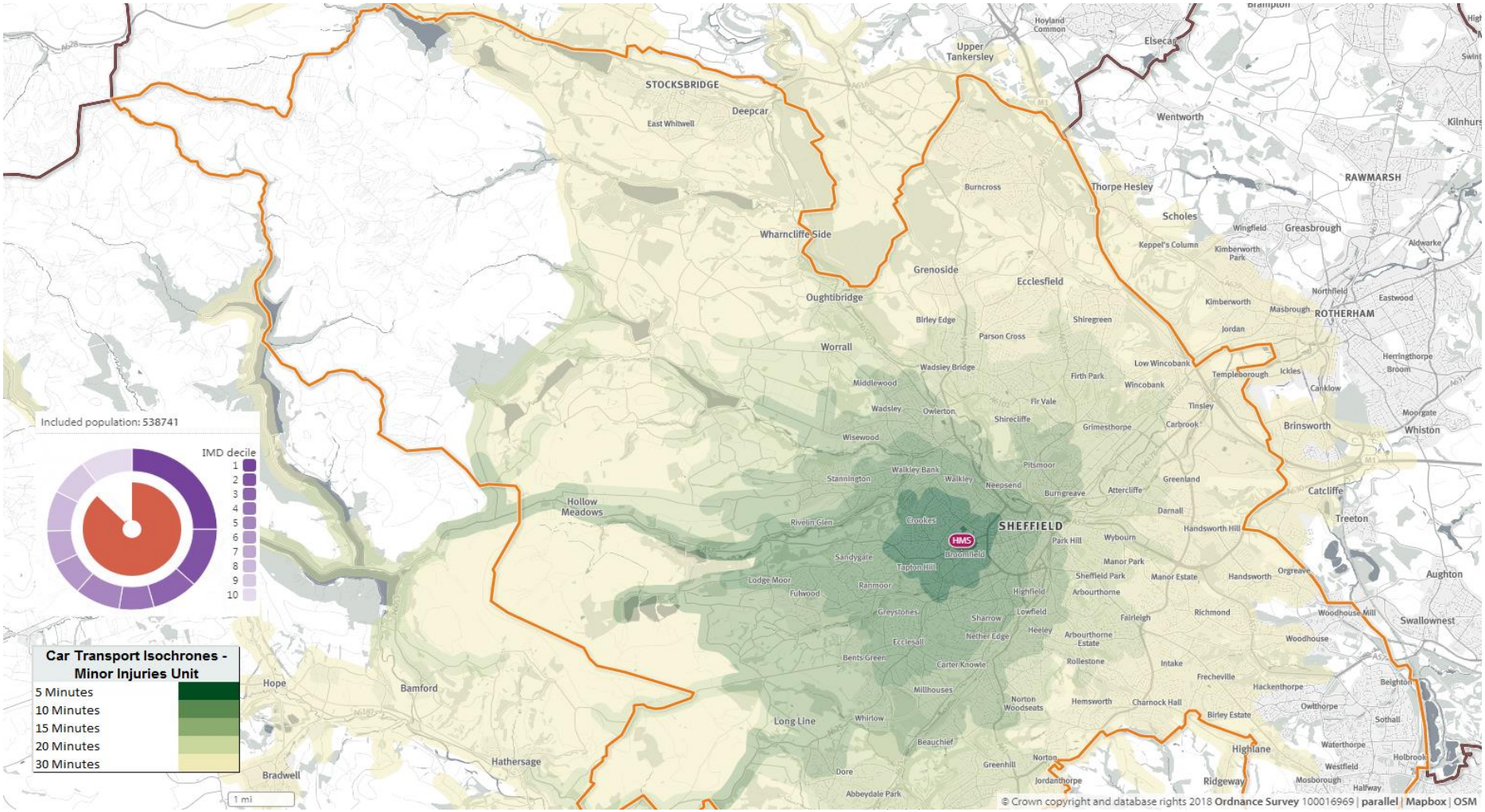


Figure 7-6 shows the areas of Sheffield that are within 5/10/15/20/30 minutes travel by car from the Minor Injuries Unit and details the total population (within the Sheffield LA Boundary) living in those areas (purple pie chart).

Figure 7-7

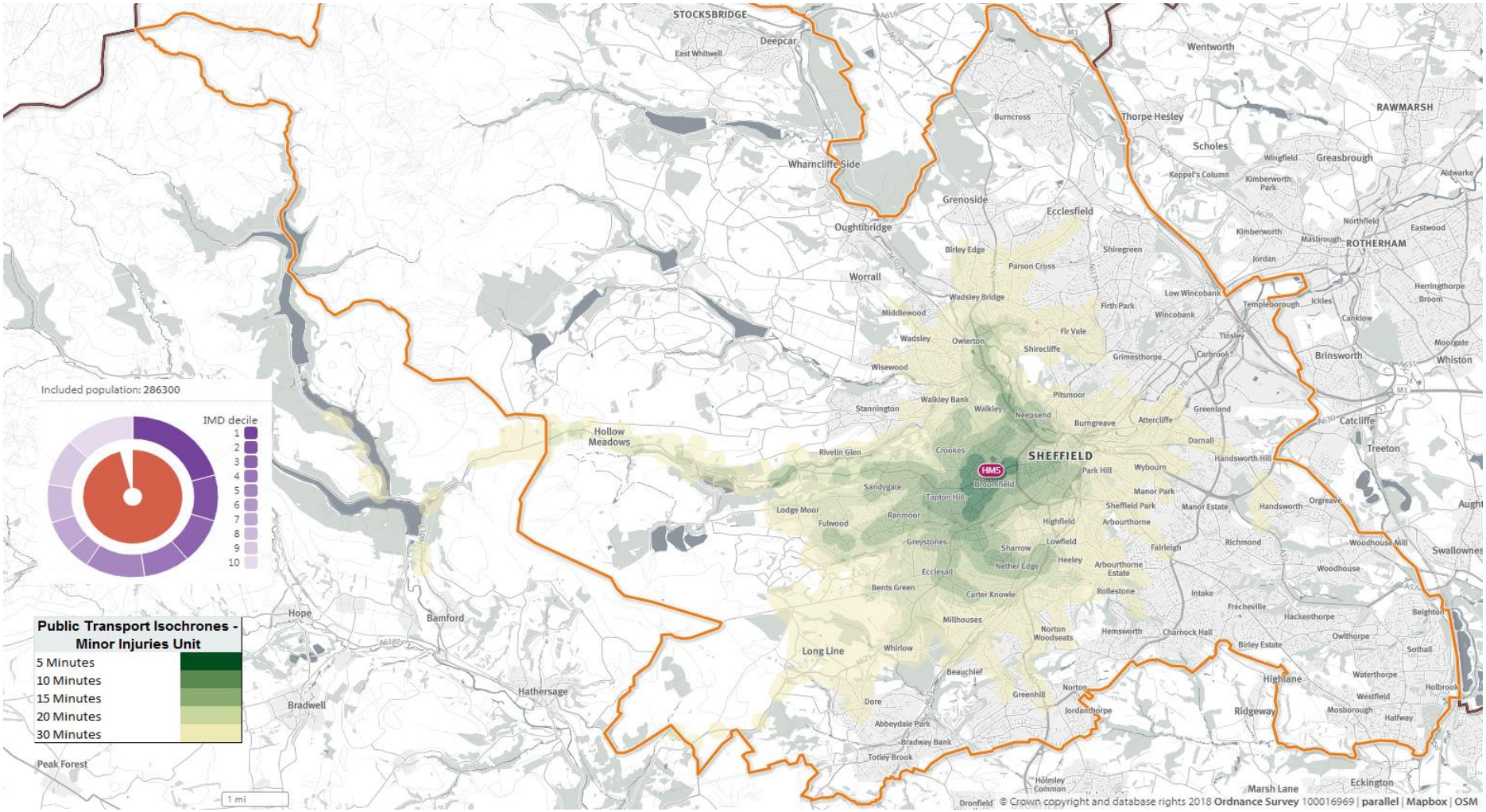


Figure 7-7 shows the areas of Sheffield that are within 5/10/15/20/30 minutes travel by public transport from the Minor Injuries Unit and details the total population (within the Sheffield LA Boundary) living in those areas (purple pie chart).

Figure 7-8

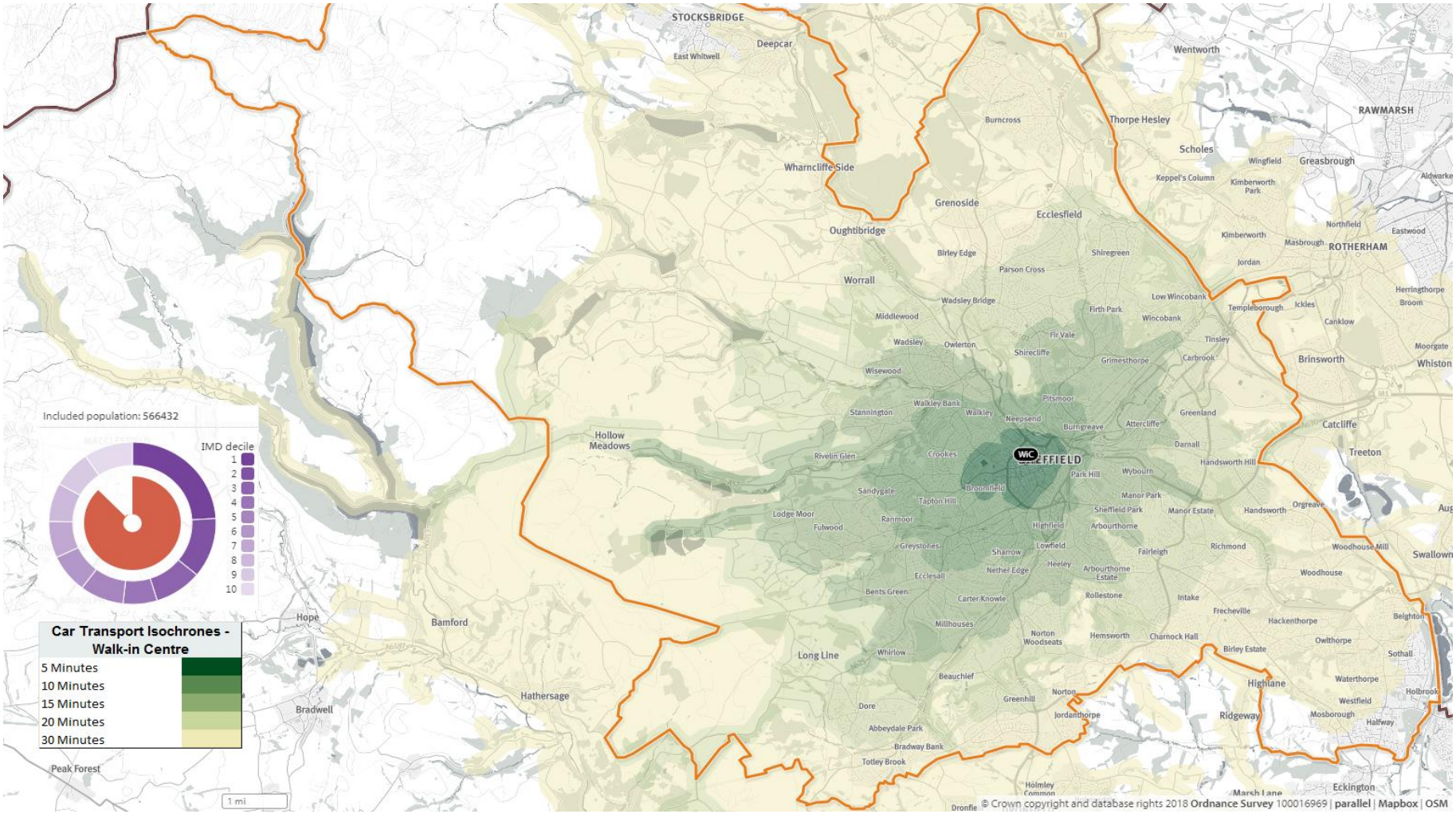


Figure 7-8 shows the areas of Sheffield that are within 5/10/15/20/30 minutes travel by car from the Walk-In Centre and details the total population (within the Sheffield LA Boundary) living in those areas (purple pie chart).

Figure 7-9

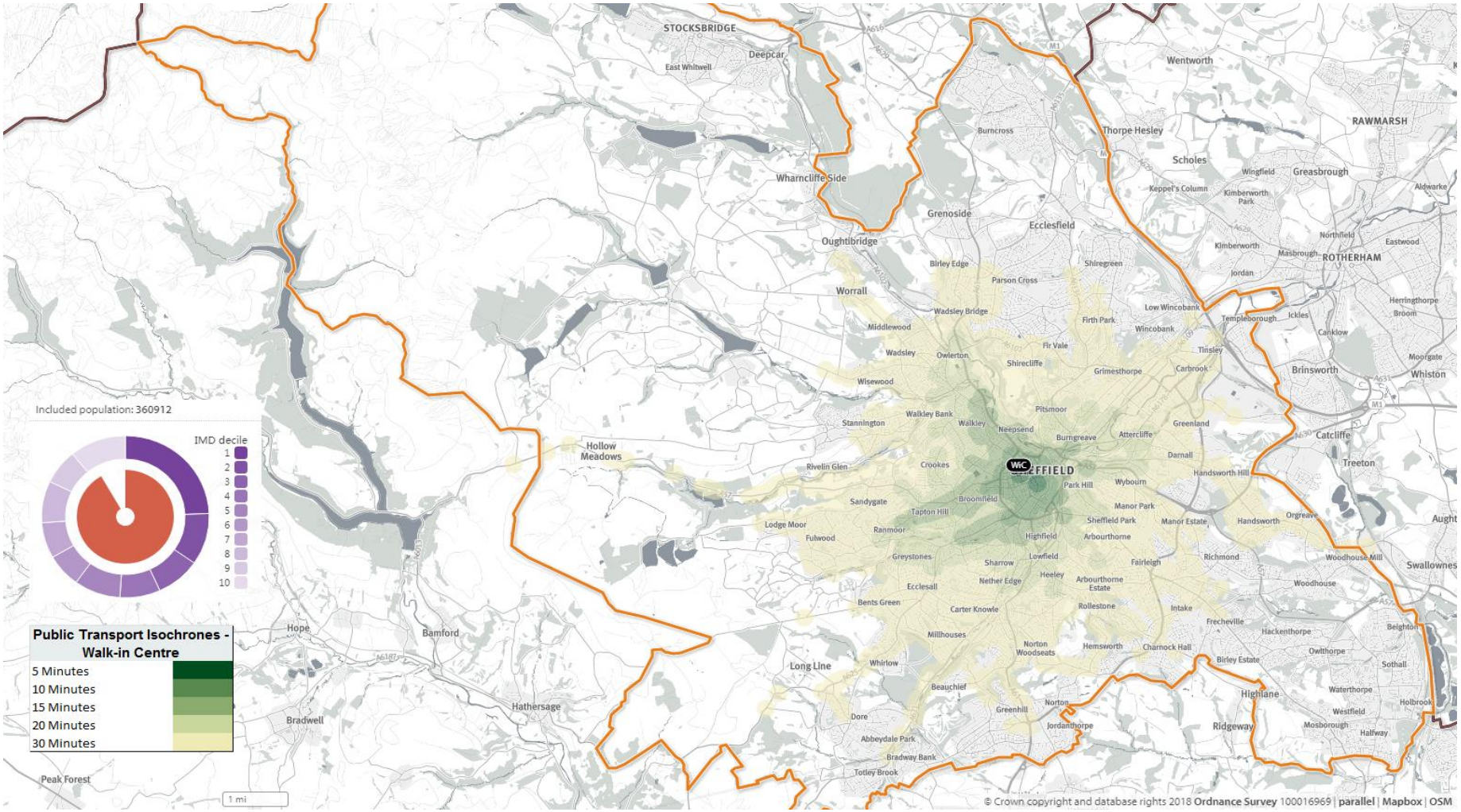
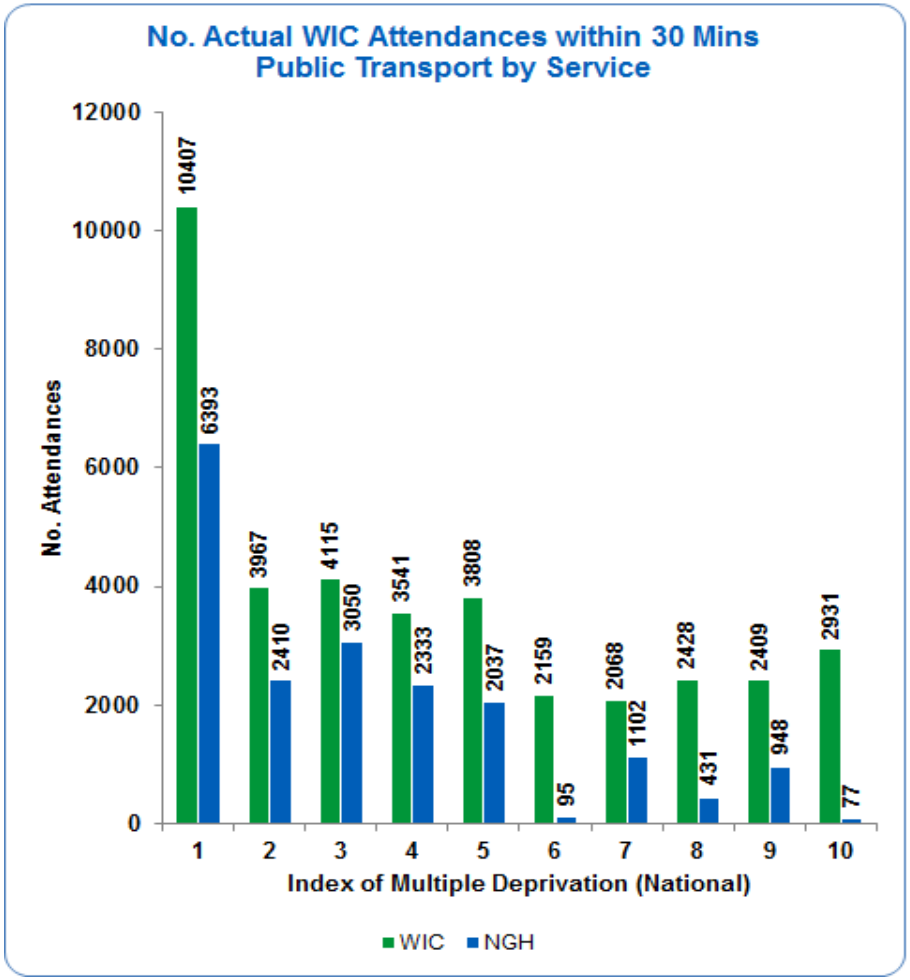


Figure 7-9 shows the areas of Sheffield that are within 5/10/15/20/30 minutes travel by public transport from the Walk-In Centre and details the total population (within the Sheffield LA Boundary) living in those areas (purple pie chart).

Figure 7-10



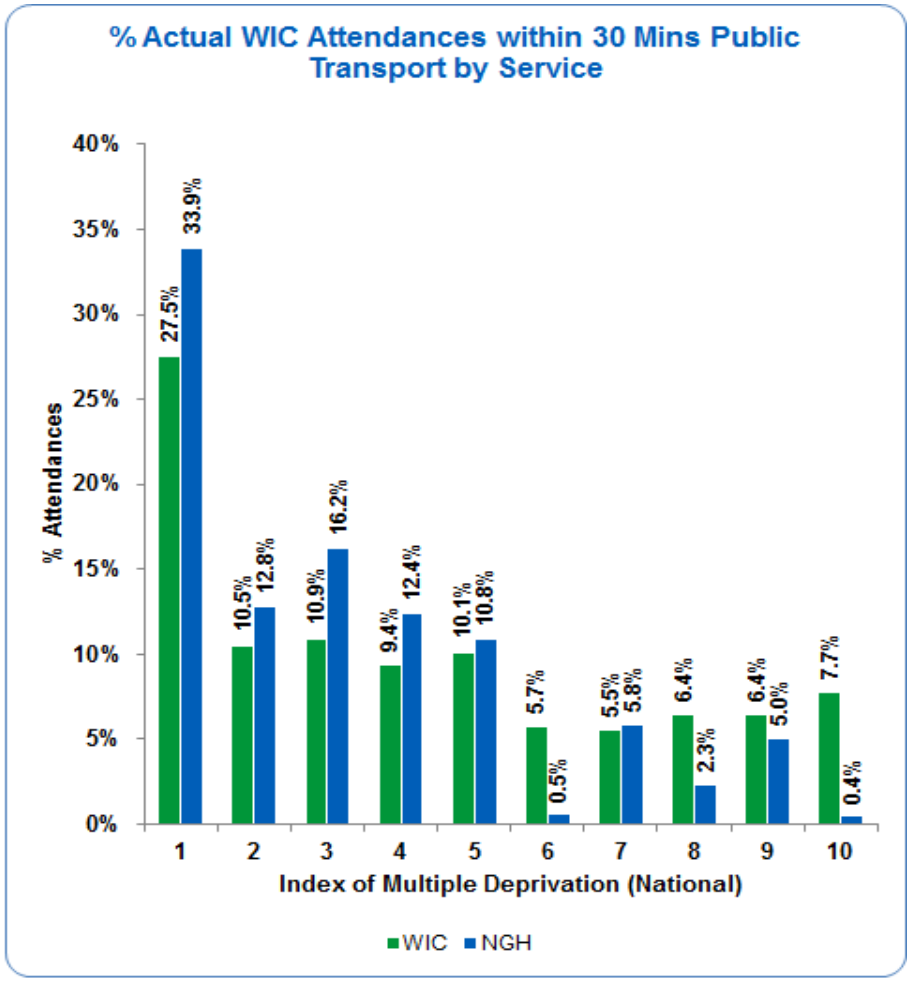


Figure 7-10 shows the dataset of actual WIC attendances filtered by those that fit within the 30 minute public transport footprints for both the WIC and NGH sites to allow for comparison. As per the overall trend there would be less public transport access to the NGH but those from more deprived areas would be less affected.

Figure 7-11

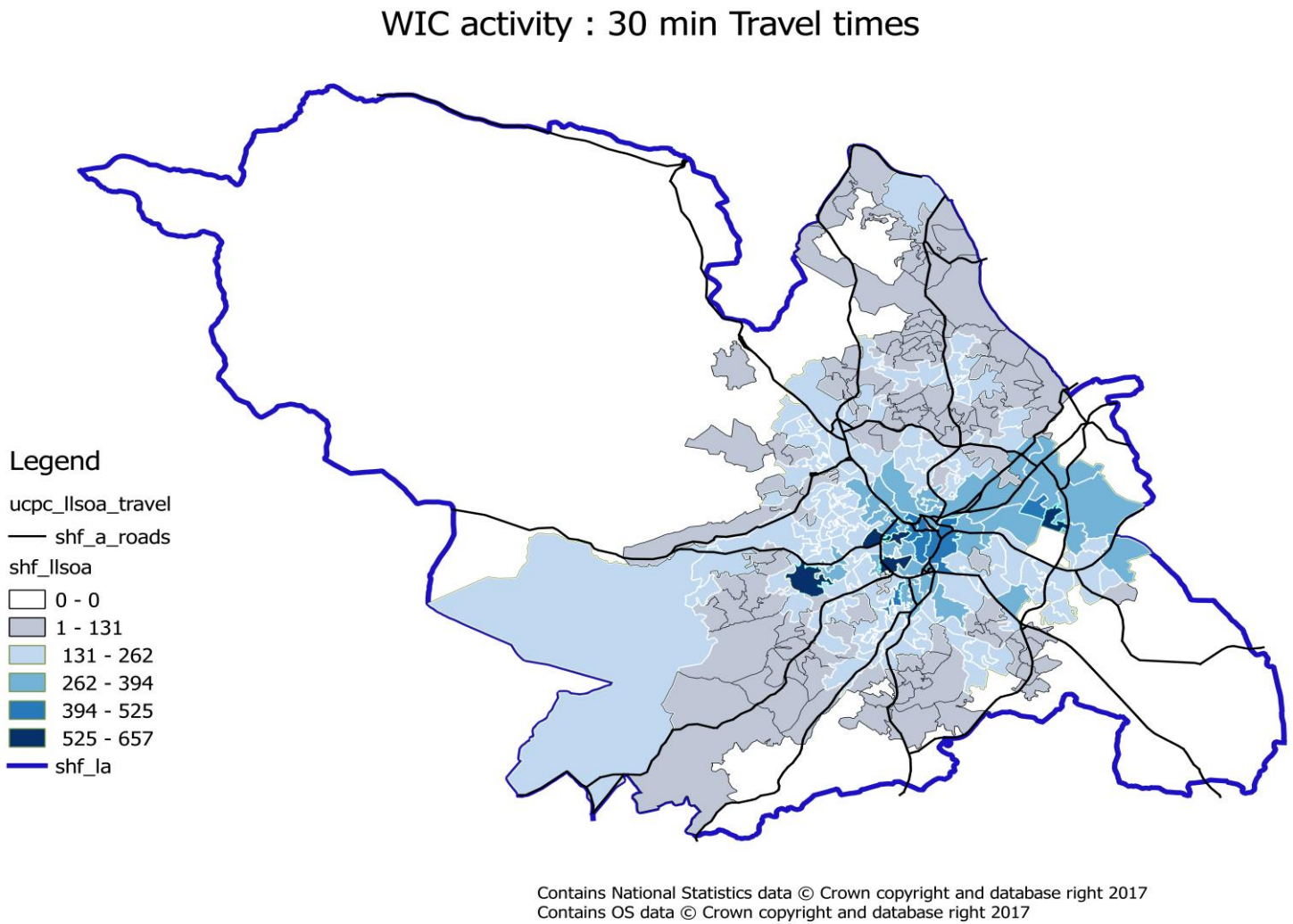
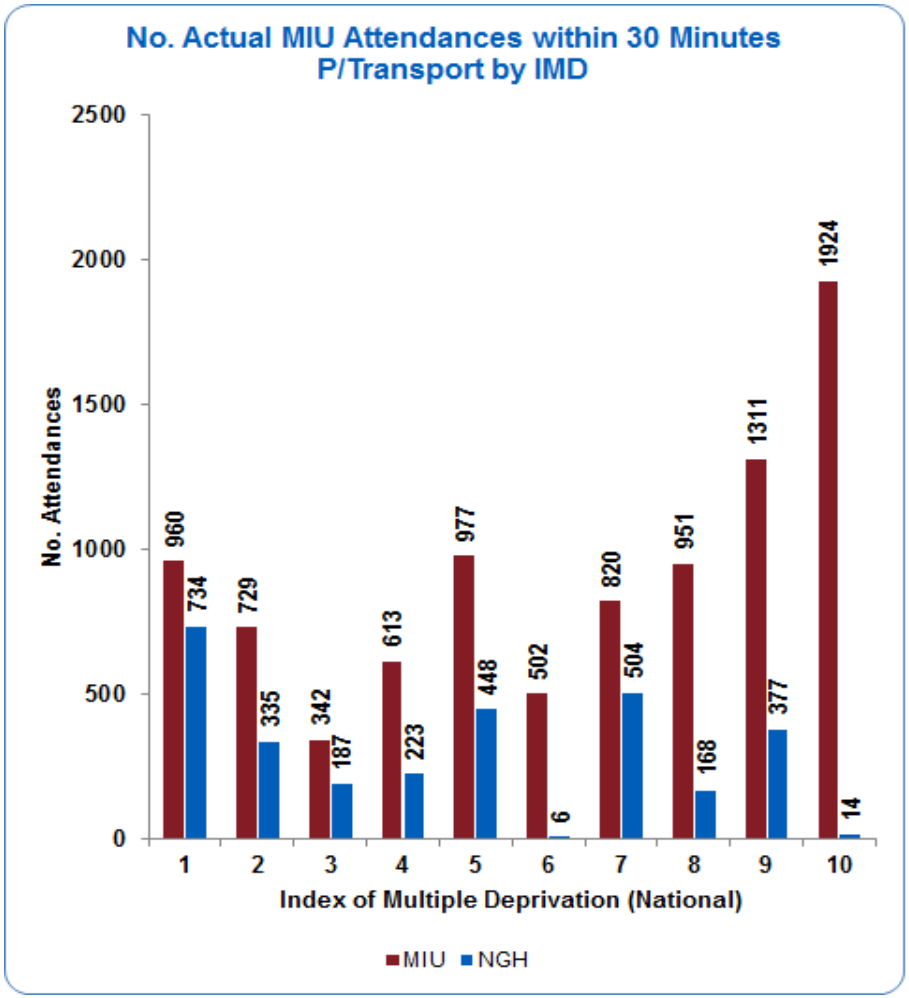


Figure 7-11 shows a heat map of the origin of those WIC attendees who fit within the 30 minute public transport footprint with the largest concentration of attendees tending to come from central and eastern parts of the city.

Figure 7-12



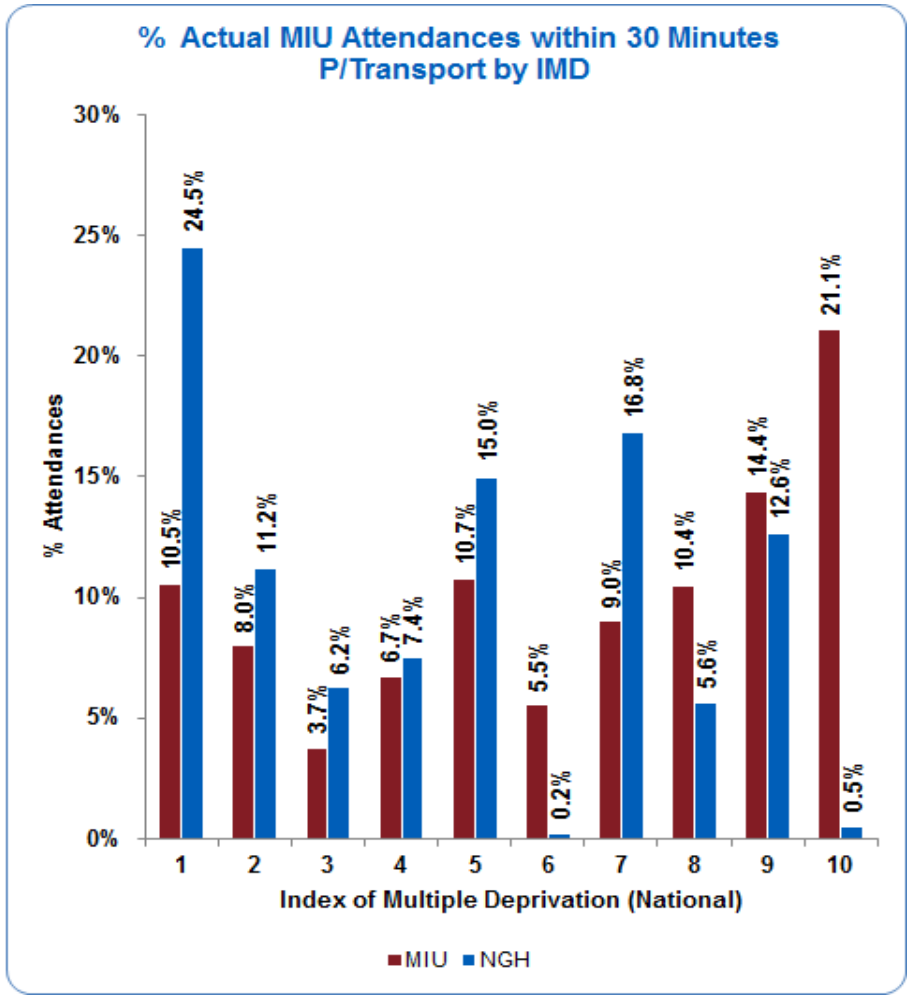


Figure 7-12 shows the dataset of actual MIU attendances filtered by those that fit within the 30 minute public transport footprints for both the MIU and NGH sites to allow for comparison. As per the overall trend there would be less public transport access to the NGH but those from more deprived areas would be less affected.

Figure 7-13

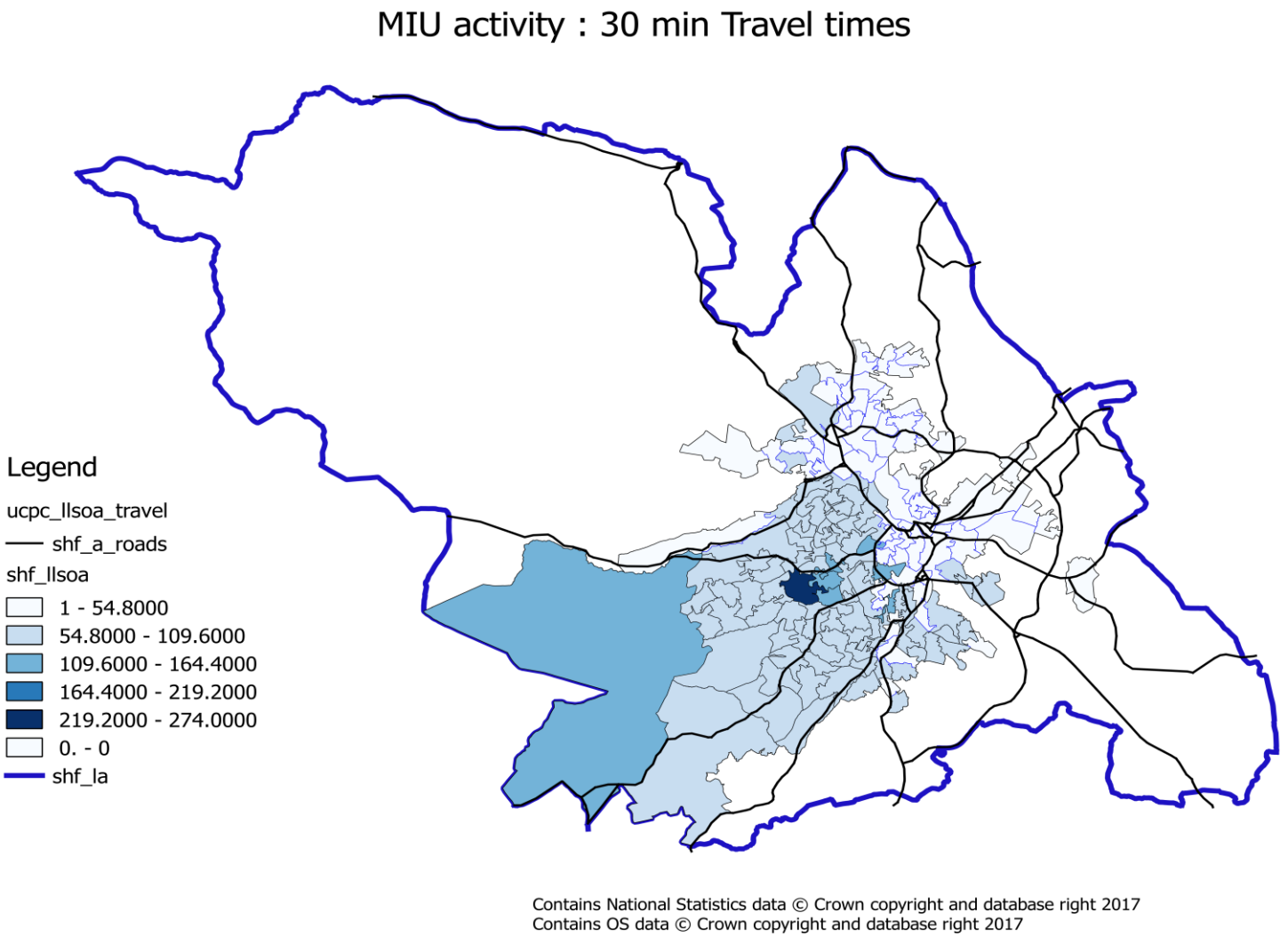


Figure 7-13 shows a heat map of the origin of those MIU attendees who fit within the 30 minute public transport footprint with the largest concentration of attendees tending to come from the southwest of the city. When compared to the heat map of access to a private vehicle these tend to be areas of high access.

Figure 7-14

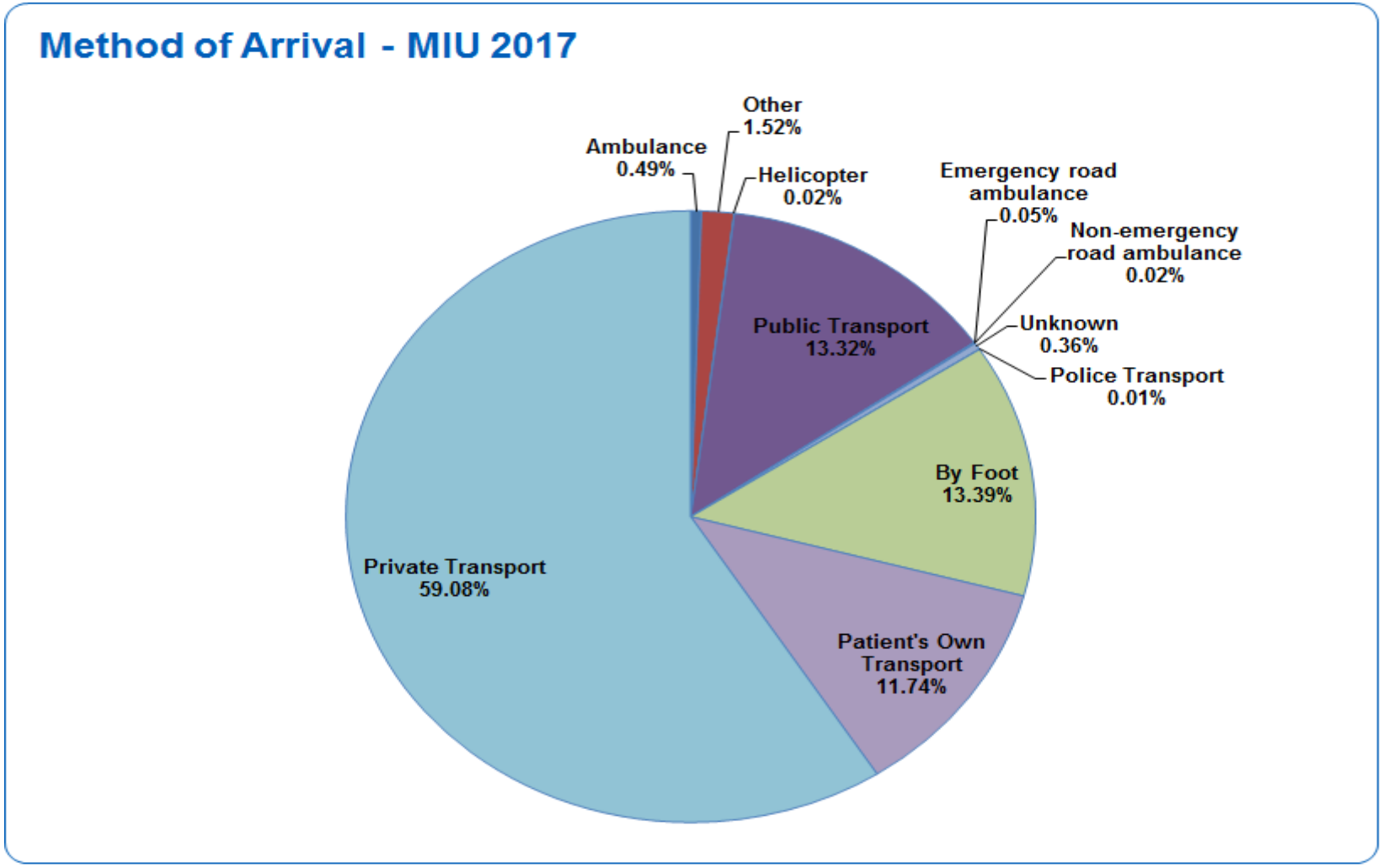


Figure 7-14 shows the breakdown of how people travelled to the MIU showing that over 70% travel via private transport which would be concordant with figure 7-13 showing that attendees tended to come from areas of high access to private vehicles.

Appendix 8 - WIC Attendances by Practice

The table below shows the number of WIC attendances per each practice within Sheffield ranked by total number of attendances. It also shows the list size for each practice and the attendance rate per 10,000 population.

Practice Name	WIC Attendances	List Size	Rate per 10,000 Pop
University Health Service Health Centre	3543	31961	1108.54
Porterbrook Medical Centre	2921	27747	1052.73
Clover Practice	2514	16471	1526.32
Baslow Rd	1783	12633	1411.38
Upperthorpe Medical Centre	1409	11471	1228.31
Devonshire Green Medical Centre	1388	6992	1985.13
Walkley House Medical Centre	1339	11825	1132.35
Sloan Practice (Main)	1229	13024	943.64
Clover City Practice	1178	4429	2659.74
Burncross Surgery	1004	15393	652.24
Handsworth Medical Practice	980	9914	988.5
Carterknowle Road Surgery	966	12393	779.47
Woodhouse Health Centre	965	12206	790.59
The Mathews Practice Belgrave	960	8575	1119.53
Tramways Medical Centre (Milner)	958	10652	899.36
Broomhill Surgery	890	9669	920.47
Dovercourt Group Practice	889	8421	1055.69
The Crookes Practice	857	8010	1069.91
Pitsmoor Surgery	781	9407	830.23
Far Lane Medical Centre	780	7225	1079.58
Duke Medical Centre	767	7010	1094.15
Tramways Medical Centre (Dr O'Connell)	747	8545	874.2
White House Surgery	743	6408	1159.49
Dykes Hall Medical Centre	727	9752	745.49
Richmond Medical Centre	685	8841	774.8
Nethergreen Surgery	635	9325	680.97
Woodseats Medical Centre	630	9859	639.01
Burngreave Surgery	610	6810	895.74
Sharrow Lane Medical Centre	609	3857	1578.95
Sothall Medical Centre	585	10180	574.66
The Hollies Medical Centre	577	9158	630.05
Heeley Green Surgery	574	5949	964.87
Shiregreen Medical Centre	558	7854	710.47
Firth Park Surgery	545	9917	549.56
Gleadless Medical Centre	541	8846	611.58
Birley Health Centre	537	8515	630.65
Manor Park Medical Centre	528	4413	1196.46
Grenoside Surgery	527	7409	711.3

Practice Name	WIC Attendances	List Size	Rate per 10,000 Pop
Richmond Road Surgery (Dr Mehrotra)	511	3426	1491.54
Meadowgreen Health Centre (Old School)	500	9642	518.56
Norwood Medical Centre	499	8035	621.03
Ecclesfield Group Practice	480	8246	582.1
Wincobank Medical Centre	461	7643	603.17
East Bank Medical Centre	452	5676	796.34
Page Hall Medical Centre	449	7739	580.18
The Medical Centre Crystal Peaks	432	6610	653.56
Park Health Centre	432	5082	850.06
Norfolk Park Medical Centre	432	4501	959.79
Hackenthorpe Medical Centre	416	6730	618.13
The Healthcare Surgery	412	5074	811.98
Foxhill Medical Centre	399	6186	645
The Avenue Medical Pract	366	7147	512.1
Buchanan Road Surgery	363	4718	769.39
The Manchester Rd Surgery	342	4724	723.96
Barnsley Road Surgery	338	2636	1282.25
Elm Lane Surgery	332	5187	640.06
Harold Street Surgery	331	3426	966.14
Valley Medical Centre	327	9612	340.2
Oughtibridge Surgery	322	5834	551.94
Greystones Medical Centre	304	3676	826.99
Jaunty Springs Health Centre	303	3649	830.36
Mosborough Health Centre	301	6630	454
Rustlings Road Med. ctr.	288	4597	626.5
Charnock Health Primary Care Centre	274	5421	505.44
Owlthorpe Surgery	269	4598	585.04
Stonecroft Medical Centre	261	4105	635.81
Dunninc Road Surgery	254	2973	854.36
Totley Rise Medical Centre	246	3460	710.98
Upwell Street Surgery	245	4729	518.08
The Flowers Health Centre	244	4917	496.24
Sheffield Medical Centre	243	1738	1398.16
Falkland House	241	3955	609.36
Mill Road Surgery	240	5279	454.63
Southey Green Medical Centre	211	2957	713.56
Abbey Lane Surgery	211	3193	660.82
Selborne Road Med. Ctr.	199	2724	730.54
Stannington Medical Centre	198	3232	612.62
Deepcar Medical Centre	158	5239	301.58
Carrfield Medical Centre	108	1255	860.56
Veritas Health Centre	101	1473	685.68
The Medical Centre	43	1190	361.34

Appendix 9: Deprivation

Figure 9-1

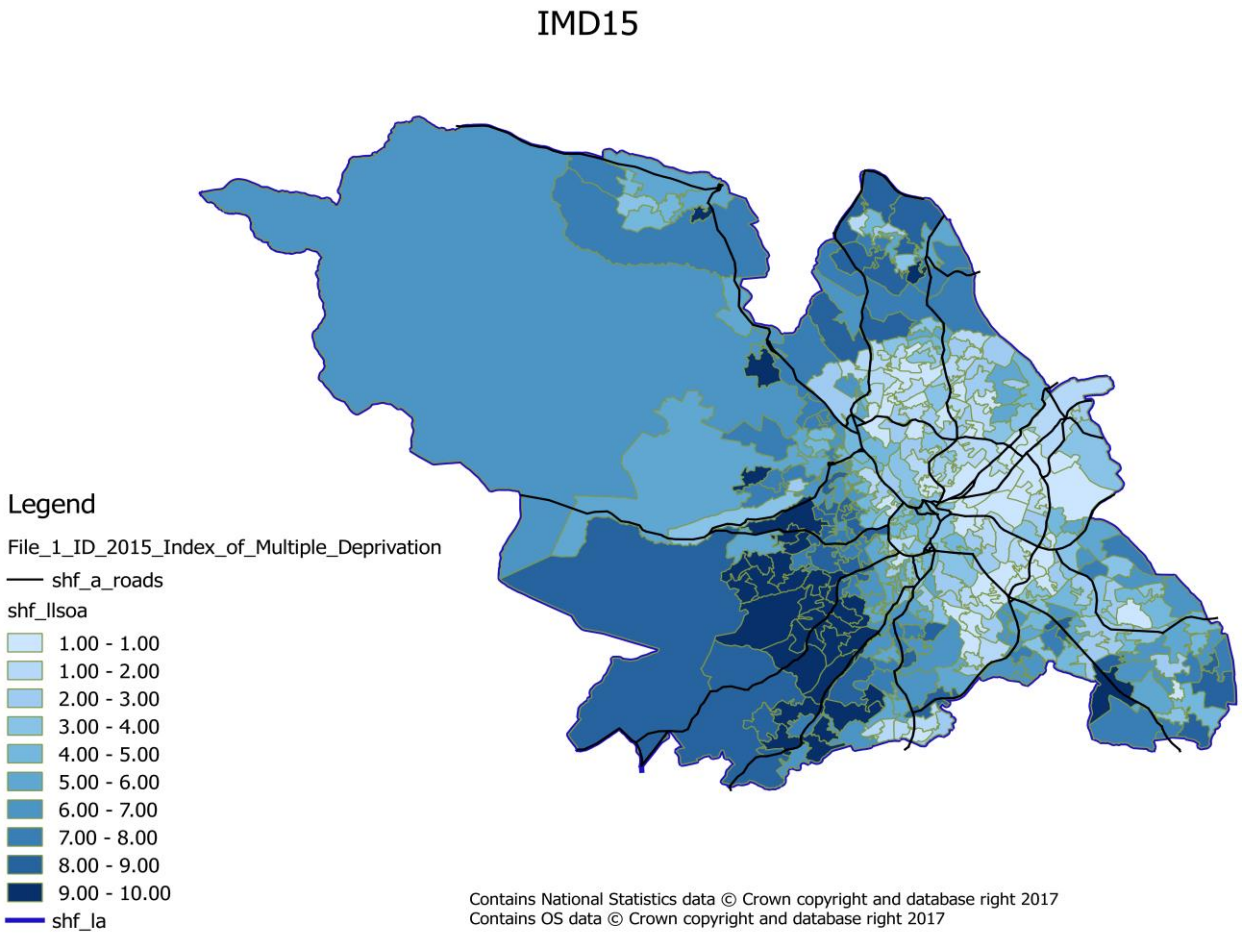
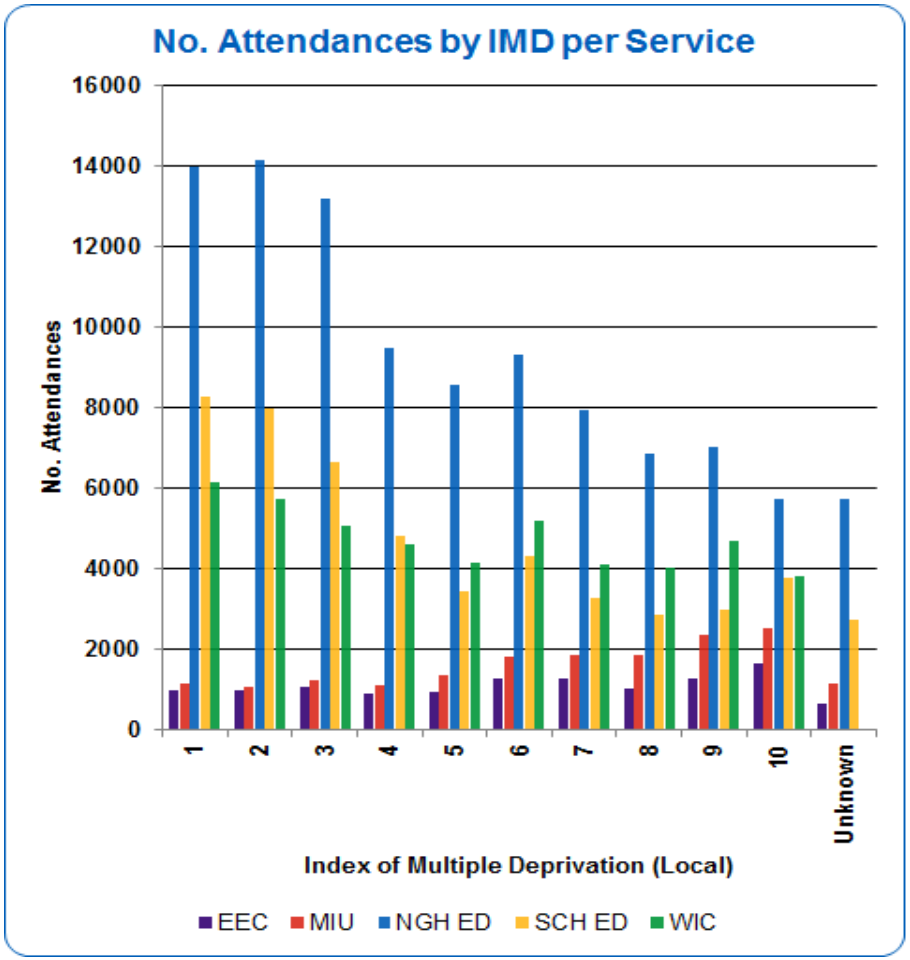


Figure 9-1 shows a heat map of deprivation within Sheffield using a local decile scale with lower numbers indicating areas of greater deprivation. The areas of most deprivation tend to be located in the north and east of the city while the southwestern parts tend to be the least deprived.

Figure 9-2



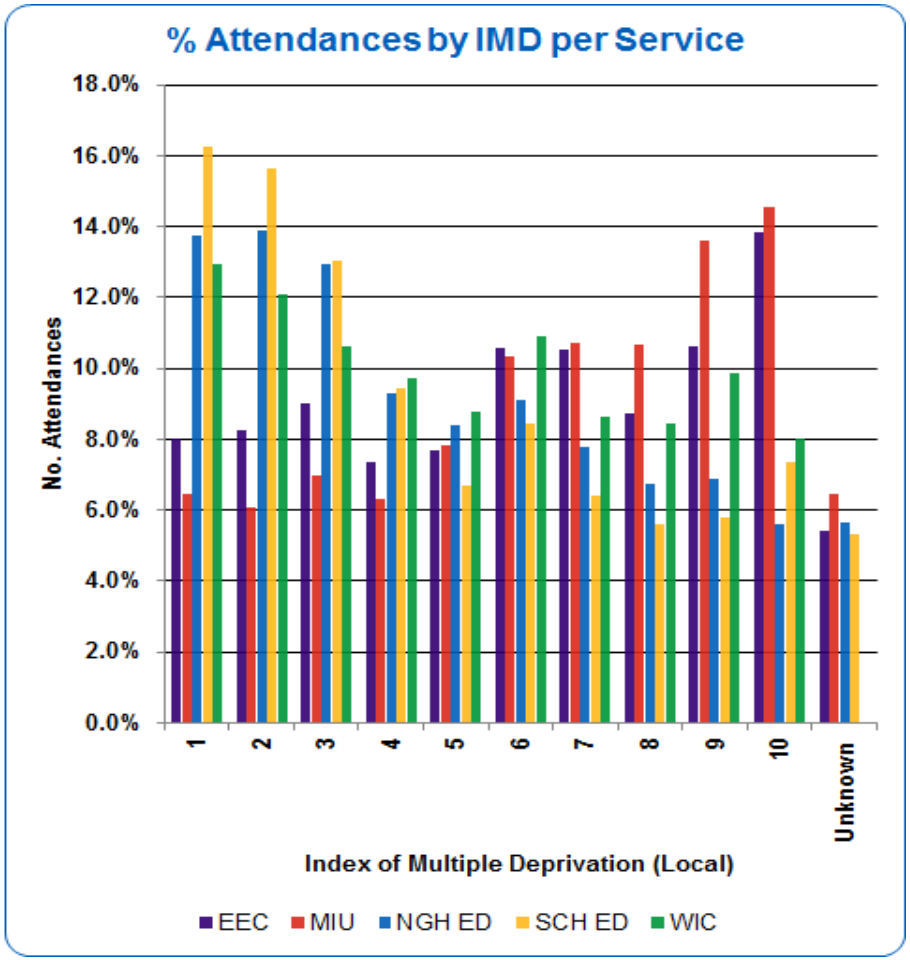


Figure 9-2 shows the attendances to each service broken by Index of Multiple Deprivation based on the attendees' LSOA. It shows that there is a disproportionate use of ED (both adults and children) by those from areas of higher deprivation with over 40% of all attendances for these services coming from areas in the top 3 deciles of deprivation. Conversely it shows that nearly 40% of all MIU attendees are from areas within the 3 deciles of least deprivation.

Appendix 10: Age

Figure 10-1

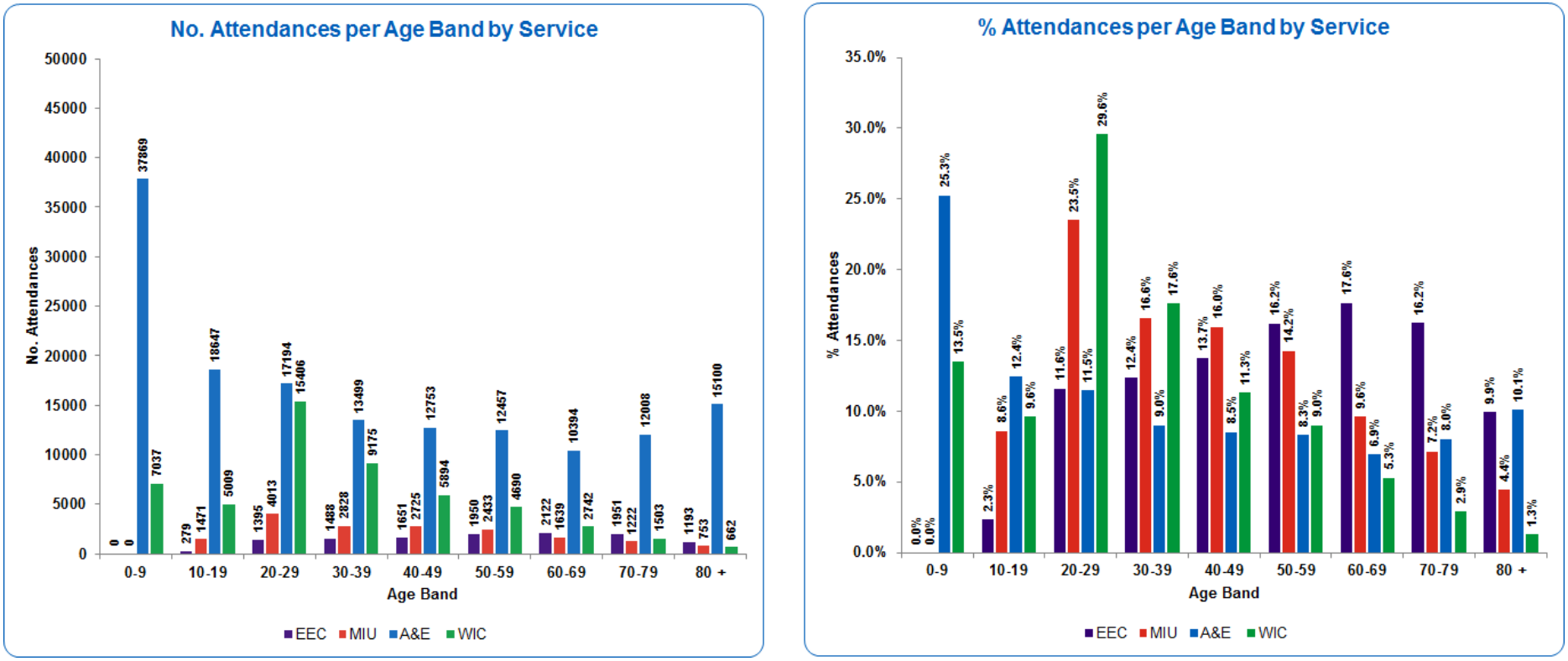


Figure 10-1 shows attendances to the services broken down via age band (A&E is both Adults/Children combined) both by total volume and by percentage. It shows that both the MIU and WIC are disproportionately utilised by the 20-29 age band, possibly due to the higher student population in Sheffield and the proximity of these services to areas with high student populations.

Figure 10-2

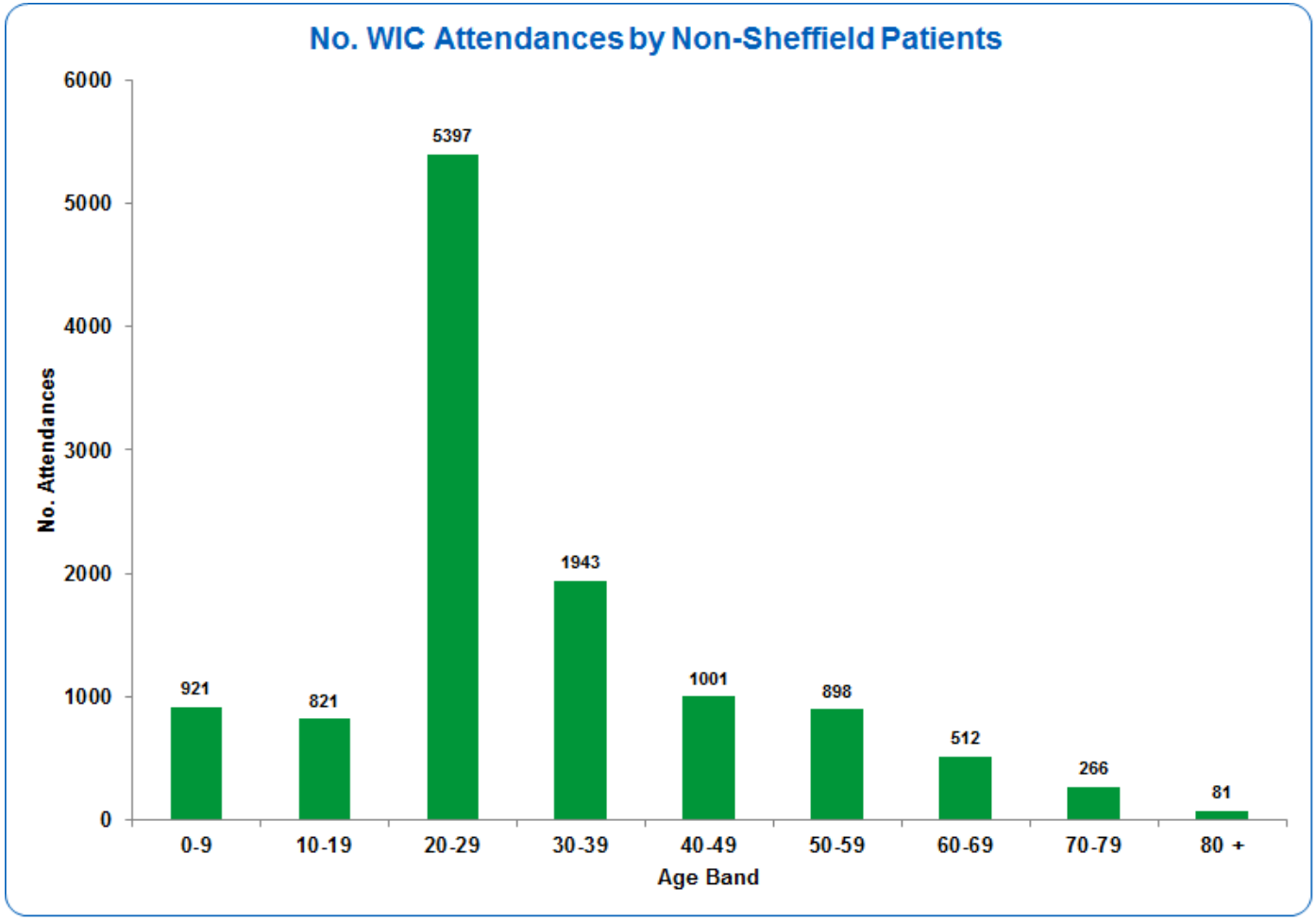


Figure 10-2 shows the number of WIC attendances per age band by patients who are not registered with a Sheffield GP. Similarly to figure 10-1 it shows disproportionate use by the 20-29 age band which could be indicative of high student usage.