Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Councillor Pat Midgley
Sheffield City Council
Town Hall
Pinstone Street
Sheffield
S1 2HH

722 Prince of Wales Road
Darnall
Sheffield
S9 4EU
Email: brianhughes1@nhs.net
Telephone: 0114 305 1168

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Dear Councillor Midgley

Thank you for the Committee's formal response to our proposals for changing Urgent Primary Care Services in Sheffield. We appreciate the time the Committee has put into considering the proposals and providing us with a comprehensive response.

As set out in our letter of the 13th September, having reflected on the Committee's response and the feedback from the consultation we have decided to reconsider the options for the reconfiguration of minor illness and minor injury services. However, our response to the issues and questions you raised is set out below, which we hope will be useful for the continuing scrutiny of our work to reconfigure urgent care services.

We found the format of the Committee's response very helpful so have followed the same approach to respond to the issues raised.

Consultation process

Q1: 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?

A total of 17 alternative suggestions were made in the consultation feedback, all of which have been considered to determine whether they could potentially be viable approaches and, if so, whether they offer any benefits that we should consider further.

The suggestions were reviewed at a number of workshops with providers, clinicians and commissioners to form a view on whether they could realistically be introduced within Sheffield over the next two to three years and potential benefits. The Urgent Care Public Reference Group also reviewed the suggestions and considered what they felt the pros and cons of each would be, plus any issues relating to access.

The outputs from the workshops were then reviewed by the CCG's Urgent Care Working Group to determine whether any of the suggestions could potentially be viable alternatives and have benefits that should be considered further. The feedback was considered alongside a number of other factors including the fit with the CCG's Primary Care, Care Outside of Hospital and Urgent and Emergency Care strategies.

In particular, the group considered whether activity levels would be sustainable (i.e. if services are likely to be too small to be economically viable or too large to be delivered safely); whether it enables the right thing to happen first time for each patient; and logistical feasibility (primarily whether there is likely to be sufficient workforce available to staff the model and whether it would meet the national Urgent and Emergency Care requirements).

As a result, six of the suggestions were determined to be unviable and the PCCC approved the recommendation that they should be discounted from further consideration (see appendix 1). The conclusions for the remaining 11 are attached as appendix 2. These would need full modelling and costing to confirm viability and for the consultation purposes the focus has been on understanding if there are any benefits from any of the alternative suggestions that should be considered against the options proposed.

Proposed siting of the Urgent Treatment Centre at the Northern General

Q2: 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?
The proposals to site the adult UTC at NGH took into account the activity information given to us by the service providers and the physical capacity of the current services. The proposal was for the UTC to be based in the space under the helipad; this already houses the GP collaborative (which would be incorporated into the UTC) and the remaining space is currently unused and would accommodate the additional patient activity. Based on the information provided, the CCG's analysis confirmed that capacity would be sufficient. However in light of the comments made by Sheffield Teaching Hospitals during the consultation, we are currently reviewing this with colleagues at the Trust to verify our assessment.

Q3: What would the impact of siting the UTC at the NGH be, in terms of patient flow, increased number of journeys, traffic modelling etc?

In terms of impact, our modelling focused on patient flow. To estimate activity levels at the UTC, we took account of activity at all current services at different times of day and days of week. Overall, we estimate that c35% of WIC activity would go to the UTC, based on the figures from Rotherham CCG on use of the new urgent treatment centre at the hospital after the city's walk-in centre closed. For the minor injuries unit, we have assumed 90% of current activity will move to the UTC, based on the fact that 10% of current service users attend with illness rather than injury. We have also taken account of the number of people currently attending A&E who would be streamed to the UTC, which is approximately 30% (NB: 10% illness which are already being streamed and 20% minor injuries, based on an audit of MIU data).

This means a total of 576 additional patients per week at NGH, with the breakdown shown in table1 below:

Per week

	Estimated no of UTC patients	Of which, no from A&E at NGH	Of which, no from GP collaborative	Additional no at NGH
Weekday	689	312	14	362
Weekend	263	111	20	131
Twilight	263	157	23	83
TOTAL	**1,215**	**580**	**57**	**576**

Q4: 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?

Overall, the proposals would mean that far fewer people need to travel for urgent care as more would be available in local GP practices. This would include the student population, many of whom use the walk in centre as an alternative to registering with a GP practice in Sheffield. This is matter of ongoing concern as it means not only that these students do not get the continuity of care afforded by being registered with a practice but also that the city does not receive the money for their care. Practices in the areas close to the university are continually promoting the benefits of registering and write to all new students to encourage them to register, as well as promoting this during the annual 'freshers' weeks'. Additional registrations would increase income to the practice, enabling them to increase their staffing if required to meet demand.

However, while the proposals would improve access for people with minor illness, we recognise that those with minor injuries would need to use the UTC and that this would impact on people in the South of the city in terms of travel times. Data on car ownership shows that there are high levels of car ownership in the South of the city so there is likely to be less reliance on public transport, and the majority of people currently using the MIU access the service by car. However, we are conscious that those using public transport are likely to find it harder to access NGH. The analysis we undertook showed that the majority of people in Sheffield (approximately 544,500) would be within an hour of NGH by public transport (see map attached as appendix 3) but we have considered mitigating actions we could take for those outside these areas.

Access to NGH was one of the key areas discussed in the workshops we held to consider the consultation feedback. From this, we agreed a number of actions that needed to be taken (attached at appendix 4), including work with STH, South Yorkshire Transport Executive and community transport providers to look at how transport to NGH could be improved. We have also committed to exploring the possibility of a shuttle service from the city centre and other alternatives to support people on low incomes to access services.

Q5: 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?

NHS England set out a number of requirements to improve urgent and emergency care including introducing standardised urgent treatment centres in every area. This includes the requirement for each area has to have at least one "standardised new **'Urgent Treatment Centres'** which will open 12 hours a day, seven days a week". These have to treat both minor illness and minor injuries and offer "appointments that are bookable through 111 as well as GP referral" (*Next Steps on the NHS Five Year Forward View, March 2017*).

All CCGs have to comply with this, and achieve the principles and standards set out by NHS England in the following document: https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf. In addition, NHS England is likely to associate failure to implement a UTC with poor A&E performance, which will put the city under increased pressure and scrutiny. It would also jeopardises access to the Sustainability and Transformation Funds that providers get if they achieve A&E targets, which could bring significant extra investment into the city. Negotiation on this if the target is narrowly missed would be supported if the system can demonstrate it has done everything required to achieve the target, such as establishing a UTC.

Retaining the current arrangement of having separate services for minor illness and minor injuries would not meet the requirements for a UTC, as this requires having a single service to treat both illness and injuries.

Other CCGs in South Yorkshire and Bassetlaw and more widely across the country are all working to introduce UTCs. Rotherham CCG closed its walk-in centre and created a UTC at the A&E department at Rotherham Hospital, which opened in July 2017. East Riding, North Tyneside and Derbyshire CCGs have also all either opened UTCs or are in the process of doing so.

Increasing capacity within Urgent Primary Care

Q6: How will the Neighbourhoods work together to provide additional appointments, is there evidence to demonstrate that this approach will work?

The neighbourhoods were established in 2016 so have already been working together for two years to coordinate health and social care, and deliver services to support the specific health and social needs of their area This has delivered a variety of improvements, including developing additional services to meet the needs of local communities, demonstrating the success of practices working together in this way. For example, practices in the Townships neighbourhood are already working together to provide shared appointments for patients with chronic pain. There are also examples

from other areas of the country that show how practices are successfully working together to deliver services at scale on the same basis as the neighbourhoods.
In view of the concerns raised about whether neighbourhoods would be sufficiently developed to deliver the proposed model, the CCG carried out a review of current maturity levels of maturity and future plans. This showed a commendable level of commitment to neighbourhood working, with an impressive number of initiatives taking place across the city. All neighbourhoods have identified patient cohorts to focus on based on their population needs – these include frail elderly, long term conditions, housebound diabetics and patients with mental health conditions.

Additional funding of £1 per head of population has been identified to develop neighbourhood services in these areas and work with key stakeholders to increase available resource in primary care. Working in a more integrated way with primary care and multi-disciplinary teams will deal with some of the same day demand and also free up GP and practice capacity to do this. This has demonstrated that neighbourhoods are already working successfully in the city and, with appropriate funding, are able to provide additional services for patients.

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 providing urgent care appointments for all patients who need them within 24 hours. There are a number of different ways that neighbourhoods might choose to do this, including sharing staff between practices or seeing each other's patients when they don't need continuity of care and some neighbourhoods are already working through potential approaches.

We have also continued discussions with GPs since the consultation to confirm that they are confident the proposals could be delivered. This has included discussions with individual practices, neighbourhoods, localities and the Local Medical Committee. This has shown that while some practices would 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. This has led us to conclude that we would need a more flexible approach rather than mandating neighbourhood working to allow practices to work individually to provide urgent care appointments within 24 hours if they wish to do so.

Q7a: How many additional appointments are needed and in which parts of the city?

We analysed walk-in centre attendances by practice during core hours (ie when practices are open) to determine the likely impact and number of additional appointments required in GP practices, and understand which practices were most likely to be affected (see appendix 5). On average, this works out as between 1 and 8 additional appointments that are likely to be required. Discussions with the practices

likely to be most affected have confirmed that they are confident they could deliver the extra appointments required.

Q7b: Which groups and communities will be most affected by the proposals and what are the mitigations?

To understand the impact of the proposals, we need to look at minor injuries and minor illness separately. For minor illness, including mental illness, people in all parts of Sheffield will see a positive impact as more care would be available in local GP practices, making it quicker and easier for them to get the care they need.

For minor injuries, people would need to go to a UTC at NGH or SCH, so those likely to be most affected are those living in the city centre and the south of the city, as they would have to travel further than they do now. Those impacted positively would be those living closer to NGH, including some of the most deprived areas of Sheffield.

City centre residents

For adults living in the city centre, access to urgent care for minor illness (including mental 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 additional investment in primary care and neighbourhood working is also likely to mean an increased number of mental health specialists being available to see patients in practices.

People would need to travel further for minor injuries care, which would be provided at the UTC at NGH, and we are conscious that this is also a concern for people living in the South of the city. The majority of people using the minor injuries service currently access it by car or taxi but we recognise the need to consider actions to mitigate the issues raised for those using public transport.

Vulnerable groups

The consultation raised concerns about the potential impact on vulnerable groups, such as the homeless, those affected by substance misuse or asylum seekers. These groups 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. However, we recognise 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

People living in deprived areas

We have reviewed extensive information relating to health inequalities and the potential impact on those in more deprived communities. This shows that 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.
It also showed that people in these areas are more likely to use the A&E departments at NGH and SCH than the MIU and WIC, indicating that these locations are accessible and that siting the adult UTC at NGH should not deter them from accessing healthcare.

Mitigations
As detailed in the response to Q4, we have discussed potential actions to mitigate the main concerns raised in the consultation feedback and the agreed actions are set out in appendix 4. These include exploring providing transport for those without easy access to transport or on very low incomes and work with STH, South Yorkshire Transport Executive and community transport providers to look at how transport to NGH could be improved.

We are conscious of the point you make about the difficulties of accessing services via a telephone triage system for some groups, such as the homeless and those for whom English is their second language. As happens now, different arrangements would be put in place for these groups to ensure they were not disadvantaged, for example drop in clinics. It is also worth noting that some practices with high numbers of non-English speaking patients, such as Pitsmoor Surgery, currently use telephone triage and find it works well

Q8: What are the workforce requirements and is the workforce available in Sheffield?

Workforce challenges and ensuring future sustainability is one of the drivers behind the changes and has been a key consideration in developing the proposed options.

Workforce planning for the UTC was based on the forecast activity numbers (detailed in response to Q3) and took account of the staffing models at the current services. This identified that 60.56 wte clinical staff would be required to support the delivery of the preferred model (Option 1) as set out in appendix 6. This workforce will be formed from a combination of existing staff working in current services, existing staff with additional training e.g. prescribing pharmacists and some additional, new staff e.g. Physician's Associates, currently being trained in Sheffield. The workforce planning anticipated that sufficient staff would be available to deliver the model.

Appendix 7 sets out details of the approach the CCG is taking to address the workforce challenges facing primary care in Sheffield. This includes increasing the use of different health professionals in practices to reduce the pressure on GPs and provide the best care for patients, which is a key focus of both neighbourhoods and the GP Five Year Forward View. The implementation of this workforce strategy will support the delivery of the proposed model and mean that the workforce requirements can be met.

Q9: Is there evidence available to demonstrate that the primary care system is willing and able to make these proposals work?

The 11 formal responses we received from practices raised a number of queries around logistics, details of the proposed approach and whether it was necessary to work as neighbourhoods to deliver additional appointments. Several also raised concerns about access to a UTC at NGH in terms of travel and parking, and there were several who felt they were already providing effective triage and delivery of urgent appointments. One also raised concerns about losing the MIU, although was supportive of the walk-in centre closing.

While this is obviously a limited number of responses, as outlined in our response to Q6 we have had numerous meetings and discussions with GPs, neighbourhoods, locality councils and the Local Medical Committee both during the consultation and afterwards. Throughout conversations, there has been a consensus supporting the principle of increasing urgent care capacity in primary care and investing to make primary care sustainable and improve access. As previously detailed, not all practices feel they would need to work as a neighbourhood to deliver the improvements, which we have taken on board. However, while there are concerns regarding logistical issues, overall members are supportive of the proposed approach to invest in primary care to improve capacity for minor illness and are willing to work with the CCG to achieve this.
In terms of delivery, the discussions have shown that some practices feel they are already meeting the standards that would be required and that others feel that with additional investment they would be able to do so, either individually or as neighbourhoods. Meetings with the practices most likely to be impacted by changes to the walk-in centre have confirmed that they are confident they can accommodate the additional patient numbers.

The implementation of clinical triage would be key to enabling practices to deliver urgent appointments within 24 hours for all those that need them. Feedback from practices that triage all patients confirms that it enables them to signpost patients to the most appropriate service and clinician. It is also in line with the national requirements to increase the number of 111 calls which are managed by a clinician rather than a call handler.

Q10: 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?

The current spend on all urgent care activity is £11.3m and this was the allocated financial envelope for the proposed changes.
To develop the financial modelling, we assessed the current annual activity demand for all urgent care services within Sheffield and the impact of implementing a triage system on current minor illness activity, and then allocated a new destination for each patient. In summary, this assumed that 90% of MIU activity would continue and need to be seen at the UTC and that there would be a 30% reduction in WIC activity due to implementing triage. Of the remaining WIC activity, we estimate that 20% would present

as walk-ins at the UTC. Of the remaining 80%, we estimate 20% will attend the UTC and 80% a GP service.

Assumed costs were then applied for this activity to calculate the overall costs of the proposed model.. The proposed model released £992k which we allocated to reinvest into neighbourhoods/GP practices to support the additional urgent care activity they would be delivering. In addition, we estimate there would be up to £160k of set up costs. No additional capital investment has been identified at this stage. This would be considered as part of the Neighbourhood business cases but it is currently considered that services would be able to operate within existing premises.

We have not agreed investment by practice or area at this stage but the approach to allocating the additional money would be in line with the CCG's agreed approach of differentially investing to support areas of greatest need.

Additional points

In addition to the questions, there were a few points you made that we thought would be helpful to respond to.

Similarity of the three options

We accept that the three configurations for the UTC were very similar. We did consider a range of approaches when developing options and the shortlist for the options appraisal included two approaches where the UTCs would have been in the city centre. The criteria we used scored options on whether they would enable patients to get care in the right place first time and this was a key factor in the outcome as co-location with A&E was considered to give the maximum chance of achieving this. Similarly, it allows maximum workforce flexibility and integration so also scored highly against 'ensuring a sustainable workforce', which was one of the other criteria.

The decision to reconsider our proposals and develop alternative options will allow us to explore whether there are benefits in other approaches that would outweigh those of co-location with A&E and we will work with partners and the public to develop new criteria, taking account of the feedback we received in the consultation.

Engagement with public and statutory stakeholders

We were disappointed that the Committee felt there had been a lack of public engagement in drawing up the proposals. We spent a lot of time on this stage, including work with Healthwatch and in depth work with specific groups who could potentially be impacted by any changes, which received positive feedback from the Committee when we shared this work at the start of 2017.
We are committed to involving the public in this process and going forward, we are looking at ways to strengthen this further including working with both the Urgent Care Public Reference Group and members of the public to develop the scoring criteria and

alternative options. We would continue to welcome any suggestions from the Committee, particularly in terms of how members would like us to work with you and how best to involve you in this work going forward.

Consultation feedback

The Committee's response referred to the "overwhelmingly negative tone of responses" to the proposals. However, while there were some very strong views against regarding the adult UTC location and replacement of the MIU and WIC, it is important to acknowledge that there were also positive responses to all elements of the proposal and different opinions expressed in the representative telephone survey to those from people who chose to complete the consultation feedback form. We also saw a range of views at the workshop we held for the Urgent Care Public Reference Group and differences in opinion - for example, while some were strongly in favour of having more services at the Royal Hallamshire, lots of people highlighted concerns around access to both this site and the current WIC location.

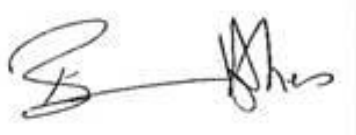
We mention this to highlight that we are trying to take account of a range of views and different opinions and also because there were some elements of the proposals that were clearly supported by the majority of people. In particular, there was widespread support for improving access to urgent same day GP appointments so we would want to make sure this remains a key focus of proposals.

Next steps

Following the decision to reconsider the reconfiguration of minor illness and minor injury services, we will be working with partners and the public to develop a new set of options for consultation. This will take account of both the feedback and the learning from the consultation, and include further consideration of the alternative suggestions that were put forward. We also recognise that there is a greater interest from the public in the data and information we have used than we had anticipated and have taken on board the level of detail required by the Committee to ensure thorough scrutiny of our work so going forward we will make sure this is provided.

As mentioned above, we would welcome views from the Committee as to how and when you would like us to engage with you throughout this process and look forward to discussing this further at the meeting on 10 October.

Yours sincerely



Brian Hughes
Director of Commissioning & Performance

Appendices

1. Unviable alternative suggestions
2. Review of remaining alternative suggestions
3. Areas within 1 hour travel time of NGH by public transport
4. Mitigating actions
5. WIC attendances by practice
6. Workforce modelling
7. Workforce strategy

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