Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee

Report of: Brian Hughes (Director of Commissioning, NHS Sheffield Clinical Commissioning Group (CCG)

Subject: Urgent Care Review – Update

Author of Report: Rachel Dillon, Strategic Programme Manager NHS Sheffield Clinical Commissioning Group

Summary:
The purpose of this report is to update the Committee of the findings from the most recent review of urgent care since NHS Sheffield Clinical Commissioning Group (SCCG) took the decision in September 2018 to agree that the approach and proposals to change urgent care services would be reconsidered.

The report describes the key findings of the review and the proposals to address the root causes of the problems identified in the engagement.

As a result of the review, we will be addressing the problems in urgent care by improving current services (evolution) rather than radically procuring/reconfiguring services (revolution).

This update is being provided as agreed at the Committee meeting in February 2019.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	**x**
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other	

The Scrutiny Committee is being asked to:
The Committee is asked to note the findings and approach and offer advice on how best to engage with communities to ensure that information about urgent care services is clear and accessible.

Background Papers:
Papers from OSC meeting of the 27th February 2019 and 10th October 2018

Category of Report: OPEN

Report of the Director of Commissioning, NHS Sheffield Clinical Commissioning Group
Update on the Urgent Care Review

1. Introduction/Background

1.1 Sheffield Clinical Commissioning Group (CCG) undertook a consultation between September 2017 and January 2018, seeking public input into proposals to reducing duplication and simplifying access to urgent care services; improving access to urgent care in GP practices and reducing pressure on A&E. A final report and recommendations were brought to the Primary Care Commissioning Committee in September 2018. It was agreed that the approach and proposals would be reconsidered and new proposals would be developed.

1.2 The Urgent Care Team evaluated the approach to identify lessons learnt and on reflection, highlighted a number of areas which could have been better. These included the need to gain partner buy in and understanding of the problems within urgent care, stakeholder engagement at all levels and the need to be transparent, both in process and outcomes. The lessons learnt and new approach were shared with the CCG Governing Body and presented to the Accountable Care Partnership (ACP) Board, securing agreement to provide strategic oversight through the most relevant ACP work streams.

1.3 Following, agreement, in order to develop new proposals, the Urgent Care Team invited partners and public representatives to be part of a refresh of reviewing urgent care services in the city. The objectives were to:

1.3.1 To understand why people use services, their experiences and what is important to them and what needs improvement.
1.3.2 Work in partnership with public and stakeholders to identify the key problems and issues and their root causes.
1.3.3 Be open and transparent with the public.
1.3.4 Meet our legal duties to involve including the Gunning principles.

2. Engagement – Approach and Findings

Approach

2.1 The full engagement report is at Appendix 1. Below are the highlights from the report. Learning from feedback during the urgent care consultation, it was important we were transparent, open and that stakeholders and public helped us design and lead the process. Therefore we had oversight from three key groups:

2.1.1 **Design Group –** Co-designed the approach, analysed information gathered and tested and challenged the products and processes developed by the CCG's Urgent Care Programme Team.

2.1.2 **Partner and Public Reference Group –** Members of the public and representatives from partner organisations locally and regionally offered experiences of urgent care services, offered oversight of the process and analysed themes and trends as they emerged from the outreach engagement with communities. It coproduced the definition of urgent care, the final list of problems and tested the approach, described later in this paper.

2.1.3 **Strategic Public Engagement, Equalities and Experience Committee (SPEEEC) –** A subcommittee of the CCG Governing Body which recently on behalf of the Governing Body, assured the process that had been undertaken and were assured that appropriate and proportionate engagement activity had been undertaken and the Gunning Principles had been adhered.

2.2 The engagement used a mixed approach as set out below and overall, 2,587 people contributed to this stage of the urgent care review. This is in addition to the 14,000+ contacts in 2015, 234 surveys in 2016 in waiting rooms, 289 community members from homeless, greatest deprivation, substance misuse, students, asylum and temporary living in 2017, students, 3,000 responses to the 2017-18 formal consultation and 2,106 telephone surveys in 2018.

Method in most recent engagement.	Number of respondents
Online surveys (public) @50 e-contacts to partners, councillors, community groups, practice patients groups, for dissemination to their contact groups.	1,783
Online survey (frontline staff) e-contacts to all GP practices, Pharmacies, Care Homes, all partners and @25 community organisations.	317
Outreach engagement work in communities	309
Discussions with patients in A&E, Minor Injuries Unit and the Walk-in Centre	20
Reference Group (public and staff in partner organisations)	63
Patient journeys (including targeted general practices) such as Pitsmoor, Page Hall and Porterbrook and the Healthcare Surgery.	95
Total	**2,587**

2.3 In this review, we specifically engaged with and heard from communities in Lowedges, Batemoor and Jordanthorpe, Stocksbridge and Oughtibridge, Darnall, Roma and Slovak communities, Pakistani communities, people with respiratory conditions, with physical impairments and mobility challenges, people with learning disabilities, with Autism, Mental health conditions, the Homeless community and Students. Contrary to the previous engagement

work, this phase focused on why people use services, their experiences and what is important and/or needs most improvement within urgent care.

Findings

2.4 The full engagement report is included at Appendix 1 but for ease the main points are summarised below. The key themes are:

2.4.1 There was praise for the quality of care in ALL services but
2.4.2 the vast majority of staff (69%) and patients (72%) agreed that urgent care services in Sheffield needed to IMPROVE.
2.4.3 It's a fragmented urgent care system.
2.4.4 The main problems can be themed into four areas: pathways, knowledge, culture and resources.

2.5 **Definition of Urgent Care.** A key lesson learnt from the previous consultation was to use clear and easy to understand language. The workshop attendees developed and agreed a definition of urgent care below which the majority of survey respondents agreed was a good definition.

> Urgent care means advice and treatment for illness* and injuries for all ages thought to be urgent (care needed within 24 hours) - but not life threatening.
>
> *"Illness includes mental and physical health."

2.6 **Patient Behaviour.** We wanted to gain insights into why and how patients access urgent care services. The most pertinent themes from both the survey and broader engagement was that:

2.6.1 The top reasons why people contacted the service they chose were:

- due to a previous experience;
- that they knew they would be seen there; and
- they knew it would be open.

2.6.2 Previous experience could be driven by either a positive or negative experience, but does show that patient behaviours really influence how urgent care services are used.

2.6.3 For some communities, 999 or GP was the automatic response, and some communities were unaware of the Minor Injuries Unit (MIU). This differed to the public survey as MIU was the 3rd choice of service to go to first.

2.6.4 Most people completing the survey got to the services by car, however outreach feedback told us that lack of own transport and cost of transport were barriers to using services further afield.

2.7 **People's thoughts about urgent care. What is important and what needs improvement.** In the staff and public questionnaires, we asked what was most important about urgent care services and what needed most improvement.

2.7.1 For the public, the following were both the most important and needed improving:

- being seen at my own GP practice;
- being seen on the same day;
- being seen by a healthcare professional best able to treat me.

2.7.2 For staff, it was:

- being able to provide enough same day appointments;
- having an up to date list of all services I can signpost to;
- access to services which can deal with urgent non health problems.

2.8 Same day access was the common theme for both. Respondents to both questionnaires were also asked what they would do if they were the boss of the NHS in Sheffield. Both staff and the public agreed that improving access was the top improvement they would make.

The Root Causes

2.9 All of the problems identified throughout the engagement have been themed into four root cause areas. These root causes were developed by workshop attendees and checked and revised at points when new information from the engagement was received. All of the below are related to access in some way, either entering into the service, the experience within the service, and then completion of the journey.

2.10 Overall, both staff and public have said the quality of the services is good, but that the interface between different services causes disjointed pathways and fragmentation. Each service or organisation has historically addressed these challenges in isolation, which may provide a temporary fix but these are not always sustainable. In order to make long term sustainable improvements to address these problems the system needs to work collaboratively. No single organisation can fix these.

2.11 All the symptoms/problems identified throughout all the engagement since 2015 and the most recent review have been grouped into four main root causes which have informed our current thinking.

I. **Confusing and inconsistent pathways**. Services are not integrated; there is a lack of consistent triage and signposting; patients felt they were passed from pillar to post, repeating their story; staff felt less confident in referring to mental health services and services for 16-18 year olds.

II. **Inconsistent knowledge and lack of knowledge** Staff and public highlighted not knowing what urgent care services offer and the services to refer on to. A common theme for improvement was communication and support for people with disabilities and impairments. There were diverse communities (geographical, health need, cultural) who were not aware of all the urgent care services they could access including MIU and 111.

III. **Differences with culture, behaviour, environment/health inequalities**. Tension between demand and need was raised by both public and staff. Inconsistent management of risk across services. Behaviours driven by experience rather than the right place to go to. Cultures have different expectations and people's circumstances (access to transport and communication) hinder access to the right services.

IV. **Ineffective use of resources and lack of resources**. If a service can't manage demand, it bounces into another part of a stretched system. Patients have difficulties accessing both physical and mental health services and there's a shortage of time to care. All services rely and compete for the same pool of GPs and urgent care staff.

3. The Agreed Approach to address the problems

3.1 The agreed approach was tested at the last of the Public and Partner Reference Group workshops. There are a number of factors which have had to be taken into account in developing the best approach.

3.1.1 The quality of urgent care is good in Sheffield and the approach has needed to build on this.

3.1.2 The approach has to be right for Sheffield and one which can be delivered in a changing NHS architecture in a time of uncertainty.

3.1.3 The approach has needed to take into consideration and align with the national and local developments already taking place, such as the national funding as part of the NHS England Long Term Plan to develop Primary Care Networks; part fund additional multi-skilled staff in primary care networks, more funding into community services and mental health; and other national funding Sheffield has received, e.g. to develop community mental health services. This is because these changes could potentially increase staffing and impact on patient flow.

3.1.4 The approach has needed to build on and complement the work already in place. Pathways across the system are being developed by the system partnership in urgent care, primary care, Children's urgent care and mental health services. A potential risk is that the areas are developed in isolation and exacerbate the fragmented system and won't address the root causes identified. So the approach has had to provide a real opportunity for a joined up collaborate approach across all the pathway work.

3.1.5 The approach has had to reflect that most of the NHS and care system provides some type of urgent care in Sheffield. By its nature, it includes mental health and physical health, children and adults, health and care and is sought by the public across Sheffield, day and night, in various settings, including but not limited to: GP practices, pharmacies, a range of helplines, A&Es, Minor Injuries Unit and Walk-in Centre. The root causes identified

must be addressed using a collaborative approach across the system in order to ensure sustainable long term improvements.

3.2 As a consequence, the approach agreed for how to address the root causes above is to **improve current services (evolution)** and not radically procure/reconfigure services (revolution).

3.3 No one single organisation can do this in isolation. The Accountable Care Partnership (ACP) recognises this and has agreed to lead the work going forward. It has agreed to focus on **Pathways** and **Knowledge** first.

Improve pathways because:

I. It will improve patient experience.
II. The process of development of pathways will improve system behaviours and improve knowledge.
III. It will make better use of resources.
IV. There are a number of work streams already in place.

and **Improve knowledge** because:

I. Improving accessibility to information and what is available will introduce some quick wins, improve behaviours and make better use of resources.
II. Targeted work in communities will improve access and contribute to addressing health inequalities.

4. Outcomes

4.1 In addressing the root causes, the aim is that the following outcomes will be achieved. They have been developed by the Public and Partner Reference group and will need finalising by a new Task and Finish Group (described later in the paper) with specific measures where possible. The below has to be underpinned with a focus on maintaining and if possible improve clinical outcomes.

I. Clear and consistent pathways.
II. Improved patient experience in urgent care pathways with improved knowledge and understanding of services and capacity.
III. Holistic and person centred approach every time.
IV. Contribute to addressing health inequalities by improving access to services.
V. Staff feel more confident in awareness of and capacity of services.

4.2 Primary care is a key asset of the urgent care system. This proposal aligns with the transformation happening in primary care regarding the planned GP contract investment and network developments over the next three years. There are key interdependencies and common objectives which are key to the success of both urgent care and primary care.

4.3 It should also be noted that the primary care changes could lead to significantly different patient flows. At that point it may be necessary to review the urgent care problems again and re-consider whether any major service changes are required.

5 Next Steps and Governance

5.1 The engagement report and new approach was presented to the (Accountable Care Partnership) Executive Delivery Group in August. They recognised and agreed that to make sustainable long term improvements to urgent care requires all partners to lead the work together and will take ownership of the programme going forward. There are key responsibilities for both the 'system' and the public of Sheffield to take on board if we are to genuinely improve urgent care in Sheffield. Together we need to co-design outcomes and co-produce the solutions. This is a partner and public co-produced programme and will continue to be so in the next phase.

5.2 The aims of the two work streams will be::

5.2.1 **Improve Knowledge and Information –** A task and finish group will be set up with representatives from Primary Care, hospitals, mental health and Pharmacy work streams as well as Communications and Engagement and Public Reference Group representatives. The group will focus on improving information about urgent care services and the access to the information for the public of Sheffield. This will start quickly to ensure any new social marketing aligns to the winter communications plan for urgent and emergency care. It will include targeted work in communities where we found particular gaps in knowledge through the engagement. This will also include work to support staff to signpost patients confidently to the right services.

5.2.2 **Improve Patient Pathways –** This will build on the current work already in place to improve how patients access services urgently.

6 Timeline

6.1 The timeline will start in September 2019. To achieve the outcomes consistently and sustainably, a six month check will be put in place in April 2020 to ensure that work is progressing against the outcomes with another stock check put in place in two years to test the success of the new interventions/outcomes and whether the urgent care root causes have been addressed or have changed. In detail:

September 2019 – September 2020

- Primary Care Commissioning Committee (CCG board) in September for final endorsement of the next steps and change in governance.
- ACP Task and Finish Group set up to deliver knowledge and education work streams (with public co-production).
- Develop set of outcomes and metrics which can be measured.
- Deliver set of tangible and sustainable solutions to develop knowledge and education interventions, introducing quick wins before winter.

- Identify clear easy mechanism for reporting on the inter-dependent pathways work streams related to urgent care through ACP.
- Six month review to ensure work is progressing against the outcomes. Review key pathways.

March 2021 to September 2021

- Review to test the success of the new interventions/outcomes and whether the urgent care root causes have been addressed or have changed.

7 Recommendations

7.1 The Committee is asked to note:

7.1.1 The Engagement Report and the key problems highlighted in the Engagement Report.

7.1.2 The approach to address the root causes.

7.1.3 Consider how the committee can contribute to the new Information and Knowledge work stream.

NHS Sheffield Clinical Commissioning Group

Urgent Care Engagement

Key Findings Report

August 2019

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Appendices

NHS Sheffield Clinical Commissioning Group would like to thank everyone who contributed to this report particularly members of the public, staff and those working in voluntary and community organisations such as Darnall Wellbeing, The Terminus Initiative and Mencap.

1. Executive Summary

Between December 2018 and May 2019, NHS Sheffield CCG engaged the public, partners and staff on urgent care services in the city. The engagement included an online questionnaire to gain views from the local population of Sheffield and staff in front line services, interviews and group discussions involving targeted groups (including harder to reach communities) and patients at the Walk-in Centre, A&E and in GP surgeries.

The themes in this report were developed with input from public and partner representatives via a Public and Partner Reference Group and a Design Group.

Key themes from the information gathered during this phase of the engagement

Overall

- There was praise for the quality of services, especially the quality of care in local GP practices in all the engagement methods we used.
- Transport remains an issue for communities in the areas of highest deprivation, particularly the cost of travel. Other broader transport concerns included the cost of parking, travelling whilst ill and travelling with sick children.
- When asked if respondents agreed or disagreed that urgent care services in Sheffield needed to improve, the majority of staff and patients stated they strongly or slightly agreed.

Confusing and inconsistent pathways

- People who live with mental health conditions and learning disabilities rely on services that they know and trust – their local GP or 999. There was very limited awareness of 111, the walk in centre or minor injuries unit. Staff who support people living with mental health conditions and learning disabilities are cautious when making decisions in relation to care navigation.
- Themes from staff in providers related to better pathways between services and access to diagnostics, alongside staff and patient education to raise awareness of services. Improving mental health services was also a big theme.
- Staff were significantly less confident that they knew the right service to refer onto when a patient had a mental health rather than physical health need.
- Access to GP or practice nurse appointments remains an issue, which was highlighted in the previous engagement. During the outreach engagement, the Walk-in Centre provides a highly valued alternative for people requiring quick access, out of hours or at a weekend.
- Other access issues such as waiting times and availability were also raised. When asked about one thing respondents would do, if they were the boss of the NHS in Sheffield, the most common theme from the public and staff was to improve access, including increased appointments and availability at GP practices and reduce waiting times. Staff also responded with increasing staff and workforce numbers, improving patient education and improving communications and engagement.

Inconsistent knowledge and lack of knowledge

- There is limited awareness about the availability of urgent care services and other supporting services which staff can refer too.

- There was a general lack of awareness of the Minor Injuries Unit and what could be treated there amongst all communities interviewed during the outreach work. In the patient journeys work, no one's first point of contact was the Minor Injuries Unit. However, in the survey, minor injuries unit was the third service which patients went to first. The majority of respondents to the survey were from the lesser deprived areas.
- There was a lack of knowledge by staff of appropriate places to refer onto for people living with mental health urgent care needs.

Culture and behaviour differences

- The biggest driver of people's behaviour for why they chose the urgent care services they did, was previous experience of using the service, they knew they'd be seen and knew the service would be open. This could be either a positive or negative experience which could impact on how they accessed services.
- Circumstances such as transport and cost of parking remained an issue in the more deprived communities.

Lack of and inefficient use of resource

- There is a shortage of time to care. If one service is unable to manage the demand, it bounces into another part of the system – day or night or between primary, community and secondary care.
- It means patients have difficulty accessing the right services for physical and mental health or care at the right time and staff don't get the time they want to care for their patients appropriately.
- Staff responded in the survey that increasing staff and workforce numbers would help improve urgent care services.

Definition of Urgent Care

- The vast majority of respondents agreed with the following definition of urgent care:

"Urgent care means advice and treatment for illness* and injuries for all ages thought to be urgent (care needed within 24 hours) - but not life threatening.

*Illness includes mental and physical health."

An infographic (see Appendix A) has been developed to illustrate the key findings of the Urgent Care Review 2019.

2. Background

Between 2015 and 2018, the CCG undertook engagement with the public of Sheffield about urgent care. The engagement identified a number of problems and issues with urgent care services. This included access to GP appointments, confusion about what services to use, the system not working cohesively, and barriers for some people that influenced the services they chose to use.

The engagement helped inform an urgent care strategy and a public consultation, which took place between September 2017 and January 2018. At the time, the Government introduced Urgent Treatment Centres as a policy to nationally address the same problems.

The aims of the proposals made in the public consultation were to improve urgent care services in Sheffield, by:

- Simplifying services, reducing duplication and confusion,
- Improving access to GP appointments to guarantee that everyone who needs an urgent appointment can get one within 24 hours, and mostly on the same day.

During and after the formal public consultation, concerns were raised about the proposals contained in the consultation as well as how the consultation had been undertaken. As a result, in September 2018, the CCG took the decision to explore further and refresh what the problems and issues are with urgent care with stakeholders and the public of Sheffield.

Consequently, between December 2018 and May 2019, Sheffield CCG engaged with the public and staff on urgent care services in the city.

The objectives were:

- To understand why people use services, their experiences and what is important to them and what needs most improvement
- Work in partnership with the public and stakeholders to identify the key problems and issues
- Be open and transparent with the public
- Meet our legal duties to involve including the Gunning principles.

3. Oversight

Learning from feedback during the urgent care consultation, it was important during this engagement that we were transparent, open and that wider stakeholder involvement helped us design the process. We therefore had oversight from three key groups:

1. Design Group – Co-designed the proposals and reference group workshops, analysed outputs and highlighted areas for further consideration, tested and challenged the products and processes developed by the Programme Team.

2. Reference Group – Members of the public and representatives from partner organisations locally and regionally offered their experiences of the urgent care system, offered oversight of the process, and analysed themes and trends as they emerged from the outreach engagement with communities.

3. Strategic Patient Engagement, Equalities and Experience Committee (SPEEEC) - A subcommittee of the CCG governing body who offered strategic oversight of the engagement process on behalf of governing body, ensuring that our statutory duties and moral obligations to the people of Sheffield were being met.

4. Report Structure

Included in the report are all the findings from the quantitative and qualitative engagement. The main thread of the report is a set of top line findings from the online survey which provides quick reference to all the questions asked. Any significant differences in opinion across the demographic groups are also illustrated and commented on throughout the report.

The views of people from community outreach (qualitative work) are after the survey question analysis, to complement, compare, contrast and enhance the analysis.

It should be noted that when the survey results are discussed within the report, often percentages will be rounded up or down to the nearest one per cent. Therefore occasionally figures may add up to 101% or 99%.

When considering how people have answered the questions, it is clear that words have different meanings for different individuals and communities, and therefore perception of terms will influence the answers given. This has been highlighted in the free text where appropriate.

5. Methodology

This engagement used a mixed method approach with an online questionnaire to gain views from the local population of Sheffield, interviews and group discussions involving targeted groups (including harder to reach communities and patients at the Walk-in Centre, A&E and in GP surgeries), and an online survey for staff.

6. Responses

Overall, 2,587 people have contributed to this stage of the urgent care review (including 317 staff from provider organisations.

Method	Month/Year	Number of respondents
Online surveys (public)	Feb – Mar 2019	1,783
Online survey (staff)	Mar 2019	317
Outreach engagement work in communities	Feb – Mar 2019	309
Discussions with patients in A&E and the Walk-in Centre	Mar 2019	20
Public and Partner Reference Group	Dec 2018 – Jun 2019	63
Patient journeys (including targeted general practices)	Jan – Mar 2019	95
Total		**2,587**

In terms of how reliable the results are, the quantitative data is accurate to +/-2.32% margin of error at a 95% confidence level. This means that, for example, if 70% of respondents agreed with the statement that urgent care needs to change, we could be 95% confident that if all the public in Sheffield had answered the question then between 67.68% and 72.23% would have agreed.

7. Overview Of The Engagement

7.1 Qualitative community outreach engagement

Feedback from these communities builds on previous engagement and consultation[1] from 2015 onwards.

Time-intensive qualitative research techniques were used, including in-depth semi-structured interviews, individual discussions and group interactions, to gain a richness of data to inform this review. This involved people sharing deeply personal stories and experiences as well as the impact the urgent care system had had on them. Where appropriate, examples have been matched to feedback from the online survey and additional information is highlighted in appendices.

Overall, 309 people were engaged in the outreach engagement (see Appendices B-D). 273 people lived in the Lowedges and Darnall areas of the city as these were under-represented in the previous engagement activity and are specific areas of high deprivation. Individuals with specific protected characteristics or life experience were encouraged to be involved:

- 8 people living with learning disabilities / difficulties
- 25 people living with mental health conditions
- 8 people with experience of substance misuse
- 100 people from the Pakistani community
- 20 members of the Roma Slovak community
- 8 people living with respiratory conditions

The activities included conversations with people from 12 different countries (UK, Iraq, Ireland, Hungary, Senegal, Nigeria, Bulgaria, Romania, China, Pakistan, India and Yemen).

In addition, 9 people who live with a learning disability or difficulty who access services at Mencap contributed as did 19 students at the University of Sheffield who were playing sports and therefore at risk of injury.

Qualitative feedback from these communities is included throughout the analysis alongside demographic data to illustrate how different geographical communities and those with protected characteristics are experiencing urgent care services.

In addition, 20 users of services at the Walk-in centre and adult A&E were interviewed (see Appendix E – F). This builds on previous engagement at children's A&E and in the Minor Injuries Unit in 2016.

[1] https://www.sheffieldccg.nhs.uk/get-involved/the-201718-consultation.htm

7.2 Patient Journeys

In addition to the outreach work and in order to understand what the patient journey looks like from patient perspectives, a journey map was developed for people to complete that provided information on the journey through the urgent care services in Sheffield, not about the problems and issues faced (see appendix G). The maps were tested and completed by participants at the workshop held on the 17 January 2019, and amended before being used to collect information from the places listed below. 95 journey maps were completed in total from:

- Participants at 3 x targeted engagement sessions at The Terminus Initiative
- Patients at Manor Clinic and Firth Park Clinic (community nursing services)
- Patients at The Healthcare Surgery (waiting room)
- Patients at Page Hall Medical Centre (waiting room)
- Patients at Porter Brook Medical Centre (waiting room)
- Patients at Pitsmoor Surgery (waiting room)
- Patients at University Health Service (waiting room)
- Participants at Chilypep.

7.3 Public online survey

The public online survey ran from 8 February 2019 to 29 March 2019. The following numbers of the public completed the online survey and shared demographic information in comparison to the Sheffield population. A summary table of the responses to all questions can be found in Appendix H.

To help promote the survey, over 50 emails were sent to various organisations for wider dissemination to partners, councillors, community groups, voluntary, charity and faith organisations, and the media. In addition, the CCG shared and posted various posts on Facebook and Twitter with groups identified as seldom heard in the previous engagement.

Demographic	Online survey feedback	Sheffield population
Sex	949 (72%) were female and 360 (28%) were male	This compares to 50/50 for the Sheffield population
Carers	334 (26%) were carers	10% are unpaid carers
Disability	196 (15%) lived with a disability. Asked subsequently about the type of disability: 116 (50%) live with a long-standing illness or health condition, 84 (36%) live with a physical or mobility disability, 58 (25%) live with a mental health condition and 10 (5%) live with a learning disability or difficulty	19% of the population lives with a disability or long-term condition
Race	1,201 (94%) were white British and 67 (6%) were Black, Asian, Minority Ethnic and Refugee (BAMER)	White British people 84% BAMER 16% of Sheffield's population.
Age	218 (18%) under 40 years old, 216 (18%) were between 40-50, 235 (19%) were between 50-60, 277 (23%) were between 60-70, 219 (18%) were between 70-80, 53 (4%) were 80+.	55% under 40, 13% 40-50, 12% 50-60, 9% 60-70, 6% 70 – 80 and 5% 80+

Religion or belief	36 (49%) said they were Christian, 40% had no religion, nearly 1% were Muslim and 0.5% Buddhist	53% of are Christian, 39.7% No religion 6% Muslim, 0.6% Hindu 0.4% Buddhist, 0.2% Sikh and 0.1%.Jewish
Parents	328 (25%) were parents of a child under 16	36% of households include children.
Access to technology	148 (11%) did not have access to a smart phone, 1,285 (99%) have access to the internet at home and 17(1%) do not	

7.4 Staff Survey

The staff survey was launched on the 1 March and closed on the 29 March 2019. We promoted the survey via GP practices, care homes, partners and around 25 community organisations. It was completed by the following staff:

Provider	Responses
GP practices	130
Sheffield Teaching Hospitals (inc GP Out of Hours)	67
Other	55
Sheffield Children's Hospital	24
Primary Care Sheffield	19
Walk-in Centre	13
Sheffield Health and Care Trust	6
Pharmacy	3

'Other' consisted of respondents from Sheffield City Council, Care Homes and Voluntary, Community and Faith organisations. Please refer to Appendix I for further detail about the responses.

7.5 Design Group

The Design Group was established with the following aims:

- To design the proposals
- To design workshops
- Test and challenge products developed by Programme Team.
- Review outputs from the workshops and highlight any areas for further consideration
- To review the feedback of the engagement

Membership of the Design Group was by invitation for stakeholders identified including the following:

- Patients (volunteers from the public reference group)
- Sheffield CCG
- Sheffield Teaching Hospitals NHS Foundation Trust
- Sheffield Children's Hospital NHS Foundation Trust

- Sheffield Health & Social Care NHS Foundation Trust
- Primary Care Sheffield
- One Medicare
- Sheffield City Council
- Yorkshire Ambulance Service
- Healthwatch
- GP Practices
- ScHARR (School of Health and Related Research)
- Public Health
- Local Pharmaceutical Committee
- Local Medical Committee

The group has met monthly from December 2018 to June 2019 and will continue to meet to have oversight of the process.

7.6 Public and Partner Reference Group

The Public Reference Group was established with the following aims:

- To share members' experiences of the urgent care system
- To oversee the process followed
- To analyse the outputs from public engagement and consider themes and trends

Membership of the Public Reference Group was by invitation for:

- Organisations from the Voluntary, Community and Faith sector
- Members of Patient Participation Groups representing GP surgeries across the City
- The University of Sheffield and Sheffield Hallam University
- Healthwatch Sheffield
- Save our NHS

In December 2018 we held an initial workshop with representatives from the Public Reference Group and a separate workshop with representatives from our Partner Organisations across the system, including:

- Sheffield Teaching Hospitals NHS Foundation Trust
- Sheffield Children's Hospital NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Yorkshire Ambulance Service
- Sheffield City Council
- NHS111
- Primary Care Sheffield

In January 2019 we held a joint workshop with members from the Public Reference Group and our Partner Organisations. Feedback from attendees led us to combine the groups to form a Public and Partner Reference Group.

This group met a further four times between February 2019 and June 2019, including a specific workshop to consider children's urgent care services. Please refer to Appendix J for a summary of the Public and Partner Reference Group Workshops.

8 Key findings

The public survey consisted of 22 questions – closed and free text. The results are summarised in the following sections alongside additional insight from the outreach engagement work, where appropriate. A summary table for each response can be found in Appendix H.

The staff survey consisted of 16 questions.

8.1 Definition of urgent care

As part of reference groups and stakeholder engagement, a draft definition of urgent care. was developed:

"Urgent care means advice and treatment for illness* and injuries for all ages thought to be urgent (care needed within 24 hours) - but not life threatening.
*Illness includes mental and physical health."

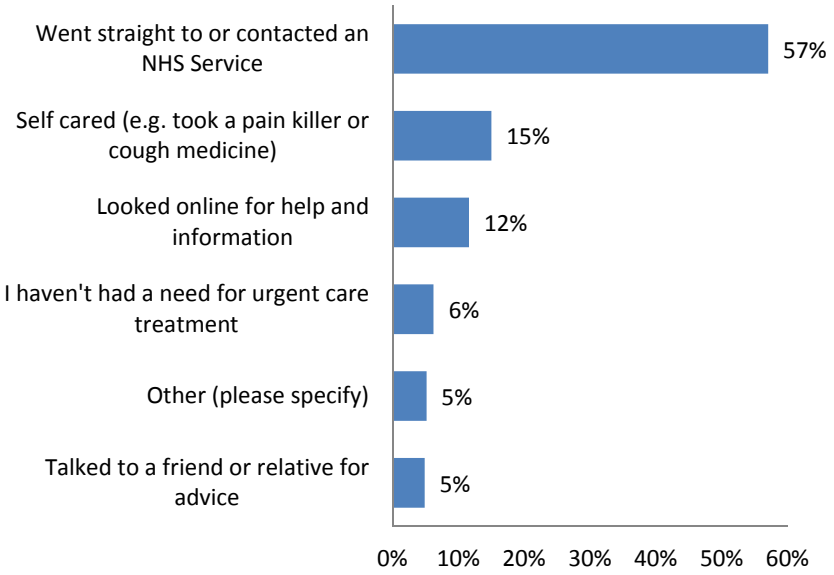
In the survey, we asked people if they agreed with the definition. The vast majority (94%) of people agreed. Of the 6% who did not agree, respondents offered alternative suggestions summarised in the quotes below:

> *"Urgent may not be doctors definition but patient may feel it is"*
>
> *"I think urgent could be interpreted or understood by some as emergency."*
>
> *"Urgent care = life threatening."*
>
> *"I would change this to "urgent care means advice and treatment for illness* and injuries for all ages thought to be urgent (care needed within 24 hours) - including illnesses that need to be treated within 24h so they don't become life threatening"*
>
> *"If it is urgent surely 24 hours is too long."*
>
> *"Within a few hours - up to 6."*
>
> *"Instead of urgent care it should be renamed urgent treatment. Care is confusing for a lot of people due to care is used in care homes, care which is used for personal care and finances."*
>
> *"If it were called "non-emergency urgent care" I think people would understand the distinction better. Most members of the lay public will not naturally draw a distinction between "urgent" and "emergency."*

8.2 Services people accessed and why

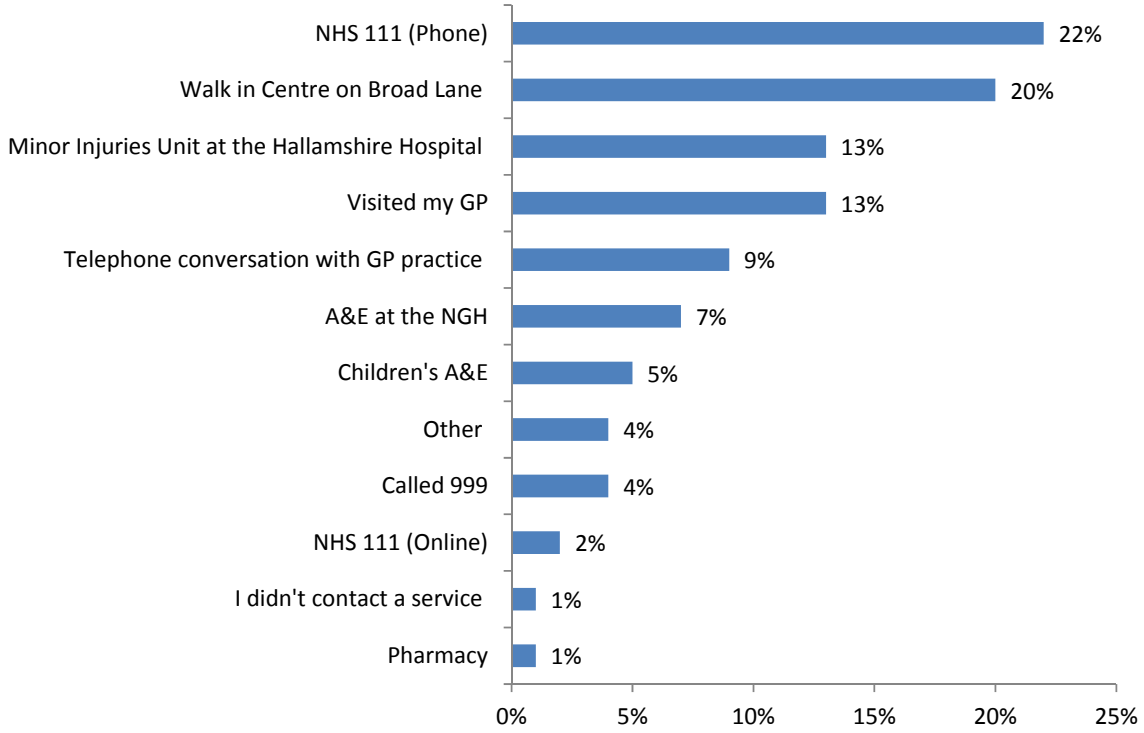
94% of respondents to the public survey had used urgent care services. Thinking about the last time, 54% used the service for themselves, 16% for a child, 9% for an adult they cared for, and 21% for an adult.

Thinking about the last time you had an urgent healthcare need for you or someone you care for, what did you do first?



- Overall, the majority of people (57%) contacted or went straight to an NHS service initially for their urgent care need.
- Males were proportionately more likely to go straight to an NHS service rather than look online or self-care in comparison to females.
- It would appear that people in the most affluent areas of the city are more likely to go to NHS services initially than those in the most deprived areas.
- Parents of children under 16 are more likely than average to look online than go straight to an NHS service.
- People from Black, Asian, Minority Ethnic and Refugee groups are no more or less likely than average to go straight to an NHS service.
- People who live with a disability are more likely to go straight to an NHS service.

Which NHS service did you contact first for advice?



- The biggest proportion of respondents' first contact with an NHS service was NHS 111 (23%), with 22% phoning and a further 2% going online. This is followed by 22% of people who visited or phoned their GP practice. 2 in 5 people went to the Walk-in Centre (20%) and 13% of people visited the Minor Injuries Unit (MIU) and 13% A&E – 7% Adults and 5% Children's.
- Carers are more likely than average to contact the GP or Walk-in Centre first
- Parents of a child under 16 were more likely to contact Children's A&E first, followed by NHS 111.
- When seeking advice for themselves, females are more likely to contact their GP first and males are more likely visit the Walk-in Centre initially.
- People living in the most deprived areas of the city are least likely to visit the Minor Injuries Unit.

Community engagement findings (see Appendices D-G)

Based on the outreach engagement with the learning disabilities community at Mencap, it emerged that 999 was the automatic response to minor injury and non-emergency conditions or for carers who often have intellectual disabilities themselves – a direct quote was:

"I need help. I'm not well. I need an ambulance."

Based on the outreach work in Darnall, young Pakistani males (under 40) who identified themselves as suffering from anxiety and depression spoke about ongoing difficulties obtaining appointments and this has resulted in frequent use of the Walk-in Centre.

"I was told that I had to wait a week and I knew that I would get worse if I waited that long"

In both the Lowedges and Darnall communities, the majority of feedback indicated that most people are unaware of the existence of the Minor Injuries Unit and there were suggestions that publicising this service could be helpful. When asked if they would consider using the Minor Injuries Unit in future, for example sprains or burns, there was confusion about which service to use

"How do I know where to go – Walk-in Centre or Minor Injuries Unit?"

This is in contrast to the survey findings, most people said their driver for choosing a service was whichever service was nearer to where they lived.

The majority of people in the Lowedges community who live with learning disabilities and enduring mental health needs either did not know about 111, the Walk-in Centre or Minor Injuries Unit for out-of-hours non-urgent care, or knew and did not wish to use the services, preferring to see their GP at the next available opportunity or use the emergency 999 service.

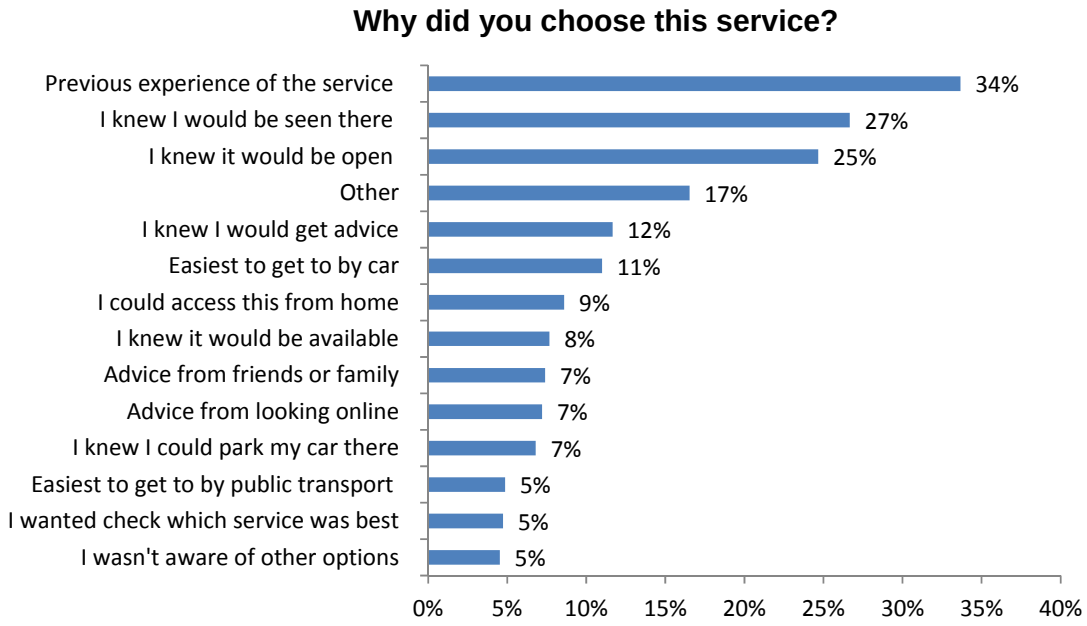
A common theme from the Roma Slovak families was the common clinical practice in their home countries to prescribe antibiotics much more frequently than would be considered appropriate in the UK. This seems to result in patients choosing to attend A&E where there is the expectation of seeing a doctor on the same day as the presenting need, and an expectation that certain medications are more likely to be prescribed.

"UK doctors are not as good as they are (back home), they don't care, and they don't give me and my son the medicines we know we need."

There was confusion regarding where patients should be signposted for urgent dental care, with several patients being told by staff at Walk-in Centre that Charles Clifford does not carry out urgent dental care and being referred back to their GP.

In the engagement carried out in 2015, a key theme was that people said they would go to a pharmacy first, particularly those from the Traveller community. In the most recent engagement activity, only a few people mentioned using their pharmacy.

Based on the information from the patient journey maps, no-one mentioned using the Minor Injuries Unit as the first point of access. A few patients mentioned using the GP hubs. Similarly to the survey, few people mentioned self-care and only one person mentioned using their pharmacy.



- Asked why they chose that service, the biggest driver of people's behaviour was due to a previous experience (34%), followed by they knew they'd be seen there (27%) and said they knew it would be open (25%).
- The fourth most popular answer was "other". Here people said that they had been referred by another professional, it was the easiest service to get too or it was at the weekend.
- In the qualitative responses within the online survey from people who had used A&E, key themes from respondents were that they felt it was the most appropriate service for their need or that they were told to attend by another professional.
- The themes relating to why 999 were called included being encouraged to do so by another professional and feeling that the situation was serious enough to warrant an ambulance.
- In relation to Children's A&E, parents chose that service because they trusted the competence, skill and service available at that site.
- Reasons given for utilising the Minor Injuries Unit included ease of access on foot, that it is the nearest service and that it was the most appropriate service based on the urgent care need. People stated they knew they would get the advice they needed as the primary reason for contacting their GP or NHS111. Other reasons given for contacting NHS111 included previous personal experience of the service, they knew it would be available or they could access it from home.

Community engagement findings

The majority of people in the Lowedges community were concerned about transport costs to the Walk-in Centre and this concern had stopped patients attending. Other comments included concerns regarding the difficulties of travelling whilst ill, travelling with sick children, and the cost of nearby parking.

Students who were aware of the Minor Injuries Unit preferred to attend this service rather than the walk in centre due to its geographical location and the experience of shorter wait

times. Students said that at freshers' induction sessions the Minor Injuries Unit is not referenced and this seems to be reflected in the low levels of awareness of this service.

As mentioned previously, the Roma Slovak population shared that they were more likely to attend A&E rather than their GP due to the expectations of the service they would receive.

Feedback from the focus group at Mencap of people with learning disabilities and their carers was that none of the members had heard of NHS111 but all members present had heard of the walk in centre and 8 members had heard of Minor Injuries Unit.

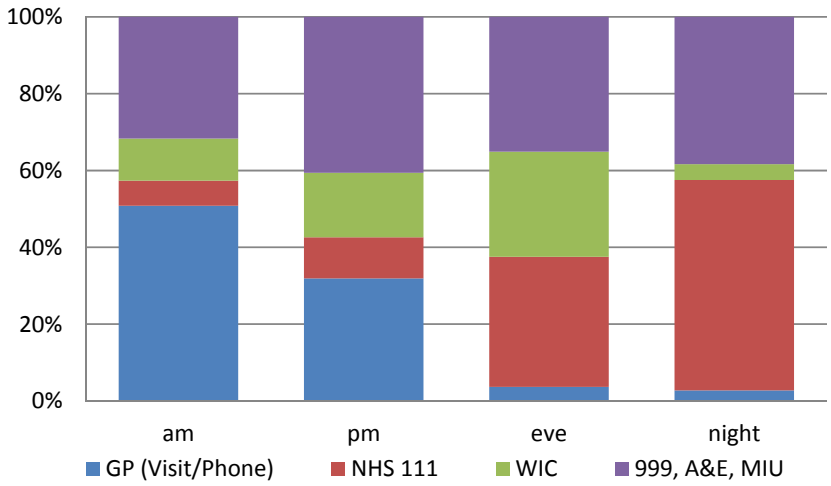
Based on the outreach work in Lowedges, the majority of usage of Walk-in Centre was prompted by local surgeries being closed at weekends and bank holidays. In the Pakistani community, most of the visits to the Walk-in Centre and A&E were prompted because the patient could not obtain an appointment with a GP during opening hours.

Although the sample size from the waiting room at the walk in centre was small, everyone shared that they weren't able to get an appointment with their GP.

8.3 Timings of people accessing services

- Nearly two-thirds of people (64%) used the services on a weekday: 26% in the morning, 21% afternoon and 17% in the evening.
- 32% of people used services at the weekend or bank holiday, with the biggest proportion of this group having used a service between 8am and 12pm (12%).
- People using their GP first is highest in the morning, declining sharply over the day
- Use of NHS111 and the walk in centre increases in the afternoon and evening
- Minor Injuries Unit use declines in the evening as it closes at 8pm.

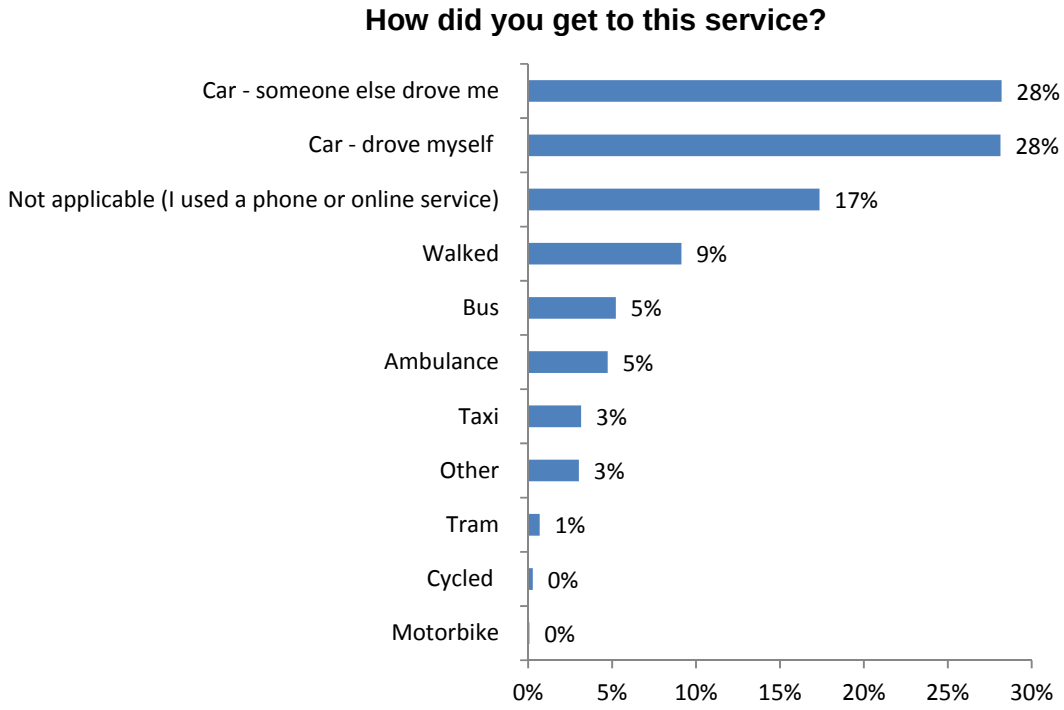
Proportion of people using services by time of day



- The proportion of people responding that they first used 999, A&E and Minor Injuries Unit is consistent at around 35-40% throughout the day.
- The focus of activity mainly switches between GP, NHS111 and the Walk-in Centre

- 50% of respondents using a service in the morning used their GP first. This drops to 32% in the afternoon and 4% in the evening.
- Only 7% of those using a service in the morning used NHS111 first, rising to 34% in the evening and 55% at night.
- 11% reported using the Walk-in Centre first on a weekday morning

8.4 How people travelled to services



- The majority of people (56%) travelled to the service by car. 17% of people didn't travel as it was a telephone or online service. Just 1 in 10 people (9%) walked and 6% got public transport.
- People living in the more affluent areas were most likely to travel by car (55%). Those people living in areas of high deprivation were more likely than average to travel by bus (7%) and least commonly by ambulance (4%).
- When asked if respondents experienced any difficulties getting to services, 87% of respondents answered no. Respondents comments included:

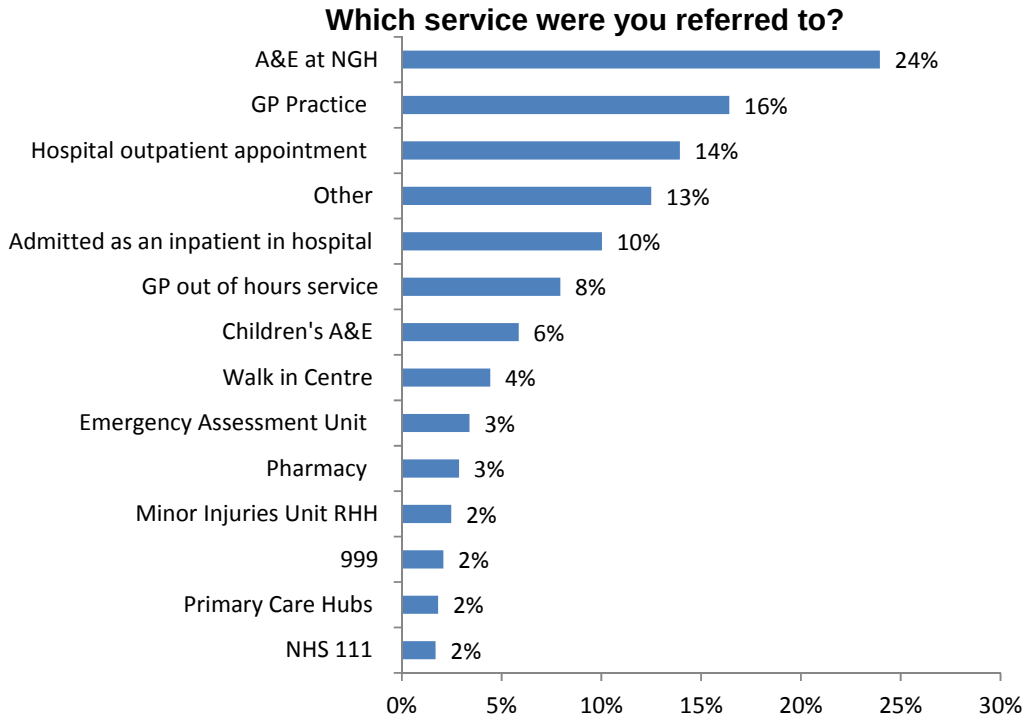
"Had to get a taxi to other side of Sheffield NGH and then a taxi back to children's hospital"

"Car parking at NGH horrendous. Unable to catch bus due to long walk up path to get to hospital"

Actually as no problem with parking given a Sunday morning. However, any other time the car parking would be a nightmare. A multi-storey car park is badly needed at NGH. Also a better bus service, or better still a tram out to NGH!

"Chose Chesterfield hospital as much quicker and easier to access from where I live in the south west of Sheffield"

8.5 Referrals to other services



- Of those who were referred elsewhere, 30% were referred to A&E - 24% A&E at NGH and 6% to children's A&E. 29% were referred to primary care - 16% to their GP practice, 8% GP out of hours, 3% pharmacy, and 2% primary care hubs.
- A small number were referred to Walk-in Centre (4%) and Minor Injuries Unit (2%).
- Of the 13% who said 'other', they were referred for further diagnostics tests, or for specialist treatments.
- After using or contacting their first service the majority of people who filled in the survey (55%) were referred to another service by a healthcare professional or service.
- 31% of those referred had initially made contact with NHS111. This would be expected, however it is interesting to note that a high proportion 53% of those referred to a second service were from services such as Minor Injuries, Walk-in Centre, both A&Es, 999 and GP practices. The reasons behind this need exploring further but could be indicative of problems in pathways and signposting and behaviours which have been highlighted in the patient journeys, workshops and survey results.
- Over a quarter were referred to hospital, 14% as an outpatient, 10% as an inpatient, and 3% to emergency assessment unit.
- The vast majority (96%) went to the service they were referred to.
- Of the patients who were referred to A&E (children and adult) said they were referred by NHS111 (41%), GP (22%) and the Walk-in Centre (16%). GP surgery referrals were via the Walk-in centre (30%) and NHS111 (29%).

8.6 Patient experiences of using services

Thinking about the last time you needed an urgent care appointment with your GP or another healthcare professional in your practice, were you able to get one within 24 hours?

- More than 50% of respondents were able to access an urgent appointment (within 24 hours) at their GP surgery, or with another healthcare professional, last time they requested one. 11% of people couldn't remember or it wasn't applicable in their situation and 33% of respondents were not able to access an appointment when they perceived they needed one.

Based on the respondents' experience of using the services, and referral from one service to another, comments included:

"It was helpful to get advice and signposted to see medical attention."

"The ambulance people were ok but I didn't see them again. And the information I communicated to them was not read up by subsequent doctors and nurses whom I came into contact with so I had to go through the story several times. This was frustrating, confusing and tiresome because I am autistic therefore communication is very difficult for me."

"They were very good but working through the required script ended up saying I needed an ambulance. I refused as I was able to get there myself and was quite local. I was trying to save the NHS money. Now I know what I know I should have accepted as I then needed further NHS "drains" by me utilising 4 GPs, 1 radiographer, 3 hospital visits, a nurse, 2 pharmacists, 2 GP collaborative visits etc. I feel had I have started in the "system" I would have been far less time, trouble and cost to the NHS."

"Absolutely wonderful as always, NHS at its best."

"They were unable to help me - agreed with my diagnosis but could not provide the cream my daughter needed without a GP confirming it so I called the GP and couldn't get an appointment so I then call 111 who then told me to go to the walk

in centre who confirmed the diagnosis which myself and the pharmacist had agreed 3 hours previously and prescribed the cream that the pharmacist had recommended and I went back the pharmacy to collect it. All of this for a 4 year old with impetigo!"

8.7 Public and staff urgent care priorities

Public's urgent care priorities

We asked the public to pick up to five areas of urgent care (from a list of 20) that were most important and up to five that were most in need of improvement.

The most important were:

1. Being seen by a healthcare professional best able to treat them (53%).
2. Being seen on the same day (51%)
3. Being seen at my own GP practice (44%)
4. Being able to walk in for an appointment (31%)
5. Being able to book in for an appointment (30%).

The most need of improvement included a slightly different list to those most important:

1. Being seen at my own GP practice (40%)
2. Being seen on the same day (37%)
3. Being able to book in for an appointment (30%)
4. Being able to see my own GP on the same day (30%)
5. Being seen by a healthcare professional best able to treat me (27%)

The graph overleaf shows the correlation between most important against most in need of improvement.

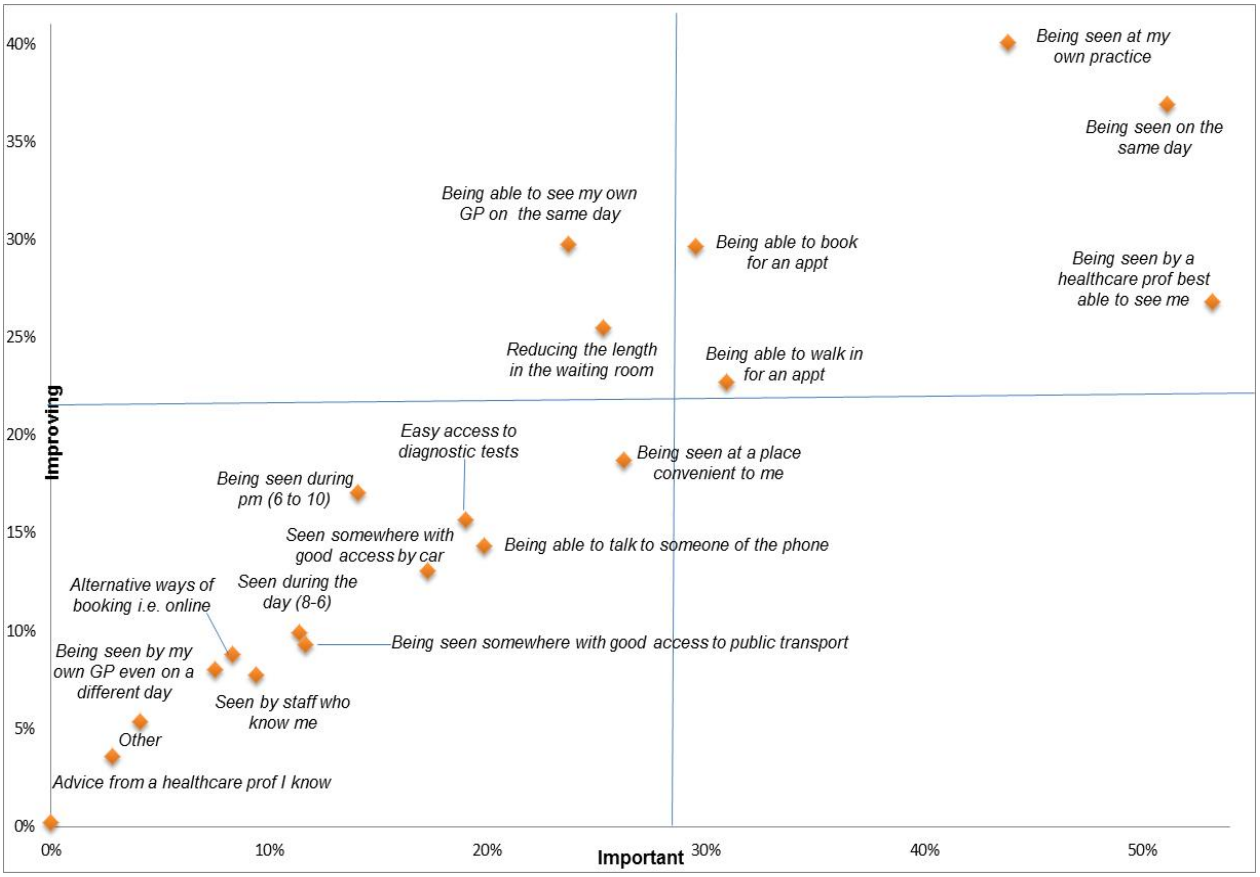
Those in the top right-hand box are those that are classified as the most important and most need improving. These are:

1. Being seen at my own GP practice
2. Being seen on the same day
3. Being seen by a healthcare professional best able to treat me
4. Being able to walk in for an appointment
5. Being able to book in for an appointment

Public's urgent care priorities

Less important but needs improvement

Important and needs improving



Less important and less in need of improvement

Important and less in need of improvement

Although numbers were small and not statistically significant, responses from different demographic groups were as follows:

- Disabled respondents selected 'seeing own GP/someone who knows me' slightly more frequently than the average (20% compared to average of 19%)
- People from Black, Asian, Minority Ethnic and Refugee groups are more likely than average to select 'seeing own GP/someone who knows me' (24% compared to average of 22%) and less likely to select 'being seen on the same day' (19% compared to 21%)
- Respondents from postcodes S10/S11 were more likely than average to select convenience to get to (16% of responses compared to average of 14%) and slightly less likely to select 'seeing own GP/someone who knows me' (18% compared to 19%)

Staff's urgent care priorities

We asked staff to pick up to five areas of urgent care (from a list of 20 that were slightly different to the public list) that were most important and up to five that were most in need of improvement:

The most important were:

1. Being able to provide enough same day appointments (50%).
2. Having an up to date list of all the services I can signpost/refer to (47%)
3. Gaining the trust of the patient, I am providing advice or treatment to (41%)
4. Putting clinical triage in place (41%)
5. Being able to electronically talk to other computer systems across services and organisations (37%).

The most need of improvement was a slightly different list to those most important:

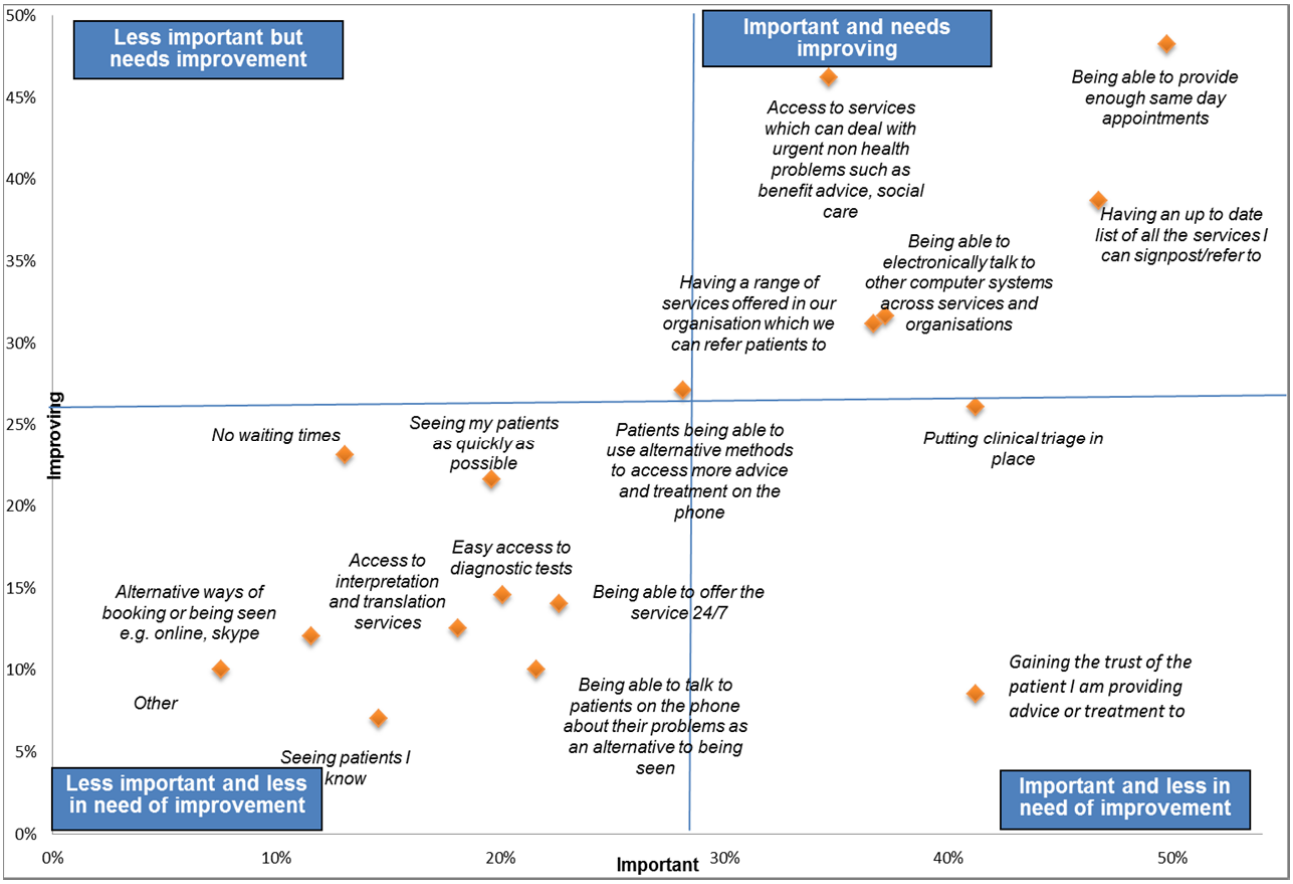
1. Being able to provide enough same day appointments (48%)
2. Access to services that can deal with urgent non-health problems such as benefit advice, social care (46%)
3. Having an up to date list of all services I can signpost/refer to (39%)
4. Being able to electronically talk to other computer systems across services and organisations (32%)
5. Having a range of services offered in our organisation which we can refer patients to (31%)

The graph overleaf shows the correlation between most important against most in need of improvement.

Those in the top right-hand box are those that are classified as most important and need most improving. These are:

1. Being able to provide enough same day appointments
2. Having an up to date list of all services I can signpost/refer to
3. Access to services which can deal with urgent non health problems such as benefit advice, social care
4. Being able to electronically talk to other computer systems across services and organisations.

Staff's urgent care priorities.



One thing people would improve

We asked people if they were the boss of the NHS in Sheffield, what one thing they would do to improve their experience of urgent care services in the city

There was a diverse range of responses from patients to this question, but the top six themes were:

1. Improve access (18%);
2. Don't close services / retain services (13%);
3. Increase number of locations / services (13%);
4. More staff / workforce (11%);
5. Improve patient education (6%);
6. Better triage (5%).

The public shared the following comments:

> *"Make it less confusing to access, and easier to navigate (or be navigated) round the system to get seen by the right person quickly. I drove past the children's hospital to get to GP Collab at NGH (as told by NHS 111), only to be told by the GP to go back to SCH."*

> *"Employ more staff. Do not shut down Walk-in Centres. Make access easy for all."*

"Increase awareness that you can get an out of hours GP appointment from 111. Maybe increase the number of locations that run it."

"Easier access to urgent healthcare in the outskirts of Sheffield, especially where public transport is lacking."

Based on all the feedback received in response to this question, the following words were used (the more prominent the word, the greater the frequency of use):

Public

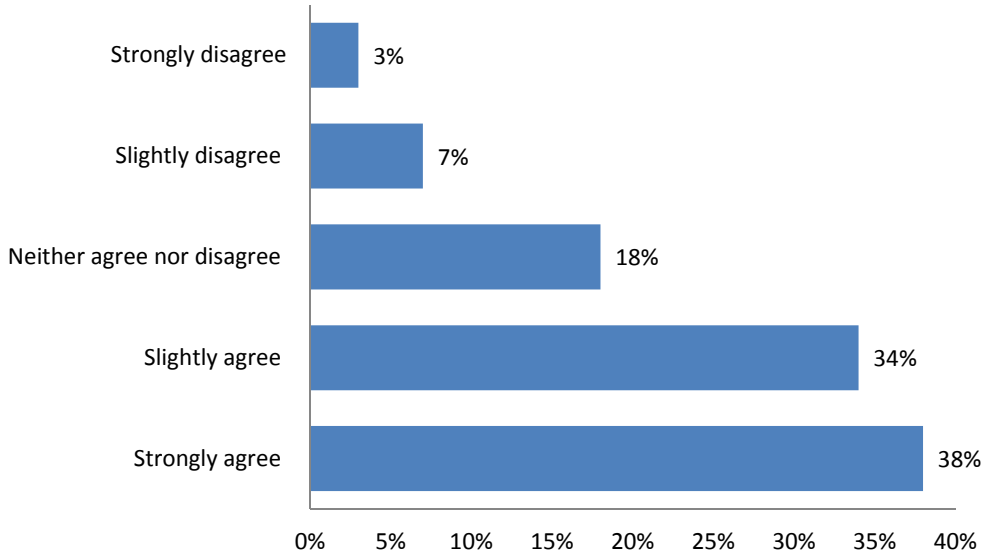
Staff

The top four themes from a staff perspective were:

Theme	Instances
Better pathways between services/ access to diagnostics	77
Improve Patient Education	69
Improve Staff Education	69
Improve Mental Health Services	68

8.8 Need for change

How much do you agree or disagree that urgent care services in Sheffield need to improve?



- Overall, 72% of people who completed the question, strongly (38%) or slightly (34%) agreed that urgent care services in Sheffield needed to improve, 1 in 10 (10%) of people disagreed. This is a net agreement of +62%.
- Older people are more likely than younger people to perceive that urgent care services require improvement
- People who live with a disability are more likely to think that services need to change - 49% strongly agreed that urgent care services need to be improved and 27% slightly agreed.
- From carers who contributed to the survey, 77% strongly or slightly agreed that urgent care services need to be improved and 67% for parents of a child.
- Of those working in urgent care services, 69% of respondents strongly or slightly agreed that services need to change.

9. Overview of similarities and differences from views gained previously in relation to urgent care

Engagement on urgent care started in 2015. A table showing the key themes from all the engagement and consultation undertaken is below.

From May to August 2015[1], the CCG talked to patients and the public using a variety of methods, estimating over 14,000 contacts with individuals and groups specifically relating to the urgent care services review.

Healthwatch Sheffield then carried out surveys in late 2015 and early 2016 at A&E, Children's A&E, Minor Injuries Unit and the Walk-in Centre. The information gathered provided a snapshot of the behaviours of people using these services at a particular date and time.

Pre-consultation engagement activity was undertaken in March 2017[2], with 289 community members from the following six groups, some of whom were considered 'seldom heard':

- Homeless people
- Substance misuse community
- Communities with greatest deprivation
- City workers
- Students
- Vulnerable people

Sheffield CCG then ran a formal public consultation between 26 September 2017 and 31 January 2018 on proposals to redesign urgent primary care within Sheffield. The consultation was then extended by a further 6 weeks. This engagement was in relation to the specific proposals in the consultation document. Then in September 2018, the CCG took the decision to explore further and refresh what the problems and issues are with urgent care with stakeholders and the public of Sheffield. This resulted in the urgent care review from December 2018 to May 2019.

In summary, over the last 4 years, NHS Sheffield CCG has used a variety of methodologies and a range of questions and has approached diverse range of communities. The analyses in the table below shows that themes that have emerged from all the engagement work conducted over this time have been very similar, which allows us to be assured that the views we have collected are a representative sample of the views of the people of Sheffield. There have been consistent themes across all engagement reports, particularly around access to the right service, first time, concerns about public transport and the cost and patients passed from pillar to post.

1 Urgent Care Survey, Healthwatch Sheffield, NHS Sheffield CCG, March 2016

2 Public Engagement with Specific Groups, Summary Report, NHS Sheffield CCG, March 2017

Themes identified from all the engagement activity mentioned above can be seen in the table below:

Summer 2015	Surveys 2015/16	Pre-consultation March 17	Consultation Activity 2017/18	Urgent Care Review 2019
• Access to GP appointments • Confusion about what services to use • System not working cohesively • Mixed view of staff attitude and communication • Differing experiences and knowledge of services – electronic access • Alternative services available closer to home • Discharge failures • Lacking a holistic approach for physical and mental health needs • People use the services they are familiar with and close to home	• Most people had chosen to access the Walk-in Centre because they were unable to make an appointment with the GP • Shorter waiting times and more information about how long they will have to wait • Most people had chosen to access A&E and Children's A&E because they felt that was the service that they needed. • People were mostly looking for medical advice • Most people who had tried to access another service before A&E had called NHS111 and been told to go there • If the service people were accessing wasn't there: - A&E said they would go to WIC - Children's A&E said they would go to the WIC - MIU said they would wait to see own GP - WIC said they would go to A&E • Only 4.6% of respondents stated they were not	• Recognising that phones give lots of people access but the cost and access to phones can be a barrier • Issues around support and after care for vulnerable patients • For homeless, substance misuse and communities of greatest deprivation, visits are higher in A&E than the Walk-in Centre, with some very high frequent attenders • 9 people = 164 attendances at A&E • Lack of specialist support to people with experience of substance misuse and revolving door • Temporary registration creates barriers and impacts on health inequalities • People with low literacy or English as second language find it difficult navigating the system • Service they had used most was pharmacy	CONSULTATION REPORT • Current access to GP appointments meant that urgent care access was not seen as a viable alternative. • Concerns about the proposals around achievability of neighbourhoods/primary care • Local care in the community close to home • Concerns around widening health inequalities and accessibility of NGH site, including transport, and after care for vulnerable patients.(contrary to high use of A&E) • Need for services to remain in the city centre • Lack of knowledge about where and when to access urgent primary care. TELEPHONE SURVEY Feb 2018 • Care in local community • Speed of being seen important – particularly for younger people • Convenient appointments important – but different for times of day depending on age • NGH site a concern as less accessible (e.g. distance, poor transport links, parking) • Public transport a concern	The findings of this review have been described in detail throughout this report. The overall themes that have been identified are: • Confusing and Inconsistent Pathways - Parity between referral and services available for people with mental health rather than physical health conditions - Speed of access important for some communities • Inconsistent knowledge and lack of knowledge - Confidence level of staff in support roles to refer - Staff – training, numbers, signposting etc • Culture and Behaviour Issues, including: - Travel using public transport – particularly cost and travelling whilst poorly - Reliance on services

Summer 2015	Surveys 2015/16	Pre-consultation March 17	Consultation Activity 2017/18	Urgent Care Review 2019
	registered with a GP	• People use services that they know and trust rather than unfamiliar environments • Choice of using a service is based on previous experience and trust	• Loss of city centre services and concern (both MIU & WIC • Need more awareness of what services to use – improve working conditions and capacity of the NHS TELEPHONE SURVEY – Selected Postcodes • Care local to home preferred • Speed of getting an appointment important, particularly to males and younger people • Older people and those living with a disability are more likely to want appointments closer to home in the daytime • Accessibility of NGH site, (distance, poor transport links, parking) • Concern about closure of WIC and MIU • Need more awareness of what services to use	people know and trust • Lack of and inefficient use of resource - Access to GPs including waiting times and availability There was a strong sense that “something needs to change”

Common themes across all engagement

- Confusion about what services to use, the recent review suggested this included patients and staff not knowing where to refer to
- Public transport a concern
- Care local to home preferred
- Access and speed of getting an appointment important
- People who are older and those who live with a disability are more likely to want appointments closer to home in the daytime
- Accessibility of NGH site, with concerns about distance, poor transport links and issues with parking. There was also feedback about lack of accessibility around the site, particularly for vulnerable, infirm and older people.
- Concern about closure of WIC and MIU (consultation onwards)

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