Urgent Care Strategy
Outline Business Case
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## Glossary

<p>| <strong>5YFV</strong> | Five Year Forward View was published in October 2014 and sets out a new shared vision for the future of the NHS based around the new models of care |
| <strong>A&amp;E</strong> | Accident and Emergency - departments (also known as Emergency Department or casualty) deals with life-threatening emergencies |
| <strong>Acute footprint</strong> | The acute footprint refers to the physical location of services and covers the main CHS site at Kayall Road and the Pallion Primary Care Centre. |
| <strong>AEC</strong> | Ambulatory Emergency Care is a way of managing a significant proportion of emergency patients on the same day without admission to a hospital bed. |
| <strong>ATB Vanguard</strong> | All Together Better Sunderland Vanguard - a programme designed to bring a wide range of specialist care providers together to explore how best to work together as one team and improve services for local people in line with the NHS Five Year Forward View |
| <strong>BME</strong> | Black and minority ethnic. |
| <strong>CIT</strong> | Community Integrated Teams - provide effective, high quality and co-ordinated care to people with the most complex needs in their own home, keeping them as independent as possible and out of hospital if they don’t need to be there |
| <strong>CCG</strong> | Clinical Commissioning Group. Clinical Commissioning Groups are groups of GPs responsible for designing local health services in England. CCGs do this by commissioning or buying health and health care services: Clinical Commissioning Groups work with patients and healthcare professionals and in partnership with local communities and local authorities. All GP practices have to belong to a Clinical Commissioning Group |
| <strong>Community Pharmacies</strong> | Community pharmacists were known in the past as chemists. Community pharmacies are situated in high street locations, in neighbourhood centres, in supermarkets and in the heart of the communities. There are several different types and sizes of community pharmacies, ranging from the large chains with shops on every high street, to small individually owned pharmacies in small communities. Community pharmacists have been developing clinical services in addition to the traditional dispensing role to allow better integration and team working with the rest of the NHS |
| <strong>DDES CCG</strong> | Durham Dales, Easington and Sedgefield Clinical Commissioning Group |
| <strong>Emergency Care</strong> | Care for life threatening injuries or illnesses |</p>
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>Emergency Department, another name for Accident and Emergency (as above)</td>
</tr>
<tr>
<td>ED Interface</td>
<td>The ED Interface is currently in development and involves community services, including the GP OOHs, working into ED to assess and turn around patients presenting to ED who do not need a hospital admission.</td>
</tr>
<tr>
<td>Equality Impact Assessment</td>
<td>Equality Impact Assessment (EIA) is a tool for identifying the potential impact of policies, services and functions on patients and staff</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GP OOHs</td>
<td>General Practice Out of Hours service designed to provide medical help or advice during the out-of-ours period, i.e. 18.30 to 08.00 on weekdays and all day at weekends and on bank holidays</td>
</tr>
<tr>
<td>Joint Strategic Needs Assessment (JSNA)</td>
<td>Looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area</td>
</tr>
<tr>
<td>IUC</td>
<td>Integrated Urgent Care - a shift in care to a 24/7 functionally integrated assessment, advice and e-prescribing consult &amp; complete service</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Conditions - these are conditions which require long term management outside hospital such as diabetes or chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>MCP</td>
<td>Multi-speciality Community Provider - general practices in collaboration with other health and social care professionals provide integrated services outside of hospital</td>
</tr>
<tr>
<td>MIG</td>
<td>Medical Interoperability Gateway – a computer system that enables the sharing of specified datasets of patient information between healthcare providers</td>
</tr>
<tr>
<td>NEAS</td>
<td>North East Ambulance Service – provides emergency ambulance and patient transport services in the NE of England</td>
</tr>
<tr>
<td>NECS</td>
<td>North of England Commissioning Support Unit NECS works across the UK to support health and social care customers in meeting strategic and operational challenges, to improve outcomes and increase efficiency</td>
</tr>
<tr>
<td>NE UECV</td>
<td>North East Urgent and Emergency Care Vanguard aim is to reduce unwarranted variation and improve the quality, safety and equity of urgent and emergency care provision by bringing together Local A&amp;E Delivery Boards and stakeholders to transform the system</td>
</tr>
<tr>
<td>NHS 111</td>
<td>The free number to call when people have an urgent healthcare need. It directs people to the right local service, first time. It is available across the whole of England making it easier for people to access urgent healthcare services when they need medical help fast. It is available 24 hours a day, 365 days a year</td>
</tr>
<tr>
<td>NHS England</td>
<td>NHS England is an independent body, at arm’s length to the government. Its main role is to improve health outcomes for people in England. It provides national leadership for improving outcomes and driving up the quality of care; oversees CCGs and allocates CCG resources</td>
</tr>
<tr>
<td><strong>NTW</strong></td>
<td>Northumberland, Tyne and Wear NHS Foundation Trust - provides mental health and learning disability services and support across North East England</td>
</tr>
<tr>
<td><strong>PAM</strong></td>
<td>Patient Activation Measure - is a validated, commercially licenced tool which helps to measure the spectrum of skills, knowledge and confidence in patients and captures the extent to which people feel engaged and confident in taking care of their condition</td>
</tr>
<tr>
<td><strong>PMS</strong></td>
<td>Personal Medical Services - locally agreed contracts between NHS. England and a GP practice. PMS contracts offer local flexibility compared to the nationally negotiated General Medical Services (GMS) contracts by offering variation in the range of services which may be provided by the practice.</td>
</tr>
<tr>
<td><strong>Recovery at Home Service</strong></td>
<td>The service operates 24 hours a day, seven days a week, ready to respond quickly to provide support during times of illness or if someone experiences an unexpected change in their condition that could develop into a crisis</td>
</tr>
<tr>
<td><strong>SCCG</strong></td>
<td>Sunderland Clinical Commissioning Group - the statutory health body responsible for the commissioning of health and healthcare services to meet the needs of the local Sunderland community.</td>
</tr>
<tr>
<td><strong>SEAS</strong></td>
<td>Sunderland Extended Access Service - a service which provides additional general practice appointments delivered outside of core general practice opening times</td>
</tr>
<tr>
<td><strong>STFT</strong></td>
<td>South Tyneside NHS Foundation Trust - provides services in hospital, in the community and in patients' homes across Gateshead, South Tyneside and Sunderland</td>
</tr>
<tr>
<td><strong>Sunderland GP Alliance</strong></td>
<td>Sunderland General Practice Alliance - formed in June 2014 to develop a model of collaborative work at scale across general practice in Sunderland</td>
</tr>
<tr>
<td><strong>Summary Care Record</strong></td>
<td>An electronic summary of key clinical information (including medicines, allergies and adverse reactions) about a patient, sourced from the GP record.</td>
</tr>
<tr>
<td><strong>UC</strong></td>
<td>Urgent Care - the range of health services available to people who need urgent advice, diagnosis and treatment quickly and unexpectedly for needs that are not considered life threatening.</td>
</tr>
<tr>
<td><strong>UCC</strong></td>
<td>Urgent Care Centre – Urgent Care Centres primarily treat injuries or illnesses requiring same day care which are not life threatening</td>
</tr>
<tr>
<td><strong>UEC</strong></td>
<td>Urgent and Emergency Care.</td>
</tr>
<tr>
<td><strong>Vanguard</strong></td>
<td>A programme of work which leads the way in the development of new service models.</td>
</tr>
<tr>
<td><strong>Vocare</strong></td>
<td>A local provider of Out-of-Hours GP and Urgency Care Centre services to the NHS in England</td>
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</table>
1. Executive Summary

1.1 Introduction
This outline business case sets out
- the context for reforming Urgent Care (UC) services in Sunderland
- the engagement work undertaken to arrive at the scenarios for public consultation
- the activity and financial modelling undertaken to inform the development of scenarios
- the two scenarios SCCG is proposing to take out to public consultation
- the timeline for this programme of work.

NHS Sunderland Clinical Commissioning Group (SCCG) is responsible for commissioning health and healthcare services for approximately 284,000 local people. This UC strategy outline business case supports the SCCG’s vision of Better Health for Sunderland; aiming to improve the health and wellbeing of local people so they live longer with a better quality of life through the delivery of our strategic objectives, which are:
- transforming out of hospital care,
- transforming in hospital care, and
- enabling self-care and sustainability.

Securing UC services which are fit for the future is key to enabling the residents of Sunderland to access UC which meets their physical and mental health and care needs.

SCCG published its UC strategy in 2016. This document sets out the work undertaken since then. Following further stakeholder and provider engagement, including with general practice, and public consultation on the proposed scenarios, a decision making business case will be written. Both the outline business case and the decision making business case will be used for internal (SCCG) and external (NHS England) assurance.

For the purpose of this document, UC refers to the care of people who do not have life threatening illness or injury but who have mental or physical health needs that require same day input from a clinician.

Examples of UC services in Sunderland include:
- NHS 111
- Community pharmacies
- Local general practice services, during and outside normal working hours
- Urgent Care Centres (UCCs)

The key reasons for changing the current UC system in Sunderland include:
- the public have told us the current system is confusing to navigate and they don’t know what service to access to get their UC needs met
- people want to be able to see a GP when they have an UC need
- the requirement to deliver nationally mandated services including the Integrated Urgent Care (IUC) service which will replace the current 111 service, an Urgent
Treatment Centre (UTC), and extended access in general practice (referred to as the Sunderland Extended Access Service (SEAS)).

- we have already undertaken extensive reform of the out of hospital system, and we now need to reform the UC system in line with these changes
- we need to deliver efficiency savings of £1.5m (£500k in 2018/19 and £1m in 2019/20) from the implementation of a new UC clinical model

The SCCG UC strategy outlines the following five design principles, these have guided the redesign of our UC service:

1. Be safe, sustainable, and provide responsive, high quality care
2. Increase self-care through access to appropriate clinical advice
3. Ensure appropriate access to treatment as close to home as possible
4. Simplify access by improving integration across health and social care and reducing duplication of services
5. Meet nationally mandated requirements

1.2 Context
The scenarios for public consultation set out in this document have been developed within the national, regional and local UC context. Key to the delivery of the national Five Year Forward View is the commissioning of the IUC service which will replace the existing ‘assess and refer’ 111 service with a ‘consult and complete’ model with increased clinical input., this is currently in procurement and is due to go live on the 1st October 2018. The regional activity and financials, including the SCCG contribution to the costs of the service, have already been agreed to enable the regional procurement to be undertaken.

Approximately 70% of attendances to the Sunderland UCCs are self-presentations, which represents a high number of missed opportunities to promote self-care and give clinical advice over the telephone or virtually. The UCCs also only undertake face to face consultations. Changing the existing model of UC in Sunderland to align with the regional IUC ‘consult and complete’ model will maximize opportunities to deliver care to better meet the UC needs of Sunderland residents.

SCCG has been asked by NHS England to include an UTC in the new UC clinical model. UTCs will replace UCCs / Minor Injury Units (MIUs) / Walk in Centres (WiCs).

Reform of the UC clinical model has been considered within the context of general practice service delivery, including the Sunderland General Practice Strategy, the General Practice Forward View (GPFV) and SCCG as a level 3 co-commissioner of general practice.

The proposed potential clinical model has been considered within the context of the work already undertaken to reform out of hospital services through the All Together Better (ATB) Sunderland Vanguard. This out of hospital model is set out in the diagram below:
The out of hospital model includes Community Integrated Teams (CITs), the Recovery at Home (R@H) service, Ambulatory Emergency Care (AEC), and mental health services. As part of the ATB Sunderland Vanguard, an Emergency Department (ED) Interface model is being developed. This out of hospital model is currently being taken forward as a proposed Multi-specialty Community Provider (MCP).

The MCP is expected to deliver a new type of integrated provision, bringing together the delivery of general practice and community-based health and care services. The integration approach with general practice is central to the delivery of the MCP, there is no MCP without general practice.

The proposed scope of the Sunderland MCP encompasses everything that is, can, or should be (taking into account medical, wellbeing, safety and quality considerations) delivered outside of a hospital environment. The MCP framework includes UC needs, and the provision of UC that is responsive to patient needs and integrated within the model of care is included in the design aims of the Sunderland MCP. This is illustrated in the framework below:
UC services are included in year one of the MCP. The MCP is expected to go live on the 1st April 2019.

Work is also underway on a number of system enablers which will also support the delivery of the UC strategy. These include information technology (IT) and workforce retention. SCCG is implementing a number of initiatives in general practice to support recruitment and retention.

The proposed potential UC clinical model has also been developed using information from the Joint Strategic Needs Assessment (JSNA), including projections for population growth.

The current UC system has multiple points of access, duplication of services and this has led to confusion about how to access the appropriate service at the right time and could even have increased demand. This duplication is set out in the diagram below which depicts which services are open and at what times of the day.
The proposed potential UC clinical model allows urgent care to be fully delivered within the out of hospital system, allowing integration, and simplification of the system.

The UCCs were commissioned to reduce activity in ED, and an analysis of activity in the UCCs and ED in Sunderland over the previous ten years provides evidence that despite increasing activity in the UCCs there has been no reduction in ED activity, which continued to increase over the previous ten years. This is illustrated below.
Not only have the UCCs not impacted upon people accessing ED, but more people are now accessing UCCs than in the past. The impact of the Grindon Lane MIU closure showed a reduction in UC activity for the twelve month period following closure. However, since the opening of further two UCCs which see people who self-present (Houghton and Pallion), UCC activity has increased and is currently at its highest point ever. At the same time the forty-three general practices across Sunderland undertake an average of 28,500 patient contacts every week, which is almost 1.5 million patient contacts annually.

In 2016, for 24% of activity (14,057) seen at Bunny Hill, Washington and Houghton-le-Spring UCCs, people were advised to go to their own general practice. Thus potentially 14,057 episodes of care were an additional step in the patient's journey.

In 2016 for 66% of activity (38,929) seen at Bunny Hill, Washington and Houghton-le-Spring UCCs, people were discharged requiring no follow up or were provided with self-care advice. In the proposed potential UC clinical model these people will be given telephone or online advice via the IUC service, thus potentially saving almost forty thousand face to face consultations annually that don’t add clinical value.

In 2016 for 66% of activity (38,929) seen at Bunny Hill, Washington and Houghton-le-Spring UCCs, people were discharged as requiring no follow up or were provided with self-care advice. In the proposed potential UC clinical model these people will be given telephone or online advice via the IUC service, thus potentially saving almost forty thousand face to face consultations annually.

There are regional and national examples where UCCs/WiCs/MIUs have closed and resulted in little impact on ED activity. In Bath and North East Somerset CCG, within the first few months of introducing a GP at the front of their ED following closure of a
Walk in Centre, it was found that 13.5% of all ED attendances were streamed to the GP. The previous walk in activity (approximately 2500 per month) did not result in any increased attendances at the ED.

Recent changes to UC systems in South Tees, Durham Dales, Easington and Sedgefield and South Tyneside validate this assumption, with little or no impact on EDs where UC activity has significantly reduced. The closure of Grindon Lane MIU in Sunderland provided local evidence that UC activity did not shift into the ED.

1.3 Developing the scenarios
The development of the scenarios set out in this outline business case has included extensive activity and financial modelling. This work is set out in detail in the main body of this document, including current usage of 111 and 999, an analysis of 111 call end dispositions, attendances in general practice, SEAS, the General Practice Out of Hours service (GP OOHs), ED, as well as UCC activity.

The scenarios set out in this outline business case have been arrived at via an iterative process which has included public and patient feedback from engagement activities and extensive co-design work with stakeholders and providers. Stakeholders and providers have been involved in ‘stress testing’ the activity and financial modelling assumptions. The following organisations have been involved in the development of the proposed principles of the clinical model and the scenarios for public consultation:

- City Hospitals Sunderland NHS Foundation Trust (CHS)
- South Tyneside NHS Foundation Trust (STFT)
- Northumberland, Tyne and Wear NHS Foundation Trust (NTW)
- North East Ambulance Service NHS Foundation Trust (NEAS)
- Vocare
- Sunderland Care and Support
- Sunderland General Practice Alliance (SGPA)
- Sunderland City Council
- The MCP Executive Team
- NHS England
- NECS
- North Durham and Durham Dales, Easington and Sedgefield CCGs (via the NECS)

The proposed principles of the clinical model and the scenarios for public consultation presented here have the support of stakeholders and senior managers from general practice, the SGPA, SCCG Clinical Leads (who are General Practitioners), NEAS, NTW, Vocare, STFT, CHS, Sunderland Care and Support and Sunderland City Council. Updates on this work have also been delivered to the MCP Executive Team (MCPET).

Each of the proposed scenarios developed as part of this outline business case have been appraised against the five design principles which have been applied as criteria. Only those proposed scenarios which meet the five criteria have been put forward for public consultation. The five design principles are:
1. Be safe, sustainable, and provide responsive, high quality care
2. Increase self-care through access to appropriate clinical advice
3. Ensure appropriate access to treatment as close to home as possible
4. Simplify access by improving integration across health and social care and reducing duplication of services
5. Meet nationally mandated requirements

1.4 Proposed potential UC clinical model

The Sunderland proposed potential UC clinical model includes:

- use of the new IUC service*
- use of self-care (via 63 community pharmacies / self-care advice from IUC service )
- integrated home visiting service as part of the MCP with full multidisciplinary support including GPs 24/7
- UTC at Pallion Primary Care Centre to see self-presenters to ED and people with minor injuries
- consistent system owned triage at any point of access to the system, encouraging a needs led rather than a wants led system

*The new IUC service will contain a clinical hub: For those people who need more clinical input than can be obtained at a community pharmacy, or who are unsure how to best get their UC needs met, the new IUC service will be available 24/7, over the telephone and also online.

If we maintain the current UCC model we will be unable to realise these efficiencies and we will still need to contribute funding to the regional IUC service. Given that the IUC service will be delivered to a regional service specification, failure to change our existing UC model to be able to maximise the impact of the IUC service would not only disadvantage Sunderland residents, but also perpetuate a fragmented approach based on piecemeal reform of individual services.

SCCG are seeking to implement consistent triage across the whole UC system, ensuring that people access services according to need, not according to how they present. This includes consistent triage across general practice, the UTC and ED. This consistent triage is currently being progressed via training to general practice staff including receptionists, and via streaming in the ED (ed interface being developed between community teams within the MCP as part of this).

The new ‘consult and complete’ IUC service will assess people, give self-care advice where appropriate and transfer patients to a clinician (within the IUC service clinical hub) where a telephone consultation would be suitable to assess their needs. Anyone clinically assessed as requiring a face to face appointment by a clinician will be booked an appointment into the service which is most suitable for their needs. This will include same day direct booking in core general practice, into the Sunderland Extended Access Service and into the UTC. Sunderland general practices and the IUC service will be able to book people into the home visiting service, which will operate 24/7. Patients will only be booked into core general practice appointments following a telephone consultation with a clinician in the IUC service.
Currently 70% of attendances at the UCCs are from people who have walked in without phoning 111 first. We also know that whilst people are self-presenting at the UCCs, the extended access service has unused appointments slots at weekends and on bank holidays which can only be accessed via 111, a service which people are currently choosing to bypass. Currently demand is not shared across the available capacity, and one service may be experiencing high demand where another service has unused appointments. We aim to create an integrated UC system so that the patient sees the right clinician at the right time in the right place.

An NHS England objective is for the UTCs is to improve ED performance against the 4 hour waiting time standard. The co-location of the UTC with ED within the acute footprint will enable appropriate patients to be streamed away from ED.

CHS send appropriate patients to Pallion UCC at all times and also to the SEAS at Pallion Primary Care Centre when there is considerable demand in the system (surge). The ability to stream to alternative UC provision during times of high demand is essential to enabling the ED to see those patients with life threatening illness and injury as quickly as possible. The location of Pallion UCC and City hospital ED site are shown below (the acute footprint).

![Figure 5: Map of ‘acute footprint’](image)

The current provision of an UCC on the ground level of Pallion PCC and SEAS hub on the first floor of Pallion PCC is an example of the over complex UC offer which has emerged in Sunderland from the piecemeal development of services over time. One scenario presented in this outline business case includes the merging of the West locality SEAS hub with the proposed UTC. This approach would be to simplify access and improve integration while meeting NHS England requirements. From the 1st April 2019 it is intended that the UTC will be delivered via the MCP.

The UTC will have both same day and pre-bookable appointments. All practices in Sunderland will be able to book into the pre-bookable appointments. The UTC will see people with minor injuries from across the city when the injury cannot be managed in general practice. Overnight, when UC activity does not justify keeping an UTC open, any UC activity requiring a face to face consultation will be seen in ED, as per existing service provision.
CHS has undertaken modelling of current and anticipated future demand on the ED, including the impact of potential regional service reconfigurations, and has concluded that currently there is no physical capacity to locate an UTC within the existing ED. CHS has confirmed that they can manage the demand which would result from centralising minor injury activity at one UTC, but that this would need to be at Pallion PCC, not within the ED. The current arrangement of streaming patients to the Pallion PCC which is immediately adjacent to the main hospital site works well, and is familiar to patients already accessing the UCC on this site. The Pallion PCC could be the location of the future UTC in Sunderland. X-ray facilities are already located at Pallion PCC, thus delivery from this site would meet NHS England’s UTC and quality standards requirements.

Maintaining an UCC or UTC on an additional site within the city (for example one of the existing UCCs) would perpetuate the current system, which we know is confusing, has duplicate services open at the same time, and which is resulting in ever increasing activity across the UC system. Therefore one UTC at Pallion PCC within the acute footprint is included in the proposed potential UC clinical model and the scenarios set out in this outline business case.

Patients presenting to ED will be streamed by a clinician to the most appropriate service to meet their needs. This will include the UTC, AEC, and the ED Interface. We are not proposing to undertake any specific communications to the public regarding these services as streaming of patients will happen upon presentation, with people directed to the most appropriate service to meet their needs. This may include booking people into offsite services, for example general practice. People will not be turned away from ED without providing an appointment in an alternative service unless they do not require any clinical input.

Partners and providers have agreed that a GP is required in ED to support the delivery of the ED Interface model in the future; ensuring patients are seen by the most appropriate clinician for their needs and supporting people within the community who do not require admission for clinical reasons. To maximise efficiencies across the system, it is proposed that the GP covering ED Interface also covers the home visiting service out of hours, providing leadership and clinical input for those patients who require the expertise of a GP.

The Recovery at Home service is currently a multidisciplinary nurse led service that delivers support including home visits to patients with complex health and social care needs to enable them to remain at home. This service is currently being further developed (as part of the wider MCP which will include UC within it) to include GP input 24/7 from 1st October 2018. This will provide increased support to general practice in hours to release capacity to practices, but practices will retain visits for their most complex patients that require the continuity of their own GP.

Consideration has been given to how the UC model in Sunderland can manage out of area patients, especially people travelling from neighboring CCG areas. The proposed potential UC clinical model will bring the UC service delivery in Sunderland in line with changes made to UC services in neighbouring CCGs, which will remove the incentives for people to travel to Sunderland to get their UC needs met, instead promoting the ‘talk before you walk’ approach which will ensure people get the right service for their needs as close to home as possible.
This proposed potential UC clinical model is depicted below:

Figure 6: Proposed UC model
The proposed potential UC clinical model mapped by opening times is as follows:

All the scenarios developed during this UC work are set out in this outline business case, including the criteria used to decide which scenarios to take forward to public consultation. The two scenarios that SCCG intend to take to public consultation are as follows:

**Scenario A**
Replace services with:
- General practice (core and five Sunderland Extended Access Service locality hubs) consumes all UCC activity 08:00 – 20:30
- ED Interface
- Minor Injuries are seen at the UTC within the acute footprint (ED overnight)

**Scenario B**
Replace services with:
- General practice (core and four Sunderland Extended Access Service locality hubs) consumes all UCC activity 08:00 – 20:30
- ED Interface
- Minor Injuries are seen at the UTC within the acute footprint (ED overnight)
- One Sunderland Extended Access Service locality hub integrated with the UTC (within the acute footprint and in addition to the four Sunderland Extended Access Service locality hubs)

Both scenarios are underpinned by:
• the regional IUC service which will replace the current ‘assess and refer’ 111 service with a ‘consult and complete’ service
• 24/7 home visiting service

A visual representation of these two scenarios is set out below:

![Figure 8: The two UC scenarios](image)

The implications of these scenarios on activity and finances have been modelled to ensure they are viable options. The full assumptions underpinning this modelling is set out in the main body of the outline business case.

In the proposed potential UC clinical model, all minor injury activity currently seen in the UCCs will be seen in the UTC and there will be no minor injury activity impact on other services. As currently happens overnight, minor injury activity will be seen in ED.

The modelling assumes that activity currently seen at Pallion UCC will be seen at the UTC, with no impact on other services.

Based on evidence from the closure of Grindon Lane MIU, regional UC service closures and national closures, modelling assumes 50% of current UCC activity will not present anywhere in the future UC system. This is a conservative figure, as evidence from other areas demonstrates that more than 50% of activity does not present in the system following UCC closures. This leaves 20,313 attendances annually for minor illness currently seen in the UCCs that would need to be seen elsewhere in the proposed potential UC clinical model. Taking into account the home
postcodes of historic UCC activity, the modelling reflects the likely flow of some of this activity into the UTC.

The modelling is based on the assumption that most minor illness activity from neighbouring CCGs currently seen in Sunderland’s UCCs will move into UC services provided by the patient’s own CCG apart from activity currently flowing into Pallion UTC. The model assumes that this activity will remain in the Sunderland system as a contingency since it is accepted it may not be possible or appropriate to re-direct all out of area activity, particularly if someone presents at the UTC who lives further afield e.g. if they work in or are visiting Sunderland.

This leaves annual minor illness activity for Sunderland patients of 18,443 which will need to be seen within general practice (core service and SEAS). This equates to 51 attendances per day (crude daily rate not taking into account variance by day of the week or seasonality. This modelling will be further developed in the decision making business case to include seasonal and daily variance to understand maximum and minimum activity).

Because SEAS will see both pre-booked and same day activity, it is not possible to model activity flows between core general practice and SEAS, so this has not been modelled within this outline business case.

This annual minor illness activity of 18,443 will need to be seen across the UC system. As a crude daily rate this equates to 127 Sunderland attendances, 76 of which are expected to be seen at the UTC. This means that a crude average of 51 attendances a day would need to be seen in general practice (core and SEAS). This means the daily rate per 1,000 registered population would equate to approximately 0.2 attendances.

It is proposed that general practice will be supported to transition to the new model through the use of quality premium funding (released from PMS review) partly in 2018/19 and fully in 2019/20. Any activity changes will be closely and regularly monitored by SCCG. Both the quality premium funding and the GP strategy will be reviewed as part of this monitoring process.

The 24/7 home visiting service is currently in development. This service will contribute to capacity in general practice by undertaking home visits for those individuals who do not require continuity of care from their GP. As this service is currently in development it has not been possible to model this activity shift and therefore this service is not included in the figures given here. This information will be included in the decision making business case.

The two scenarios that are being recommended to go to public consultation cost the same based on the assumptions used within the business case. The current UC system cost is £10.817m. Scenarios A and B costed in line with the assumptions set out in the outline business case and timeline 3 (1st April 2019) would cost £9.417m, thus achieving the required efficiency savings.

1.5 Next steps
This outline business case will be presented to the SCCG Governing Body on 30th January 2018. The SCCG Governing Body will be asked to agree that the two
scenarios set out above can be taken to public consultation. If this agreement is reached, the outline business case will then be shared with NHS England to meet the requirements of the Stage three service change assurance process.

The SCCG Governing Body will also be asked to agree the timeline for the delivery of the proposed potential UC clinical model. The preferred timeline is to extend the UCC contracts to the 1st April 2019 so that the UC clinical model is mobilised within the MCP. This option would mitigate any slippage in the regional procurement timeline for IUC. It would also provide some double running of services and embedding of the key enablers to support sustainability of general practice over the busy winter period during which public communications can be undertaken to promote the use of the new IUC ‘consult and complete’ service. The existing GP OOHs service would cease at the end of the current contract, and from the 1st October 2018 all ‘speak to’ 111 call dispositions would be delivered by the IUC service, and all out of hours home visits would be undertaken by the 24/7 home visiting service.

The key milestones captured in the SCCG corporate programme management documentation are set out below:

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Delivery Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will have signed off the UC outline business case at the SCCG Governing Body</td>
<td>30th January 2018</td>
</tr>
<tr>
<td>We will have presented an update to the Health and Wellbeing Scrutiny Committee (report deadline is 16/02/18)</td>
<td>28th February 2018</td>
</tr>
<tr>
<td>Engagement with general practices by localities and Time in Time Out sessions</td>
<td>February 2018 17th March TITO</td>
</tr>
<tr>
<td>We will have undergone NHS England Stage two Strategic Sense Check</td>
<td>w/c 5th March 2018</td>
</tr>
<tr>
<td>We will have undertaken planning and promotion for public consultation</td>
<td>w/c 12th March 2018</td>
</tr>
<tr>
<td>We will have completed a travel impact analysis</td>
<td>w/c 23rd April 2018</td>
</tr>
<tr>
<td>We will have conducted formal public consultation (includes 1 week for a mid-consultation review)</td>
<td>w/c 11th June 2018</td>
</tr>
<tr>
<td>We will have completed an equality impact assessment</td>
<td>w/c 11th June 2018</td>
</tr>
<tr>
<td>We will have completed a health equality impact assessment</td>
<td>w/c 11th June 2018</td>
</tr>
<tr>
<td>We will have completed an independent impact analysis</td>
<td>w/c 11th June 2018</td>
</tr>
<tr>
<td>We will have a Consultation Report written by NECS</td>
<td>w/c 2nd July 2018</td>
</tr>
<tr>
<td>The draft Consultation Report will have been shared with SCCG for review</td>
<td>w/c 9th July 2018</td>
</tr>
<tr>
<td>We will have shared the Consultation Report with SCCG Executive Committee</td>
<td>17th July 2018</td>
</tr>
<tr>
<td>We will have shared the Consultation Report with the Health and Wellbeing Scrutiny Committee (Statutory requirement). (Report to be sent by 6th July 2018)</td>
<td>w/c 9th July 2018</td>
</tr>
<tr>
<td>We will have conducted the consideration phase and feedback to public</td>
<td>w/c 6th August 2018</td>
</tr>
<tr>
<td>We will have written the Decision Making Business Case</td>
<td>w/c 20th August 2018</td>
</tr>
<tr>
<td>End of current UCC contracts</td>
<td>31st August 2018</td>
</tr>
</tbody>
</table>
We will have undergone the NHS England Stage three Assurance Checkpoint (Decision Making Business Case) | w/c 24th September 2018
End of current GP OOH contract | 30th September 2018
Go live date for regional IUC service | 1st October 2018
Go live date of the 24/7 home visiting service | 1st October 2018
SCCG Executive Committee will have signed off the Decision Making Business Case | w/c 1st October 2018
SCCG Governing Body will have signed off the Decision Making Business Case (the Governing Body scheduled for Oct 18 is a Development Session) | w/c 29th October 2018
MCP provisional go live date | 1st April 2019

Table 1: Key milestones
2. Introduction

NHS Sunderland Clinical Commissioning Group (SCCG) is responsible for commissioning health and health care services for approximately 284,000 local people. This Urgent Care (UC) strategy outline business case supports the SCCG’s vision of Better Health for Sunderland aiming to improve the health and wellbeing of local people so they live longer with a better quality of life through the delivery of our strategic objectives, which are:

- transforming out of hospital care,
- transforming in hospital care, and
- enabling self-care and sustainability.

Securing UC services which are fit for the future is key to enabling the residents of Sunderland to access UC which meets their physical and mental health and care needs.

This outline business case sets out the UC work undertaken since SCCG published its refreshed UC Strategy in 2016. This outline business case articulates the journey from the 2016 refreshed UC strategy to the scenarios which we intend to take out to public consultation. Following public consultation a decision making business case will be written. Both the outline business case and the decision making business case will be used for internal (SCCG) and external (NHS England) assurance.

This outline business case also sets out how SCCG will achieve nationally mandated UC service requirements, notably the delivery of an Integrated Urgent Care (IUC) service, and an Urgent Treatment Centre (UTC). This outline business case also sets out how the proposed potential UC model builds upon the extensive out of hospital reform already undertaken in Sunderland.

Public and patient engagement work was undertaken prior to the publication of the refreshed UC strategy in 2016. Through the engagement work that SCCG has already undertaken, patients and the public have told us:

- the system is confusing
- people want to be able to see a GP when they have an UC need
- people with long term conditions want continuity of care because their needs are more complex

This public and patient feedback was used to inform the key aims set out in the UC strategy published in 2016. The key aims set out in the UC Strategy document are the key aims of this outline business case, namely the transformation of UC services to ensure they:

- are easy to navigate
- deliver UC as close to people’s homes as possible
- meet national requirements
- align with service transformation undertaken in the Sunderland out of hospital system
- secure general practice at the heart of UC service delivery
- achieve the required efficiency savings of £500k in 2018/19 and £1m in 2019/20
To deliver an UC model fit for the future SCCG developed a vision for UC in Sunderland with stakeholders, the public and partners. This vision was included in the UC strategy document, and is set out in the following five design principles which have guided the redesign of UC services across Sunderland:

1. Be safe, sustainable, and provide responsive, high quality care
2. Increase self-care through access to appropriate clinical advice
3. Ensure appropriate access to treatment as close to home as possible
4. Simplify access by improving integration across health and social care and reducing duplication of services
5. Meet nationally mandated requirements

The development of this outline business case has included extensive consultation with stakeholders which has been undertaken via a series of events. Working with stakeholders SCCG has developed the proposed principles of the new UC model over a period of time, taking an iterative approach to the model as new guidance, evidence, and business intelligence has emerged.

This outline business case presents the proposed principles of the new UC model, and the activity and financial modelling which has been undertaken to ensure the proposed model is credible, sustainable and will meet the future UC needs of the residents of Sunderland. This document sets out the work undertaken to develop the UC scenarios, and describes the two scenarios that SCCG will take out to public consultation in 2018.

2.1 Urgent Care definition
For the purpose of this document, urgent care (UC) refers to the care of people who do not have life threatening illness or injury but who have mental or physical health needs that require same day input from a clinician.

Examples of UC services in Sunderland include:
- NHS 111
- Community Pharmacies
- Local doctor services (GPs), during and outside normal working hours
- Urgent Care Centres (UCCs)

2.2 Setting the Scene
NHS Sunderland Clinical Commissioning Group (SCCG) is the statutory health body responsible for the planning and buying of local NHS care and services to meet the needs of the local community. SCCG is made up from a membership of forty three general practices, divided into five localities across the city: Coalfields, Sunderland North, Sunderland East, Sunderland West and Washington. SCCG is responsible for a local population of approximately 284,000 local people and has an annual budget of £507 million which equates to approximately £1,785 per person per year.

SCCG’s vision is to achieve ‘Better Health for Sunderland’. We aim to improve the health and wellbeing of local people so they live longer with a better quality of life. SCCG delivers high quality, cost effective, care to improve healthcare provision for the people of Sunderland and reduce disparities in health and social care. By using effective clinical decision-making we can make a real impact on the health, wellbeing and life expectancy of our patients.
SCCG takes a whole system approach, working closely with the public, patients, carers, providers and partners to utilise evidence based service improvement techniques to maximise ‘value adding’ activities. SCCG has worked hard to develop meaningful relationships with providers and stakeholders across the city, including with mental health providers, hospital trusts, and the local authority.
3. Context

This section sets out the context in which UC services in Sunderland will be delivered, including current and future service provision. This section is divided into national, regional and local context. The section on national context includes services mandated by NHS England, which are ‘must do’s’ for SCCG.

3.1 National Context

Key to any service change in Sunderland is the delivery of nationally mandated services and standards. In 2014 NHS England set out a ‘Five Year Forward View’ (5YFV) for the NHS, including the need to redesign urgent and emergency (UEC) care services in England for people of all ages with physical and mental health problems. The 5YFV sets out new models of care to ensure:

“for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people’s homes as possible, minimising disruption and inconvenience for patients and their families”. [1]

The following schematic sets out the shape and structure of the future national UEC system:

![Figure 9: The future national urgent and emergency care system][2]

3.2 Integrated Urgent Care

The NHS Operational Planning and Contracting Guidance for 2017 – 2019 sets out the requirements to deliver the Five Year Forward View (5YFV). The planning guidance includes the requirement to implement a 24/7 Integrated Urgent Care (IUC) service for physical and mental health by March 2020, including a clinical hub.
that supports NHS 111 and 999. The IUC Commissioning Standards published in 2015 outline the standards which commissioners should adhere to in order to commission a functionally integrated 24/7 UC access, treatment and clinical advice service (incorporating NHS 111). These standards seek to bring UC access, treatment and clinical advice into much closer alignment through a consistent and integrated NHS 111 service model. IUC aims to:

“deliver a functionally integrated 24/7 urgent care service that is the ‘front door’ of the NHS and which provides the public with access to both treatment and clinical advice.” [3]

The IUC service will replace the existing NHS 111 ‘assess and refer’ model with a ‘consult and complete’ model. The following diagram depicts IUC from a patient perspective:

In the new IUC model patients will be asked to contact NHS 111 when:

- they need medical help fast, but it’s not a 999 emergency
- they don’t know who to contact for medical help
- they think they need to go to A&E or another NHS urgent care service
- they need to make an appointment with an urgent care service
- they require health information or reassurance about how to care for themselves or what to do next
The IUC service will also
- have access to the Summary Care Record
- have the ability to make an electronic referral into a service which best meets their needs
- book face to face appointment times directly with the relevant urgent care service whenever this is appropriate
- directly book into core general practice and SEAS

The existing regional NHS 111 service contract is due to end on the 30th of September 2018. At the time of writing this document the Urgent and Emergency Care (UEC) Network is leading the procurement of the new IUC service on behalf of the North East region. This work has involved amending the national service specification to meet the requirements of the region. The key difference between the national and regional service specification is that the regional service specification does not include the delivery of any face to face treatment services. The regional service specification will still deliver the ‘consult and complete’ model, with at least 50% of suitable calls being passed to a clinician for clinical input.

The regional activity and financials, including the SCCG contribution to the costs of the service, have already been agreed to enable the regional procurement to be undertaken, therefore SCCG is already financially committed to the IUC service. The regional IUC service is due to go live on the 1st October 2018.

SCCG agrees to fully support the nationally mandated IUC model and this is included in the scenarios for public consultation set out in this outline business case.

3.3 Urgent Treatment Centres
Nationally, it is recognised that the current variation in names for Urgent Care Centres (UCCs), Minor Injury Units (MIUs) and Walks In Centres (WiCs) is very confusing for the public, so NHS England is re-designating centres as Urgent Treatment Centres (UTCs). NHS England’s objectives for UTCs include standardising and simplifying access, ensuring UC is easy to navigate for local people, and creating efficiencies through integrated working. NHS England has asked SCCG to include an UTC in our scenarios for consultation.

NHS England has published twenty seven standards UTCs must meet in order to ensure a consistent service to the public. These standards set out that UTCs will be integrated with local UC services, usually led by General Practitioners (GPs), and ideally co-located with primary care facilities, such as the Sunderland Extended Access Service (SEAS). The nationally mandated UTC standards also include:
- bookable appointments with a GP or other members of the multi-disciplinary team
- be open for at least twelve hours a day seven days a week, including bank holidays
- provide pre-booked same day and “walk-in” appointments
- ensure an effective and consistent approach to primary prioritisation of “walk-in” and pre-booked appointments
- offer appointments through 111 as well as GP referral
- treat minor illness and injury in adults and children of all ages
- have access to diagnostic facilities that will usually include an X-ray machine.

3.4 Regional Urgent and Emergency Care Context
The implementation of the 5YFV for UC was facilitated by UEC networks, and UEC vanguards. The North East UEC Vanguard (NE UECV) commenced in 2015. Its strategic aims were:

- System leadership, with an overarching framework to address fragmentation
- Promoting self-care among patients
- Improving general practice access through GP bookings
- Improvements and integration to out-of-hospital care

The overarching NE UECV approach is set out in the diagram below:

![Diagram of the overarching NE UECV approach](image)

Whilst the NE UECV has now come to an end, the NE continues to maintain an active UEC network approach at both strategic and operational levels. This network now includes North Cumbria as well as the North East.

The NE UEC Network is leading the regional procurement of the nationally mandated IUC service (see section 3.19). The regional IUC service is due to go live in the NE on the 1st October 2018. The procurement for this is underway and is being undertaken by the North of England Commissioning Support Unit (NECS) on behalf of the region.

3.5 General Practice Forward View
NHS England published the General Practice Forward View (GPFV) in April 2016. It set out a plan, backed by investment, to stabilise and transform general practice. There are five main areas within the GPFV:

- Investment
- Care redesign
• Workforce
• Workload
• Practice Infrastructure

Each of these areas is designed to enable general practice to become sustainable and includes plans for practice transformational support. The GPFV builds on the work SCCG had already developed within the SCCG GP Strategy. Workforce and workload issues are addressed within the GPFV document and it encourages and supports working at scale. This includes the development of Multispecialty Community Providers or Primary and Acute Care Systems.

3.6 Primary Care Co-commissioning
In April 2015 SCCG became a level three co-commissioner, assuming full responsibility for the commissioning of general practice services in Sunderland. Co-commissioning is seen as an enabler in developing seamless, integrated out of hospital services based around the diverse needs of the local population.

3.7 General Practice (GP) Strategy (2016 – 2021)
The Sunderland GP Strategy aims to ensure the sustainability of general practice in Sunderland in light of challenges, building on existing strengths and ensuring safe, effective and high quality care. Our responsibility as a level three co-commissioner gives SCCG an opportunity to integrate general practice into the wider health and social care system in Sunderland to give greater flexibility and influence at a local level over the way in which services are delivered to patients. Delivery of this five year strategy will contribute to our strategic objective to transform the way care is delivered out of hospital in Sunderland. The GP Strategy key areas will support the UC changes within general practice. There are five key changes that SCCG feel need to happen:

1. Supporting general practice to increase capacity and build the workforce
2. Improving patient access
3. Ensuring the central, co-ordinating role of general practice in delivering out of hospital care
4. Supporting better health through prevention and increasing patients’ capacity for self-care
5. Encouraging new working arrangements between practices

Some of these areas are in progress i.e. supporting mergers to allow practices to work in more efficient ways, improving access via SEAS, increasing capacity via the 24/7 home visiting service, additional GPs via a golden hello initiative and a career start programme. All these initiatives should increase capacity and support the delivery of the UC strategy.

3.8 Sunderland Joint Strategic Needs Assessment
As at 1st July 2017, 284,219 people are registered with a Sunderland general practice and this is predicted to rise to 285,000 by 2030. The population is forecast to grow by just over 1% by 2020 compared to 4.8% for England. Sunderland is much less ethnically diverse than the England average, but is becoming more ethnically diverse, driven by patterns of migration.

The population profile of Sunderland is changing with a rapidly ageing population and a declining younger population. The Sunderland population is projected to increase
by just over 1% over the next ten years and by 3.2% over the next twenty years. Within this overall population growth, the rate of growth in particular age groups is significantly different. The under sixty five year old population is projected to decrease over this period by 2.6% over ten years and 5.3% over twenty years whilst the sixty five and over population is projected to increase by 18.9% over the next ten years and by 37.7% over the next twenty years. Older people use health and social care services more intensively than any other population group and so the growth in the absolute number of older people in Sunderland as well as the percentage of the total population has strong implications for the capacity and planning of health and care services.

3.9 Sunderland Health Issues and Concerns

People living in Sunderland experience higher levels of deprivation than the national average. Unhealthy lifestyles remain a key cause for increased rates of premature death. Many people in Sunderland continue to follow unhealthy lifestyle behaviours when compared to England. This is directly linked to a range of social, economic and environmental factors.

The health of people in Sunderland is varied compared with the England average. Sunderland is one of the 20% most deprived districts/unitary authorities in England and about 26% (12,600) of children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 10.1 years lower for men and 8.2 years lower for women in the most deprived areas of Sunderland than in the least deprived areas.

Preventing premature deaths due to cancer, cardiovascular disease and respiratory disease remains a priority for health partners across the City. Current strategic plans [5] include a strong focus on identifying and managing long term conditions, including through self-care. There are currently programmes looking at hypertension, atrial fibrillation, diabetes treatment and diabetes prevention.

A key challenge for the Sunderland health economy is the need to manage the high and increasing levels of long term conditions in the population, including increasing proportions of people with multiple long term conditions.

Sunderland’s population makes relatively high use of hospitals, with standardised rates of elective admissions that are 40% higher than the England average [6] and standardised rates of emergency admissions that are 18% higher than the England average [7]. The rate of alcohol-related harm hospital stays (adults) is 948 per 100,000 population, worse than the average for England. The rate of self-harm hospital stays is 180 per 100,000, which is better than the average for England which is 191.4. The rate of smoking related deaths is 423 per 100,000, worse than the average for England. This represents 648 deaths per year. Estimated levels of adult excess weight, smoking and physical activity are worse than the England average. The rate of hip fractures is worse than average.

3.10 Increased Demand across the Urgent and Emergency Care System in Sunderland

In line with the national position, general demand for health services in Sunderland continues to grow. UC activity in Sunderland is high and is rising. Sunderland is a national outlier for emergency admissions and it is only in 2017/18 that emergency
admissions have begun to plateau (September 2017) due to the positive impact of the out of hospital model.

Driving up numbers ambulatory care pathways and improvements in coding. From April 2013 to March 2016, emergency admissions have grown by 10% (average 3% growth per year) despite a previously static position. The development of Ambulatory Emergency Care (AEC) at City Hospitals Sunderland NHS Foundation Trust (CHS) has contributed to this growth with very short lengths of stay emergency admissions growing by 50% over the same period.

CHS continues to experience significant challenges in achieving the national four hour waiting time standard for ED (which states patients should be admitted, transferred or discharge within four hours of their arrival) but remains comparable across the region and better than the national position. This is due to a variety of reasons, including the increased complexity of patients and increased activity.

The reasons for the rises in UC activity (particularly the UCCs) is multi-factorial but evidence from providers shows a direct link to the growing demands on general practice and ability to access general practice services. This supports the capacity releasing schemes implemented as part of the SCCG GP Strategy, including Sunderland Extended Access Service (SEAS) and the Recovery at Home and 24/7 home visiting service.

Although patient satisfaction relating to access to general practice remains high, it is clear from activity surges which occur outside GP opening times, that the public value access to prompt care (including weekends), particularly in relation to treating children (0-4 years) and to services that offer convenient appointments which fit with work and school commitments.

3.11 Duplication in the System
In Sunderland multiple services to meet UC needs are open at the same time, causing confusion for people who do not understand which service is most appropriate for their needs. This duplication has emerged from historic reform in Sunderland, the opening of two Minor Injury Units in 2008, including one which was initially open overnight but which closed overnight due to a lack of activity in 2014. A Walk in Centre was opened in 2009, and an UCC in early 2014. Later in 2014 a further three UCCs were opened, replacing the two Minor Injury Units and the Walk in Centre. The historic UC system in Sunderland is set out in the diagram below:
The naming of services, and the changes to both service provision and terminology, has caused further confusion for members of the public. For example, the WICs in Sunderland did not see children under two years of age but the UCCs were commissioned to see all patients from birth upwards. The WICs saw people who self-presented, but when the UCCs were opened in 2014, they used an appointment system, filling appointment slots via 111 and giving appointments to people who walked in. We know from our public and patient engagement that this created further confusion, with people unsure whether they could walk in to an UCC and be seen, or not.

The UCCs were commissioned to reduce activity in ED, and an analysis of activity in the UCCs and ED in Sunderland over the previous ten years provides evidence that despite increasing activity in the UCC there has been no reciprocal reduction in ED activity, and ED activity has continued to increase over the previous ten years. The activity over the last ten years in ED and the UCCs is presented in section 3.25 of this document.

Some patients are using UCCs in addition to other services for the same health concerns further duplicating service cost and activity as most patients attending UCCs are already registered with a GP practice. We know from an analysis of the data that a high percentage of patients attending UCCs are referred back to their own general practitioners for follow up care, creating further unnecessary duplication in the UC system (see section 3.23).

There are regional and national examples where UCCs/WIC/MIU have closed and resulted in little impact on ED activity. In Bath and North East Somerset CCG, within
the first few months of introducing a GP at the front of their ED following closure of a WiC, it was found that 13.5% of all ED attendances were streamed to the GP. The previous walk in activity (approximately two thousand five hundred per month) did not result in any increased attendances at the ED.

Recent changes to UC systems in South Tees, Durham Dales, Easington and Sedgefield and South Tyneside validate this assumption, with little or no impact on EDs where UC activity has significantly reduced. The closure of Grindon Lane MIU in Sunderland provided local evidence that closing an UCC did not shift previous UC activity to the ED.

3.12 Costs Associated with the Provision of Urgent Care
Changes in demographics, particularly a growing elderly population, are driving up demand and the overall cost of healthcare in Sunderland. This growth in demand is taking place at a time of austerity and puts pressure on NHS funding. The NHS has less money than it has had in previous years and for SCCG this means that it must spend its money wisely to ensure that the best outcomes are achieved for the Sunderland population. The cost of delivering UC is high and therefore there is a need to ensure that any future model of UC is able to demonstrate that SCCG are making best use of tax payers’ money. There are potential economies to be made by reducing duplication of some service provision, particularly in relation to matching capacity with demand, multiple service providers, improved integration and enabling patients to self-care.

3.13 Confusion in Accessing the Urgent Care System
Members of the public and patients have already told us that the current UC system in Sunderland is complex and confusing to access. There are a number of UC services with a variety of opening times, making the system difficult for patients and carers to navigate. As nationally mandated ‘must do’s’ and local reform has been implemented the system has become more complex, with multiple services providing duplicate access to UC. The Sunderland UC model currently includes core general practice, SEAS, GP OOHs, four UCCs, and the Recovery at Home service, all services which provide assessment and treatment for minor injuries and minor illness at different times of the day in different locations. This complicated provision of services is set out in the diagram below:
### 3.14 Urgent Care Strategy


The UC Strategy describes the current services and challenges faced by the health and social care system. These include:

- Patients and public find the UC service complex and confusing to navigate
- Patients and public don’t understand which service they should access to meet their urgent care needs
- There is duplication in the urgent care system
- The provision of additional urgent care services such as the urgent care centres has led to a rise in urgent care attendances across the city with no reduction in ED attendances
- The cost of the UC service is unsustainable

### 3.15 Current Urgent Care Service Provision in Sunderland

This section of the outline business case sets out current UC service provision in Sunderland including the reform work already undertaken across the out of hospital health system in Sunderland through the All Together Better (ATB) Sunderland Vanguard. The scenarios set out in this outline business case build upon this existing reform work. This section includes activity data for the services that we currently have in place across the Sunderland UC system. This section also includes a summary of further reform work that is currently underway.
3.16 Self-Care

It is estimated nationally that around 80% of the population are helped to self-care [8]. The majority of people feel comfortable managing everyday minor ailments like coughs and colds themselves, particularly when they feel confident in recognising the symptoms and have successfully treated themselves using over-the-counter medicines before.

SCCG has commissioned a number of patient education programmes to promote self-care. The Self Care and Prevention Group in Sunderland are currently focussed on rolling out the patient activation measure (PAM) tool. Training for the PAM is completed, and work is now concentrating on ensuring the changes to ways of working are embedded and to track the impact of using the PAM alongside the training. There have been 626 PAM questionnaires administered in Sunderland since May 2017. Organisations using the tool include 8 GP practices, Age UK Sunderland (Hospital Discharge Team and Essence Service) and the Council’s ‘Move To Improve’ programme.

A website is also underdevelopment to become the main tool/directory in assisting the workforce and public in identifying community resources for supporting self-care and personalised care planning. An app linked to the website will also be developed for staff.

3.17 Community Pharmacy

The traditional role of a community pharmacy (preparing and dispensing prescription and non-prescription drugs) has changed over the years, expanding to deliver advice and treatments of minor ailments such as coughs and colds and supporting people with long term conditions. The national vision for community pharmacy over the next five years is that it will integrate with the wider health and social care system to relieve pressure on general practice and EDs, ensure optimal use of medicines, promote healthy lifestyles and prevent ill-health, and help people to develop the knowledge and skills to self-care for minor and long-term conditions.

There are sixty three community pharmacies in Sunderland, provision for the population that is above the England average. All are easily accessible by car and generally accessible on foot. Five pharmacies offer up to 100 hours of opening per week and are open on Saturdays and Sundays. Two are located in Sunderland East, one in Sunderland North and two in Washington (which includes the Galleries shopping centre). Currently thirty three of the other pharmacies in Sunderland open on Saturdays and five are open on Sundays.

Community pharmacy provision is in place for the SEAS, with seven community pharmacies open during weekday SEAS opening times, fourteen community pharmacies are open during Saturday SEAS opening times and four pharmacies are open during Sunday SEAS opening times.

Community pharmacies across Sunderland also offer additional services that support UC provision. Twenty three community pharmacies in Sunderland offer the emergency hormonal contraception service commissioned by Sunderland City Council. Six pharmacies (covering all localities) are commissioned by SCCG to provide an on-demand supply of intravenous antibiotics for primary care cellulitis treatment, and a further two are commissioned to stock emergency palliative care
medicines. In addition, SCCG commissions a community pharmacist on-call service to dispense and supply specified palliative care medicines out of hours. Nineteen community pharmacies provide the NHS England commissioned NHS Urgent Medicine Supply Advanced service which allows pharmacists to provide an emergency supply of a patient’s usual repeat medicine if they are unable to obtain a prescription.

### 3.18 Minor Ailments Scheme

SCCG commissions a Minor Ailments Scheme, which provides people who are eligible for free prescriptions with a certain medications for a defined range of conditions. The Sunderland Minor Ailments Scheme is currently limited in terms of the pharmacies that are signed up to deliver it. The existing Minor Ailments Scheme is no longer considered fit for purpose as many of the items available on the scheme are now readily available over the counter.

More recent guidance from NHS England regarding the de-prescribing of an increasing number of items which can be readily purchased over the counter is shifting the emphasis away from the provision of such items by the NHS. Concerns remain that pharmacy schemes create further dependency within the system, rather than promoting the self-care ethos.

Currently NHS England is commissioning a regional Community Pharmacy Referral Service which patients access via 111. The evaluation of this scheme will be used to inform future service provision in Sunderland.

### 3.19 NHS 111

NHS 111 is the free number to call when people have an urgent healthcare need. The service directs people to the right local service, first time. The 111 service is available across the whole of England making it easier for people to access urgent healthcare services when they need medical help fast. The service is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones.

People are advised to call 111 when they need medical help fast, but it’s not a 999 emergency, don’t know who to call for medical help or don’t have a GP to call, think they need to go to A&E or another NHS urgent care service but are not sure which one is most appropriate, or require health advice or reassurance about what to do next.

When someone calls 111 they are assessed by fully trained advisers who are supported by experienced nurses and paramedics. The caller is asked questions to assess symptoms and is then given healthcare advice or is directed to the most appropriate local service, including out of hours services such as an emergency dentist. If the NHS 111 team think a caller needs an ambulance, they will send one immediately. This current model of 111 service delivery is referred to as ‘assess and refer’ and is currently delivered by NEAS. The existing contract is due to end on the 30th September 2018.

The current ‘assess and refer’ 111 model is being replaced by the nationally mandated IUC ‘consult and compete’ model. The procurement for the North East of England IUC service is underway and is being undertaken by the North of England
Commissioning Support Unit on behalf of the region. The service is due to go live in on the 1st October 2018.

3.20 Current 111 Sunderland Activity

NHS 111 calls from Sunderland have increased, with a notable increase when the current UCCs were mobilised in 2014 and 111 could directly book into the UCCs. The following chart shows the number of 111 calls from April 2015 to November 2017. In the latest twelve month period (December 2016 to November 2017) there were 97,000 111 calls from Sunderland.

![Number of 111 Calls](image)

**Figure 14: Number of calls to NHS 111 in Sunderland (April 2015 to November 2017 inc.)**

In terms of the end dispositions for the Sunderland 111 calls, 7% of the calls end with the recommendation to go to ED, 14% end with an ambulance disposition, 22% of callers are advised to attend an UCC, and 9% of callers are advised to contact their general practice. The remaining dispositions are for Recovery at Home, community nursing and other out of hospital services.

![111 Calls by End Disposition](image)
3.21 Core General Practice provision in Sunderland

The total number of patients registered with GP practices across Sunderland CCG is 283,931 (as at 01/01/17). Sunderland has forty three practices spread across five localities. The North Locality has 45,655 registered patients across eight practices, the East Locality has 48,136 registered patients across eight practices, the West Locality has 90,559 registered patients across twelve practices, Washington Locality has 50,931 registered patients across nine practices, and the Coalfields Locality has 48,834 registered patients across six practices.

SCCG’s aim is to sustain and transform general practice to ensure the provision of high quality primary medical care delivering improved health outcomes for local people, now and in the future, with the objectives of supporting general practice to increase capacity and build the workforce, improving patient access, and ensuring the central, co-ordinating role of general practice in delivering out of hospital care, supporting better health through prevention and increasing patients’ capacity for self-care and encouraging new working arrangements between practices.

The following examples of developments have been funded from the core SCCG budget, over and above the delegated GP budget:

- Sunderland Extended Access Service
- GP input into integrated teams and recovery at home
- GP Recruitment and Retention schemes
- Practice Nurse Recruitment and Retention scheme
- Health Care Assistant Recruitment and Retention scheme
- Local enhanced services
- GP Information Technology
- Out of Hours GP budget

Core general practice activity is significant and over the past twelve months (December 2016 to November 2017), there were 1,026,945 attendances in general practice for GPs, healthcare assistants and practice nurses (figures taken from EMIS Web). This activity is set out in the graph below. Due to the variation of recording across the practices, it is highly likely that attendances are higher as telephone triage is recorded differently across practices. There is also a significant amount of community based activity that is carried out within general practice by other providers such as community midwifery and community nursing.
3.22 Sunderland Extended Access Service

To support the achievement of the core requirements of the NHS Operational and Planning Guidance 2017 – 2019, SCCG has secured full coverage of general practice extended access from 17/18. This service is known as the Sunderland Extended Access Service (SEAS). SEAS provides general practice appointments in addition to core general practice services. SEAS currently provides an additional thirty minutes consultation capacity per 1000 population, which equates to an extra 142 of appointments per week delivered on evenings and weekends. Weekday SEAS provision from 18:00 – 18:30 is funded via CCG funding, and from 18:30 – 20:30 financed through national funding of £6 per head of registered practice population with. This means SEAS provides an additional 10 hours of appointments every week in addition to the one hundred and forty two hours of appointments. This is an additional 152 hours in total, which equates to 608 appointments per week.

In each locality, practices are working together to deliver these additional appointments from one central practice known as a ‘hub’. Staff working in the centralised hubs also work in one of the practices in that locality. All the hubs currently have data sharing agreements in place and read and write access to each patient’s general practice medical record.

The weekday evening SEAS is delivered from 18:00 – 20:30 from five hubs, one in each locality. Weekend opening hours are determined by local need, and have initially been modelled on intelligence from practice and national patient survey results as well as the learning from the East, West and North pilots. Currently, weekend SEAS opening times and locations vary. All hubs may not be open at any one time if there is predicted to be insufficient demand to utilise appointments. Patients registered to a general practice in Sunderland can access SEAS appointments in any of the localities, not just they locality they are registered in.
In 2018/19, the national requirement for extended access services is to increase to forty five minutes per 1000 population. This equates to an additional 71 hours of appointments per week, which is an additional 284 appointments per week. Again, this is in addition to the separately funded opening from 18:00 to 18:30, so in total from 2018/19 there will be **892 SEAS appointments per week**.

### 3.23 General Practice Out of Hours service

The current General Practice Out of Hours (GP OOHs) service is accessed via 111 and delivers telephone advice and home visits. The service is also has the ability to book patients into the UCCs. The service runs from 18:00 to 08:00 on weekdays and 24 hours a day on weekends and bank holidays.

The existing service providers are currently working closely with CHS to move the GP OOHs service from their current base at Leechmere into the ED Interface. This will enable the service to see patients in ED when the UCCs are closed, and only undertake home visits for those people who are permanently or temporarily housebound. This will free up time the GPs would have spent travelling to home visits to see patients who have self-presented in ED and who are streamed appropriately to the GP.

Over the twelve month period December 2016 to November 2017, the GP OOHs service undertook 12,500 consultations. 11,200 of these consultations were telephone advice and 1,300 were home visits. This activity is depicted in the graph below.

![Graph showing GP Out of Hours Consultations](image)

**Figure 17: Number of GP Out of Hours consultations (November 2016 to November 2017 inc.)**

Of the consultations undertaken from December 2016 to November 2017, 38% of people were given self-care advice, 23% were advised to contact general practice and 13% were advised to go to ED.
3.24 Urgent Care Centres

There are currently four Urgent Care Centres (UCCs) in Sunderland. One UCC is provided by CHS, and is currently delivered from Pallion Primary Care Centre. The other three UCCs are provided by Vocare and are delivered from the following sites:

- Bunny Hill Primary Care Centre
- Washington Primary Care Centre
- Houghton-le-Spring Primary Care Centre

All the UCCs in Sunderland are open from 10:00 to 22:00 weekdays and 08:00 to 22:00 at weekends and bank holidays. Patients can access the UCCs by walking in, or, if they phone NHS 111 and are suitable to be seen in an UCC, then NHS 111 can book an appointment for the patient to attend the UCC of their choice. The UCCs are GP led and see patients with minor illness and minor injuries.

3.25 Urgent Care Centre Activity

Over the past twelve months (December 2016 to November 2017) there were 103,000 attendances at the UCCs. Activity at the UCCs has increased over time with no evidenced reduction in ED activity. This evidence suggests that additional points of entry into the UC system generate activity. The chart below shows urgent and emergency care activity over time and it clearly shows that when facilities open, additional demand is generated. SCCG have previously closed only one facility and whilst the initial impact showed a decrease in overall system wide UC activity, as SCCG commissioned other facilities, demand eventually increased.
The development of the UCCs (and previous to the UCCs, MIUs and WiCs) has generated approximately an additional 103,000 UC contacts in Sunderland with Sunderland now having a higher rate of UC/ED attendances per head of population than most in the region. Sunderland is now an outlier nationally for UC/ED attendances per head of population.

The chart below shows the crude rate per 100,000 population for all UCC and ED activity for a twelve month period and shows Sunderland as having the second highest rate in the region. Sunderland is also nearly two times higher than the England rate. Activity over the past few years is also increasing by approximately 4% in total, year on year.
The activity at each of the four UCCs in the period December 2016 to November 2017 is set out in the table below. Approximately 86% of attendances were for minor illness, and approximately 14% were for minor injury.

<table>
<thead>
<tr>
<th>Site</th>
<th>Illness</th>
<th>Injury</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pallion</td>
<td>27,493</td>
<td>2,102</td>
<td>29,595</td>
</tr>
<tr>
<td>Bunny Hill</td>
<td>21,137</td>
<td>3,587</td>
<td>24,724</td>
</tr>
<tr>
<td>Houghton</td>
<td>16,359</td>
<td>3,694</td>
<td>20,053</td>
</tr>
<tr>
<td>Washington</td>
<td>23,868</td>
<td>4,656</td>
<td>28,524</td>
</tr>
<tr>
<td></td>
<td><strong>88,857</strong></td>
<td><strong>14,039</strong></td>
<td><strong>102,896</strong></td>
</tr>
</tbody>
</table>

Table 2: Urgent Care Centre attendances by illness and injury categorisation and by site

As the UCCs accept walk in patients who self-present, a number of patients from outside Sunderland attend the UCCs annually. This activity has increased since April 2017, as set out in the graph below. SCCG is currently working with neighbouring CCGs and Vocare to stream patients into their local services.
Figure 20: Out of Area CCG activity being seen in Sunderland Urgent Care Centres

The following maps show the activity flows into the UCCs. Each map depicts the activity flow into one of the four UCC. The maps highlight the concentrated activity from nearby localities for each UCC, but also highlight the level of activity flowing into the Sunderland UCCs from other CCGs.
Colour coded key to the maps below:

<table>
<thead>
<tr>
<th>KEY - Annual Figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;1200 attendances</td>
</tr>
<tr>
<td>&lt;1200 attendances</td>
</tr>
<tr>
<td>&lt;500 attendances</td>
</tr>
<tr>
<td>&lt;100 attendances</td>
</tr>
<tr>
<td>&lt;10 attendances</td>
</tr>
</tbody>
</table>

Pallion UCC:

Figure 21: Activity flow into Pallion UCC
Bunny Hill UCC:

Figure 22: Activity flow into Bunny Hill UCC

Houghton-le-Spring UCC

Figure 23: Activity flow into Houghton UCC
3.26 Emergency Department

There is one ED in Sunderland located at the CHS main site on Kayll Road. The ED is open 24 hours a day and seven days a week. CHS opened a new ED department in 2017/18. CHS has dedicated adult and paediatric EDs with activity over the past twelve months of 93,714. Activity in ED has risen over time despite current UC service provision across Sunderland. Over the past twelve months, ED activity has grown by 4%-6% (on a like for like basis) which is consistent with previous years. This figure does not include activity which is “streamed” away from ED into the Pallion UCC and into the west locality SEAS (also located within Pallion Primary Care Centre). Approximately sixteen Sunderland patients per day are streamed to the UCC from ED and vice versa.

The following table shows the activity over the past twelve months into adult and paediatric ED for CHS overall (all commissioners) for all referral sources e.g. self-presentations, ambulance, GP and other:

<table>
<thead>
<tr>
<th>Site</th>
<th>Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult ED</td>
<td>68,626</td>
</tr>
<tr>
<td>Paediatric ED</td>
<td>25,088</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93,714</strong></td>
</tr>
</tbody>
</table>

Table 3: Activity over the past 12 months into adult and paediatric ED for CHS
The chart below shows attendances to the adult and paediatric EDs over time:

![CHS Emergency Department Activity](image)

**Figure 25: CHS Emergency Department Activity (April 2013 to November 2016 inc.)**

### 3.27 North East Ambulance Service

The North East Ambulance Service (NEAS) is commissioned to deliver ambulance services for the North East, including the SCCG population. The service also provides the call handling and triage of 999 calls, to ensure an appropriate response to patients.

NEAS staff are working in new ways to deliver an increase in calls resolved through ‘hear and treat’ (telephone triage and advice) and ‘see and treat’, where patients are treated on scene as required and their care transferred to a community provider, instead of conveying the person to ED. The ‘see and treat’ approach has been embedded in Sunderland through the roll out of Paramedic Pathfinder. Through Paramedic Pathfinder over one hundred paramedics have been trained in the approach. This has resulted in increasing numbers of people having their care transferred to a community provider instead of being conveyed unnecessarily to CHS ED.

999 incidents in Sunderland have remained static over the past year but significant seasonal variation exists. This variation is set out in the chart below:
3.28 All Together Better (ATB) Sunderland Vanguard Programme

Around seventy nine thousand people in the City of Sunderland have at least one long term condition, and one in four adults report some form of long term illness, health problem, or disability. Long term conditions become more common with age and Sunderland has an aging population. Approximately 80% of local people between the age of seventy and seventy nine have at least one long term condition.

The planning for closer integration between health services and social care in Sunderland began in May 2013, when both the new clinically led SCCG and the Local Authority agreed a vision for the future of community services which was supported by the main local providers. This vision aimed to move from fragmented services to integrated services which would provide more effective, person centred, co-ordinated care. This led to a range of local developments which provided the evidence to support Sunderland’s application and selection to join the NHS England Vanguard programme with the intention to develop the Multi-speciality Community Provider (MCP) model.

The All Together Better (ATB) Sunderland Vanguard Programme has been in place since 2015 and, through the unified vision and combined efforts of both health and social care commissioners and providers, has made significant progress with the development and implementation of an integrated Sunderland Out of Hospital Care Model. This model is set out in the diagram below:
3.29 Community Integrated Teams

Five multi-disciplinary Community Integrated Teams (CITs) across Sunderland provide an effective, high quality and coordinated response to the most vulnerable people with the most complex needs, keeping them out of hospital. CITs focus on the top 3% of patients who are most at risk and who use 50% of our health and social care resources. Teams are made up of district nurses, community matrons, general practitioners, practice nurses, social care professionals, living well link workers and carers support workers. CITs create holistic health care plans with patients and carers, tailored to the needs of the person, and supported by their own GP, who leads clinical decision-making to ensure that the medical, social and emotional needs of their patients are addressed.

3.30 Recovery at Home Service

The Recovery at Home service is designed to improve the care offered to people who need it most if they experience an unexpected change in their condition that could develop into a crisis. The Recovery at Home service aims to support adults who live in Sunderland and are registered with a Sunderland GP.

Operating 24/7, the Recovery at Home team is ready to respond quickly to provide intensive support to those who need more help while they're getting back to normal after a short term illness or injury in their own home, including residential or nursing care homes.

Support is tailored to a person’s needs and can be any combination of a short term care package, including nursing and/or therapy, without having to be hospitalised or needing long term care. Recovery at Home also provides social care elements and is aligned with Sunderland Care and Support and the Independent Living Centre where specialist equipment and assessment can be provided.
3.31 Ambulatory Emergency Care
Ambulatory Emergency Care (AEC) is a way of managing a significant proportion of emergency patients on the same day without admission to a hospital bed. It is a transformational change in care delivery and has the potential to be as significant to emergency care as day case surgery is to elective care.

AEC is a key priority for Sunderland as it’s acknowledged that this way of working will support the sustainability and delivery of the urgent and emergency care system.

AEC has been developed with partners across the system, particularly the acute trust and is commended by the National AEC Network for its whole system approach.

The development of ambulatory care at CHS has increased short stay emergency admissions in Sunderland due to the recording of activity as emergency admissions.

3.32 Mental Health Services
A variety of mental health services exist to respond to urgent mental health needs. For patients requiring assessment and treatment for physical health conditions as well as mental health treatment, the Rapid Assessment Interface Discharge (RAID) team operate in the ED at CHS and in-patient wards. If someone is experiencing a mental health crisis, Northumberland, Tyne and Wear NHS Foundation Trust operate a Crisis Team that visits people in their own homes.

3.33 Emergency Dental Services
NHS England is responsible for commissioning dental services. Dental practitioners are required to provide emergency treatment for patient’s in-hours, if the patient is registered with them and is currently receiving a course of treatment. If the patient is not registered with a dental practice, information on who they can register with is detailed on NHS Choices website and available through NHS 111. When a patient has dental pain out of hours, NHS 111 directs the patient to the Out of Hours GP Service.

3.34 Services currently in development
In addition to the existing services already in place in Sunderland, there are also a number of service reform projects in development across Sunderland. The two key services pertinent to this outline business case are the 24/7 home visiting service and the ED Interface service. Both of these service developments are being led by the Sunderland Provider Board. The Provider Board was established in spring 2015 to oversee the mobilisation and delivery of the Sunderland Out of Hospital model and associated use of NHS England vanguard funding. Its role has since expanded to include mobilisation of provider elements of the UC Strategy and delivery of financial efficiencies across Out of Hospital services.

3.35 Emergency Department Interface
Sunderland has an ED Interface model currently in place in the ED at CHS. The ED Interface model is where out of hospital and in hospital services work together to manage patients who would otherwise require a hospital admission. Providers in Sunderland have worked collaboratively to deliver the ED Interface model. With the input of the ED Interface team many patients, including the elderly frail, can be managed in the ED and supported to return and remain at home without a hospital admission.
The ED Interface model will be developed to include services currently being delivered by Recovery at Home with the addition of GP services and other specialist teams (from either the community or the acute trust) to provide a triage for people arriving at the ED, streaming appropriate patients away from ED and to more appropriate services to meet their needs. Clinical leads for this new team could be a GP, a community nurse or one of the hospital’s specialist medical team. This role is currently under development.

In the future, the ED Interface team will identify the most effective level of care someone needs and stream them to the right service. This could include referral back to their own GP or another community-based service or into the more specialised services provided by the ED. As well as releasing pressure on hospital services, there is potential for community patient transport to take people who need it to other treatment centres or home if they don’t need emergency treatment.

3.36 Home Visiting Service
C CGs are required to commission an out of hours home visiting service by NHS England. The current out of hours home visiting service is included in the GP OOHs contract which is due to end on the 30th September 2018. From the 1st October 2018, the ‘speak to’ element of the GP OOHs contract will transfer to the regional IUC service. This means SCCG needs to re-commission the home visiting element of this service.

The existing 24/7 Recovery at Home service is working closely with the Sunderland General Practice Alliance to integrate general practitioners into the current service, including across the out of hours period to provide a GP led 24/7 home visiting service.

The home visiting service will be accessed via the general practice or via the IUC service. The IUC service specification sets out the requirement for all home visits to be triaged by a clinician. Patients who are under the care of the Recovery at Home Team will be able to request GP input as required. In line with the integrated service delivery ethos, SCCG is proposing that the home visiting service is not advertised to patients, where a patient requires a home visit this will be triaged via the practice or the IUC service, with the result that the patient receives the service most appropriate for their needs, rather than on the basis of what the person has chosen to access. A separate home visiting service will mean GPs won’t have to spend time travelling and this will support general practice by releasing time and capacity for other appointments. Where a patient requires continuity of care from their GP, the GP will still be able to choose to undertake the home visit themselves.

3.37 The Multi-speciality Community Provider
This outline business case builds upon the work already undertaken in Sunderland by the All Together Better (ATB) Sunderland Vanguard, and more recently the evolution of this work into the proposed Multi-speciality Community Provider (MCP).

The purpose of the MCP is to ensure that the care system in Sunderland is fit to meet patients’ future needs, delivering the effective, efficient and seamless care that the local population deserves. To achieve this, the MCP must work towards a service which focuses on:
Improving care quality including safety, clinical effectiveness and patient experience
- Improving health and wellbeing
- Creating a more sustainable health and care system

The underlying principle of the MCP is that it will enable GPs, nurses and other health professionals to come together and work with social care and the community and voluntary sector to plan and deliver integrated care that leads to better outcomes for people. This means that when people do need support from public services it is delivered close to them, with hospitals only needed for specialist care, so making best use of the limited resources available.

An MCP is expected to deliver a new type of integrated provision. It should bring together the delivery of primary care and community-based health and care services. MCPs can incorporate a much wider range of services and specialists wherever this is the best thing to do. The integration approach with general practice is central to the delivery of the MCP, there is no MCP without general practice.

An MCP is a place-based model of care. It will serve the whole population, with the offer of decision-making rights to deploy the integrated budget flexibly, so the provider can reshape the local care delivery system around what really works best for different groups of patients. This framework is depicted in the diagram below:

![Figure 28: MCP Framework](image)

The proposed scope of the Sunderland MCP encompasses everything that is, can, or should be (taking into account medical, wellbeing, safety and quality considerations) delivered outside of a hospital environment. The MCP framework includes UC needs, and the provision of an UC system that is responsive to patient needs and integrated within the model of care is included in the design aims of the Sunderland MCP. It was agreed by the SCCG Executive Committee in December 2017 that UC services (including the current UCCs, the current GP OOHs service, the SEAS, and the Recovery at Home service) will be secured via the MCP. UC services are included in year one of the MCP. The MCP is expected to go live on the 1st April 2019.
4. Financial overview

4.1 Introduction
SCCG is currently deemed to be overfunded by 17% according to the national funding formula for CCGs and as such, there is a need to deliver significant efficiencies across the system in order to secure system sustainability. SCCG is committed to meeting its financial duties which includes ensuring that it delivers value for money on the services that it commissions. The reform of UC services aims to contribute to these commitments whilst also improving and simplifying the service offer to the Sunderland population.

4.2 Financial Objective
SCCG’s financial plan assumes recurrent efficiencies from implementing a new model can deliver efficiency savings of £1.5m (£500k in 2018/19 and £1m in 2019/20). The financial modelling for this outline business case has been influenced by the UC planning work completed in collaboration with local partners, and the national ‘must do’s’.

4.3 Current Cost of the Urgent Care Model
The total 2017/18 budgeted expenditure in relation to the current UC model is set out below. The below service lines cover contracts with differing time periods from a number of providers.

<table>
<thead>
<tr>
<th>Service Line Description</th>
<th>£000s</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Centres x 4</td>
<td>3,936</td>
<td>Service commissioned from September 2014.</td>
</tr>
<tr>
<td>Community based X-Ray Activity</td>
<td>166</td>
<td>Service has been in place for a number of financial years - part of larger acute contract.</td>
</tr>
<tr>
<td>Sunderland Extended Access Service</td>
<td>1,704</td>
<td>Newly commissioned service - mobilised in Sep 2017 for a number of hours. National directive requires extension of hours in Sep 2018.</td>
</tr>
<tr>
<td>ED Interface Teams</td>
<td>660</td>
<td></td>
</tr>
<tr>
<td>GP Out of Hours Contract</td>
<td>1,785</td>
<td>Service commissioned from September 2015.</td>
</tr>
<tr>
<td>Existing 111 contract</td>
<td>956</td>
<td></td>
</tr>
<tr>
<td>Winter Surge Funding</td>
<td>1,610</td>
<td></td>
</tr>
<tr>
<td><strong>Total Current Urgent Care System Costs</strong></td>
<td><strong>10,817</strong></td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Current Cost of Urgent Care Model

4.4 Provider Financial Stability Impact
SCCG is committed to minimising the potential impact on workforce from the potential proposed changes to the UC system in Sunderland (including avoiding where possible redundancy costs). A full workforce plan will be developed to ensure a smooth transition to the final agreed model.

At the time of writing this outline business case it is not possible to complete a financial sustainability impact of current providers as SCCG does not have access to the information required to complete this analysis.
5. System Enablers

This section sets out additional work that is ongoing across the Sunderland health system which will support the delivery of the UC strategy.

5.1 IT
SCCG is enabling record sharing capability for urgent and emergency care services which will enable a view of the GP record to be available by secure methods. There are a number of methods being used to digitally share patient information across partner organisations:

- all practices have access to, and use, EMIS Web
- general practice has direct access to a summary view of their registered patients on the local hospital system.
- EMIS to EMIS sharing between community services, Sunderland GP Alliance and general practice is also used to share patient level data. This functionality allows controlled access to defined views of patient records and facilitates the transfer of agreed electronic documents and referrals.
- the Medical Interoperability Gateway (MIG) which allows controlled access to a set of views within a patient’s GP record has also been enabled. Initially this was limited to urgent care environments as part of the Urgent and Emergency Care Vanguard Project across the region, however it has now been expanded to trust wide availability.
- all information is underpinned by information sharing agreements between the parties involved and these are managed using a tool call the Information Sharing Gateway (ISG).

5.2 General Practice Workforce
Data published by NHS England reveals that the North East region had 1,454 full-time equivalent GPs at the end of June 2017, compared to 1,564 in March 2016. This is a loss of more than one hundred GPs in a little over a year.

The GPFV sets out schemes to help support GP recruitment and retention, including:

- an international GP recruitment programme. This is a national programme where NHS England will recruit GPs from overseas, providing support to doctors making this transition from other countries whilst providing reassurance to the practices recruiting that the doctor who joins them will be a valued member of their team. This support will be ensured through the recruitment and training model used for the North East. SCCG has asked practices to give an expression of interest if they are interested in employing an overseas GP where they have a vacancy.
- recruiting other clinicians, including pharmacists, therapists and physiotherapist to work in GP practices to help reduce GP workload. Some practices have recruited other health care professionals to ensure a good skill mix within practice including employing paramedics who can see the acute patients and also carry out house calls.
- implementing a national scheme to support GPs by providing mental health support, when required, to reduce ‘burn out’
SCCG has invested additional funding into general practice workforce and through their Workforce Development Group have developed the following schemes to support the initiatives undertaken under the GPFV:

- GP Career Start Scheme
- Golden Hello Scheme
- Practice Nurse Career Start and HCA Programmes
- General Practice Workforce Toolkit
- GP Trainers Bursary
- Training programmes for clinical staff
- Paramedic Placements
- Physicians Associate placements
- Longer term development of a possible medical school at Sunderland University

Further details of each of these Workforce Development Group initiatives can be found in Appendix A.

SCCG is also working closely with Sunderland University and Newcastle University to develop bespoke training for General Practice clinical staff.

All of the above initiatives will support GPs to release time by other professionals seeing and treating patients where it is safe and appropriate to do so leaving the GPs to see more complex patients.

There is recognition that current service duplication is diluting the workforce and development of new models of care may ease these pressures. Examples would include overlapping provision of GPs in and out of hours, SEAS and UCCs.

5.3 Other Workforce Considerations
The whole out of hospital system in Sunderland is keen to retain the existing UC workforce in Sunderland. The mechanisms to secure this are currently under discussion, potentially through the MCP. The outcome of these discussions will be included in the decision making business case.
6. Engagement

The scenarios set out in this outline business case have been arrived at via an iterative process which has included public and patient feedback from engagement activities and extensive co-design work with stakeholders and providers.

6.1 National Engagement with the Public
As part of the development of the national strategy, an extensive public engagement exercise was undertaken seeking the views of patients, the public and key stakeholders. A National Patient Association survey was also published in May 2015 explored the choices, decisions and experiences of patients accessing ED services for UC needs and concluded that:

- Patients are aware of alternatives to ED but many still attend ED because they are unable to access timely help elsewhere
- Patients attend ED because they are advised to do so by other health professionals
- The ED brand is very powerful and
- The arguments for co-locating general practice with ED are compelling.

Some caution should be given to this as opinion was collated via an open access survey on the Patient Association website, and therefore may not be a truly representative picture.

6.2 Regional Public Engagement
In 2016 NECS undertook a desktop review of UC in Sunderland using information from a regional level. Key messages from this desktop review included:

- access to the general practice appears to cause contention, as well as be the cause for misuse of services. Even so, when access is possible, the general practice is always the preferred service
- when looking at comparisons between a general practice and a community pharmacy, people have very strong views, with a major preference towards a General Practitioner (GP)
- a common theme showing amongst regional UC is that people tend to access the wrong service
- having to “ring [the] practice at a specific time (usually first thing in the morning) to access a same day urgent appointment” isn’t popular with people
- seeing their own GP appears to be specifically more important to those who have a long term condition
- the general practice is always viewed as the preferred option
- UCCs regionally are very much seen as an alternative to the general practice. Lack of understanding and the ability to acknowledge that other services could have perhaps been more appropriate majorly influences patient’s attendance to UCCs

The full desktop review report can be found in Appendix B

6.3 SCCG Public Engagement
Through the engagement work that SCCG has already undertaken, patients and the public have told us:

- the system is confusing
- people want to be able to see a GP when they have an UC need
people with long term conditions want continuity of care because their needs are more complex

From engagement activities we know that:
1. The current system is too complicated to navigate effectively. We know this because:
   - historically additional services have been opened piecemeal to cope with increasing demand
   - in previous engagement exercises Sunderland residents have said they find the UC system confusing, and they don’t know where best to go to get their health care needs met

2. The current system does not provide the UC service that the people of Sunderland would prefer. We know this because:
   - people living in Sunderland have told us that they would prefer timely access to their general practice for same day urgent care (General Practice Strategy engagement)
   - local data shows us that people in Sunderland continue to access ED for non-life-threatening needs despite the provision of UCCs across the city
   - local data show us that the number of people going into ED has increased year on year

3. People are not getting their UC needs met effectively in the current system. We know this because:
   - people go to ED who do not require any treatment or follow up
   - we know from the number of people accessing the UCCs who either need no further treatment or who require follow up by their GP that their care needs could have been met by their own GP
   - we know that when people are seen by their general practice or in SEAS the GP can see their whole medical history, but this currently isn’t possible in ED or the UCCs
   - national engagement work as part of the 5YFV highlights the need for services to keep pace with societal and technological changes, particularly the use of online services which have led to a culture of immediacy and rising expectations
   - UCC providers are struggling to recruit GPs to work in the centres
   - people with long term conditions tell us through the ATB Sunderland Vanguard engagement process that they want care that is joined up, agreed with them, and has continuity because of their often complicated needs.

4. Sunderland residents have an overreliance on hospital care. We know this because:
   - the amount of people accessing ED has not reduced despite the provision of four UCCs
   - in the twelve months up to October 2016, 56% of people attending ED in Sunderland either left the department without receiving any treatment or were discharged requiring either no follow up or follow up by their GP.

SCCG went on to undertake further pre-engagement work in Sunderland from 22nd November 2016 to 23rd December 2016 using the following methods:
The pre engagement work in Sunderland resulted in the following key findings:

- if a participant has a LTC they are more likely to choose to go to their general practice during normal working hours if they have an UC need
- location of service is important, with most strongly agreeing that UC should be close to home or their community
- participants are more likely to make their way to the ED than use GP OOHs or the SEAS
- there’s lots of confusion surrounding services with many still not understanding which service to use and when
- ability to access medical history/notes is important when receiving advice, diagnosis or treatment
- there should be a single point (sign-posting) of contact that directs people to the most appropriate service when they need UC
- opening other services longer, and easier access could prevent unnecessary visits to ED

The full pre-engagement report can be found in Appendix C. For information, the ‘Sunderland CCG Public satisfaction/perception of primary care – General Practice report’ undertaken in 2015 as part of the General Practice Strategy work can be found in Appendix D.

Engagement with general practices has also been undertaken in each of the five localities. SCCG visited each of the general practice locality meetings to share and discuss the UC work to date in April and May 2017. Following these engagement events, an online survey was distributed to general practice staff including GPs, Nurse Practitioners, Practice Nurses and Practice Managers. The full general practice online survey results report can be found in Appendix E. Further engagement with general practice will be undertaken via the general practice Time In Time Out sessions and future Locality Meetings. Further details regarding proposed consultation with general practices can be found in the Consultation Plan in Appendix F.

A significant amount of engagement has also been carried out as part of the MCP work prior to and through the ATB Sunderland Vanguard. For example, Age UK Sunderland was commissioned to undertake engagement with the Sunderland Carers’ Centre, and they conducted a series of events with diverse groups across the city. This raised awareness of the ATB Sunderland Vanguard as well as gained comprehensive feedback regarding the MCP. Further details of this work are set out in the separate MCP prospectus (available at: http://www.sunderlandccg.nhs.uk/wp-content/uploads/2017/11/Sunderland-CCG_MCP_Sum17-DRAFT8.pdf).
6.4 Path to Excellence

The Path to Excellence is a five-year transformation of healthcare services across South Tyneside and Sunderland. It has been set up to secure the future of local NHS services and to identify new and innovative ways of delivering safe, high quality, joined up, sustainable care that will benefit the population of South Tyneside and Sunderland both now and in the future.

The public consultation for the Path to Excellence programme is being led by the commissioners of local health services (NHS South Tyneside Clinical Commissioning Group (CCG) and SCCG) who are responsible for planning and buying healthcare services on behalf of patients. Working in partnership with STFT and CHS, who formed a strategic alliance in March 2016 known as ‘South Tyneside and Sunderland Healthcare Group’, all four NHS organisations are committed to delivering the best possible NHS services for the future through the Path to Excellence programme.

The Path to Excellence listening exercise started in October 2016. This was aimed at understanding public views, needs and experiences relating to stroke, maternity and gynaecology, and paediatric services. Also included in this work is the travel and transport impact assessment.

The Path to Excellence asked local people to share their views on clinical services in South Tyneside and Sunderland to help identify how they can be improved and how things might be done differently in the future. Public engagement and market research within South Tyneside and Sunderland provided key findings and insight to support consultation around any possible future proposed changes to the clinical areas.

The primary findings of the listening exercise have been published and available at: https://pathtoexcellence.org.uk/wp-content/uploads/2017/05/A-review-of-patient-insight-South-Tyneside-and-Sunderland-Version-4.pdf

The formal consultation phase of the Path to Excellence proposals to gather public views around the different ways NHS services could be arranged in South Tyneside and Sunderland took place from 5 July to 15 October around:

- Stroke services specifically hospital (acute) care and hospital based rehabilitation services
- Maternity services (obstetrics) covering hospital based birthing facilities i.e. where you would give birth to your baby and special care baby units
- Women’s healthcare (gynaecology) services covering inpatient surgery where you would need an overnight hospital stay
- Children and young people’s healthcare services (urgent and emergency paediatrics) specifically urgent and emergency care

NHS South Tyneside and Sunderland Partnership has a requirement to develop a robust level of knowledge and understanding on public perception of clinical services currently under review as part of the Path to Excellence programme (the Sustainable Transformation Partnership for the area).

The draft formal consultation feedback can be found at: https://pathtoexcellence.org.uk/wp-content/uploads/2017/12/Path-to-Excellence-Consultation-Analysis-Draft-Final-Report.pdf
6.5 Stakeholder Engagement
SCCG has undertaken extensive stakeholder engagement to ensure any proposed potential UC clinical model for the future is credible, deliverable, and sustainable. The proposed principles of the clinical model and the scenarios for public consultation have been developed through an iterative process of ongoing discussion and involvement with partners and stakeholders, including current providers. The details of this process are set out in section 6.3 of this document. The SCCG clinical lead (a practicing GP) has been closely and actively involved in the UC strategy work. Stakeholders have participated in seven interactive workshops over eighteen months to develop the proposed principles of the clinical model and the scenarios for public consultation set out in this outline business case. The latter two workshops were led by the Multi-speciality Community Provide Executive Team (MCPET) in collaboration with SCCG.

The following organisations have been involved in the development of the proposed principles of the clinical model and the scenarios for public consultation:
- City Hospitals Sunderland NHS Foundation Trust (CHS)
- South Tyneside NHS Foundation Trust (STFT)
- Northumberland, Tyne and Wear NHS Foundation Trust (NTW)
- North East Ambulance Service NHS Foundation Trust (NEAS)
- Vocare
- Sunderland Care and Support
- Sunderland GP Alliance (SGPA)
- Sunderland City Council
- The MCP Executive Team (MCPET)
- NHS England
- North of England Commissioning Support Unit (NECS)
- North Durham and Durham Dales, Easington and Sedgefield CCGs (via NECS)

The proposed principles of the clinical model and the scenarios for public consultation presented here have the support of stakeholders and senior managers from general practice, the SGPA, SCCG Clinical Leads (who are General Practitioners), NEAS, NTW, Vocare, STFT, CHS, Sunderland Care and Support and Sunderland City Council. Updates on this work have also been delivered to the MCPET.

The whole system approach taken by SCCG, working closely with partners and providers in the city builds upon existing good relationships between providers to benefit both the patients using UC services and the whole system in terms of achieving an efficient, simple to navigate, model to deliver UC.
7. Development of Scenarios to Deliver Urgent Care in Sunderland in the Future

This section sets out how the proposed scenarios for public consultation have been developed and appraised to arrive at the two proposed scenarios.

7.1 Developing the proposed principles of the clinical model
The high level potential proposed principles of the UC clinical model are based on national ‘must do’s’, including the IUC service, UTCs and extended access in general practice, regional reform including the regional procurement of the IUC service, and local reform of the out of hospital system. These reforms have been further informed by public and patient engagement and extensive engagement with stakeholders and providers.

7.2 Development of Scenarios
The proposed scenarios to take out to public consultation have been developed through seven stakeholder events which commenced in December 2016 and continued to November 2017.

All the scenarios for public consultation are underpinned by the national ‘must dos’ and local enablers. The national ‘must dos’ include the provision of the IUC service and an UTC. Access to UC services will be via the IUC (111) service, except for those patients (for example with long term conditions) where the practice has specifically asked them to contact the practice instead of the IUC service, or where the patient has a LTC or comorbidities which mean continuity of care via the general practice is required.

The existing Sunderland Out of Hospital Model provides the local enablers and includes the R@H Service, CITs, the 24/7 home visiting service, the ED Interface and AEC.

The scenarios have been informed by extensive modelling of current and anticipated future activity. The scenarios have undergone stress testing by SCCG and existing providers to provide assurance that the scenarios are credible and viable. The scenarios have also been informed by the public and patient engagement and engagement with member practices.

7.3 Development of Criteria
Each of the proposed scenarios developed as part of this outline business case have been appraised against the five design principles which have been applied as criteria. Only those proposed scenarios which meet the five criteria have been put forward for public consultation. The five design principles are:
1. Be safe, sustainable, and provide responsive, high quality care
2. Increase self-care through access to appropriate clinical advice
3. Ensure appropriate access to treatment as close to home as possible
4. Simplify access by improving integration across health and social care and reducing duplication of services
5. Meet nationally mandated requirements
7.4 Proposed Potential Clinical Model Narrative
The proposed clinical model (see figure below) has self-care and the use of the sixty three community pharmacies as the most common urgent care provision for the majority of people, most of whom will have self-limiting conditions.

For those people who need more clinical input than can be obtained at a community pharmacy, or who are unsure how to best get their UC needs met, the new IUC service (111) will be available 24/7, over the telephone and also online. SCCG are seeking to implement consistent triage across the whole UC system, ensuring that people access services according to need, not according to how they presented. Constant triage will be in place across IUC, general practice, the UTC and ED. Consistent triage is being progressed via IUC, training to general practice staff including receptionists, and via streaming in the ED.

The new ‘consult and complete’ IUC service will assess people, give self-care advice where appropriate and transfer patients to a clinician where a telephone consultation would be suitable to assess their needs. Where a person is assessed as requiring a face to face appointment with a clinician, then the patient will be booked an appointment into the service which is most suitable for their needs. This will include same day direct booking in core general practice, into the Sunderland Extended Access Service and into the UTC. Sunderland general practices and the IUC service will be able to book people into the home visiting service, which will operate 24/7. Patients will only be booked into core general practice appointments following a telephone consultation with a clinician in the IUC service.

It is proposed that in line with required standards the UTC will be located within the acute footprint, at Pallion Primary Care Centre. The UTC will have both same day and pre-bookable appointments. All practices in Sunderland will be able to book into the pre-bookable appointments. The UTC will see people with minor injuries from across the city, where the injury cannot be managed in general practice.

Patients presenting to the ED will be streamed by a clinician to the most appropriate location within the acute footprint to meet their needs. This will include the UTC, AEC, and the ED Interface. We are not proposing to undertake any specific communications to the public regarding the services which are included in the acute footprint as streaming of patients will happen upon presentation, with people directed to the most appropriate part of the service to meet their needs. This may include booking people into offsite services, for example core general practice. There is no intention to turn patients away from ED without providing the patient an appointment in an alternative service unless their presentation does not require any clinical input.
Figure 29: Proposed potential urgent care service model
Note 1: direct access to the practice would remain available for those patients who choose to contact their practice directly, including those people who require continuity of care
Note 2: the acute footprint in the diagram includes streaming as appropriate to the ED Interface, Ambulatory Emergency Care, the Urgent Treatment Centre or the Emergency Department.
Note 3: this diagram is for use with professionals and will be adapted for public communications
7.6 Scenario Activity Assumptions

As part of the scenario development work significant activity modelling has been undertaken over the past twelve months to understand the potential implications of commissioning a new UC system. The current UC assumptions for activity section was modelled based on historical activity levels seen in each UCC and also takes into account population/demographic changes. This modelling has been undertaken with providers, including general practice. The assumptions detailed in section 7.7 underpin the output from the modelling.

The following activity flow shows activity before the implications of commissioning the potential proposed UC clinical model and after:

![Figure 30: Sunderland urgent care centre activity impact model – Annual Activity Levels](image-url)
Figure 31: Sunderland urgent care centre activity impact model – Crude Daily Activity Levels

The expectation is that all minor injury activity will remain in the system and will flow to the UTC, although a small proportion will continue to flow to those practices which currently deal with minor injuries. It is also expected that current illness activity carried out at Pallion UCC will remain and be seen at the UTC. Based on local and regional evidence from other CCGs, the expectation is that 50% of current illness activity carried out at Bunny Hill, Houghton and Washington UCCs will be subsumed within the current system. This activity will be subsumed through self-care, use of pharmacies, the new IUC service, core general practice and SEAS.

All illness activity from other CCGs that flows into the Sunderland system (11,000) will need to be managed by the host CCG through their own primary and UC systems and reform. This activity is currently paid for by the patients CCG and this arrangement is expected to apply in any new UC model. There is potential risk that activity continues to flow into Sunderland, flowing into the UTC or ED. Neighbouring CCGs are currently implementing strategies to address the flows into the Sunderland system and SCCG will continue to work closely with neighbouring CCGs to mitigate this risk for Sunderland.
The modelling in this outline business case only includes activity from other CCGs which flows into Sunderland, and not Sunderland activity that flows to other CCGs as this is not expected to change and is funded separately within other contracts and non-contract activity budgets.

It is expected that the residual 16,000 annual UC attendances will be managed by general practice, either through core general practice or SEAS. This residual activity will vary by locality due to historical use of the UCCs.

The residual annual 16,000 residual activity equates to approximately forty five additional appointments per day across Sunderland but the variation across localities ranges from five appointments in the East to fifteen in Coalfields and Washington (due to historical usage of the UCCs and due to the assumption that the UTC will be located within the acute footprint). From 1st April 2018 SEAS will offer a total of eight hundred and fifty two appointments per week, which is two hundred and eighty four more appointments per week than is currently provided. This equates to approximately one hundred and twenty two appointments per day in total.

The 24/7 home visiting service will also release appointments in general practice. This service is currently under development and the modelled impact of this service will be included in the decision making business case.

7.7 Scenario Activity and Finance Assumptions

The following assumptions have been made to facilitate the modelling set out in this document:

- the three UCCs contracts ending will result in 50% of current activity being managed in alternative way e.g. self-care or via the IUC service based on evidence from other closures across the region
- this has been tested against previous experiences in Sunderland but also tested against various local and national service changes, including. South Tees and Durham Dales, Easington and Sedgefield (DDES) CCG
- current activity being seen at the Pallion UCC will be seen in the UTC where a walk in facility will be maintained
- the UTC and will be part of the acute footprint
- the reclassification of the Pallion UCC as an UTC will not increase system costs
- the UTC will see the current levels of minor illness
- all minor injuries will be seen at the UTC which can accommodate this activity
- the minor injuries activity seen by the UTC will remain at cost
- out of area patients from neighbouring CCGs (non SCCG registered patients) will be treated by services commissioned by those respective CCGs. e.g. DDES and North Durham CCGs
- activity currently carried out between 20:30 and 22:00 at the community UCCS will be seen by the home visiting service and/or the SEAS (approximately 2,193 attendances per annum)
- the residual activity (16,000) will have their needs addressed by general practice (including SAES) or the IUC service
- based on the UC planning work which is ongoing with general practice it is suggested that in 2018/19 quality premium, practices will engage with the UC
agenda to gain robust data and feedback from UC activity to inform any additional activity in 2019/20

- workforce planning will need to take place to ensure minimal to no redundancy costs for the system
- SEAS funding will continue and is sufficient to deliver the requirements of the system
- the ED Interface work will continue to be delivered within the funding available
- the current GP OOHs APMS contract ceases at the end of its current contract (30th September 2018)
- all speak to dispositions will be undertaken by the IUC Service following cessation of the GP OOHs APMS contract
- there will be sufficient service capacity to deliver the requirements of the scenarios for public consultation
- a replacement for the current out of hours home visiting service provided by the GP OOHs service will be in place when the contract ends on 30th September 2018
- the in hours home visiting service will be in place and mobilised for the 1st April 2018 to support the release of capacity in general practice
- the current funding for GP cover into Farmborough Court and R@H is not considered in the financial implications
- all estates implications (voids) are modelled into the financial case
- if required, contract extensions can be negotiated with Vocare
- the future model will be delivered by the MCP from 1st April 2019 as per SCCG’s strategy of reforming out of hospital care.

7.8 General Practice modelling
The proposed model assumes a residual activity of approximately forty five appointments per day across Sunderland will be seen by general practice. The potential proposed model assumes investment into an in hours home visiting service which will release capacity in general practice in order to manage this additional activity. If the potential proposed model is implemented, it has been agreed that there will need to be an assessment of these assumptions to ensure there is no material difference and resultant adverse impact on general practice.

7.9 Urgent Treatment Centre activity modelling
The potential proposed model assumes additional activity of 4,063 attendances per year (which equates to 11 additional attendances per day) will need to be seen by the UTC. On the basis of the system approach to working in Sunderland it is assumed within the modelling that the additional costs will need to be funded for this activity which is assumed at 60% of tariff (in line with STP assumptions on marginal rate of emergency activity). As per other providers it has been agreed there will need to be an ongoing assessment of the actual activity impact in order to ensure there is no material impact and resultant adverse impact on patient care and the provider.

7.10 Modelling the scenarios for public consultation
The financial modelling is based around the potential proposed UC model that was outlined at the Co-design of UC and ED Interface workshop held on 15th November 2017. The financial modelling compares the ‘do nothing’ scenario against the potential proposed model from this workshop.
A number of variations of this modelling have been completed for the proposed model from the 15th November 2017 workshop. These all contain consistent assumptions with the exception of when the UC clinical model will be fully operational. These assumptions are set out below for information:

- three UCC contracts will cease (with varying timescales depending on a range of factors)
- the GP OOHs contract will cease at its planned contract end date of 30th September 2018 and all ‘speak to’ dispositions will transfer from the GP OOH contract to the IUC contract on 1st October 2018
- a home visiting service will be commissioned both for in-hours (to support practices and release GP capacity) and out of hours to cover the service previously provided by the GP OOHs (April 2018 for in hours and October 2018 for out of hours)
- the new IUC service will be fully operational by 1st October 2018
- SEAS will be operational for all hours required in each locality from September 2018 (providing eight hundred and fifty two appointments per week)
- general practice will be supported to transition to the new model through the proposed use of additional quality premium funding (released from PMS review) partly in 2018/19 and fully in 2019/20.

As noted above the final timescales have yet to be determined. Depending on the final timescale there is the potential to have a material impact on SCCG’s current financial plans over 2018/19 and 2019/20. The table below outlines the financial impact of each of the options.
Table 5: Sunderland CCG Financial Modelling

As outlined earlier, SCCG’s financial plan assumes £500k of efficiencies would be released in 2018/19. From table two, option A and option B are the only options which deliver against SCCG’s financial plans for 2018/19 however all the options apart from do nothing would fully deliver against SCCG’s efficiency requirements on a recurrent basis. There are a range of possibilities in between the October 2018 and April 2019 dates some of which are included above.

Both remaining scenarios being recommended to go to public consultation produce the same financial outputs. Therefore the timeline options included within table 5 are the same for each.

The financial impact against SCCG’s plans will need to be balanced against allowing enough time for a safe transfer to the new model, NHS England assurance processes, and to ensure statutory duties in relation to public consultation are followed.

Some key points in relation to the potential proposed UC model should be noted:

- the additional costs included for activity has been based on estimated activity modelling. The activity modelling on which this has been based is informed by previous experience of closing an UCC within Sunderland, and also with other local areas who have adopted similar UC models. The expectation is that
benchmarking with other local areas with similar demographics will ensure robust activity planning

- additional UTC activity has been modelled on funding the additional activity at cost, as opposed to being at tariff. This approach is in line with the current approach being taken between SCCG and the provider
- the modelling has included a series of scenarios to test the robustness of the financial modelling. These include funding activity at different levels, and in factoring in an additional 20% activity coming through the UTC
- part of the UC work involves workforce planning to recognise that if particular access points in the system are no longer in place the workforce affected could be re-deployed to other parts of the local UC (and wider health) system to enable service delivery of a new model and system resilience
- resource has been set aside to cover void and estates costs
- it is not anticipated that the proposed potential UC clinical model will require any capital expenditure
- funding of 10% has been allocated to a contingency / system sustainability fund to mitigate risks within the UC strategy and model, including the identified scenario planning, demographic changes and unforeseen costs.

Based on the above modelling the proposal potential UC clinical model is financially affordable on a recurrent basis, and as part of this assessment scenario planning has been completed to test the robustness of the financial modelling.

7.11 Scenarios for consultation
The potential scenarios which were developed, including where each scenario was proposed and an appraisal of each scenario against the benefits criteria can be found in Appendix G.

Having assessed each of the scenarios against the five design principles, only two proposed scenarios (5 and 8 in Appendix G) meet all the appraisal criteria. Therefore, SCCG is seeking to take these two scenarios to public consultation. For clarity the two scenarios for public consultation set out below have been labelled A and B to avoid confusion with the numbered long list set out in Appendix G.

In the proposed scenarios:

- general practice core service refers to services accessible during normal working hours from a patient's general practice, including the GP, nurses and healthcare assistants. The opening hours for general practices vary but usually include from 08:00 to 18:00 Monday to Friday excluding bank holidays.
- Sunderland Extended Access Service (SEAS) refers to the additional general practice appointments currently available across the city and delivered in each of the five localities from one central practice. This service is already operational and further details can be found in section 3.22 of this document.
- ED streaming refers to the clinical triage of people presenting at the CHS ED. People are streamed to the most appropriate clinician for their health needs, which may include a GP as part of the ED Interface service which is currently in development as part of the Out of Hospital model and ED Interface work.

**Scenario A**
Replace services with:
- General practice (core and five Sunderland Extended Access Service locality hubs) consumes all UCC activity 08:00 – 20:30
- ED Interface
- Minor Injuries are seen at the UTC within the acute footprint (ED overnight)

**Scenario B**
Replace services with:
- General practice (core and four Sunderland Extended Access Service locality hubs) consumes all UCC activity 08:00 – 20:30
- ED Interface
- Minor Injuries are seen at the UTC within the acute footprint (ED overnight)
- One Sunderland Extended Access Service locality hub integrated with the UTC (within the acute footprint and in addition to the four Sunderland Extended Access Service locality hubs)

The following two diagrams illustrate these scenarios:

**Figure 32: The two scenarios for public consultation**
7.12 Methodology for public consultation

The objective for the public consultation is to provide a range of engagement activity that allows different stakeholders and groups to get involved in the way that is most appropriate for them. All methods ensure that feedback and dialogue is captured, which will then be analysed and included in a final feedback report. All methods will include data monitoring of the key characteristics of participants to ensure SCCG is hearing from key groups and that equality monitoring can take place.

Consultation activity that will be undertaken includes:

- Formal events
- Online events
- Survey
- Protected characteristic groups targeted by community and voluntary sector through the CCG’s equality and diversity group
- Focus group delivered by asset based approaches
- Focus groups for GP participation groups
- CCG run focus groups
- In-depth interviews
- Briefings for providers/stakeholders
- Roadshows in shopping centre
- Attendance at relevant existing meetings, groups and networks
- Attendance at events in Sunderland
- Submissions received from groups, teams and individuals

The full Consultation Plan can be found in Appendix E.
8. Programme Management

8.1 Governance Arrangements
The effective delivery of the Sunderland UC strategy is based on the principle of working together to achieve whole system change. Whole system change is a joint responsibility that requires a robust governance process overseeing all delivery projects and programmes. SCCG uses a corporate project management approach to achieve this aim.

This UC programme of work is monitored via the SCCG corporate project management approach, with information captured in the Project Outline Documentation. Regular highlight reports are presented to the SCCG Sustainability Delivery Group.

An UC Strategy Task and Finish Group meets weekly to progress the work with representation from the sponsor Director, the UC clinical lead, service reform, finance, contracting, the Localities Team, and NECS Communications and Engagement. The UC Strategy Task and Finish Group formally reports in the Sunderland Care Model Assurance Group (SCMAG). Terms of reference are available for the UC Strategy Task and Finish Group. The UC Strategy Task and Finish Group is a formal part of the MCP governance arrangements.

The UC strategy work is also reported into the Sunderland Local A&E Delivery Board and to the SCCG Executive Committee. Updates have also been presented, and will continue to be presented, to the Health and Wellbeing Overview and Scrutiny Committee.

8.2 NHS England assurance
CCGs are asked to adhere to NHS England’s four tests when undertaking service transformation as set out in the ‘Planning, assuring and delivering service change for patients’ published by NHS England in 2014 [9]. This outline business case sets out how the UC Strategy work meets the requirements of these four tests. The four tests are as follows:

1. Strong public and patient engagement
2. Consistency with current and prospective need for patient choice
3. Clear, clinical evidence base
4. Support for proposals from commissioners

As the implementation of the UC strategy requires service change, SCCG is following the NHS England service change assurance process. SCCG achieved the stage one strategic sense check of this process for the UC strategy in December 2016. This outline business case will be shared with NHS England to meet the requirements of the Stage two strategic sense check. Timescales for the Stage three strategic sense check are set out in the programme milestone plan below.

The MCP is also undergoing NHS England assurance, but this is via the Integrated Support and Assurance process (ISAP), whilst the UC service reform is undergoing the NHS England service change assurance process. SCCG is working with NHS England to reduce duplication across these two processes. Current advice from NHS England is that SCCG needs to be assured by both processes.
### 8.3 Programme Milestones

The programme milestones set out below meets all statutory requirements as quickly as possible:

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Delivery Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will have signed off the UC outline business case at the SCCG Governing Body</td>
<td>30th January 2018</td>
</tr>
<tr>
<td>We will have presented an update to the Health and Wellbeing Scrutiny Committee (report deadline is 16/02/18)</td>
<td>28th February 2018</td>
</tr>
<tr>
<td>Engagement with general practices by localities and Time in Time Out sessions</td>
<td>February 2018 17th March TiTO</td>
</tr>
<tr>
<td>We will have undergone NHS England Stage two Strategic Sense Check</td>
<td>w/c 5th March 2018</td>
</tr>
<tr>
<td>We will have undertaken planning and promotion for public consultation</td>
<td>w/c 12th March 2018</td>
</tr>
<tr>
<td>We will have completed a travel impact analysis</td>
<td>w/c 23rd April 2018</td>
</tr>
<tr>
<td>We will have conducted formal public consultation (includes one week for a mid-consultation review)</td>
<td>w/c 11th June 2018</td>
</tr>
<tr>
<td>We will have completed an equality impact assessment</td>
<td>w/c 11th June 2018</td>
</tr>
<tr>
<td>We will have completed a health equality impact assessment</td>
<td>w/c 11th June 2018</td>
</tr>
<tr>
<td>We will have completed an independent impact analysis</td>
<td>w/c 11th June 2018</td>
</tr>
<tr>
<td>We will have a Consultation Report written by NECS</td>
<td>w/c 2nd July 2018</td>
</tr>
<tr>
<td>The draft Consultation Report will have been shared with SCCG for review</td>
<td>w/c 9th July 2018</td>
</tr>
<tr>
<td>We will have shared the Consultation Report with SCCG Executive Committee</td>
<td>17th July 2018</td>
</tr>
<tr>
<td>We will have shared the Consultation Report with the Health and Wellbeing Scrutiny Committee (Statutory requirement). (Report to be sent by 6th July 2018)</td>
<td>w/c 9th July 2018</td>
</tr>
<tr>
<td>We will have conducted the consideration phase and feedback to public</td>
<td>w/c 6th August 2018</td>
</tr>
<tr>
<td>We will have written the Decision Making Business Case</td>
<td>w/c 20th August 2018</td>
</tr>
<tr>
<td>End of current UCC contracts</td>
<td>31st August 2018</td>
</tr>
<tr>
<td>We will have undergone the NHS England Stage three Assurance Checkpoint (Decision Making Business Case)</td>
<td>w/c 24th September 2018</td>
</tr>
<tr>
<td>End of current GP OOH contract</td>
<td>30th September 2018</td>
</tr>
<tr>
<td>Go live date for regional IUC service</td>
<td>1st October 2018</td>
</tr>
<tr>
<td>Go live date of the 24/7 home visiting service</td>
<td>1st October 2018</td>
</tr>
<tr>
<td>SCCG Executive Committee will have signed off the Decision Making Business Case</td>
<td>w/c 1st October 2018</td>
</tr>
<tr>
<td>SCCG Governing Body will have signed off the Decision Making Business Case (the Governing Body scheduled for October 18 is a Development Session)</td>
<td>w/c 29th October 2018</td>
</tr>
<tr>
<td>MCP provisional go live date</td>
<td>1st April 2019</td>
</tr>
</tbody>
</table>

*Table 6: Milestone Plan*
This milestone plan does not allow for any slippage to the deadlines set out above. In the milestone plan set out above, we have been able to set the dates up until the 17th of July Executive Development Session. This includes undertaking public engagement during March, April, May and June 2018. The date of the subsequent Health and Wellbeing Scrutiny Committee is yet to be confirmed, but we are working with the Committee to agree a date. Assuming we can agree a suitable date with the Health and Wellbeing Scrutiny Committee the decision making business case will be completed by the end of August 2018.

8.4 Timeline option 1 – 1st November 2018
The decision making business case will be completed following formal public consultation and submitted to NHS England for the Stage three strategic sense check. Following approval by NHS England, the decision making business case will be submitted to the SCCG Executive Committee and the SCCG Governing Body. If all parties are satisfied with the decision making business case, then sign off would be complete by the end of October 2018. Under timeline option 1 the proposed potential clinical model would be implemented from 1st November 2018. This assumes there is no requirement to revise either the outline or decision making business case.

Timeline option 1 would go live one month after the proposed start date of the new IUC service, assuming it is procured on time. This option would require the extension of UCC contracts for two months. The home visiting service would need to be in place from the 1st October 2018 to undertake the out of hours home visits formerly undertaken under the GP OOHs contract which ends on the 30th of September 2018.

Due to the likely winter pressures at this time, implementing a new UC clinical model during the winter period presents a high risk of destabilising the UC system. Early informal discussions with NHS England have indicated that they would want extensive assurance if a go live date was proposed during the winter period. To mitigate the risk of destabilising the UC system timeline options 2 and 3 (as set out below) should be considered.

8.5 Timeline option 2 – 1st February 2019
Timeline option 2 is as above, but deferring the go live of any new UC clinical model until 1st February 2019 to mitigate the risk of destabilising the UC system over winter. This would require UCC contracts to be extended to 1st February 2019. The home visiting service would still need to be in place from the 1st October 2018 to undertake the out of hours home visits formerly undertaken under the GP OOHs contract which ends on the 30th of September 2018. This option would also mitigate any slippage in the regional procurement timeline for IUC. As February is technically winter, both NHS England and SCCG would want robust assurance that the UC system will not be destabilised.

8.6 Timeline option 3 – 1st April 2019
Timeline option 3 is to extend the UCC contracts to the 1st April 2019 so that the UC clinical model is mobilised within the MCP. The home visiting service would still need to be in place from the 1st October 2018 to undertake the out of hours home visits formerly undertaken under the GP OOHs contract which ends on the 30th of September 2018. This option would also provide some double running of services and
embedding of the key enablers to support sustainability of general practice over the busy winter period during which public communications can be undertaken to promote the use of the new IUC service.

8.7 Equality and Health Inequalities Impact Assessments
Equality and health inequalities impact assessments are underway as part of the SCCG project management toolkit. These documents are iterative and will be added to as this work progresses. They will be completed after public consultation and prior to the final sign off of the clinical model and decision making business case.

8.8 Travel Impact Analysis
The impact of the potential proposed UC model on the requirement for people to travel to access UC services is currently being analysed by NECS on behalf of SCCG. The detailed travel impact analysis will be included in the decision making business case. How residents across the whole city of Sunderland will access the proposed potential UC clinical model has been considered as part of the UC strategy work. The opportunity to reduce inequality of access has influenced the potential proposed model.

8.9 Independent Impact Assessment
SCCG will seek an independent impact assessment of the proposed potential UC clinical model. The Independent Impact Analysis will be included in the decision making business case.
9. Urgent Care Services in Other Local CCGs

9.1 Durham Dales, Easington and Sedgefield CCG
Sunderland is bordered to the south by Durham Dales, Easington and Sedgefield (DDES) CCG. On the 1st April 2017 DDES implemented a new model of UC which has general practice at the core of service delivery.

DDES is promoting a ‘talk before you walk’ approach to ensure people access the most appropriate service to meet their needs. From 1st April 2017 DDES ceased commissioning any walk in services during general practice core hours. They do commission two MIUs which are open 24/7. DDES has increased capacity in general practice, which includes additional appointments during the day and appointments at evenings and weekends.

Given the current provision of UCCs in Sunderland, people registered to a practice in DDES continue to have the option of accessing one of Sunderland’s UCC, and the number of people choosing to self-present at an UCC in Sunderland has risen since April 2017.

The disparity between the new DDES model and the historic model in Sunderland is undermining the service reform work DDES have implemented, and is a barrier to DDES achieving population behaviour change. The current UC system in Sunderland undermines the ‘talk before you walk’ IUC consult and compete approach. However the proposed potential model would support the service changes undertaken and promoted in neighbouring CCGs.

9.2 Hartlepool and Stockton-on-Tees CCG and South Tees CCGs
From 1st April 2017, Hartlepool and Stockton-on-Tees CCG and South Tees CCG are delivering extended access from 18:00 to 21.30 from Monday to Friday, and 08:00 to 21.30 on weekends and bank holidays. The extended access services operate an appointment-based system and do not accept walk in patients.

People can access the extended access services via their own general practice or via 111. When core general practice and extended access services are closed, people are advised to phone 111 to be directed to the most appropriate service.

Hartlepool and Stockton-on-Tees CCG now have their GP OOHs service collocated at the University Hospital of Hartlepool and the University Hospital of North Tees, with home visits undertaken by Advanced Nurse Practitioners. Hartlepool and Stockton-on-Tees CCG also have two UTCs located at the University Hospital of Hartlepool and the University Hospital of North Tees.

South Tees CCG has a Minor Injury Unit, located at the Redcar Primary Care Hospital which is open from 08:00 to 21:30 seven days per week. The walk in centres at North Ormesby and Eston Grange closed on the 31st March 2017.
10. Dependencies

The following dependencies have been identified:

- contract ends dates for UCC contracts and GP OOHs contract
- regional procurement of the IUC service
- provision of SEAS appointments to meet the NHS England requirements
- provision of an out of hours home visiting service to release capacity in general practice
- securing the Multi-specialty Community Provider model from the 1st April 2019

The impact of these dependencies has been considered in the scenarios and timelines.
11. Conclusion

The proposed potential model for UC set out in this document builds upon the national 'must dos', including commissioning the IUC (111) service, delivering SEAS in general practice, and achieving the UTC standards; the regional UEC Vanguard work, and the substantial local out of hospital reform including the development of the MCP. The potential proposed UC clinical model brings together UC with the out of hospital system to build integration, minimize duplication, and simplify the out of hospital system for the public and patients. We have taken nationally mandated services as the building block of this approach, stripping out unnecessary duplication and putting mechanisms in place to better match provision with patient needs not wants.

We are seeking to simplify UC access by replacing multiple access points with the IUC service. Via the IUC service a greater number of people will receive self-care advice and e-prescribing, reducing the number of people who need a face to face appointment.

The analysis set out in this document shows that attendances at ED have increased year on year despite the additional activity seen in the UCCs. Not only have the UCCs not impacted upon people accessing ED, but more people are now accessing UCCs than in the past. At the same time the forty-three general practices across Sunderland undertake nearly 1.5 million patient contacts every year.

We know that high numbers of people present to ED despite alternative UC provision. The UCCs were intended to reduce the number of people accessing ED; however ED activity has increased year on year, despite increased activity in the UCCs.

People can call 111 24/7, but we know the majority of people in Sunderland do not. We also know that whilst people are self-presenting at the UCCs, the SEAS has unused weekends and bank holidays appointments slots which can be accessed via 111. Demand is not shared across the available capacity, and one service may experience high demand where another service has unused appointments. This creates waste in the UC system and does not represent best value for public money. We have implemented solutions to work around these issues in the short term, but in the longer term we want to change the UC model so that 'work arrounds' are not required.

The UCCs only undertake face to face consultations, and therefore the existing model of UC in Sunderland needs to change in line with the regional IUC ‘consult and complete’ model. Approximately 70% of attendances to the UCCs are self-presentations, which represents a high number of missed opportunities to promote self-care and give clinical advice over the telephone or virtually.

We also know that in 2016, 14,057 UCC attendances resulted in the patient being advised to go to their own general practice. In the same time period 38,929 people were discharged from their UCC attendance as requiring no follow up or were provided with self-care advice.

The current provision of an UCC on the ground level of Pallion PCC and SEAS hub on the first floor of Pallion PCC is an example of the over complex UC offer which has been emerged in Sunderland over time. One scenario presented in this outline
business case includes the merging of the West locality SEAS hub in Pallion PCC with the proposed UTC.

The continued streaming of patients from ED to an UC service is a key enabler to ensuring patients are seen in the most appropriate setting for their needs. The ability to stream to UC provision during times of high demand is essential to enabling CHS to treat those people with life threatening emergencies who require care which is only available in the ED.

SCCG are working closely and engaging with general practice to test their capacity to absorb the likely activity impact if the contracts for the UCCs at Bunny Hill, Washington and Houghton-le-Spring were to come to an end. This impact has been modelled, and modelling continues as further intelligence is received, e.g. the impact of the IUC service. This outline business case includes the capacity releasing initiatives currently underway in general practice.

The GP led 24/7 home visiting service will support the integration of services within Sunderland, rather than commissioning additional services to sit alongside existing services. Through the delivery of a 24/7 home visiting service, patient continuity will be secured, minimizing handoffs across the system.

Consideration has been given to how the UC model in Sunderland can manage out of area patients, especially people travelling from neighboring CCGs. The proposed potential UC clinical model will bring the UC service delivery in Sunderland in line with changes made to UC services in neighboring CCGs, which will remove the incentives for people to travel to Sunderland to get their UC needs met. The proposed potential clinical model is encapsulated in the following two scenarios for public consultation:

**Scenario A**
Replace services with:
- General practice (core and five Sunderland Extended Access Service locality hubs) consumes all UCC activity 08:00 – 20:30
- ED Interface
- Minor Injuries are seen at the UTC within the acute footprint (ED overnight)

**Scenario B**
Replace services with:
- General practice (core and four Sunderland Extended Access Service locality hubs) consumes all UCC activity 08:00 – 20:30
- ED Interface
- Minor Injuries are seen at the UTC within the acute footprint (ED overnight)

**Both scenarios** are underpinned by:
- the regional IUC service which will replace the current ‘assess and refer’ 111 service with a ‘consult and complete’ service
- 24/7 home visiting service

These scenarios are open to change following consultation with members of the public.
### Appendix A: GPFV Workforce Development Group initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description of initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GP Career Start Scheme</strong></td>
<td>This scheme has been running for just over a year in Sunderland. These GPs are fully qualified GPs who have the opportunity to develop specialist skills whilst working in general practice. Ten GPs were recruited in the first year of the scheme. Of the original cohort five have now taken up substantive posts in the city with another two indicating that they will do the same. Cohort two saw five GPs recruited on a two year fixed term contract commencing between May and September 2017. Recruitment for Phase three has started, with one Career Start GP taking up a post October 2017, one will commence February 2018, and one will commence April 2018. There is strong interest from another three prospective GPs.</td>
</tr>
<tr>
<td><strong>Golden Hello Scheme</strong></td>
<td>This is a recruitment and retention scheme which incentivises GPs to come and work in Sunderland. GPs must stay for a minimum of three years and will be incentivised with £20k pro rata.</td>
</tr>
<tr>
<td><strong>Local GP Recruitment Scheme</strong></td>
<td>Sunderland have a clinical lead who attends the BMJ recruitment fair with a team that includes a Practice Manager to promote Sunderland. The team have made contacts in Portugal who will link into the national scheme.</td>
</tr>
<tr>
<td><strong>Practice Nurse Career Start and HCA Programmes</strong></td>
<td>In addition to the shortage of GPs there is also a shortage of nurses in Sunderland. This scheme is similar to GP career start but enables nurse to work in general practice and gain the skills needed for chronic disease management etc.</td>
</tr>
<tr>
<td><strong>General Practice Workforce Toolkit</strong></td>
<td>This will give a true picture of the workforce position for all professionals in general practice. The data shows that compared with the North East region Sunderland has an older age profile for GPs, we have the second highest number of patients per GP and our GPs work a higher number of sessions per week. The picture for practice nursing is similar but particular issues were identified with advanced nurse practitioners where there are very small numbers of staff and almost 40% eligible for retirement.</td>
</tr>
<tr>
<td><strong>GP Trainers Bursary</strong></td>
<td>This scheme will support GPs wishing to become GP trainers. In the longer term this will encourage newly qualified GPs to stay in Sunderland.</td>
</tr>
<tr>
<td><strong>Training programmes for clinical staff</strong></td>
<td>Including spirometry and electrocardiograms.</td>
</tr>
<tr>
<td><strong>Paramedic Placements</strong></td>
<td>This is a scheme which is run by Sunderland University where paramedics go on placement in GP Practices. Currently five practices have participated in the scheme with positive feedback on the treatment of patients with acute symptoms.</td>
</tr>
<tr>
<td><strong>Physicians Associate placements</strong></td>
<td>This is a scheme which is run by Newcastle University and Sunderland have requested four placements commencing September 2017.</td>
</tr>
</tbody>
</table>
Appendix B: Urgent Care in Sunderland Desktop Review

Urgent Care means any form of medical care that you need quickly that does not require a hospital stay or visit to accident or emergency (A&E). It is recommended that there should be a provision of highly responsive Urgent Care services outside of hospital so people no longer choose to queue in A&E. (Commissioning Standards Integrated Urgent Care, Sept 2015; Transforming Urgent and Emergency Care Services in England Update on the Urgent and Emergency Care Review, Aug 2014; Kings Fund: Urgent & Emergency Care Review – Time to Do It, 2013).

Currently Urgent Care includes the following services:

- How you look after yourself (self-care)
- Community Pharmacies
- NHS 111 – the non-emergency telephone number for NHS Services
- GP Practices
- GP Out of Hours
- Urgent Care Centres

This review mainly covers information from a regional level and will be added too, once the engagement activity is completed.

How you look after yourself (self-care)

From a regional level, self-care is used far more than people actually realise; with the majority of respondents that completed a questionnaire within the Regional Urgent Care Campaign (2015), stating that if they were unwell “they would ‘do nothing’ and ‘get on with it’”. However, with prompting this actually meant that this involved buying over the counter medications. Typically, someone would self-diagnose and then attend a shop or pharmacy to buy a product that they thought would help.

Looking at the comments received from a public stakeholder engagement about Urgent Care, suggestions were received about prevention and how it plays an important role within self-care: “Some people talk about the need for prevention and say they would welcome more drop-in sessions and more wellness checks.” This is particularly important for people with long term conditions, “Self-management is important for some people with long term conditions – the knowledge that patients and carers have built up needs to be respected.
Contact with other patients with the same condition and self-management programmes would be welcomed by some people.” This can be affirmed when addressed on a national level, with national literature suggesting that there should be personalised care and support planning, that there should be support for self-management and support for carers. (Urgent and Emergency Care Route Map, Nov 2015; Kings Fund: Urgent & Emergency Care Review – Time to Do It, 2013).

**Community Pharmacies**

From a regional perspective there has been a great deal of market research on community pharmacies, with great emphasis on educating people on what pharmacies can actually help with. However, there are still “significant barriers to pharmacy, strongest amongst those unfamiliar [with suggestions being made to] reposition pharmacists as experts in diagnosis and care, avoiding comparisons to GPs - Focus on education of specific services in regard to access and capabilities - Prescription collection an opportune moment to improve knowledge and familiarity.” (Key Considerations – NECS Urgent Care Campaign Research).

Key Findings from NECS Market Research substantiates this when it states, “work needs to be done on the perception of pharmacists and their qualifications… A large proportion of participants that have never used a pharmacy were not aware that the service was available (38% not aware). Awareness of the medical advice service in pharmacies needs to be increased.” Although this research is on a regional level, it was ascertained that the people who had never used a pharmacy were not necessarily influenced by their particular demographic, nor their geography, with this in mind we can assume the same can be said for the people within the Sunderland area. (Key Findings from NECS Market Research). Regionally research also indicates that older respondents were more likely to be aware of the range of service available at the pharmacy and were more experienced in using it, such as repeat prescriptions and general advice. (Regional Urgent Care Campaign, 2015).

From the focus groups within the Key Considerations – NECS Urgent Care Campaign, younger profiles proved to be especially resistant to pharmacy use. In 2015, a regional Urgent Care Campaign was conducted, this campaign is in line with younger
profiles being more resistant to pharmacy use as it states that those that were younger were "much less familiar with the use of pharmacies for anything other than a prescription."

Additionally, though younger C2DE’s (three lower socio economic groups in society) were "generally aware of 'pharmacy first', they too lacked knowledge as to what this meant and the wider range of services available." Younger people thought of pharmacists as shops, where they already knew what they needed and would simply go and purchase it: “I don't class them as being in that category – not to give advice. It’s a shop.” (Regional Urgent Care Campaign, 2015).

Moreover, all demographics would typically buy over the counter medication from supermarkets rather than the pharmacy, as they deemed the pharmacy to be ‘expensive’. (Regional Urgent Care Campaign, 2015).

From the literature discussed so far, we can see that a person’s age appears to influence thoughts on the pharmacy, however, results from surveys conducted within regional market research, Key Considerations – NECS Urgent Care campaign found that gender and age did not influence pharmacy use.

When looking at comparisons between a GP Practice and a community pharmacy, people have very strong views, with a major preference towards a GP.

Amongst the younger ABC1’s (upper middle class, middle class and lower middle class) demographics, negative perceptions of pharmacies in comparison to other healthcare services are prominent. This includes the belief that pharmacists lack expertise when compared to GP’s. Another belief is that pharmacies lack privacy. (Regional Urgent Care, 2015). Looking at the regional Keep Calm Evaluation: “A number of participants expressed concerns about the privacy of pharmacies, and whether individuals would be required to pay for medication when buying over the counter despite being exempt from prescription charges.”

In addition, concerns have arisen relating to access to pharmacies. There have been suggestions that if more people were to use a pharmacy instead of their GP, the issue with access to the GP would just transfer over to the pharmacy, with a rise in waiting
times etc… “You can wait 15 minutes for your prescription and now if you’ve got every Tom, Dick and Harry going to the pharmacy for a cough you’ll be waiting longer!” (Regional Urgent Care, 2015).

Following on from here, the same group of people who have never used a pharmacy are the same group that are less likely to consider using a pharmacy in the future. This same group of people are also 24% less likely to have considered alternative services. Therefore, suggesting that there are a group of people who use the same services time and time again with little considered deviation from their preferred service. (Never Used a Pharmacy)

Linked to this, is the ‘Keep Calm Campaign’, mentioned earlier, a regional campaign with the key message to ‘keep calm and look after yourself’ in order to get people to use the right services in the right way: “a third of participants who had seen this campaign indicated that their health-seeking behaviour has changed as a result, with a further 13% indicating that their behaviour would change in the future. However, the majority stated that there had been no change in their behaviour (44%).” (Keep Calm Evaluation: Executive Summary). Thus, indicating that people understand the campaign, but again the majority haven’t deviated from their normal pattern of care.

**NHS 111 – the non-emergency telephone number for NHS services**

From a national perspective, NHS 111 has been discussed on numerous occasions and various recommendations/improvements have been suggested; the Commissioning Standards Integrated Urgent Care (Sept 2015) states that there should be a re-procurement of the 111 service to align existing 111 and Out of Hour’s contract to provide a more integrated service.

It was also recommended that certain patients calling NHS 111 should be flagged; if a patient has complex problems and needs to speak to a clinician, they should be quickly identified and transferred to the the relevant clinician. In order to do this, it is recommended that commissioners work together with providers and clinical governance leads to identify and utilise the effective, safe tools, that are fit for this purpose. (Commissioning Standards Integrated Urgent Care, Sept 2015).
Furthermore, suggestions have been made to state that frequent callers or frequent users of the Urgent/Emergency Care system should be managed. (Commissioning Standards Integrated Urgent Care, Sept 2015). As well as managing frequent users, the NHS 111 Commissioning Standards (June 2014), suggests that there should be alternative routes of telephone access to the Urgent Care system perhaps via a clinical hub. Further suggestions were made stating that the local Directory of Service (DoS) should be maintained, and up to date with local services and referral protocols. (NHS 111 Commissioning Standards, June 2014). A clinical hub is being piloted as part of the North East Urgent and Emergency Care Network.

Following on from here, recommendations have been that the NHS 111 share patient notes, as well as make it possible to directly book appointments for patients in to GP practices, emergency departments as well as Urgent Care Centres. (NHS 111 Commissioning Standards, June 2014).

**GP Practices**

A common theme showing amongst regional urgent care is that people tend to access the wrong service, with limited access to GP Practices proving to be the main reason for this, “Waiting times for appointments and speed to be seen are the main reasons people will not reconsider the service they will use.” (Key Findings from NECS Research). Lack of access to the GP plays a major part with people accessing A&E unnecessarily: “Comments that GP access needs to be better to reduce avoidable attendances at A&E.” (Comments from Public and Stakeholder Engagement about Urgent Care).

As we have already touched upon, access to the GP practice is an area within Urgent Care that receives a lot of attention. Common themes that are mentioned include: the time needed to call the practice for an appointment; waiting times for an appointment; online booking and prescription service as well as the telephone triaging. (Comments from Public Stakeholder Engagement about Urgent Care)

Continuing on from here looking at the Comments from Public Stakeholder Engagement about Urgent Care, we can see that having to “ring [the] practice at a specific time (usually first thing in the morning) to access a same day urgent appointment” isn’t popular with people who work
or with families who may be taking children to school at that time. It is also suggested that waiting times were mentioned a great deal, with some suggesting there was a long wait to see their own GP or in some cases any GP. Seeing their own GP appears to be specifically more important to those who have a long term condition. Older people weren’t as forthcoming with the online booking system and online repeat prescription service, with some not having internet access, these systems were however popular with others. With regards to telephone triaging, some simply didn’t understand why it was introduced and what purpose it was there for.

With this in mind, this is an area that has also been addressed on a national level, with literature suggesting that the GP Practice/Primary Care should extend their hours for Urgent Care needs. What’s more, from a national level, it has been suggested that GP Practices/Primary Care should be supported to manage long-term care and end of life care. (Commissioning Standards Integrated Urgent Care, Sept 2015; 5 Year Forward View; Oct 2014; Kings Fund: Urgent & Emergency Care Review – Time to Do It, 2013).

Surprisingly, when people are able to get an appointment, the GP practice is always viewed as the preferred option and suggestions are made to improve the service: “no substitute for GP and strong preferences to access as first choice, GPs to play critical role in campaign messaging and delivery. Consider accessibility to GPs for the future, e.g. seven day services.” (Key Considerations – NECS Urgent Care Campaign Research).

Regionally the GP Practice, although the preferred option, raises further concerns surrounding the recruitment of GP’s and the impact this could have on the small practice. Funding is also mentioned, suggesting that small practices won’t be sustainable in the longer term. (Comments from Public Stake Holder Engagement about Urgent Care).

Other feedback received regionally includes; proposals that telephone appointments could reduce travel time, with others indicating text messaging as an appointment reminder would be welcomed, access to translators has also been mentioned, with others suggesting: “Health information advice and disease specific information isn’t always available in alternative formats (other languages and Easyread).” (Comments from Public Stakeholder Engagement about Urgent Care).
GP out of hours

From a national perspective it has been suggested that there is a need for the GP out of hours’ service. (Urgent and Emergency Care Route Map, Nov 2015; Commissioning Standards Integrated Urgent Care, Sept, 2015).

Although there is limited research in this area, we can corroborate the national theme, with over a third of people from Sunderland having used the service within a 12-month period. Additionally, regionally the majority of people who have accessed the GP out of hours’ contacted, “the service by contacting NHS 111 (56%) or their GP practice (33%).” (Keep Calm Evaluation – Executive Summary).

Regionally levels of satisfaction in the service vary, “53% were very satisfied with the care and advice they received, 36% indicated that they were very dissatisfied. This finding could relate to the proportion of participants who had to wait longer than they expected for an appointment or to see a health professional (50%) and those that waited for a shorter amount of time than they expected (44%). Consequently, 42% rated their overall experience as excellent and 39% as poor.” (Keep Calm Evaluation – Executive Summary).

When looking at the responses from the dissatisfied people that have used the service regionally, reasons for dissatisfaction include: “length of time they had to wait for someone from NHS 111 to call them back, the number of irrelevant questions asked by NHS 111, the unpleasant attitude of staff and the assumption made by NHS 111 that individuals are able to travel to the service, especially for those with young children and the elderly. Participants suggested that the service should be improved by offering more home visits, providing more local out-of-hours services, reducing waiting times and ensuring easier access to the service (e.g. improving signage directing patients to the service).” (Keep Calm Evaluation – Executive Summary).

Urgent Care Centres

Urgent Care Centres are often seen as an alternative to attending the GP practice, “At my GPs you can wait weeks for an appointment... if I need to see somebody I will always go to the walk-in centre. The GP will see the kids quickly, but for me, I can wait
three weeks. It’s really overcrowded at mine.” (Regional Urgent Care Campaign, 2015).

Moreover, people who were questioned regionally about whether their attendance at an Urgent Care Centre was justified - struggled to comprehend that another service may have been more appropriate, with some laying the blame elsewhere. A good example of this is a quote from a Gateshead man: “I went to the drop-in centre and she asked ‘Do you have chest pains?’ I said ‘Aye but it’s just trapped wind, can I have some Smithodene?’ She went out the room and I heard her on the phone; ‘I’ve got a young man here with chest pains’ I thought ‘Ah the poor sod’. On my kid’s life, there was blue flashing lights and an ambulance pulled up ... I was embarrassed ... it was the drop-in centre, it was them that got it wrong.” (Regional Urgent Care Campaign, 2015). However, younger ABC1’s were more likely to knowingly access the wrong service, suggesting they did so due to the difficulty accessing their own GP. In addition, this group of people admitted to selfishness and even recognised that their actions could impact on other peoples need of care. (Regional Urgent Care Campaign, 2015).

Conclusion

From regional literature, we know that the majority of people do self-care even if they don’t realise that they are, they just, ‘get on with it.’ (Regional Urgent Care Campaign, 2015). We also know that prevention plays a big part of self-care, and that there should be more support available to help people to self-manage conditions. (Public Stakeholder Engagement about Urgent Care).

There is an abundance of regional literature on the community pharmacy, from the literature we can see that patients, specifically younger patients, need to be educated on what they can use a pharmacy for. For instance, they need to be made aware of the fact that a pharmacy is much more than a shop. Suggestions have been made that this education could happen when people are collecting prescriptions. (Key Considerations – NECS Urgent Care Campaign Research). We can also conclude that pharmacists are seen as expensive, with all regional demographics suggesting they would buy their medication from the supermarket.
Privacy at the pharmacy also received attention, with younger ABC1’s suggesting there was a lack of privacy at the pharmacist. (Regional Urgent Care, 2015; Keep Calm Evaluation –Executive Summary). Furthermore, drug use was mentioned in Regional Urgent Care (2015), with the younger demographics not wanting to visit a pharmacy if “all of them crack heads are there.”

From a national point of view, NHS 111 has received a lot of recommendations to improve the current service. The key message is that the service needs to be more integrated to help it run more smoothly. In order to do this, different departments / commissioners need to work together, as well as having access to patient notes. In doing so, patients will get the right care quicker. (Commissioning Standards Integrated Urgent Care, 2015; NHS 111 Commissioning Standards, June 2014).

From a national and regional view, access to the GP practice appears to cause contention, as well as be the cause for misuse of services. Even so, when access is possible, the GP practice is always the preferred service.

Following on from here, the GP out of hours’ service is needed and well used nationally and regionally with over a third of people in Sunderland using it within a 12-month period. (Keep Calm Evaluation – Executive Summary). Furthermore, the majority (53%) of people regionally are very satisfied with the service with 42% rating their overall experience as excellent. When looking at the dissatisfied people’s responses, they majority of comments were surrounding NHS 111 and not necessarily their attendance with the GP out of hours.

Regional concerns have also arisen surrounding access to the pharmacist, suggesting there could be a transference from lack of access to the GP Practice to lack of access to the pharmacist.

Finally, Urgent Care Centres regionally, are very much seen as an alternative to the GP practice, with one big bonus - patients can be seen on the same day. Lack of understanding and the ability to acknowledge that other services could have perhaps been more appropriate majorly influences patient’s attendance to Urgent Care Centres. From the literature, we can see that often patients won’t accept responsibility for attending this service incorrectly, Furthermore, younger ABC1’s are more likely to
knowingly access this service incorrectly, even going as far as admitting their actions are selfish. (Regional Urgent Care C
Appendix C

Engagement activity report: Sunderland Urgent Care

For NHS Sunderland CCG

DRAFT
Executive Summary

NHS Sunderland Clinical Commissioning Group (CCG) has a requirement to develop a robust level of knowledge and understanding on public perception of urgent care. Public engagement and market research within Sunderland has provided the following key findings in order to provide a basis to support further consultation around any future, potential changes.

Key findings:

Urgent care currently:

- In general, in the last six months, the GP or practice nurse was used the most. However, participants with a Long Term Condition (LTC) were more likely to use the following services - GP or practice nurse, a hospital doctor or nurse, pharmacy, A&E, the GP OOHs, NHS 111 and the health visitor, community nurse or district nurse. 26-35 and 46-55 year olds are also most likely to use the health visitor, community nurse or district nurse (on-street and online/postal).

- Two-thirds of participants do treat themselves for minor ailments, although men and participants with a LTC are more likely to indicate that they don’t do so (online/postal). Two key reasons for participants with a LTC and/or disability not caring for themselves: confidence and lack of equipment at home to monitor their condition. Women were likely to cite money as a reason for not looking after themselves (on-street).

- If a participant has a LTC they are more likely to choose to see their local doctors service during normal working hours if they have an urgent care need. They are also, more likely to get an appointment on the same day. Their reasons for choosing the services are more likely to be due to using the service before and feeling comfortable with it, as well as location. They are also most likely to choose this service in the future (on-street and online/postal).

- In general, location of service is important, with most strongly agreeing that urgent care should be close to home or their community (on-street and online/postal).

- Males are more likely to strongly disagree with it being their own responsibility to look after their own health needs and they are significantly more likely to use an urgent care centre more frequently over a six-month period.

- In the future, males are significantly more likely to make their way to A&E (online/postal). Future research could look at why males are more likely to make their way to A&E and why their behaviour has changed.

- Gender influences the use of services as males are least likely to understand the roles of the various services in the area. However, males are more likely to trust the advice of healthcare professionals in comparison to females (online/postal).

- Only attending the A&E if they have an emergency or life threatening condition is also important to most participants (single participants are most likely to disagree), with most also strongly believing that this department is not used as it should be. A reason suggested for this
is due to the lack of access to other services (on-street and online/postal) as well as the knowledge they will definitely be seen at A&E (Sunderland Health Forum).

- If participants need medical help fast but it’s not a medical emergency or they think they need to go to A&E or an NHS urgent care service, they will either call NHS 111 or visit an urgent care centre. Participants with a disability, LTC or over 75 years old were most likely to attend A&E if urgent care was unavailable (on-street and online/postal).

- Participants are more likely to make their way to the A&E than use GP OOHs or the GP extended hours (online/postal).

- In general, non-urgent care is viewed as pharmacies and local doctor services during normal working hours. Urgent care is viewed as GP OOHs, urgent care centres, NHS 111 and the extended hours services. Although, 46-55 year olds viewed the extended hours services as non-urgent and over 75 year olds viewed local doctor services during normal working hours as urgent care. There’s lots of confusion surrounding services with many still not understanding which service to use and when, however, nearly half of participants do feel that they know what to do if they have an urgent care need (online/postal, Sunderland Health Forum, Focus Groups).

- Ability to access medical history/notes is important when receiving advice, diagnosis or treatment, although this is less important to males (online/postal).

- The time it takes to receive treatment or advice provided mixed responses with some participants citing the time-scales as good, and others citing it as poor. However, getting treatment or advice as soon as possible is important with the majority of participants citing this as a reason for choosing the service they chose. Furthermore, time scales have been cited as a reason for participants accessing other services, rather than their GP (Facebook, online/postal, Focus Groups).

- Mixed responses are cited over accessing the same standard of urgent care day or night, with 26-35 year olds more likely to suggest that access is not the same (online/postal).

Suggestions for improvements to urgent care:

- Participants with a LTC are significantly less likely to feel confident that they can look after their own minor health needs with participants strongly agreeing that getting guidance and support from an NHS professional and/or someone who had the same concerns/problem/condition as themselves would increase their confidence about caring for their own health (on-street and online/postal).

- Fees – Suggestions have been made to charge fees for either attending the A&E unnecessarily, or for non-attendance at GP appointments (Sunderland Health Forum).

- In order to improve urgent and emergency services it has been suggested that more staff are required, and existing staff (GPs and nurses) need further training. It has also been suggested that there is a need for further education/communication on what constitutes urgent and emergency care. Understanding is required on the function, opening hours, and available
appointments within urgent care. Clarity over the distinction of urgent care and walk-in centres is required as well as a need to remove the jargon (online/postal, Sunderland Health Forum, Focus Groups).

- There should be a single point (sign-posting) of contact that directs people to the most appropriate service when they need urgent care (single participants are most likely to disagree),

- Participants believe that they should be able to access advice, diagnosis or get treatment from whichever healthcare professional they choose (single participants are most likely to strongly disagree) (online/postal, Focus Groups).

- Participants feel that they need access to the pharmacist rather than the pharmacist’s assistant. Although, according to the focus groups they are perceived favourably as they can help people take medication as well as check whether medications can be taken together (online/postal, Focus Groups).

- Opening other services longer, and easier access could prevent unnecessary visits to A&E (on-street).

- Improve speed and accessibility of services (Focus Groups).

- Attitude of staff – participants suggest that it’s important GPs and nurses show respect, care and compassion to patients (Facebook, Sunderland Health Forum).

- NHS 111 needs to be “less scripted”, with the staff educated and qualified (Focus Groups, Sunderland Health Forum).

- GP’s receptionists to not act as gatekeepers with clearer and easier booking/appointment system (Focus Groups, Sunderland Health Forum).
Introduction

NHS Sunderland Clinical Commissioning Group (CCG) are responsible for planning, developing and commissioning NHS healthcare and health services so that people living in Sunderland have access to the best possible care within the resources available. The CCG want to deliver the vision of ‘Better Health for Sunderland.’

Sunderland CCG are reviewing urgent care provision in Sunderland to make sure that people have access to the best possible patient care. To do this, we need to use our resources effectively, and ensure that clinical staff across all urgent and emergency care provision can work together to reach the patients who need their specific skills.

Sunderland CCG has been asking people to share their views on local urgent care provision as they want to know how current services can be adapted to improve the health and wellbeing of local people.

Urgent care services cannot stay as they are as the way people use the NHS is changing. This is from a national level and on a local level.

Nationally, NHS England has set out a five-year plan to review and simplify health services (NHS Five Year Forward View). Locally, people have already told the CCG to focus on:

- Whether people know what services are available
- Which services best suit their health needs
- Where to go for advice and support
- Whether people understand how to access services and use of emergency services
- The best way to deliver high quality affordable services

Sunderland CCG is reviewing urgent care provision against five areas:

- Providing better support to help people care for themselves and the people who depend on them
- Helping those who need urgent care to get the right advice in the right place, first time
- Working together to strengthen the health and social care system to improve physical health and mental health
- Through sharing information and resources
- Providing responsive, urgent physical and mental health services outside of hospital every day of the week, reducing reliance on emergency services

Full details of the listening exercise, including the rationale, are included in the Sunderland Urgent Care listening document, published by Sunderland CCG and can be viewed at:

Your Views about Urgent Health Care
Methodology

Sunderland residents were invited to take part in the listening and engagement exercise from 22\textsuperscript{nd} November to 23\textsuperscript{rd} December 2016.

The on-street research was conducted in October 2016.

Overview of Sunderland urgent care engagement activity

Summary

- 866 respondents have been involved either through answering the survey, attending focus groups/events, responding via social media – this gives a good representation of the population within Sunderland.
- 165,000-awareness generation (calculated via reach. Please note that people could have seen the information multiple times).
- More detailed information is below on each area of engagement and promotion.

<table>
<thead>
<tr>
<th>Engagement method</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-street market research</td>
<td>396 respondents</td>
</tr>
<tr>
<td>Survey – both online and via post</td>
<td>429 respondents</td>
</tr>
<tr>
<td>Sunderland Health Forum</td>
<td>20 attendees</td>
</tr>
<tr>
<td>Focus groups</td>
<td>Took place on 19\textsuperscript{th} and 20\textsuperscript{th} December</td>
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<td></td>
<td>21 attendees</td>
</tr>
<tr>
<td>Leaflet distribution to community venues</td>
<td>294 venues throughout Sunderland displayed leaflets</td>
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<tr>
<td>Sunderland Echo online advert</td>
<td>50,103 impressions</td>
</tr>
<tr>
<td></td>
<td>47 click (0.09%)</td>
</tr>
<tr>
<td>Sunderland Echo</td>
<td>2 x articles in the Sunderland Echo</td>
</tr>
<tr>
<td></td>
<td>15,000 circulation</td>
</tr>
<tr>
<td>Platform</td>
<td>Reach</td>
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<td>------------------</td>
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<tr>
<td>Facebook</td>
<td>37,172</td>
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<tr>
<td>Video</td>
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<td>Twitter</td>
<td>62,741</td>
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<td>MY NHS emails</td>
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Methods of getting involved:

- On street survey
- Online and postal questionnaire
- Briefings with key stakeholders
- Sunderland Health Forum
- Focus groups
- Via email and social media
- Working with CVS organisations

Surveys (on-street and online and postal questionnaire)

A total of 825 participants completed a survey designed to understand patients’ experience and opinions about how urgent care is delivered in Sunderland.

- 396 were completed on street using quota sampling to map participants’ demographics against the profile of Sunderland.
- 429 either completed the questionnaire online or returned via the post.

Briefing with key stakeholders
A number of meetings were also held with key stakeholders. Details of these are as follows:

- GP practices – briefing at council of Practices and Practice Manager forum.
- Meeting with Sunderland overview and scrutiny committee on 4th January 2017.
- Briefings sent to key stakeholders through listening period including providers of urgent care services.

**Sunderland Health Forum**

The Sunderland Health Forum focused specifically on Urgent Care for two of the planned meetings for the CCG:

- Tuesday 22nd November, 6-8pm, Bede Tower, SR2 7EA
- Wednesday 23rd November, 2-4pm, Bede Tower, SR2 7EA

**Focus Groups**

Focus groups were held on 19th and 20th December in the evening in Sunderland, with 21 respondents.

**Other engagement methods**

Individuals were able to provide their comments by email, post, phone or social media. 49 individuals provided comments directly via Facebook and these have been included in the analysis. It was noted that social media also contributed to the self-completion element of the questionnaire.

Existing community groups and organisations were also invited to participate and a number of organisations confirmed that they distributed information and asked individuals to complete the online survey.
Survey findings

On-street research

An on-street market research was conducted with Sunderland residents with a sample of 396 people, which gives a 95% confidence level (recognised market research methodology).

Online and postal survey

Demographic profile for online and postal questionnaires

The quota levels are as follows:

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<th>Gender</th>
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<tr>
<td>Male (54)</td>
<td>17.59%</td>
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<tr>
<td>Female (250)</td>
<td>81.43%</td>
</tr>
<tr>
<td>Prefer not to say (3)</td>
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<table>
<thead>
<tr>
<th>Age</th>
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<tr>
<td>Under 16 years (2)</td>
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<tr>
<td>16-25 years (16)</td>
<td>5.52%</td>
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<tr>
<td>26-35 years (35)</td>
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<td>36-45 years (44)</td>
<td>15.17%</td>
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<tr>
<td>46-55 years (78)</td>
<td>26.90%</td>
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<tr>
<td>56-65 years (65)</td>
<td>22.41%</td>
</tr>
<tr>
<td>66-75 years (29)</td>
<td>10%</td>
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<tr>
<td>Over 75 years (21)</td>
<td>7.24%</td>
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<table>
<thead>
<tr>
<th>Ethnicity</th>
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<td>65.91%</td>
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<tr>
<td>Ethnicity</td>
<td>Percentage</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>White English (6)</td>
<td>2.27%</td>
</tr>
<tr>
<td>British (35)</td>
<td>13.26%</td>
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<td>English (10)</td>
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<td>1.14%</td>
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<tr>
<td>White non British (1)</td>
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<tr>
<th>Location</th>
<th>Sublocations</th>
<th>Percentage</th>
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<td>1.33%</td>
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<tr>
<td>Pelton (1)</td>
<td>DH2 2</td>
<td>0.27%</td>
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<tr>
<td>Coalfields (26)</td>
<td>DH4 4, DH4 5, DH4 6, DH4 7</td>
<td>6.93%</td>
</tr>
</tbody>
</table>
Access to services

Participants were most likely to have visited a GP or practice nurse (37.2%) or a local pharmacist (28.6%), 2-3 times within the last six months (figure 1).

In general, participants within the age of 46-55 years were most likely to use the GP or practice nurse (43.75%) and the GP OOHs (37.5%). Health visitors, community nurses or district nurses were most likely to be used by the ages 26-35 and 46-55 year olds (18.52%, 18.52% respectively).

Gender influences the use of urgent care centres, with males (m: 2.2%, f: 0%) significantly more likely to use the service 7-10 times within a period of 6 months. Also, over a six month period if a participant was married they were more likely to visit the GP or practice nurse once, compared to a single participant, (m: 26.6%, s: 13.3%); and a single participant is more likely to visit a hospital doctor 7-10 times (m: 0.7%, s: 6.7%) and the A&E, 4-6 times, in comparison to a married participant, (m: 0%, s: 5.3%).

Participants with a LTC were significantly more likely to use the GP or practice nurse 4-6 times (LTC: 26.2%, no condition: 9.2%) in the last six months.

The pharmacy is used more frequently amongst participants with a LTC with significantly more using it 4-6 times over that last six months (LTC: 23.4%, no condition: 12.7%), 7-10 times (LTC: 9.6%, no condition: 1.3%), and over 10 times (LTC: 16.1%, no condition: 1.3%).

Also, participants with a LTC were significantly more likely to visit a hospital doctor or nurse 2-3 times over the last six months (LTC: 26.3%, no condition: 8.2%), 7-10 times (LTC: 3.2%, no condition: 0%), over 10 times (LTC: 5.5%, no condition: 0.6%).

<table>
<thead>
<tr>
<th>Location</th>
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<td></td>
<td>NE37 1, NE37 2, NE37 3, NE38 7, NE38 8, NE38 9</td>
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</table>
The same participants were also most likely to visit the A&E 2-3 times (LTC: 8.5%, no condition: 3.2%); the GP OOH’s 2-3 times (LTC: 2.9%, no condition: 0%) and call NHS 111, 2-3 times (LTC: 9%, no condition: 3.2%) within a six months period. They were also most likely to visit the health visitor, community nurse or district nurse, (LTC: 3.9%, no condition: 0%) 4-6 times, in the last six months.

Figure 1: Use of the following services

Considerations of the types of services

It is clear that the majority of participants view pharmacies (82.3%) and local doctor services during normal working hours (73.2%) as non-urgent care. However, over 75 year olds were most likely to view local doctors during normal working hours as urgent care (57.14%).

The majority of participants also view OOhs (76.6%), urgent care centres (87.2%), NHS 111 (58.3%) and the extended hours service (54.3%) as urgent care. Additionally, 46-55 year olds were most likely to view GP extended hours as non-urgent care (43.82%).

Continuing on, most participants (89.5%) viewed the A&E as an emergency service (figure 2).

It’s important to note, men were significantly more likely to have not heard of the local doctors during normal working hours (m: 3.4%, f:0%), the A&E (m: 3.4%, f:0%), urgent care centres (m: 5.4%, f: 0%) or calling NHS 111 (m: 3.4%, f: 0.3%). Also single participants were significantly more likely not to have heard of the A&E in comparison to married participants (m: 0%, s: 2.9%).
Self-care

More than half of participants strongly agree that it is their own responsibility to look after their own minor health needs (56.3%). Males are most likely to strongly disagree (m: 1.9%, f: 0%) and married participants are most likely to strongly agree in comparison to single participants (m: 67.7%, s: 50.5%). Furthermore, participants with a LTC (LTC: 8.3%, no condition: 2.7%) are significantly more likely to neither agree nor disagree, with this statement, rather than strongly agree.

Also, nearly half of participants agree that they trust the advice that is provided by healthcare professionals (49.9%), though 36-45 year olds (45.46%) were most likely to strongly agree (figure 3). There is also a significant difference between responses from males and females, with a significantly higher response from males strongly agreeing (m: 47.2%, f: 30.8%) and a significantly higher response from females agreeing (m: 34%, f: 52%).

Just over half agree that they understand the role of the various healthcare services available in the area (50.5%); 26-45 year olds were more likely to strongly agree (43.18%).

Responses from participants with a LTC are significantly higher when agreeing with their understanding of the roles of the various services (m: 54.2%, f: 43.6% respectively). Also, males are most likely to not understand the roles of the various healthcare services in their area with males strongly disagreeing (m: 5.7%, f: 1.2%).

Figure 2: Considering the types of services
Furthermore, nearly half of participants strongly agree that they feel confident to look after their own minor health needs (47.6%); with strongly agree responses from participants with a LTC significantly lower (LTC: 44.2%, no condition: 54.7%) and 16-25 year olds most likely to agree (56.25%).

Most participants either strongly agree (42.8%) or agree (44.7%), that they would know whom to contact if they had an urgent health care need.

Mixed responses were received regarding confidence levels with a slight majority (27.5%) agreeing that they feel confident that they have access to the same standard of urgent care at any time of day or night and 25.4% disagreeing. While 75 year olds were most likely to neither agree nor disagree (28.57%) and 26-35 year olds were most likely to disagree (34.28%).

Finally, nearly half of participants strongly agree (48.9%) that they want to receive advice, diagnosis or treatment from someone that has access to my medical history/notes (figure 2). Although, females were more likely to agree (m: 22.6%, f: 39.9%) to this statement, and males were most likely to disagree (m: 5.7%, f: 1.2%).
Urgent Care

When respondents were asked about urgent care in Sunderland the majority agreed that people should be able to access advice, diagnosis, or get treatment from whichever healthcare service they choose to contact (34.6%) (figure 4). Males (m: 54.7%, f: 27.2%) are most likely to strongly agree, whilst participants with a LTC (LTC: 34.8%, no condition: 28.2%) and females are most likely to agree (m: 20.8%, f: 37.6%) with this statement. Single participants in comparison to married participants are most likely to strongly disagree (m: 2.5%, s: 11.5%).

Just short of half (41.7%) strongly agree that there should be a single point of contact that directs people to the most appropriate service when they need urgent care with females (m: 26.4%, f: 41.6%) and 26-35 and 46-65 year olds most likely to agree (56%, 50% respectively). Furthermore, single
participants are most likely to strongly disagree in comparison to the married participant (m: 0%, s: 3.3%).

Moreover, more than half of participants strongly agree that it is important that people have access to urgent care services close to their home or community (58.5%) and that people should only go to an A&E if they have an emergency or life-threatening condition (68.1%) (figure 4). Married participants were more likely to strongly agree that they should only go to an A&E if they have an emergency or life-threatening condition, (m: 74.5%, f: 60%) in comparison to single participants and single participants are significantly more likely to disagree in comparison to the married participant (m: 0.6%, s: 5.0%).

In the last six months, more than half of participants (60.6%) have not had a need for urgent care for a non-life threatening condition. Single participants were more likely to have a need, in comparison to the married participants (m: 33.3%, s: 54.2%) and participants with a LTC (LTC: 45.84%, no condition: 28.3%) and the over 75’s (52.38%) were also more likely.

Various recent illness/injury/conditions were given for requiring urgent care.
Figure 4: Statements on urgent care in Sunderland

To what extent do you agree or disagree with the following statements about urgent care in Sunderland?

1. People should be able to access advice, diagnosis or treatment from whichever health care service they choose to contact.
2. There should be a single point of contact that directs people to the most appropriate service when they need urgent care.
3. It is important that people have access to urgent care services close to their home or community.
4. People should only go to an emergency department (A&E) if they have an emergency or life-threatening condition.

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Don't know

Figure 5: reasons for requiring urgent care.

Q7 Briefly, what was the nature of your most recent illness/injury/condition?

Asthma Attack Toe Cancer Pregnancy
Kidney Stones Child Knee Blood Clot on Lung
Rash Mini Stroke Injury Blood Pressure
Infection Bleeding Naval Pain
Right Breast Broken Unable to Walk Heart
Bladder Acute Persistent Needed Stitches
Problems UTI Tonsillitis Hospital
Participants mostly chose to firstly, call NHS 111 (28.2%) when they had an urgent care need, closely followed by local doctors service during normal hours (23.9%). Interestingly participants were more likely to make their way to the A&E (12.7%) than to use GP OOHs (0.7%) or GP extended hours (1.4%).

Participants with a LTV are more likely to choose to see their local doctor during normal hours (LTC: 30.5%, no condition: 11.6%). Also, 36-45 year olds were equally as likely to choose NHS 111 (25%), their local doctors service during normal hours (25%), or an urgent care centre (25%); with 46-55 year olds more likely to choose either their local doctor service during normal hours (25%) or an urgent care centre (25%). The 56-65 year olds and 66-75 year old age range were most likely to choose their local doctors service during normal working hours (43.75%, 50% respectively).

Furthermore, over half of participants (58.2%) chose the service they chose first, because they wanted to get treatment/advice as soon as possible with the responses from participants with a LTC significantly higher (y: 66%, n: 46.5%). A good proportion of participants (39%) also suggested that as far as they were aware, it was the most appropriate service to contact for their needs at the time (figure 6).

Furthermore, participants with a LTC were most likely to have used the service they chose before and/or felt comfortable with it (LTC: 25.5%, no condition: 9.3%).

Interestingly, married participants were more likely to suggest that this is the service that came to mind first at the time, in comparison to the single participants (m: 17%, s: 3.0%).

Advice/treatment was received from the first service mostly all of the time (89.3%), with over half (51.2%) very satisfied with the service from the first point of contact (figure 7). Over 75’s were more likely to state that they were only satisfied with the service (63.64%)

Following on from contact with the first service, nearly two-thirds (63.9%) of participants were transferred or directed to another service (either before or after receiving advice/treatment from their first port of call). Nearly a quarter (22.6%) of participants felt their needs were full met by the first service, and nearly one-tenth (9.8%) of participants weren’t transferred to another service but felt that their needs were not fully met by the first service.
Out of the participants that were transferred to another service, the majority (46.3%) suggested that they were transferred to a service that was not listed, out of the options available the urgent care centre was transferred to the most (22.5%) (figure 8). Again, participants (41.6%) were very satisfied with the service received.
Examples of services participants suggested they were transferred to, that weren’t listed, include:

“...A rapid response was called who then called for paramedics and I was admitted to City Hospitals Sunderland for 5 days”

“Fracture clinic”

“Hospital orthopaedic fast track service”

Figure 8: Service directed to

Participants were asked to think about their experience of urgent care services in the last six months and what they thought was good about it. Generally they thought that the urgent care centres were quick and that there were short waiting times.

“Urgent care response is really quick and efficient”

“Short waiting time, local point of contact and easy access. Reassuring staff and treatment”

Two key themes showed when participants were asked what was poor about Urgent Care in the last six months. Waiting times (30%), and nothing was poor (22.5%):
Future Access to services

Participants were then asked which service they would contact in the future if they had urgent care needs, NHS111 (30.2%), local doctor services during normal hours (25.5%), and the Urgent Care Centres (22%) were the services most likely to be used (figure 9) with men significantly more likely to make their way to A&E (m: 15.1%), f: 3.7%). Responses from participants with a LTC were significantly higher for using the local doctor services during normal hours (y: 29.8%, n: 19.8%).

A theme for choosing this service first is for advice (14.34%):

“To get advice before going to hospital”

Because their training and expertise and knowledge would help me get the right advice and treatment.”

The above theme can be corroborated when participants were given the opportunity to suggest what would be important to them when choosing their urgent care service in the future; 79.3% suggested getting the treatment/advice as soon as possible was important. Getting access to the most knowledgeable/relevant person for my needs at the time (60.5%) was also viewed as important (figure 10), with married couples more likely to find it important in comparison to single participants (65.6%, 50% respectively).

Additionally, participants with a LTC were significantly more likely to find contacting a service that I have used before/feel comfortable with (LTC: 29.3%, no condition: 14.5%) and contacting a service that comes to mind first when the need arises (LTC: 12.2%, no condition: 5.3%) as important.
The majority of participants (67.3%) would contact NHS 111 if they needed medical help fast but it was not a 999 emergency. Just less than half (40.3%) suggested they would contact NHS 111 if they think they need to go to A&E or need an urgent care service (figure 11), with
single participants significantly more likely to contact NHS 111 if they needed medical help fast but it was not a 999 emergency, compared to married participants (m: 33.6%, s: 52.6%).

Most participants (87.2%) would use a local pharmacist if they needed health information or reassurance about what to do next (figure 12). 61.5% of over 75’s suggested they would use a pharmacist if they needed medical help fast but it wasn’t a 999 emergency.

Furthermore, more than three-quarters (76.5%) of participants suggested that they would contact an urgent care centre if they needed medical help fast but it’s not a 999 emergency. Just over two-fifths (41.9%) would contact an urgent care centre because they think they need to go to A&E or need an NHS urgent care service (figure 13), with single participants most likely to cite this as a reason, in comparison to married participants (m: 35.7%, s: 35.7%).

Participants were also given the opportunity to list up to 5 ways that urgent and emergency care services could be improved locally. Two key themes are staff issues (13.1%) and public education (7.5%):

“More nurse practitioners available”

“Improve staff training”

“Educate people more on what is an emergency”

“Leaflets to describe best use of services”
Figure 11: Use of NHS 111

Thinking about the following situations, please tell us why you would use NHS 111? Tick all that apply:

- You need medical help but it’s not an emergency: 202
- You think you need to go to A&E or need an NHS urgent care service: 121
- You don’t know who to call or you don’t have a GP to call: 74
- You need health information or reassurance about what to do next: 143

Figure 12: Use of a pharmacist

Thinking about the following situations, please tell us why you would use a local pharmacist? Tick all that apply:

- You need medical help but it’s not a GP: 51
- You think you need to go to A&E or need an NHS urgent care service: 17
- You don’t know who to call or you don’t have a GP to call: 33
- You need health information or reassurance about what to do next: 253
Focus Group

The CCG ran focus groups on the 19th and 20th December 2016 where 21 participants attended. The aim of these groups was to explore awareness and perceptions of urgent care services in Sunderland. No previous knowledge or use was required – participants ranged from those with significant experience to those with virtually none.

The key themes have been incorporated in the summary of findings and the executive summary.
Sunderland Health Forum Findings

The Sunderland Health Forums took place on 22\textsuperscript{nd} November 2016 (6-8pm) and 23\textsuperscript{rd} November 2016 (2-4pm) where 20 people in total attended. The summary of findings is:

Which services do you consider to be an emergency service?

83.33% of the discussion focused on A&E with main comments including:

- **Consistency**: attending A&E ensures that someone will be seen, on attending other facilities a person is moved around the system e.g. calling 111 and sent them to urgent care centre, and then sent to A&E. This causes confusion, patients not knowing whom they should contact first.
- **Children**: The importance of attending A&E if a child is hurt.
- **The definition of emergency**: clarity required over what an emergency is. One comment suggests, “Severe pain, bleeding heavily would go to A&E, anything less would probably go to GP. Severe chest pains ring 999.
- **Inappropriate attendance**: Fees should be incurred for attending A&E inappropriately and/ or people should be turned away.
- **GP records**: Lack of access to GP records at A&E.

Which services do you consider to be urgent care?

56.25% of the discussion focused on confusion of which services to go to with main comments including:

- **Various services**: so many options available, people are uncertain over which service to contact, focusing on the potential 8 possible routes.
- **Definition of urgent care**: clarity required over what urgent is.

31.25% of the discussion focused on GPs with main comments including:

- **Lack of access**: problems with getting GP appointments lead people to access other services.
- **Relationship**: people may prefer to see their own GP.

Which services do you consider non-urgent?

41.67% of the discussion focused on GP with comments including:

- **Physio**: Having to book a physio through the GP is now a further burden on GPs.
- **Lack of access**: people suggesting the GP is for non-urgent reasons due to it taking a long time to get an appointment.
25% of the discussion focused on confusion:

- **Conflicting information**: too much conflicting information surrounding non-urgent care.
- **Definition of non-urgent care**: clarity over what non-urgent is.

25% also focused on pharmacy:

- **Lack of access to pharmacist**: On attending a pharmacy, the pharmacist rarely fronts the shop; you are therefore speaking to an assistant with no medical training.

**What is good about urgent care?**

Focus on 111:

- **Treatment/attitude**: It is important to treat people properly, attitude is important. Concern arises over the operators reading from a script.
- **Prompt treatment**: 111 provides prompt treatment with one respondent commenting, “NHS 111 – my grandchild jammed his head and made an appointment in hospital, made appointment with triage nurse and seen straightaway.”

Focus on GP:

- **Prompt treatment**: ability to get swift appointments.
- **Other services**: Availability of other services relieving the pressure on GP’s.
- **Treatment/attitude**: Care and compassion are important.

**What was poor about urgent care?**

Focus on Pharmacy:

- **Inability to see pharmacist**: Receiving bad advice from the pharmacist’s assistant.

Focus on A&E:

- **System**: Lack of integration with urgent care.
- **Treatment refused**: On attendance via ambulance.
- **Transport**: patient transport to A&E, people having to wait a long time for an ambulance if the need isn’t life threatening.

Focus on Confusion:

- **Clear information**: lack of clear information on urgent care.
- **Appointment system**: This can be confusing.
Focus on GP:

- **Pharmacy**: People are advised to see the pharmacist, not their GP – but pharmacies are closing.
- **Gratitude**: Lack of respect, gratitude and appreciation for GPs.
- **Reception gatekeepers**: Receptionists who are not medically trained deciding whether or not a person can see the GP.

**How could we improve urgent or emergency care locally?**

Focus on GPs:

- **Lack of GPs**: The need to employ and train more GPs.
- **Patient history**: GPs no longer have access to patient information. One joined up system is required.
- **Fee**: Charge people for non-attendance.
- **Treatment/attitude**: Important to be treated with care and compassion.

Other engagement methods – Facebook comments

Facebook comments were received between the 29th November 2016 and 12th December 2016, where 43 comments in total were received. Below is the summary of comments:

**Nurses:**

- **Attitude**: lack of care and poor treatment of patients.
- **Lack of resources**: Nurses are extremely busy.

**GP Access:**

- **Lack of access**: the need to be able to get an appointment straight away without having to wait.

**Bureaucracy:**

- **Management**: too many people in management not enough doctors and nurses.
- **Lack of ability**: management’s lack of ability to make the right decision.
- **Funding**: Not enough funding available having a negative effect on care.

**Accessibility for all:**

- **Subtitles**: provide subtitles for deaf people.
- **Involvement**: reach out to deaf people and involve them in the consultation.
Communication:

- **Education:** clarity of what is and isn’t urgent care.

New ward:

- **Resources:** A designated ward for people who are drug abusers, binge drinkers, and time wasters, freeing up resources for genuine cases.

Services:

- **Availability:** The crisis team and mental health services need to be available in urgent care and A&E.
Summary of findings

The following provides an overview of the key findings from the online and postal survey, the focus groups, Sunderland Health Forum and Facebook messages:

- In general, out of all of the services available, the GP or practice nurse was used the most, with 37.2% of participants using it 2-3 times in the last 6 months. However, 26-35 and 46-55 year olds were most likely to see a health visitor, community nurse or district nurse (18.52%, 18.52% respectively) (online/postal).

- Furthermore, males (m: 2.2%, f: 0%) are significantly more likely to use an urgent care centre 7-10 times within a period of six months, whilst single participants are more likely to visit a hospital doctor (7-10 times) and the A&E (4-6 times) more frequently (6.7%, 5.3% respectively) (online/postal).

- Also, in the last six months participants with a LTC were more likely to use the GP or practice nurse (4-6 times: 26.2%), pharmacy (4-6 times: 23.4%, 7-10 times: 9.6%, over 10 times: 16.1%), hospital doctor or nurse (2-3 times: 26.3%, 7-10 times, 3.2%, over 10 times: 5.5%), A&E (2-3 times: 8.5%), the GP OOHs (2-3 times: 2.9%), calling NHS 111 (2-3 times: 9%) as well as visit the health visitor, community nurse or district nurse (4-6 times: 3.9%) more frequently (online/postal).

- In general, most participants view pharmacies (82.3%) and local doctor service during normal working hour (73.2%) as non-urgent care. Additionally, 46-55 year olds were most likely to view GP extended hours as non-urgent care (43.82%) (online/postal).

- Issues arise around the usage of the pharmacy, with participants suggesting a lack of access to the actual pharmacist with most only able to speak to the assistant (Sunderland Health Forum). Although, others deem the service provided by pharmacies favourably, suggesting they are very proactive, they check medications can be taken together as well as show people how to take specific medications. Improvements surround, more privacy: for example consultation rooms, more proactivity and more consistency (Focus Groups).

- Also, suggestions were made towards a requirement to employ and train more GP’s and that their should be a fee for non attendance at the GP surgery. Other concerns surrounded receptionists preventing patients from accessing the GP by acting as a gatekeeper (Sunderland Health Forum, Focus Groups).

- The majority of participants view OOHs (76.6%), urgent care centres (87.2%), NHS 111 (58.3%) and the extended hour service (54.3%) as urgent care. However, over 75 year olds (57.14%) were most likely to view local doctors during normal working hours as urgent care (online/postal).

- Additionally, males were more likely to have not heard of the local doctors during normal working hours, the A&E, urgent care centre or NHS 111 (3.4%, 3.4%, 5.4%, 3.4% respectively). Single participants (m: 1%, s: 2.9%) were also more likely to have not heard of the A&E (online/postal).
• Furthermore, in general, males are more likely to not understand the roles of the various services available in the area (m: 5.7%, f: 1.2%).

• More than half (56.3%) of participants strongly agree that it’s their own responsibility to look after their own minor health needs. However, males are more likely to strongly disagree (m: 1.9%, f: 0%) and participants with a LTC (LTC: 8.3%, no condition: 2.7%) are significantly more likely to neither agree nor disagree (online/postal).

• Additionally, nearly half of participants (49.9%) agree that they trust the advice that is provided by healthcare professionals (online/postal).

• Differences to the general trends can be seen with males (f: 30.8%, m: 47.2%) and 36-45 year olds (45.46%) most likely to strongly agree that they trust the advice of healthcare professionals (online/postal).

• Just over half (50.5%) agree that they understand the roles of the various healthcare services available in the area, with 26.42% of 36-45 year olds more likely to strongly agree (online/postal).

• Again, nearly half (47.6%) of participants strongly agree that they feel confident to look after their own minor health needs, with participants with LTCs (LTC: 44.2%, no condition: 54.7%) significantly less likely to strongly agree (online/postal).

• Most participants either strongly agree (42.8%) or agree (44.7%) if they had an urgent healthcare need they would know who they should contact.

• Mixed responses received over access, with the majority of participants either agreeing (27.5%) or disagreeing (25.4%) that they feel confident that they have access to the same standard of urgent care at anytime of day or night, with 75 year olds (28.57%) most likely to neither agree nor disagree and 26-35 year olds (34.28%) most likely to disagree (online/postal).

• Continuing on, nearly half of participants (48.9%) strongly agree that they want to receive advice, diagnosis or get treatment from someone that has access to my medical history/notes. Though males (m: 5.7%, f: 1.2%) were more likely to disagree with this statement (online/postal).

• Participants agree that they should be able to access advice, diagnosis or get treatment from whichever healthcare service they choose to contact (34.6%). Males (m: 54.7%, f: 27.2%) however are most likely to strongly agree and single participants in comparison to married, are most likely to strongly disagree (11.5%, 2.5% respectively) (online/postal).

• A high proportion (41.7%) strongly agrees that there should be a single point of contact that directs people to the most appropriate service when they need urgent care. However, single
participants are most likely to strongly disagree in comparison to the married participant (3.3%, 0% respectively) (online/postal).

- Clear signposting is required with local information about opening times and locations (Focus Groups).
- Access to urgent care close to their home or community is also important to participants, with 58.5% strongly agreeing (online/postal).
- Only attending the A&E if they have an emergency or life-threatening condition is also important to most participants with 68.1% strongly agreeing. However, single participants are significantly more likely to disagree in comparison to the married participant (5.0%, 0.6% respectively) (online/postal).
- However, questions arise with regards to the definition of emergency care. Some participants feel fees should be charge for inappropriate attendance as well as the lack of access to GP records at A&E and that all systems should be integrated (Sunderland Health Forum, Focus Groups).
- To continue, the majority of participants (60.6%) have not needed to use urgent care for a non-life threatening condition. Single participants (s: 54.2%, m: 33.33%), participants with a LTC (45.84%), and the over 75’s (52.38%) were more likely to have a need (online/postal).
- Two key themes cited for participants requiring urgent care are pain and infection (online/postal).
- In the most part, patients would choose to call NHS 111 (28.2%) if they had an urgent care need. It is important to note that participants were more likely to make their way to the A&E (12.7%), than use GP OOHs (0.7%) or the GP extended hours (1.4%) (Online/postal).
- A higher proportion of participants with a LTC (LTC: 30.5%, no condition: 11.6%), 56-65 and 66-75 year olds (43.75%, 50% respectively) would chose their local doctor service during normal hours (online/postal) if they had an urgent care need.
- Furthermore, the majority of participants (58.2%) chose the first point of contact because they wanted to get treatment/advice as soon as possible, with a good proportion (39%) suggesting that as far as they were aware, it was the most appropriate service to contact for their need at the time (online/postal).
- Also, according to the Sunderland Health Forum, NHS 111 provides prompt treatment and findings from the focus groups corroborate the importance of participants wanting treatment/advice as soon as possible suggesting speed and accessibility to services is regarded as important (Sunderland Health Forum, Focus Groups).
- Interestingly, when participants were asked what was good and poor about urgent care speed and accessibility to services and or advice cropped up on both accounts (35.96%, 30% respectively) (online/postal).
During discussions regarding GPs, speed and accessibility to services was raised suggesting it can take a long time to get an appointment - with this wait-time contributing to people accessing other services. Although, in contradiction some participants suggest they could get swift treatment from their GP (Sunderland Health Forum, Facebook).

Communication is important as people need to be informed on times-scales and availability for services in general (Focus Groups).

Significantly, when choosing which service to contact, participants with a LTC are more likely to choose the service that they have used before and/or felt comfortable with (LTC: 17%, no condition: 3.0%) and married participants were more likely to suggest that the service they chose came to mind first, in comparison to single participants (m: 17%, s: 3.0%) (online/postal).

The first service attended would give advice/treatment 89.3% of the time, with just over half (51.3%) very satisfied with the service (online/postal).

Just short of two-thirds (63.67%) of participants were transferred or directed to another service (before or after treatment), and just short of a quarter (22.6%) felt their needs were fully met by the first service. However, nearly one-tenth (9.8%) of participants weren’t transferred to another service, but also felt that their needs were not fully met (online/postal).

According to comments from Facebook, there is a lack of resources with nurses extremely busy and certain services aren’t readily available. For instance the crisis team and mental health services need to be available in urgent care and A&E. Furthermore, comments from Facebook suggest another ward be set up for ‘time wasters and binge drinkers’ (Facebook).

Furthermore, there is a lack of consistency in urgent care, with the only consistent thing being A&E. People can be transferred from one service to another, to finally be sent to A&E (Sunderland Health Forum).

The most likely services to be used in the future for urgent care needs are NHS 111 (30.2%), local doctor during normal working hours (25.5%) and an urgent care centre (22%).

In the future males are more likely to make their way to A&E than females (m: 15.1%, f: 3.7%) and participants with a LTC are significantly more likely to use the local doctor during normal working hours (LTC: 29.85%, no condition: 19.8%) (online/postal).

In the future, the majority of participants would prefer to choose a service for advice (14.34%), with 79.13% suggesting that it was important to get treatment/advice as soon as possible (online/postal).

Again, participants with a LTC are significantly more likely to find contacting a service that they have used before/ feel comfortable with as important (LTC: 29.3%, no condition: 14.5%) (online/postal).
• NHS 111 (67.3%, 40.3% respectively) and an urgent care centre (76.5%, 41.9%) is most likely to be contacted if participants need medical help fast but it was not a 999 emergency and if they think they need to go to A&E or need an NHS urgent care service (online/postal).

• Single participants are most likely to call NHS 111 (s: 52.6%, m: 33.6%) or go to an urgent care centre (s: 57.6%, m: 35.7%) if they need to go to A&E or need an NHS urgent care service (online/postal).

• With regards to local improvements to urgent and emergency services, two key themes have emerged surrounding staffing issues - including staff training and employment (13.1%), and education to public on urgent and emergency services (7.5%). Furthermore, suggestions have been made to remove the jargon, keep things clear and stop changing the names of services (online/postal, Focus Groups, Facebook).

• There is confusion over the services and what is available, with many people not knowing the definition of urgent and non-urgent care, suggesting a lack of clear information and too much conflicting information. Suggestions made to publicise services available, perhaps leaflets, to aid awareness (Sunderland Health Forum, Facebook, Focus Groups).

• Other concerns surround the treatment and attitude of staff, the importance to treat people with respect, care and compassion (Sunderland Health Forum).

• Finally, suggestions towards management issues - too many people in management and not enough doctors and nurses, a lack of funding having a negative effect on care as well as deaf patients being under represented and subtitles being available for patient with hearing difficulties.
Appendix D

Partners in improving local health

Sunderland CCG public satisfaction/perception of primary care – General Practice

FINAL REPORT

September, 2015
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1. Introduction

There is a requirement of the CCG as a 3rd tier commissioning body to develop a robust level of public perception around primary care and General Practice offered to residents of the city.

In order to provide evidence for the general practice strategy, both primary and secondary data will be used. The CCG wants to build on the comprehensive national, regional and local data already available through the use of local patient and public engagement in order to inform and develop a new General Practice strategy for the city.

The CCG want to find out ‘what a good [great] General Practice service looks like’ and wants to understand what this would mean to local people.

This document outlines both information gained from the most recent, available national and regional sources and detailed reports into local engagement carried out in August, 2015. 3 Helen Gray/Helen Fox: NECS communications and engagement team 2015
2. Secondary research

2.1 National data

Public satisfaction / perception of Primary Care – GP

Satisfaction with GP services has traditionally been high, with less variation year on year than other services and the NHS overall. However, since 2009 satisfaction with GP services has generally shown a downward trend. In 2014 it reached 71 per cent, the lowest reported level since the survey began. (Ref Kings Fund British Social Attitudes Survey)

National GP Practice Patient Survey (GPPS)

The GPPS provides data at practice level using a consistent methodology, which means it is comparable across organisations and over time. The survey is an independent survey administered by Ipsos MORI on behalf of NHS England.

The survey has limitations:

- Sample sizes at practice level are relatively small
- The survey does not include qualitative data which limits the detail provided by the results
- The data are provided twice a year rather than in real time

However, given the consistency of the survey across organisations and over time, GPPS can be used as one element of evidence.

It can be triangulated with other sources of feedback, such as feedback from Patient Participation Groups, local surveys and the Friends and Family Test, to develop a fuller picture of patient journeys.

Over all practices in the Sunderland CCG area score highly with most being on or above the national average in all areas covered by the bi-annual survey. Those being:

- Making appointments
- Waiting times
- Perceptions of care at appointments
- Practice opening hours
- Out-of-hours services

Relevant stats from GPPS
Between July – Sept 2014 and January – March 2015 18,201 questionnaires were sent out in Sunderland CCG, and 5,588 were returned completed. This represents a response rate of 31%. This is positively comparable to the national overall return rate of 33% and provides a 95% confidence rate. 4 Helen Gray/Helen Fox: NECS communications and engagement team 2015
The Friends and Family Test (FFT)

The FFT is relatively new only being introduced to record [very general] patient perception of GP practices since December 2014.

There are three key requirements of GP practices:

- To make the opportunity to provide feedback through the FFT available to all patients at any time
- To submit FFT data to the NHS England analytical team via the Calculating Quality Reporting Service (CQRS) each month
- Publish the data locally

Relevant stats from FFT

While a statutory requirement, the most recently published data from NHS England shows [as ‘no data’] 23 out 52 practices do not participate / offer patients the FFT in Sunderland.

NHS England clearly states it is the role of commissioners to ensure submission.

2.2 Regional data

NECS Insights

In March 2015, NECS reported on a comprehensive piece of research, The North East Health Service Public Perception Survey 2, which provides extensive insight into the regional population’s perceptions of a range of NHS and general health and well-being services. The research included a cohort from Sunderland CCG area.

Particularly relevant to this exercise, participants were asked to identify

- The key health issues in their local area
- Perceived issue relating to delivery of health services
- Which services they had accessed recently
- What was good, bad and suggested improvements to GP practices

Participants in Sunderland identified obesity, smoking, and drug and alcohol use as key issues in their area, as well as the health conditions related to these lifestyle behaviours, notably cancer, lung and heart disease. Alcohol and drug misuse was perceived to be a problem specifically for young people.

The majority demonstrated an understanding of, and identified, issues concerning the delivery of local services, specifically:
Funding cuts / lack of local services available (i.e. walk-in centres)
The shortage of doctors and nurses and other healthcare staff to ensure a high quality standard of care
The difficulty participants have in making appointments at the GP practice and the limited opening hours of practices (i.e. lack of appointments available outside of normal working hours)
People using services inappropriately and placing undue demand on services
Lack of hospital beds
Appointments being moved/cancelled

5 Helen Gray/Helen Fox: NECS communications and engagement team 2015
When asked to rate [all] the services that their local NHS delivers, approximately two thirds described them as good (65%) with a further 11% rating them as excellent. Whilst 7% of respondents had no opinion, 16% rated them as fair and 1% as poor. Compared with regional findings participants from Sunderland rated their local NHS services more positively than other regions, with more participants rating them as good (regional average 26%) and less participants as fair and poor (regional averages 20% & 6% respectively).

Just under half of participants from Sunderland reported accessing a health service in the last 12 months (42%), this is notably lower than the regional average (61%).

Use of the GP surgery was the highest of all services (37%, regional average 42%), followed by use of the hospital outpatient service (17%, regional average 14%).

Participants showed a greater preference for receiving information about self-care from health professionals (75%, regional average 47%) and/or from a pharmacist (20%, regional average 20%). One in ten participants indicated a preference for information on the internet or from NHS 111 (10% & 9% respectively).

These findings emphasise the importance of health professionals in influencing individuals in Sunderland in terms of their health-seeking behaviour, more so than neighbouring regions.

When asked about service improvement, the most common suggestions were:

- Improved attitude of health professional – more understanding
- Improved attitude of reception staff
- Longer appointments
- Longer opening hours
- Reduce the length of time patients have to wait for an appointment / greater availability of appointments
- More health professionals on duty
- Better communication between GP and hospital

Information from CCG engagement activity

Sunderland CCG has carried out two extensive pieces of work that provides comprehensive local data including that of Primary Care General Practice in the Out-of-Hours Service, 2015 and Urgent Care Review, 2012 studies.

In particular the Out-of-Hours (OOH) report offered valuable insight into a service directly impacting on General Practice and in relation to relevant national data available, in particular:

- 15% of patients had contacted the service in the last 12 months (In smaller, more qualitative face-to-face interviews with patients in practices a similar 14% had done so)
48% of the patients surveyed were happy/very happy with their experience and 52% were unhappy (In face-to-face interviews with patients in practices this rose was 93% satisfaction of those accessing the service)

6 Helen Gray/Helen Fox: NECS communications and engagement team 2015
39% of patients would be willing to travel 7-10 miles to attend an appointment. (In face-to-face interviews with patients in practices this rose to 77%)
85% of patients felt the OOH service should have access to medical records. (Conversely, in face-to-face interviews with patients in practices this dropped to 77%)

Incidentally, the report also provided the following recommendations in relation to improve stakeholder communications and engagement for both the service improvement and procurement processes:

   Extended engagement timeline to enable further patient engagement - 6 weeks possibly too short.

   Allocate more time to face to face patient interviews during engagement process as richer information received.

   Collection of data via an online survey is limited.

   Be more specific about level of data required when a third party is completing patient questionnaires, particularly with a GP Incentive Scheme.

   Utilise the Patient and Public Involvement (PPI) lead to access and engage with patients including those with learning disabilities, autism or mental health issues.

   Involve patients throughout the whole project process i.e. representation on project groups as well as improvement events and procurement panels.

   Utilise CCG PPI lead within procurement process i.e. part of procurement panel to represent as well as support patients on the panel

Potential lack of awareness of the OOH service reflecting feedback from a both local and national research that shows, without **continuous** communication, many services offered in primary care that ultimately influence impact on General Practice and vice versa can be misunderstood, forgotten or misused.
For example, in relation to OOH, 57% of people from Sunderland questioned in the national GP survey had not heard of the service (compared to a 26% national average).

3. New, local research

A series of research methods were used to explore the ‘what a good [great] General Practice service looks like’ ideal, based on a brief provided by the CCG and reported in detail in the NECS Proposal CE Informing the Development of a Primary Care Strategy. The research provides local insight into how residents feel about GP Primary Care by drawing out not just past/current perception of the service provided but where improvements could be made. Insight from this preliminary research is designed to

Helen Gray/Helen Fox: NECS communications and engagement team 2015
provide responses that will both inform strategy and provide a basis to support further consultation on any future, proposed changes relating to the strategy.

Research was conducted using the best practice principles of market research which are industry standard. Methods that have been used include:

- On-street interviews with a quota used to ensure that the sample will be statistically representative of the population of Sunderland.
- An online survey directed at established practice patient groups (PPGs).
- Focus groups to provide an opportunity to ask very specific questions and explore responses in much more detail.

The Sunderland CCG Public satisfaction / perception of primary care – General Practice Report (Appendix 1) provides detailed information based on combined insight gained the above.

### 3.1 High level observations

Worthy of noting, in order to reduce the length of time patients have to wait for an appointment at their practice, 38% of those from Patient Participation Groups (PPGs) and 69% of the general public stated that they would be willing to attend another GP practice.

A further 25% of those from PPGs and 9% of the general public felt that it would depend on factors such as accessibility of the other practice, the severity of the condition, and having the reassurance that the other practice would have access to the patient’s medical records.

The reasons given by those who wouldn’t consider attending another practice included other GPs not being aware of the patient’s medical history/ not having access to the patient’s notes, the distance required to travel to another practice and having a preference to see their own GP.

Specifically individuals with long-term conditions and those with a disability have a greater reliance on their GP practice, compared to those without. As a result, those patients have a greater preference to be seen at their own GP practice as opposed to being seen at other nearby practices and to be seen by their own doctor as opposed to other health professionals within the practice. Reasons cited are concerns around consistency of information/another GP understanding their needs and their history.

More PPGs members perceived that their GP practice has improved over the last five years, compared to the general public (63% & 19%, respectively). Consequently, 42% of the general public and just 15% of those from PPGs felt it had stayed the same, whilst equivalent proportions felt it hadn’t improved (21% of the general public & 19% of those from PPGs).
In terms of future GP services, being able to see a doctor emerged as the most important factor in terms of accessing services (91% of the general public and 89% of those from PPGs rating this as very important). Other important factors identified by members of the general public included being able to see a nurse and being seen at a suitable time, however a lower proportion rated these as very important (27% for each factor).

In terms of the health professionals’ individuals are willing to see, the majority said they would see any doctor. 8 Helen Gray/Helen Fox: NECS communications and engagement team 2015
Approximately a third of those from PPGs and a fifth of the general public would like to see other services available at their practice (39% & 20%, respectively).

Some of the suggestions put forth to encourage more people to self-care, included health promotion campaigns, educating people how they can self-care through information booklets and leaflets, enabling GPs to spend more time with patients talking to them about the ways they can self-care, and promoting greater use of the pharmacy service for minor ailments.

Some of the most common suggestions for improved GP services from survey respondents included were: longer opening hours, reduced waiting times, increased availability of same day appointments, more GP practices/Doctors to cope with demand, less reliance on locum doctors and greater consistency of care, and improved attitude of GPs and reception staff.

Specific suggestions made by individuals within the focus group, included: consistency and sharing of good practice, giving patients a voice, better communication between GPs and hospitals and encouraging GPs and the CCG to adopt a more holistic approach to health.

### 4. Appendices

**4.1 Appendix 1:** Final report on all local research combined

**4.2 Appendix 2:** All data – on street market research

**4.3 Appendix 3:** All data – PPG online research

### 5. Reference documents


2. North East Health Services Public Perception Survey Summary Report, March 2015
   North East Health Services Public Perception Survey FINAL REPORT.pdf
PPI Strategy Report.pdf

4 NECS Proposal CE Informing the Development of a Primary Care Strategy
527 NECS Proposal CE Informing the Development
General Practice Online Survey

Urgent Care

For Sunderland Clinical Commissioning Group

June 2017 – Headline Report

Lisa Anderson, Involvement Officer, NECS
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The majority of responses to this survey were from a GP (35%) or practice manager (33%). See Figure 1 for more information. Only four additional roles were included in the ‘other’ category. These included an administrator, a medical administrator, a secretary, and a senior HCA.

*Figure 1: Question 1*
Q2: The practice you work for is located in which locality? (N=43)

There was a relatively even spread of responses across the five localities, with the most responses being received from the North locality (26%), and the fewest responses received from Coalfields (14%). See Figure 2 for more information.

*Figure 2: Question 2*
Q3: Did you attend a Locality Meeting where the Urgent Care Strategy work was presented by Dr Tracey Lucas, SCCG Exec GP for Urgent Care? (N=43)

Two thirds (63%) of respondents told us they attended the locality meeting on the urgent care strategy. A third (35%) did not attend this. See Figure 3 for more information.

Figure 3: Question 3
Q4: What are the advantages of the current Urgent Care Centres in Sunderland? (N=42)

Respondents were asked to tell us what they felt were the advantages of the current Urgent Care Centres in Sunderland. In total, 42 people provided 64 comments. The most common words used in response to this question can be seen in Figure 4. Table 1 shows the main comments received by respondents.

Figure 4: Question 4 common words

Centres Problems Patient Demand OOH Care
GP Surgeries Minor Injuries Practices Choice for Patients
A&E Attendances Access Additional Appointments Self Hospital

Overall, respondents felt that a main advantage of the current urgent care centres in Sunderland were that they provided an improved and flexible access for patients, including out of hours (11 comments) for patients to be seen for minor injuries (11 comments). Respondents also commented how this freed up accident and emergency services (8 comments), provided the opportunity for patients to be seen the same day (8 comments), and also reduced the pressure on GPs (7 comments). More information can be seen in Table 1.
Table 1: Question 4 main comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients can be seen for minor injuries</td>
<td>11</td>
</tr>
<tr>
<td>Improved / flexible access to services, including out of hours</td>
<td>11</td>
</tr>
<tr>
<td>Frees up Accident and Emergency services</td>
<td>8</td>
</tr>
<tr>
<td>Same day appointment for patients / more appointment options / addresses patient demand and appointment pressure</td>
<td>8</td>
</tr>
<tr>
<td>Addresses GP crises / pressure on GPs</td>
<td>7</td>
</tr>
<tr>
<td>More services / increased choice for people to access</td>
<td>6</td>
</tr>
<tr>
<td>Ease pressure on current services / adds capacity to deliver services</td>
<td>4</td>
</tr>
<tr>
<td>Based local to patients / convenient for patients to access</td>
<td>4</td>
</tr>
<tr>
<td>Negative comment / no major advantages</td>
<td>2</td>
</tr>
<tr>
<td>Understood by patients</td>
<td>1</td>
</tr>
<tr>
<td>Information sharing (patient information accessible by services)</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
</tr>
</tbody>
</table>
Q5: What are the disadvantages of the current Urgent Care Centres in Sunderland? (N=41)

Respondents were asked to tell us what they felt were the disadvantages of the current Urgent Care Centres in Sunderland. In total, 41 people provided 65 comments. The most common words used in response to this question can be seen in Figure 5. Table 2 shows the main comments received by respondents.

Figure 5: Question 5 common words

Overall, people felt the urgent care centres were not staffed appropriately, with no GP being available, and the level of medical support / skills available not enough. They also felt the services offered through urgent care were not enough (9 comments). A number of comments were made about how urgent care services bounce people back to their GP, despite having been directed to urgent care by 111 or their GP (9 comments). This lead to confusion amongst patients, who would end up requesting a GP appointment anyhow, rather than go to Urgent Care services. Respondents also commented how they were no-longer walk-in centres, and how people needed to make an appointment (8 comments). Patients were left confused about what they should be going to Urgent Care services for, and more information, better communication, and more clarity was needed (7 comments). A number of comments were also received about how patients use the urgent care service inappropriately, including to get a same-day appointment if their GP was unable to offer them one (7 comments). More information can be seen in Table 2.
### Table 2: Question 5 main comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited staff skills / no GP available / limited services offered</td>
<td>9</td>
</tr>
<tr>
<td>Redirects people back to GPs / Patients bounce around / patients just request GP appointment in response</td>
<td>9</td>
</tr>
<tr>
<td>Need appointments – no-longer walk-in</td>
<td>8</td>
</tr>
<tr>
<td>Poor communication to patients about what they’re for / lack of information / patients confused</td>
<td>7</td>
</tr>
<tr>
<td>Inappropriate use by patients</td>
<td>7</td>
</tr>
<tr>
<td>Too much choice for patients. Increases demand simply by being available</td>
<td>6</td>
</tr>
<tr>
<td>Cost</td>
<td>5</td>
</tr>
<tr>
<td>Lack of continuity of care for patients / staff don’t know patients / no access to patient information</td>
<td>4</td>
</tr>
<tr>
<td>Opening hours not enough</td>
<td>3</td>
</tr>
<tr>
<td>Not monitored / performance monitored / well run / standards vary</td>
<td>2</td>
</tr>
<tr>
<td>No disadvantages</td>
<td>2</td>
</tr>
<tr>
<td>Transport for older people to attend</td>
<td>1</td>
</tr>
<tr>
<td>Too much demand</td>
<td>1</td>
</tr>
<tr>
<td>Duplicates services available</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
</tr>
</tbody>
</table>
Q6: What elements of Urgent Care do you think your practice should offer in the future? (N=43)

Seven out of ten (72%) respondents told us that they thought their practice should offer urgent / same day appointments for urgent care services in the future. Only a third (33%) felt they should offer minor injury services.

Figure 6: Question 6

Respondents were asked to tell us any other urgent care services they thought their practice should offer in the future. In total, 17 people provided 31 comments. The most common words used in response to this question can be seen in Figure 7. Table 3 shows the main comments received by respondents.
Overall, respondents told us that they already provide urgent care services (7 comments) and same day appointments (7 comments). They also told us they had no capacity to deliver more, or said they thought they should deliver none (6 comments). Four comments were made about needing additional funding and resources in order to provide more services. Only four comments were made in relation to urgent care services which could be delivered. These included nurse triage, minor injuries, and a walk in system. More information can be seen in Table 3.

Table 3: Question 6 main comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Already provide other urgent care services</td>
<td>7</td>
</tr>
<tr>
<td>Already provide same day appointments</td>
<td>7</td>
</tr>
<tr>
<td>No capacity to provide more / none</td>
<td>6</td>
</tr>
<tr>
<td>Need more resources / funding to provide more services</td>
<td>4</td>
</tr>
<tr>
<td>Can offer nurse triage / minor injuries / walk in system</td>
<td>4</td>
</tr>
<tr>
<td>Other medical services need stopped / reviewed. Funding can be used better</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Hubs should offer more services</td>
<td>1</td>
</tr>
<tr>
<td>Same day appointments not appropriately used by patients</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
</tr>
</tbody>
</table>
Q7: What elements of Urgent Care do you think your practice could offer in the future? (N=43)

Respondents were then asked to tell us what urgent care services they could offer in the future. Responses mirrored the answers to the previous question, with three-quarters (77%) saying they could offer urgent / same day appointments, and a third (35%) saying they could offer minor injuries.

Figure 8: Question 8

Respondents were asked to tell us any other urgent care services they thought their practice could offer in the future. In total, 18 people provided 29 comments. The most common words used in response to this question can be seen in Figure 9. Table 4 shows the main comments received by respondents.
Overall, respondents told us they would need more money and/or resources in order to provide additional urgent care services (6 comments), or that they already offered these services (5 comments). People were worried this would put too much pressure on the current service, or that there was no capacity to offer more (4 comments). A number of isolated suggestions were made as to which urgent care services could be offered. These included a nurse triage, walk-in system, more appointments, extended access service, minor ailments, treatments rooms, pharmacy advice, and a nurse practitioner. See Table 4 for more information.

**Table 4: Question 7 main comments**

<table>
<thead>
<tr>
<th>Comment</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need more money / resources to provide</td>
<td>6</td>
</tr>
<tr>
<td>Already offered</td>
<td>5</td>
</tr>
<tr>
<td>Too much pressure on service / no capacity</td>
<td>4</td>
</tr>
<tr>
<td>See previous answer</td>
<td>3</td>
</tr>
<tr>
<td>None</td>
<td>2</td>
</tr>
<tr>
<td>Urgent care in GP surgeries not in patients best interests</td>
<td>1</td>
</tr>
<tr>
<td>Nurse triage</td>
<td>1</td>
</tr>
<tr>
<td>Walk-in system</td>
<td>1</td>
</tr>
<tr>
<td>More appointments</td>
<td>1</td>
</tr>
<tr>
<td>Extended access scheme</td>
<td>1</td>
</tr>
<tr>
<td>Minor ailments</td>
<td>1</td>
</tr>
<tr>
<td>Treatment rooms</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacy advice</td>
<td>1</td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>
Q8: If you think there are elements of Urgent Care that your practice should and/or could offer, what would enable your practice to do this? (N=43)

Respondents were asked to tell us what their practice would need to enable them to provide urgent care. Over half of respondents told us they would need comprehensive minor ailments service in community pharmacies (54%), and urgent home visiting service (53%). See Figure 10 for more information.

Figure 10: Question 8

Respondents were asked to tell us what else would enable their practice to offer urgent care services in the future. In total, 17 people provided 28 comments. The most common words used in response to this question can be seen in Figure 11. Table 5 shows the main comments received by respondents.
Overall, respondents felt that they needed more qualified staff (GPs, practice nurses) to be able to offer extended services (9 comments). They also said they would need more money to provide these services (4 comments). A number of respondents felt there was no capacity to provide anything extra, and that the current service was already under too much pressure (4 comments), or that nothing could be provided to help (4 comments). More information can be found in Table 5.

**Table 5: Question 8 main comments**

<table>
<thead>
<tr>
<th>Comment</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>More qualified staff</td>
<td>9</td>
</tr>
<tr>
<td>Increased budget</td>
<td>4</td>
</tr>
<tr>
<td>No capacity / too much pressure currently on services</td>
<td>4</td>
</tr>
<tr>
<td>Nothing / none of the above / unsure</td>
<td>4</td>
</tr>
<tr>
<td>Home visit resources</td>
<td>2</td>
</tr>
<tr>
<td>Resources to ensure continuity of care</td>
<td>1</td>
</tr>
<tr>
<td>Guidelines / detailed process</td>
<td>1</td>
</tr>
<tr>
<td>More time in order to deliver services</td>
<td>1</td>
</tr>
<tr>
<td>Patient education so they didn’t misuse urgent care services</td>
<td>1</td>
</tr>
<tr>
<td>Out of hours service</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
</tr>
</tbody>
</table>
Q9: How do you think patients with minor injuries should be managed? (N-43)

Respondents were asked to tell us how they thought patients with minor injuries should be managed, and three-quarters (74%) said by an urgent care centre / urgent treatment centre. Four out of ten (40%) respondents thought this should be by the patients’ own general practice.

Figure 12: Question 9

Respondents were asked to tell us any other ways patients with minor injuries should be managed. In total, 10 people provided 11 comments. The most common words used in response to this question can be seen in Figure 13. Table 6 shows the main comments received by respondents.
Overall, respondents felt that GPs did not have the correct resources, equipment, or skills to deliver urgent care services (3 comments). They also felt the what was needed would be dependent on the type of injury (2 comments), and that more GPs were needed (2 comments) See Table 6 for more information.

Table 6: Question 9 main comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs not equip / skilled to provide service</td>
<td>3</td>
</tr>
<tr>
<td>Dependent on injury</td>
<td>2</td>
</tr>
<tr>
<td>More GPs needed</td>
<td>2</td>
</tr>
<tr>
<td>Should not be GPs</td>
<td>1</td>
</tr>
<tr>
<td>2 Tier system in A&amp;E</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacy treatment room</td>
<td>1</td>
</tr>
<tr>
<td>No capacity to provide this</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
</tr>
</tbody>
</table>

Q10: Are there any other / additional services in the community that we should be considering to effectively manage people's Urgent Care needs? (N=31)

Respondents were asked to tell us any other or additional services in the community that we should be considering to effectively manage people’s urgent care needs. In total, 31 people provided 39 comments. The most common words used in response to this question can be seen in Figure 14. Table 7 shows the main comments received by respondents.
Predominantly, respondents felt that patients needed more education and information so they knew what urgent care meant, to ensure they did not misuse urgent care services. They also felt there should be more education about self-care, and the cost of medications, to reduce unnecessary prescriptions, and the costs associated with that (11 comments). Five comments were received in relation to greater pharmacy support or lead on urgent care. In addition, home visit services (2 comments) and nurse practitioners (2 comments) were also mentioned. More details can be seen in Table 7.
Table 7: Question 10 main comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient information / education. To increase self-care and to educate about what urgent care means / cost of their medication</td>
<td>11</td>
</tr>
<tr>
<td>Pharmacy support / lead on urgent care</td>
<td>5</td>
</tr>
<tr>
<td>Home visit service / urgent care home visit service</td>
<td>3</td>
</tr>
<tr>
<td>Nurse practitioners / community nurses</td>
<td>3</td>
</tr>
<tr>
<td>No unnecessary spending / reduce costs on medications</td>
<td>2</td>
</tr>
<tr>
<td>Keep service simple / single point of contact</td>
<td>2</td>
</tr>
<tr>
<td>Staff skill mix</td>
<td>1</td>
</tr>
<tr>
<td>Equipment (x-ray, eye infirmary)</td>
<td>1</td>
</tr>
<tr>
<td>Access to community minor injury service</td>
<td>1</td>
</tr>
<tr>
<td>111 staff clinical supervision</td>
<td>1</td>
</tr>
<tr>
<td>Long Term Condition team link with practice</td>
<td>1</td>
</tr>
<tr>
<td>24 / 7 service</td>
<td>1</td>
</tr>
<tr>
<td>Keep urgent care centres open / make no changes</td>
<td>1</td>
</tr>
<tr>
<td>DVT Clinics in the community</td>
<td>1</td>
</tr>
<tr>
<td>Enhanced locality extended access scheme</td>
<td>1</td>
</tr>
<tr>
<td>Invest in hubs – hubs to provide additional hours and services</td>
<td>1</td>
</tr>
<tr>
<td>More GPs</td>
<td>1</td>
</tr>
<tr>
<td>Treat more conditions</td>
<td>1</td>
</tr>
<tr>
<td>Sexual health</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>
Q11: How do you currently manage patients who require a same day appointment? (N=43)

Over three-quarters (77%) of respondents told us their reception signpost patients to available slots within the practice for patients who require a same day appointment. Over half of respondents triage by a GP (56%) or have reception staff signpost to an available slot with the Locality Extended Access Scheme (56%). Respondents were asked to say which scheme this was, and four responses were received. These included Pallion extended hours, out of hours, local chemists, and an internal GP dedicated to home visits and same-day appointments. More information can be seen in Question 11.

Figure 15: Question 11

Q12: If you use your Locality Extended Access Scheme for patients with an Urgent Care need, how do you decide who needs to be seen that day? (N=43)
Respondents were asked to tell us how they decide which patients need to be seen that day, if they use the Locality Extended Access Scheme. Four out of ten respondents (40%) told us they book into the Scheme for anyone who asks to be seen the same day. A third (33%) said they use their clinical judgement.

Figure 16: Question 12

Respondents were asked to tell us how else they decide who gets a same day appointment. In total, 11 people provided 11 comments. The most common words used in response to this question can be seen in Figure 13. Table 8 shows the main comments received by respondents.
Figure 17: Question 12 common words

Overall, respondents told us they use a flowchart or checklist to determine who can have access to a same-day appointment (3 comments). Two people told us the reception or admin staff book the appointments, and that they don’t use the service. More information can be seen in Table 8.

Table 8: Question 12 main comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flowchart / check list / locality tool</td>
<td>3</td>
</tr>
<tr>
<td>Admin / reception staff</td>
<td>2</td>
</tr>
<tr>
<td>Don’t use</td>
<td>2</td>
</tr>
<tr>
<td>Use if appropriate</td>
<td>1</td>
</tr>
<tr>
<td>Use on rare occasions</td>
<td>1</td>
</tr>
<tr>
<td>Some practices misuse service</td>
<td>1</td>
</tr>
<tr>
<td>Limited appointments available through scheme</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
</tr>
</tbody>
</table>
Q13: Is there anything else you would like to tell us or ask us about future Urgent Care provision? (N=14)

Respondents were asked to tell us anything else about the future of urgent care provision. In total, 14 people provided 19 comments. The most common words used in response to this question can be seen in Figure 18. Table 9 shows the main comments received by respondents.

Figure 18: Question 13 common words

Respondents felt that urgent care services needed to be commissioned effectively, and comprehensively resourced (3 comments). They also felt that patients needed increased education on what urgent care means and on self-care (2 comments). There were comments relating to making urgent care simpler (2 comments), and reducing the current pressure on GPs (2 comments). Full details can be seen in Table 9.
Table 9: Question 13 main comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective commissioning of services / review of services needed / need comprehensively resourced</td>
<td>3</td>
</tr>
<tr>
<td>Increased patient education needed on Urgent care and self-care</td>
<td>2</td>
</tr>
<tr>
<td>Make urgent care simpler</td>
<td>2</td>
</tr>
<tr>
<td>Free up GPs / reduce pressure on GPs</td>
<td>2</td>
</tr>
<tr>
<td>Should be provided in Hubs</td>
<td>1</td>
</tr>
<tr>
<td>Keep it local</td>
<td>1</td>
</tr>
<tr>
<td>Use a mix of staff / skill sets</td>
<td>1</td>
</tr>
<tr>
<td>More staff needed</td>
<td>1</td>
</tr>
<tr>
<td>Limit the changes to be made to current urgent care provision</td>
<td>1</td>
</tr>
<tr>
<td>Need 24 / 7</td>
<td>1</td>
</tr>
<tr>
<td>Stop providing urgent care services</td>
<td>1</td>
</tr>
<tr>
<td>Patients view urgent care services negatively</td>
<td>1</td>
</tr>
<tr>
<td>Improve signposting to services</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>
## Appendix F

**Urgent Care Strategy Public Formal Consultation Plan**

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Event</th>
<th>Venue</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wed</td>
<td>21/02/2018</td>
<td>Voluntary Sector event</td>
<td>Bede Tower, SR2 7EA</td>
<td>3-5PM</td>
</tr>
<tr>
<td>Thu</td>
<td>15/03/2018</td>
<td>Launch Event</td>
<td>Bede Tower, SR2 7EA</td>
<td>12 - 2PM</td>
</tr>
<tr>
<td>Thu</td>
<td>05/04/2018</td>
<td>Locality - North</td>
<td>Bunny Hill Centre, SR5 4BW</td>
<td>1 - 3PM</td>
</tr>
<tr>
<td>Wed</td>
<td>11/04/2018</td>
<td>Locality - West</td>
<td>Hope St Xchange, SR1 3QD</td>
<td>2 - 4PM</td>
</tr>
<tr>
<td>Wed</td>
<td>18/04/2018</td>
<td>Locality - Washington</td>
<td>Washington Arts Centre, NE38 8AB</td>
<td>2 - 4PM</td>
</tr>
<tr>
<td>Wed</td>
<td>25/04/2018</td>
<td>Locality - East</td>
<td>Sunderland Bangladeshi International Centre, SR1 2QD.</td>
<td>2 - 4PM</td>
</tr>
<tr>
<td>Wed</td>
<td>09/05/2018</td>
<td>Durham</td>
<td>The Glebe Centre, SR7 9BX</td>
<td>5 - 7PM</td>
</tr>
<tr>
<td>Thu</td>
<td>10/05/2018</td>
<td>Locality - Coalfields</td>
<td>Chester-le-street Cricket Club, DH3 3PF</td>
<td>12 - 2PM</td>
</tr>
<tr>
<td>Wed</td>
<td>23/05/2018</td>
<td>Travel and transport</td>
<td>Bede Tower, SR2 7EA</td>
<td>5 - 7PM</td>
</tr>
</tbody>
</table>

**Online Events**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Type of event</th>
<th>How to access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday 15 March</td>
<td>12-2pm</td>
<td>Consultation launch</td>
<td>Follow us Twitter @sunderlandccg, Facebook @sunderlandhealth to see this event live or it will be saved so you can watch it later</td>
</tr>
<tr>
<td>Event one</td>
<td>TBC – evening</td>
<td>Questions and answers</td>
<td>TBC</td>
</tr>
<tr>
<td>Event two</td>
<td>TBC – evening</td>
<td>Questions and answers</td>
<td>TBC</td>
</tr>
</tbody>
</table>
answers
## Appendix G: Full list of all proposed scenarios

<table>
<thead>
<tr>
<th>Scenario 1</th>
<th></th>
<th>Do nothing</th>
<th>Retain all services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where the scenario was proposed</td>
<td></td>
<td>Executive Development Session on 20/12/16</td>
<td></td>
</tr>
<tr>
<td>Summary of appraisal against criteria</td>
<td>Design principle</td>
<td>Meets the design principle?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Rationale for appraisal against criteria</td>
<td>1. Be safe, sustainable, and provide responsive, high quality care</td>
<td>Meets the design principle? No</td>
<td>This option is not considered to be sustainable in the long term due to financial and workforce considerations. It will not be possible to achieve the MCP productivity plan savings of £1.5 million over two years with this option.</td>
</tr>
<tr>
<td></td>
<td>2. Increase self-care through access to appropriate clinical advice</td>
<td>Meets the design principle? No</td>
<td>This option would not capitalise upon the new Integrated Urgent Care (111) ‘consult and complete’ model which aims to manage more people over the telephone and online. This option is likely to perpetuate increasing activity (including from neighboring CCGs) without any decrease in ED activity as evidenced by historic activity.</td>
</tr>
<tr>
<td></td>
<td>3. Ensure appropriate access to treatment as close to home as possible</td>
<td>Meets the design principle? No</td>
<td>This option would not ensure that people accessed the most appropriate service for their needs. From historic activity we know many people every year attend an UCC who required advice which could have been available in a less resource intensive setting. This means people may travel further than required to access the service they thought would best meet their needs, for example accessing an UCC where the most appropriate service for their needs may have been a call to the IUC service.</td>
</tr>
<tr>
<td></td>
<td>4. Simplify access by</td>
<td>Meets the design principle? No</td>
<td></td>
</tr>
</tbody>
</table>

Version 8
improving integration across health and social care and reducing duplication of services | This option would maintain the existing complexities and confusion within the UC system
---|---
5. Meet nationally mandated requirements | Meets the design principle? No
---|---

**Scenario 2**

**Scenario description**
Replace services with:
- General Practice core service
- Sunderland Extended Access Service in locality hubs (evening and weekends)
- ED with streaming to GP led primary care service and minor injuries 08:00 – 24:00
- Enhanced minor ailment community pharmacy scheme

**Where the scenario was proposed**
Attendees at the Executive Development Session on the 14/02/17 refined the scenarios from earlier discussions and replaced this scenario with scenarios 5 and 6.

**Summary of appraisal against criteria**
<table>
<thead>
<tr>
<th>Design principle</th>
<th>Meets the design principle?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>No</td>
</tr>
</tbody>
</table>

**Rationale for appraisal against criteria**
1. Be safe, sustainable, and provide responsive, high quality care
   - Meets the design principle? Yes
   - Clinical and provider input agrees the scenario meets this design principle
2. Increase self-care through access to appropriate clinical advice
   - Meets the design principle? No
   - Access to an enhanced minor ailment community pharmacy scheme is not considered to be in line with current evidence regarding increased self-care as many treatments offered by this service are readily available over the counter.
   - There is also a national Community Pharmacy Referral Service currently in pilot with access via 111 instead of direct access via the community pharmacy. The outcomes of the evaluation of this pilot will be included in this work once they are available
3. Ensure appropriate access to treatment
   - Meets the design principle? Yes
as close to home as possible | This scenario would facilitate the IUC approach, with people accessing the IUC service for assessment of their needs. This will mean that many people will be given advice over the telephone or online rather than travelling to a location for a face to face appointment. Where a person needs a prescription this will be issued electronically to the pharmacy of their choice.

People would also be able to access General Practice services via the Sunderland Extended Access Service in locality hubs at evening and weekends. In Sunderland there is one hub in each of the five localities, and people can access whichever hub is closest to them, not just the hub which is situated in the locality they live in.

4. Simplify access by improving integration across health and social care and reducing duplication of services | Meets the design principle? Yes

Access will be simplified by people phoning the IUC service for assessment, advice, and electronic prescribing. People phoning the IUC service will be directed to the service which is most appropriate for their needs. Thus people do not need to understand each and every service available.

IUC will have access to the patients record, enabling people’s health needs to be met within their personal context.

5. Meet nationally mandated requirements | Meets the design principle? No

The Enhanced minor ailment community pharmacy scheme has been superseded by the Community Pharmacy Referral Service currently in pilot. The Enhanced minor ailment community pharmacy scheme is not accessed via the IUC service but directly via the Community Pharmacy. The Community Pharmacy Referral Service currently in pilot is accessed via the IUC service and thus aligns with the NHS England vision for UC services.

### Scenario 3

<table>
<thead>
<tr>
<th>Scenario description</th>
<th>Replace services with:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• General Practice core service</td>
</tr>
</tbody>
</table>
|                      | • Sunderland Extended Access Service in locality hubs (evening...
- ED with streaming to GP led primary care service and minor injuries 08:00 – 24:00
- Enhanced minor ailment community pharmacy scheme
- Minor injury all day across 5 hubs

Where the scenario was proposed
Attendees at the Executive Development Session on the 14/02/17 refined the scenarios from earlier discussions and replaced this scenario with scenarios 5 and 6.

<table>
<thead>
<tr>
<th>Design principle</th>
<th>Meets the design principle?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>No</td>
</tr>
</tbody>
</table>

Summary of appraisal against criteria

1. Be safe, sustainable, and provide responsive, high quality care
   Meets the design principle? No
   Clinical and provider input has agreed that the provision of Minor injury all day across 5 hubs is not viable from a workforce perspective.

2. Increase self-care through access to appropriate clinical advice
   Meets the design principle? No
   Access to an enhanced minor ailment community pharmacy scheme is not considered to be in line with current evidence regarding increased self-care as many treatments offered by this service are readily available over the counter.

3. Ensure appropriate access to treatment as close to home as possible
   Meets the design principle? Yes
   This scenario would facilitate the IUC approach, with people accessing the IUC service for assessment of their needs. This will mean that many people will be given advice over the telephone or online rather than travelling to a location for a face to face appointment. Where a person needs a prescription this will be issued electronically to the pharmacy of their choice
People would also be able to access General Practice services via the Sunderland Extended Access Service in locality hubs at evening and weekends. In Sunderland there is one hub in each of the five localities, and people can access whichever hub is closest to them, not just the hub which is situated in the locality they live in.

Minor injury provision all day across 5 hubs would mean people could get minor injury treatment in a hub near their location.

4. Simplify access by improving integration across health and social care and reducing duplication of services

Meets the design principle? Yes

Access will be simplified by people phoning the IUC service for assessment, advice, and electronic prescribing. People phoning the IUC service will be directed to the service which is most appropriate for their needs. Thus people do not need to understand each and every service available.

IUC will have access to the patient’s record, enabling people's health needs to be met within their personal context.

5. Meet nationally mandated requirements

Meets the design principle? No

The Enhanced minor ailment community pharmacy scheme has been superseded by the Community Pharmacy Referral Service currently in pilot.

### Scenario 4

<table>
<thead>
<tr>
<th>Scenario description</th>
<th>Replace services with:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- General Practice core service</td>
</tr>
<tr>
<td></td>
<td>- Sunderland Extended Access Service in locality hubs (evening and weekends)</td>
</tr>
<tr>
<td></td>
<td>- ED with streaming to GP led primary care service and minor injuries 08:00 – 24:00</td>
</tr>
<tr>
<td></td>
<td>- Enhanced minor ailment community pharmacy scheme</td>
</tr>
<tr>
<td></td>
<td>- Minor injury all day across five hubs</td>
</tr>
<tr>
<td></td>
<td>- One hub / UC centre with diagnostics (8am – 12pm)</td>
</tr>
</tbody>
</table>

| Where the scenario was proposed | Attendees at the Executive Development Session on the 14/02/17 refined the scenarios from earlier discussions and replaced this scenario with scenarios 5 and 6. |

<table>
<thead>
<tr>
<th>Summary of appraisal against criteria</th>
<th>Design principle</th>
<th>Meets the design principle?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Rationale for appraisal against criteria</td>
<td>Meets the design principle?</td>
<td>Reasoning</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>1. Be safe, sustainable, and provide responsive, high quality care</td>
<td>No</td>
<td>The ED with streaming to GP led primary care service and minor injuries 8am – 12 midnight element of this scenario is currently under development as part of the ED Interface work, as well as part of this work. Clinical and provider input has agreed that the provision of Minor injury all day across five hubs is not viable from a workforce perspective. Given the level of historic and projected demand provision of minor injury services all day across five hubs would not be financially sustainable or best use of public money. Running a hub/UC centre with diagnostics from 08:00 0 24:00 in addition to the other services in this scenario would create duplication and confusion.</td>
</tr>
<tr>
<td>2. Increase self-care through access to appropriate clinical advice</td>
<td>No</td>
<td>Access to an enhanced minor ailment community pharmacy scheme is not considered to be in line with current evidence regarding increased self-care as many treatments offered by this service are readily available over the counter. There is also a national Community Pharmacy Referral Service currently in pilot with access via 111 instead of direct access via the community pharmacy. The outcomes of the evaluation of this pilot will be included in this work once they are available</td>
</tr>
<tr>
<td>3. Ensure appropriate access to treatment as close to home as possible</td>
<td>Yes</td>
<td>This scenario would facilitate the IUC approach, with people accessing the IUC service for assessment of their needs. This will mean that many people will be given advice over the telephone or online rather than travelling to a location for a face to face appointment. Where a person needs a prescription this will be issued electronically to the pharmacy of their choice.</td>
</tr>
</tbody>
</table>
People would also be able to access General Practice services via the Sunderland Extended Access Service in locality hubs at evening and weekends. In Sunderland there is one hub in each of the five localities, and people can access whichever hub is closest to them, not just the hub which is situated in the locality they live in.

Minor injury provision all day across 5 hubs would mean people could get minor injury treatment in a hub near their location.

4. Simplify access by improving integration across health and social care and reducing duplication of services

Access will be simplified by people phoning the IUC service for assessment, advice, and electronic prescribing. People phoning the IUC service will be directed to the service which is most appropriate for their needs. Thus people do not need to understand each and every service available.

IUC will have access to the patient’s record, enabling people’s health needs to be met within their personal context.

5. Meet nationally mandated requirements

The Enhanced minor ailment community pharmacy scheme has been superseded by the Community Pharmacy Referral Service currently in pilot.

<table>
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<tr>
<th>Scenario 5</th>
<th>Replace services with:</th>
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<tr>
<td>Scenario description</td>
<td>General practice (core and five Sunderland Extended Access Services in locality hubs) consumes all UCC activity 08:00 – 20:30</td>
</tr>
<tr>
<td></td>
<td>ED Interface</td>
</tr>
<tr>
<td></td>
<td>Minor Injuries are seen at the UTC within the acute footprint (ED overnight)</td>
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<tr>
<th>Where the scenario was proposed</th>
<th>Executive Development Session on 14/02/17</th>
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<th>Design principle</th>
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<tr>
<th>Rationale for</th>
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<td>Appraisal against criteria</td>
<td>Meets the design principle?</td>
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<tr>
<td>2. Increase self-care through access to appropriate clinical advice</td>
<td>Yes</td>
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</tr>
<tr>
<td>3. Ensure appropriate access to treatment as close to home as possible</td>
<td>Yes</td>
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<tr>
<td>4. Simplify access by improving integration across health and social care and reducing duplication of services</td>
<td>Yes</td>
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<tr>
<td>5. Meet nationally mandated requirements</td>
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<td>Scenario 6</td>
<td>Replace services with:</td>
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<td>Scenario description</td>
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<tr>
<td>Rationale for appraisal against criteria</td>
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<tr>
<td>1. Be safe, sustainable, and provide responsive, high quality care</td>
<td>Meets the design principle? No</td>
</tr>
<tr>
<td></td>
<td>The provision of GP led hubs located in each locality open from 08:00 – 20:00 is not considered viable from a workforce perspective by the SCCG Clinical leads and providers.</td>
</tr>
<tr>
<td>2. Increase self-care through access to appropriate clinical advice</td>
<td>Meets the design principle? Yes</td>
</tr>
<tr>
<td></td>
<td>Places IUC at the heart of access to face to face services. Appropriate access to the GP OOHs is being considered as part of the ED Interface work.</td>
</tr>
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<td>3. Ensure appropriate access to treatment as close to home as possible</td>
<td>Meets the design principle? Yes</td>
</tr>
<tr>
<td></td>
<td>This scenario would facilitate the IUC approach, with people accessing the IUC service for assessment of their needs. This will mean that many people will be given advice over the telephone or online rather than travelling to a location for a face to face appointment. Where a person needs a prescription this will be issued electronically to the pharmacy of their choice. People would also be able to access General Practice services via the Sunderland Extended Access Service in locality hubs at evening and weekends. In Sunderland there is one hub in each of the five localities, and people can access whichever hub is closest to them, not just the hub which is situated in the locality they live in. People would need to travel to the central</td>
</tr>
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<td>Scenario 7</td>
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</tr>
<tr>
<td><strong>Scenario description</strong></td>
<td>Replace services with:</td>
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<tr>
<td></td>
<td>• GP (core and Sunderland Extended Access Service) consumes all UCC activity 08:00 – 20:30</td>
</tr>
<tr>
<td></td>
<td>• GP OOHs (20:30 – 08:00) co located with the ED Interface</td>
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<tr>
<td></td>
<td>• Minor Injuries are seen at the Royal site</td>
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<td></td>
<td>• Minor Ailment Scheme is rolled out to all community pharmacies in Sunderland</td>
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</tr>
<tr>
<td><strong>Rationale for appraisal against criteria</strong></td>
<td>1. Be safe, sustainable, and provide responsive, high quality care</td>
</tr>
<tr>
<td></td>
<td>Agreed by SCCG Clinical leads and providers as meeting the design principle.</td>
</tr>
<tr>
<td></td>
<td>2. Increase self-care through access to appropriate clinical advice</td>
</tr>
<tr>
<td></td>
<td>Access to an enhanced minor ailment community pharmacy scheme is not considered to be in line with current evidence regarding increased self-care as many treatments offered by this service are readily available over the counter.</td>
</tr>
<tr>
<td></td>
<td>There is also a national Community Pharmacy Referral Service currently in pilot</td>
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</tbody>
</table>
with access via 111 instead of direct access via the community pharmacy. The outcomes of the evaluation of this pilot will be included in this work once they are available

<table>
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<tr>
<th>3. Ensure appropriate access to treatment as close to home as possible</th>
<th>Meets the design principle? Yes</th>
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<tr>
<td>This scenario would facilitate the IUC approach, with people accessing the IUC service for assessment of their needs. This will mean that many people will be given advice over the telephone or online rather than travelling to a location for a face to face appointment. Where a person needs a prescription this will be issued electronically to the pharmacy of their choice.</td>
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<td>People would also be able to access General Practice services via the Sunderland Extended Access Service in locality hubs at evening and weekends. In Sunderland there is one hub in each of the five localities, and people can access whichever hub is closest to them, not just the hub which is situated in the locality they live in.</td>
<td></td>
</tr>
<tr>
<td>People would need to travel to the central CHS ED site for treatment of minor injuries if required.</td>
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<td>IUC will have access to the patient’s record, enabling people’s health needs to be met within their personal context.</td>
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<table>
<thead>
<tr>
<th>5. Meet nationally mandated requirements</th>
<th>Meets the design principle? No</th>
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<tr>
<td>The Enhanced minor ailment community pharmacy scheme has been superseded by the Community Pharmacy Referral Service currently in pilot</td>
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</table>
## Scenario 8

### Scenario description

Replace services with:
- General practice (core and four Sunderland Extended Access Services in locality hubs) consumes all UCC activity 08:00 – 20:30
- ED Interface
- Minor Injuries are seen at the UTC within the acute footprint (ED overnight)
- One additional Sunderland Extended Access Service in a locality hub integrated with the UTC (within the acute footprint)

### Where the scenario was proposed

Co-Design of Urgent Care Model and ED Interface Workshop held on 4th August 2017

### Summary of appraisal against criteria

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</tbody>
</table>

### Rationale for appraisal against criteria

1. Be safe, sustainable, and provide responsive, high quality care

   Meets the design principle? Yes

   Agreed by SCCG Clinical Leads and providers as meeting the design principle.

2. Increase self-care through access to appropriate clinical advice

   Meets the design principle? Yes

   Places IUC at the heart of access to face to face services.

   Appropriate access to the GP OOHs is being considered as part of the ED Interface work.

3. Ensure appropriate access to treatment as close to home as possible

   Meets the design principle? Yes

   This scenario would facilitate the IUC approach, with people accessing the IUC service for assessment of their needs. This will mean that many people will be given advice over the telephone or online rather than travelling to a location for a face to face appointment. Where a person needs a prescription this will be issued electronically to the pharmacy of their choice.

   People would also be able to access General Practice services via the Sunderland Extended Access Service in locality hubs at evening and weekends. In Sunderland there is one hub in each of the five localities, and people can access whichever hub is closest to them, not just the hub which is situated in the locality they live in.
### Scenario 9

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<thead>
<tr>
<th>Scenario description</th>
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<tbody>
<tr>
<td>Replace services with:</td>
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<tr>
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<td>- Minor Injuries are seen at the Royal site</td>
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</tr>
<tr>
<td>- Sunderland Extended Access Service locality hub co-located with CHS ED on Royal site</td>
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<tr>
<td>- Enhanced Minor Ailment Scheme is rolled out to all community pharmacies in Sunderland</td>
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**Where the scenario was proposed**
Co-Design of Urgent Care Model and ED Interface Workshop held on 4th August 2017

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<td>5</td>
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</table>

**Rationale for appraisal against criteria**

1. **Be safe, sustainable, and provide responsive, high quality care**
   Meets the design principle? Yes
   Agreed by SCCG Clinical Leads and providers as meeting the design principle.

2. **Increase self-care through access to appropriate clinical advice**
   Meets the design principle? No
   Access to an enhanced minor ailment community pharmacy scheme is not considered to be in line with current evidence regarding increased self-care as many treatments offered by this service are
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<th>3. Ensure appropriate access to treatment as close to home as possible</th>
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<thead>
<tr>
<th>5. Meet nationally mandated requirements</th>
<th>Meets the design principle? No</th>
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<tr>
<td></td>
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</tr>
<tr>
<td>The Enhanced minor ailment community pharmacy scheme has been superseded by the Community Pharmacy Referral Service.</td>
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</tbody>
</table>
### Scenario 10

**Scenario description**

Replace services with:

In core General Practice hours:
- First point of access is via general practice
- General Practice triages and streams patients to the most appropriate service for their health needs, including the Sunderland Extended Access Service, centralised Minor Injury Service, Ambulatory Care, ED etc.

Out of core General Practice hours:
- People call 111 where they can get telephone advice, an appointment in the Sunderland Extended Access Service, centralised Minor Injury Service, Ambulatory Care, ED etc.

**Where the scenario was proposed**

Co-Design of Urgent Care Model and ED Interface Workshop held on 4th August 2017

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</table>

| 2. Increase self-care through access to appropriate clinical advice |
| Meets the design principle? No |
| This scenario was superseded by the IUC national service specification which sets out how the IUC will be the route via which people access healthcare, including access online. |

| 3. Ensure appropriate access to treatment as close to home as possible |
| Meets the design principle? No |
| This scenario was superseded by the IUC national service specification which facilitates access to assessment, advice and electronic prescribing by telephone and online. |

| 4. Simplify access by improving integration across health and social care and reducing duplication of services |
| Meets the design principle? No |
| This scenario was superseded by the IUC national service specification which sets out how the IUC will be the route via which people access healthcare, including access online. |

| 5. Meet nationally mandated requirements |
| Meets the design principle? No |
| This scenario was superseded by the IUC |
### Scenario 11

<table>
<thead>
<tr>
<th>Scenario description</th>
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<tr>
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<td>In core General Practice hours:</td>
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<td>• General Practice triages and streams patients to the most appropriate service for their health needs, including the Sunderland Extended Access Service, centralised Minor Injury Service, Ambulatory Care, ED etc.</td>
</tr>
<tr>
<td></td>
<td>• Acute Home Visiting Service</td>
</tr>
<tr>
<td></td>
<td>Out of core General Practice hours:</td>
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<td>• People call 111 where they can get telephone advice, an appointment in the Sunderland Extended Access Service, centralised Minor Injury Service, Ambulatory Care, ED etc.</td>
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Co-Design of Urgent Care Model and ED Interface Workshop held on 4th August 2017

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### Rationale for appraisal against criteria

1. Be safe, sustainable, and provide responsive, high quality care

   Meets the design principle? Yes

   Agreed by SCCG Clinical Leads and providers as meeting the design principle.

2. Increase self-care through access to appropriate clinical advice

   Meets the design principle? No

   This scenario was superseded by the IUC national service specification which sets out how the IUC will be the route via which people access healthcare, including access online.

3. Ensure appropriate access to treatment as close to home as possible

   Meets the design principle? No

   This scenario was superseded by the IUC national service specification which facilitates access to assessment, advice and electronic prescribing by telephone and online.

4. Simplify access by improving integration across health and social care and reducing duplication of services

   Meets the design principle? No

   This scenario was superseded by the IUC national service specification which sets out how the IUC will be the route via which people access healthcare, including access online.

5. Meet nationally

   Meets the design principle? No
| mandated requirements | This scenario was superseded by the IUC national service specification |
References

1 Sunderland Urgent Care Strategy

2 Sunderland Urgent Care Strategy

3 NHS Operational Planning and Contracting Guidance 2017 – 2019

4 Sunderland Urgent Care Strategy

5 Sunderland Health & Care System Strategic Plan 2014 – 2019

6 Local Health. Public Health England, October 2017
Elective hospital admissions for all causes, standardised admission ratio, 2011/12–2015/16

7 Local Health. Public Health England, October 2017
Emergency hospital admissions for all causes, standardised admission ratio, 2011/12–2015/16


9 Planning and delivering service change for patients