MAKING URGENT CARE
WORK BETTER IN SHEFFIELD
Sheffield LMC Response: December 2017

The main areas proposed for change are:

1. Improve and simplify access for patients to urgent appointments across the city.
2. Continuity of access for those deemed to need it (11% in recent audit). See any doctor either in a Neighbourhood or urgent treatment centre (UTC) where non-continuity is recognised.
3. UTCs: 3 proposals that use 2 sites across the city. The consultation document states that the preferred option is to site all adult services at UTC Northern General Hospital (NGH) site and Children's services at UTC Sheffield Children's Hospital (SCH) site.
4. Urgent eye care.

We have taken into account the presentation and discussion at our Committee meeting on 9 October, which was attended by Sheffield Clinical Commissioning Group (CCG) representatives, meetings of the Urgent Care Team with Localities, feedback from GPs across the city, opinions from Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) staff and Ophthalmology opinions.

The issues raised for us to consider relate particularly to 1, 2 and 3 above, although we are aware that the Ophthalmologists have concerns about the level of equipment and service that could be provided by community opticians.

Whilst all agree that current workload and demand is unsustainable, we have major concerns about the implications of the proposed changes, not only activity within core contract but also the direction of travel towards a system driven by Urgent Care agendas.

We have 3 overarching themes that create a framework for our more specific concerns.

i) General Practice core contract and autonomy to manage care within their practice. Under current contractual arrangements Sheffield CCG could not force practices to accept patients into their core contractual arrangements for appointment provision. Practices would have to agree to changes on an individual basis and funding should be considered accordingly.

ii) Costs of indemnity are rising considerably and will possibly double with the change in the Discount Rate. Sheffield CCG has been keen to seek local solutions to reduce indemnity costs. We have contacted the 3 major Medical Defence Organisations and been advised that indemnity costs are likely to rise for any practice employed staff who engage in managing these patients, eg Advanced Nurse Practitioners (ANPs). Unless there is access to full records and clear guidance on following patients up then costs could rise for GPs as well.

iii) Sheffield CCG signed up to *Key Principles for Future General Practice and its Role in the Delivery of Primary Care in Sheffield* in 2017. One of these principles is *"The practice based list is fundamental to the safe delivery of care…"* These proposals do not respect the practice based list, but cut across this fundamental principle.

Issue 1: Workload

This is recognised by all as being unsustainable for many, well documented reasons. The proposed clinical triage system, it is proposed, will reduce the need for appointments by 100,000 across the city. However, the increased workload through clinical triage has been ignored.

A recent study https://doi.org/10.1136/bmj.j4197 and commentary on this, and previous studies https://doi.org/10.1136/bmj.j4345 are somewhat damning of telephone triage. *"The marked reduction in time spent consulting in surgery is more than compensated for by an increase in time spent on telephone consultations. The telephone first approach was not associated with a reduction in attendances at emergency departments, as proponents have claimed, and led to an increase in emergency admissions. Introduction of such systems might increase overall costs."*

Although the suggestion was that other Health Care Professionals may do some of the face-to-face contact, the telephone consultations will be expected to be done by GPs, the study suggesting up to 12 fold increase in this model.

Using clinical triage and review by GPs in different practices is likely to increase indemnity costs. This is the reason Medical Defence Organisations charge 20% more for out of hours work as they have done the risk stratification.

STHFT staff have raised the concern that by having the UTC and A&E on one site it will become a magnet for patients who know they will get seen regardless, and is likely to increase activity at the NGH site. GPs raised the issue that patients seen in A&E now can be booked directly into Sheffield GP Collaborative, so patients know they can just turn up and see a GP.

Issue 2: Continuity

There is a clear need for continuity in some cases, and we argue that this is not just for patients with long term conditions (LTCs). New presentations in patients that require follow up will result in patients returning to their own practice for repeat consultations. What may initially seem a simple problem may require complex interventions.

Continuity of care has been shown to reduce hospital admission https://doi.org/10.1136/bmj.j84. Therefore, this proposal is likely to increase demand on hospital services. *"Strategies that improve the continuity of care in general practice may reduce secondary care costs, particularly for the heaviest users of healthcare. Promoting continuity might also improve the experience of patients and those working in general practice."*

Issue 3: Practice Engagement at Neighbourhood Level

This proposal produces no guidance on variation of activity within practices, nor local problems with telephone usage. Practice variation in consultation times and number of appointments offered by each will create indifference to this system. There cannot be centralised regulation of appointment numbers or lengths as it is up to practices to decide what is "reasonable" for their own patients. Neighbourhoods are not practice-chosen alliances; many are very loose associations and there may be little clinical activity in common. Some practices may feel that they are adequately managing demand and so do not need to engage with other practices. They may consider they will end up managing their own and others' demands. There is a risk that this takes away managing autonomy and core contract.

Issue 4: Patient Opinion of Telephone Triage

Evidence suggests that, whilst telephone triage may improve patient satisfaction with access slightly, it reduces patient satisfaction in other areas. Patients do not like waiting by the phone for 2 hours until they are called back. They may have to discuss confidential medical information on the phone when others can overhear. Patients lose control of when they want to discuss their problems and this may limit what they can discuss. This is from study evidence and anecdotal evidence from patients registered with practices using "Doctor First" services.

Some practices have such a high proportion of non-English speakers to render telephone triage almost impossible. Trying to use a translation service when your telephone consultations have increased 12-fold is impossible. Due to cultural differences many ethnic minorities will not use the telephone but will attend in person (hence "drop-in" clinics).

Issue 5: Workforce

The current Primary Care workforce is inadequate to meet the current needs of patients, let alone the increasing demand. This is universally accepted. Study evidence suggests this strategy is going to increase workload, therefore, we have a huge disconnect.

The recently published South Yorkshire & Bassetlaw Accountable Care System (ACS) document on Primary Care suggests 112 more GPs are required across the footprint to maintain services. Sheffield CCG admitted that this was not going to be achieved, so we are left with increasing workload through development of these proposals with no prospect of having the right number of staff or skill-mix to achieve it.

The strategy makes no reference to workforce, therefore, it is expected that the GPs (and others) working in practices in the day and Access Hubs in the evening are going to be expected to man adult and children UTCs 24 hours a day, 365 days a year. Something will give and GPs always remain loyal to their practice registered patients. GPs interviewed have already suggested they are reducing input at Sheffield GP Collaborative and the Hubs because of the "Access by all to any appointment" approach.

There is already a dearth of IAPT services with patients no longer receiving face-to-face appointments but a phone call and then an offer of group therapy. Mental health workforce, as well as Primary Care nursing, MSK, Health Care Assistants etc will need to expand if they are expected to do more face-to-face work whilst the GP is on the telephone.

Although the Workforce Hub is a step in the right direction it will take a long time to achieve objectives, which have not yet been outlined.

Issue 6: Transport and Access

By removing acute services - Walk in Centre (WIC) and Minor Injuries Unit (MIU) - from the south of the city, patients will have to travel further to be seen. Patients being seen within neighbouring practices also increases the distance patients will have to travel and transport links may be difficult. Therefore, the proposals tend to move services further away from patients, not closer and transport links need to be considered and strengthened.

LMC Proposals

We discussed this strategy further at our Committee meeting on 11 December 2017. Whilst we are aware that a UTC is a mandatory requirement, all Committee members thought that keeping urgent activity more local at Hubs (currently 4 and 2 newly proposed sites) would be more manageable. The sites are already established, although there have been some concerns about their positions. Workforce patterns are working well and this would keep all "Primary Care Urgent Activity" in Primary Care rather than establishing it at a secondary care provider site. The Hub sites are generally known to patients now and would result in far less traffic to the NGH site and ultimately A&E, the whole reason for developing such a strategy.

Questions

We have submitted below a series of questions raised at various stages of our own consultation processes and look forward to further discussion and updates on developments.

1. What consideration has been given to increased indemnity costs?

2. Who is going to be responsible for initiating and following up investigations when patients attend UTCs or neighbouring practices?

3. Who is going to be responsible for referral to out patients and dictating any letters?
4. Who is going to work in these new UTCs?
5. Are the UTC sites considered the best option because of access or because STHFT/Sheffield GP Collaborative have had a major say?
6. How is access to these sites modelled (public/private transport), especially from South and East of the city compared to the Minor Injuries Unit (MIU) and Walk in Centre (WIC)?
7. Can a practice opt out of 111 booking into practices?
8. Can a practice opt out of seeing other practices' patients?
9. Can a practice opt out of any element of the proposal?
10. The modelling needs to support the principles and it needs to be tested - could this way of working be piloted?
11. How does this fit with Care Navigation?
12. Should Care Navigation be fully rolled out first?
13. How will extra funding be allocated to Neighbourhoods?
14. Who would deal with a complaint if it was from a patient from another practice?
15. How would practices manage patients who require continuity of care if also seeing more patients on the same day?
16. What provision has been built in to accommodate patients who will not attend another practice or UTC.

DR ALASTAIR BRADLEY
Vice Chair
on behalf of Sheffield LMC Executive