Making Urgent Care work better in Sheffield

Sheffield Green Party consultation response
29th January 2018

Summary

The proposals for changes to urgent care in Sheffield are obviously a response to the Government's national thinking and directives to set up Urgent Treatment Centres (UTC) near Accident & Emergency departments and to shift all but the care of long-term conditions away from General Practitioner (GP) teams based in local communities. This in turn is a (misplaced) response to an inexorable rise in demand for urgent care.

We set out our **principles**, explaining that the solution to this problem must address the root causes and be based on strengthening long-term relationships between patients and clinicians in their local communities. Anonymous telephone triage and locating services in hospitals is a move in the opposite direction.

Our **concerns about the consultation** are not merely quibbles about the process: we think that the lack of clarity or detail on essential elements demonstrates that they have not been thought through or justified. Essentially, the CCG is saying, "*let us close these local services and merge them in a new, hospital-based site, but don't worry because we will offer telephone advice and more appointments with your GP*" – but not explaining how the latter will be delivered or funded. If the changes are being driven by government diktat, this should be made clear.

Finally, we outline three specific **concerns about the proposals**– these are brief but fundamental: we want to retain the Minor Injuries Unit and Walk-in Centre as separate services in the centre of Sheffield. We cannot comment on the proposals to improve telephone triage and access to GP appointments as no detail is given beyond defining "neighbourhoods" of GPs who will apparently work together to achieve this.

Principles

1. We believe that the determinants of health and of health-seeking behaviour are rooted in social and environmental living conditions and that health and social care should not be considered in isolation. In particular, poverty – especially in very unequal societies – makes people ill. Stressful lives mean that they have less capacity to care for themselves within their communities. With regard to social care, when basic services for elderly and disabled people are cut to the bone, families turn to the health service, sometimes inappropriately. We welcome the reference to addressing inequality of access in the proposals but **note that demand for urgent care is likely to continue rising until the wider issues of social inequalities, environmental degradation, lack of social care and community resilience are addressed.** Seeing health care as a commodity – a growing trend amongst providers and users - has worsened the situation. It is a fallacy to pretend that simply reviewing the way urgent care is provided will reduce demand.

2. We also believe that the most efficient and effective use of health care resources is in primary care, where generalist clinicians see patients in a local setting. Ideally, these clinicians (doctors, nurses, pharmacists) know the patients and their families personally. At the least, they are familiar with their background. Local care has a triple benefit: it is more convenient for patients; they are less likely to be exposed to the inappropriate, costly and potentially damaging procedures readily available in hospitals; and there is more continuity of care. **We therefore welcome the aim to provide more urgent care within General Practice, which will save people having to go to a hospital-based Urgent Treatment Centre. Unfortunately, we do not find the proposals credible, as no extra resources will be provided.**

3. Ultimately, health care is about a relationship between a clinician or carer and patient, whether they are negotiating a once-off urgent issue or a long-term problem. There is a continuous interplay between “acute” and “chronic” health care. The relationships built up through seeing a local primary care team foster two-way trust and a greater likelihood of self-care or resolving problems quickly. Access to records is helpful, but finding vital information in long, complex notes is time-consuming and, in any case, the background knowledge developed in primary care is much deeper than those records. **We welcome the reference to continuity of care but believe it is appropriate or valuable for all patients, not just the 11% of patients needing urgent advice about chronic conditions).**

4. Triage can be effective in a GP setting, where patients requesting an appointment speak to a doctor or nurse based in that practice, with access to their notes and able to advise, prescribe, and refer, as well as make a same-day appointment. The consultation document quotes a small survey which found that 40% of callers could be dealt with by phone, either with a prescription or advice. **We are concerned that the proposals appear to extrapolate these findings to triage carried out by a “doctor, nurse of trained adviser” via the 111 phone line or a neighbourhood GP-based system (the details or cost are not specified).** The 111 NHS telephone advice service is not comparable. Indeed, it seems to increase the use of primary care and emergency ambulances.[1]

Concerns about the consultation

2.1 The document refers to **national government guidance and the "need" to provide a UTC** which deals with minor illness and minor injuries on one site. It is not clear whether this is an absolute requirement, whether there is room for manoeuvre and if there are penalties for non-compliance. Making this clear would clarify the obstacles facing the CCG and the campaigning needed to retain the current system of separate sites for minor injuries, minor illness and emergency services.

2.2 The "choices" offered all involve closing the MIU and the WIC and replacing them with a single UTC (for adults). **There is no option to keep the MIU and/or WIC.** The CCG may have persuaded itself that the latter is not a viable option, but to the public it makes the consultation seem like a pointless exercise and a foregone conclusion.

2.3 The proposals include encouraging people to contact their GP practice or 111 to seek advice and/or be given an urgent appointment with your GP or at a practice nearby (or at the UTC in the evenings or weekends). **There is absolutely no detail about how either of these – the telephone triage/appointment service or the extra GP appointments – will be provided.** This makes the proposals seem like wishful thinking and do not engender trust.

2.4. **An argument given for the changes is that people are confused about where to go for urgent care. There is no evidence given**– other than comments in a "pre-consultation". Staff at the MIU say that they see few people with minor illness as opposed to injuries. We know that people attend A&E inappropriately, but this is largely because they can't get an appointment with their GP.

2.5. **The proposals on eye-care are not clear.** It is stated that urgent eye appointments would be available in the community but there is no detail about how people would judge the level of urgency or make an urgent appointment and it appears that they will still have direct access to the Emergency Eye Clinic in the Royal Hallamshire Hospital.

Concerns about the proposals

3.1 The Green Party opposed the Walk in Centre (WIC) when it was first set up, arguing that investment in city centre General Practices would have been a better use of new money. We favoured locally-based primary care offered by a stable NHS provider rather than a private medical company (Devonshire Green Surgery was keen to expand; the Walk-in Centre was run by private company One Medicare). Many of its users are students (25%) and young city centre workers for whom the lack of continuity of care is the least detrimental. We accept that, in the absence of sufficient daytime and out of hours GP services in the city centre, the WIC is the next best option for primary care. **Replacing the WIC with a UTC would mean that people were forced to attend hospital to deal with primary care problems, i.e. it shifts resources even further away from GP provision. Using GPs to lead the care team and having access to patients' records does not create a primary care setting.**

3.2 We do not agree with concentrating more services at the Northern General Hospital. Public transport and parking on or near the NGH are notoriously difficult. This will be of real detriment to people living in the south and west of Sheffield, creating a new set of inequalities of access to health care. The location will also be far less convenient for a large

group of city centre-dwellers who currently use the WIC. The option of an urgent appointment with a GP in their “neighbourhood” is not workable. Many – 1 in 8 - are not registered with a GP, but those who are will find that their proposed “neighbourhood” stretches to Sharrow, Walkley, Crookes or even as far as Shiregreen.

3.3 **We do not agree with moving the Minor Injuries Unit (MIU) to the Northern General Hospital**. It works well where it is and successfully keeps minor injuries away from A&E.

Reference

[1] Pope C, Turnbull J, Jones J, *et al* Has the NHS 111 urgent care telephone service been a success? Case study and secondary data analysis in England BMJ Open 2017;7:e014815. doi: 10.1136/bmjopen-2016-014815 at http://bmjopen.bmj.com/content/7/5/e014815