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Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 9 February 2017 at 4.30 pm in Committee Room 1 - City Hall, Bradford

Members of the Committee – Councillors

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Carmody Gibbons	Greenwood A Ahmed Duffy Mullaney Sharp	N Pollard

Alternates:

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Barker Poulsen	Berry S Hussain T Hussain H Khan	Griffiths

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer
Jenny Scott	Older People's Partnership

Notes:

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- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From: **To:**

Parveen Akhtar
City Solicitor
Agenda Contact: Palbinder Sandhu/Claire Tomenson
Phone: 01274 432269/432457
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A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct - Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. MINUTES

Recommended –

That the minutes of the meeting held on 17 November 2016 be signed as a correct record (previously circulated).

4. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Claire Tomenson - 01274 432457)

5. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

Any referrals that have been made to this Committee up to and including the date of publication of this agenda will be reported at the meeting.

B. OVERVIEW AND SCRUTINY ACTIVITIES

6. DAISY HILL INTENSIVE THERAPY UNIT 1 - 4

The Deputy Director, Specialist Inpatient Services, Bradford District Care NHS Foundation Trust, will submit **Document "Y"** which outlines the closure of the Daisy Hill Intensive Therapy Centre (Lynfield Mount Hospital).

Recommended –

That the report be noted.

(Allison Bingham – 01274 363858)

7. HILLSIDE BRIDGE HEALTH CENTRE 5 - 78

The report of the Bradford Districts and Bradford City Clinical Commissioning Groups (**Document "Z"**) explains the future of primary care service provision from Hillside Bridge Health Centre.

Recommended –

That the Committee:

(1) Receives the update report which details the next steps around the future of the general medical services and 'enhanced primary care' elements of the Alternative Provider Medical Services (APMS) Contract.

(2) Notes the engagement and consultation processes which will support the future commissioning decisions regarding these services.

(Vicki Wallace – 01274 237524)

8. ACCESS TO PRIMARY MEDICAL (GP) SERVICES IN AIREDALE, WHARFEDALE AND CRAVEN 79 - 88

The report (**Document "AA"**) submitted by the Airedale, Wharfedale and Craven Clinical Commissioning Group (CCG) provides an updated position relating to access to primary medical services in Airedale, Wharfedale and Craven.

Recommended –

That the report be received and noted.

(Lynne Scrutton – 01274 237325)

9. ACCESS TO PRIMARY MEDICAL SERVICES IN BRADFORD 89 - 98

NHS Bradford City and NHS Bradford Districts Clinical Commissioning Groups (CCGs) continue to work with patients and stakeholders to improve the quality of all services they commission and to fulfil their statutory duty to improve the quality of primary medical care. **Document "AB"** describes initiatives that primary care providers are undertaking to improve access, including how they are engaging patients in the process and the challenges in maintaining sustainability of the service in the face of the nationally mandated funding review, increasing demand and workforce challenges.

Recommended –

That the Committee:

(1) Receive and note the Clinical Commissioning Groups' commitment and actions taken to improve access to appropriate primary medical services.

(2) **Receive and note initiatives within Bradford that are being developed that will impact the primary medical service offer to Bradford residents.**

(Karen Stothers – 01274 237430)

10. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2016/17 99 - 104

The City Solicitor will submit the Work Programme 2016/17 (**Document "AC").**

Recommended –

That the Committee notes the information in Appendix 1 and 2.

(Caroline Coombes – 01274 432313)

THIS AGENDA AND ACCOMPANYING DOCUMENTS HAVE BEEN PRODUCED, WHEREVER POSSIBLE, ON RECYCLED PAPER

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Report of Bradford District Care NHS Foundation Trust to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on Thursday 9 February 2017

Y

Subject: **Closure of Daisy Hill Intensive Therapy Centre Lynfield Mount Hospital**

Summary statement: This report outlines the closure of Daisy Hill Intensive Therapy Centre (Lynfield Mount Hospital)

Report Contact:
Allison Bingham, Deputy Director
Specialist inpatient services, Dental Services, Administration Services
Phone: 01274 363858
E-mail: Allison.bingham@bdct.nhs.uk

Portfolio:

Health & Wellbeing

1. Summary

- Planning for Daisy Hill Intensive Therapy Centre (DHITC) commenced in November 2012.
- Daisy Hill Intensive Therapy Centre opened on 22nd June 2015.
- The centre opened as a 12 bedded provision for women who experience Personality Disorder (a disorder affecting how people think, feel and behave)
- The centre was taken from concept to delivery based on a business model of spot purchase (no block contract arrangements) via sale of beds to either local or out of area commissioners.
- When the Trust's Annual Plan for FY 2016/17 was examined, and approved by the Board, consideration was given to the much lower than planned DHITC occupancy levels and therefore subsequent trading risk.
- The Board delegated authority to the Trust's Executive Management Team in March 2016 to determine the future of the centre following urgent follow up discussions with commissioners in early April 16 to attempt to increase occupancy to a sustainable level.
- Whilst open the centre admitted and treated 8 patients.

2. Background

Decision to Close DHITC

- Demand for the centre's beds did not match forecast.
- Assertive Marketing of the Centre was ongoing since early 2015 until end March 2016 (15 months).
- The service was not a Bradford commissioned service and local commissioners had only agreed that they would spot purchase beds as needed (therefore, no guaranteed usage from the local area).
- Additionally, following opening of the Centre the Department of Health announced a policy change around the provision of care and treatment closer to home (preventing patients being sent long distances from their place of domicile to access treatment. It is very likely that this policy change influenced commissioning patterns, encouraging commissioners, external to Bradford and Airedale, to seek alternative close to home treatment options.
- The national NHS financial position deteriorated significantly in the interval between planning the centre and opening the centre. The Trust, like many Trusts, have been required to implement austerity measures to try to contribute to the national deficit. As such, it was not viable for the Trust to maintain a service which was not achieving return on investment per forecast. A risk adverse approach was needed and without guaranteed income the Trust sensibly moved to a decision to close the centre.
- On 12th April 2016, a decision was taken by the Trust's Executive Management Team to close DHITC to further admissions (from 12th April 2016) and to undertake complete closure of the Centre beyond discharge of the remaining patients.
- The last patient was discharged from the DHITC on 19th Sept 2016 and the ward was formally closed on 26th Sept 2016.
- The Trust's commitment to the discharged patients is support them to complete both their inpatient and outpatient treatment pathways. Arrangements for ongoing outpatient therapy for affected patients have been established.

3. Report Issues

Closure - DHITC

The closure is complete.

The main element of closure was redeployment of the Centre's staff cohort.

An internal staff' consultation was held regarding the closure of the DHITC between 26th April 2016 and 29th May 2016.

The service management team and Human Resources worked to re-deploy the 29 staff who were employed to work at the unit and a further 3 staff who were employed within Hotel Services.

Since the end of the consultation period, 5 staff resigned from their employment with the Trust to work at other Trusts, voluntary organisations or to move on to higher education.

Of the remaining 27 employees all secured excellent redeployment options within Bradford District Care NHS Foundation trust. In this way skills were retained within the Trust and no redundancies were necessary. Retained staff remain positive and pragmatic about their future careers with the Trust.

4.1 Options

4.1 Members may wish to comment on the information provided in the report.

5. Recommendations

5.1 That Members note the report

6. Background documents

None

7. Not for publication documents

None

8. Appendices

None

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Report of the Bradford Districts CCG and Bradford City CCG to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 9 February 2017

Z

Subject: Future of primary care service provision from Hillside Bridge Health Centre

Summary statement: There are currently three GP services being operated from Hillside Bridge Health Centre. The service delivered by the Primrose Medical Practice is not relevant to this paper and will not be affected by any future decision made by the CCGs outlined in this paper. Local Care Direct currently deliver two GP services from the Health Centre, general medical services via an APMS contract and an 'enhanced primary care' service delivered 365 days a year. Although these are separate services they have been commissioned via one contract since the commencement of the two services in 2008. The current contract extension is due to expire on 31st March 2017 and the CCGs are currently in negotiation for a further extension of this contract until 31st October 2017. Therefore the CCGs in Bradford need to make a decision regarding the future of these services.

The future of the APMS general medical service will be made by Bradford City CCG, but the 'enhanced primary care' service is commissioned by Bradford City and Bradford Districts CCG so this decision will be made by both CCGs.

Report Contact: Vicki Wallace
Phone: (01274) 237524
Email: victoria.wallace@bradford.nhs.uk

Portfolio:

Health &Wellbeing

1. Summary

1.1 There are currently three GP services being operated from Hillside Bridge Health Centre. The service delivered by the Primrose Medical Practice is not relevant to this paper and will not be affected by any future decision made by the CCGs outlined in this paper. Local Care Direct currently deliver two GP services from the Health Centre, general medical services via an APMS contract and an ‘enhanced primary care’ service delivered 365 days a year. Although these are separate services they have been commissioned via one contract since the commencement of the two services in 2008. The current contract extension is due to expire on 31st March 2017 and the CCGs are currently in negotiation for a further extension of this contract until 31st October 2017. Therefore the CCGs in Bradford need to make a decision regarding the future of these services.

1.2 The future of the APMS general medical service will be made by Bradford City CCG, but the ‘enhanced primary care’ service is commissioned by Bradford City and Bradford Districts CCG so this decision will be made by both CCGs.

2. Background

2.1 Hillside Bridge Health Centre opened in December 2008 as part of the ‘Darzi’ strategy to increase access. There are two practices located in the building but this paper is only concerned with the contract being held by Local Care Direct. The contract held by Local Care Direct includes general medical care services (GP practice) and an ‘enhanced primary care’ service via one APMS contract.

The general medical care service provides traditional GP services to registered patients Monday to Friday 8am – 6.30pm as per the national contract specifications. The current registered list is 4891. As part of the delegated commissioning arrangements from NHS England, Bradford City CCG is responsible for the future commissioning of this element of this service.

2.2 In 2008 the ‘enhanced primary care’ service provided services for both registered and non-registered patients between 8am and 8pm, 7 days a week. Originally, a key objective of the walk in service was to provide a facility which would be used by the most deprived and socially excluded people in the district, such as homeless people and travellers, refugees, asylum seekers and those with substance misuse issues. However, analysis of the service activity highlighted that these groups were only using the service rarely, and the heavy users of the service were patients of local GP practices in the BD3 area.

Following public engagement and an information campaign in 2011 changes to the opening hours of the service were made. This was on the back of analysis of the use of the service, with the main usage being from the patients registered with practices near to the Health Centre. The service was rarely being used by the most socially excluded members of the community and the change was needed to make sure the service was not misused and provided value for money. Public feedback showed a large majority of people agreed that the changes should take place as the review highlighted that most patients who used the service were already registered with another local GP in the BD3 area.

The current access hours for the 'enhanced primary care' service are:

- For non-registered patients - 2pm-8pm 7 days a week.
- For Bradford registered patients – 6pm-8pm Monday to Friday, 2pm-8pm Saturday and Sunday

It must be noted that at times the 'enhanced primary care' service has in the past been referred to as a 'walk in centre' (for example, the attached Ipsos-MORI report). However it is not what would be classed as a walk in centre under the current Keogh work. The centre actually operates an appointment based system (maximum of 20 per day), with a smaller proportion of these being available 2-6pm (when out of area patients can attend) with the remainder being available 6-8pm (when Bradford residents can attend). Therefore once these appointments are filled the capacity has been utilised and no further appointments are given. Therefore, this is not a walk in centre (unlike, for example, St George's Centre in Leeds) and is referred to within this paper as an 'enhanced primary care' service.

Both Bradford City CCG and Bradford Districts CCG commission this element of the contract, so both CCGs will be involved in the decision around the future of this service.

2.3 In 2013, following discussions with the Health and Social Care Overview and Scrutiny Committee (previous papers referenced below) the CCGs commissioned Ipsos-MORI to work in partnership with local NHS and VCS engagement teams to undertake in-depth research as to why people used the 'enhanced primary care' service. The full report is attached at Appendix 1.

This approach was taken to enable the CCGs to benefit from the experience of an established national organisation with vast experience of research, blended with local organisations with strong established relationships with marginalised and under-represented groups. Working together, they provided information representing the general population of Bradford and under-represented groups which do not always enter mainstream systems and services.

The main messages from the 'enhanced primary care' service research were:

- That the service is largely seen by patients as a back-up service when they are unable to access other health services. It is mainly used by patients who live in the local vicinity.
- Those who use it on a weekend see its function as an urgent care provider. Those who use it during the week see it as a convenient alternative if they find it difficult to get an appointment with their own GP during opening hours.
- Whilst the vast majority of those surveyed prefer to see their own GP and are satisfied with the services s/he delivers, it is widely perceived that it is difficult to get a GP appointment.
- Awareness of the service among the under-represented and marginalised groups is fairly low, and those who have used it tend to have viewed it as a negative experience.
- Over half the patients visiting the service also used A&E in the last 12 months, making A&E the most commonly used health service in this cohort of patients.

3. Report issues

3.1 Drawing on the findings of this research the CCGs agreed to work on initiatives to improve primary care access and to develop an urgent care strategy before making any decision around the future of the ‘enhanced primary care’ service element of the contract. The CCGs have committed to this through the production and ongoing delivery of the Urgent and Emergency Care Strategy for Bradford, Airedale, Wharfedale and Craven. Especially pertinent is the Urgent Care Service being commissioned at Bradford Teaching Hospitals NHS Foundation Trust.

The recent development of the Primary Medical Care Commissioning Strategy will also help deliver improvements to primary care access, and work has been ongoing in this area, especially with the Access Management Plans which have been produced by each practice as part of their contract agreements.

3.2 The CCGs wish to continue to commission general medical services (the GP practice element of the current APMS contract) and will therefore be undertaking a competitive procurement process to re-commission this service. This will include consultation with patients registered with the practice and other stakeholders.

3.3 To meet the access needs of our patients, the CCGs wish to commission ‘enhanced access’ to primary care services (currently commissioned via the ‘enhanced primary care’ element of the APMS contract) differently in the future which will increase capacity and plans include:

- The Urgent Care Service co-located at Bradford Royal Infirmary A&E which manages primary care patients who present to A&E at 6pm to midnight on weekdays and 12 noon to 12 midnight at the weekend. The first phase of this service formally commenced in November 2016 with the introduction of streaming to the primary care service. The CCGs are commissioning additional hours as part of phase two of implementation (from Spring 2017), where the service will be operational 12 noon to 12 midnight seven days a week.
- Extended Primary Care Access (6.30pm – 8pm Monday to Friday and weekend access) which will be rolled out from 2017 in Bradford. We expect to commission this service for 100% of the population by 2020, providing approximately 337 extra hours of primary care services per week by that time. We will be engaging with our populations to understand when the best time to offer this additional access will be.
- Continued work via the GP contract to improve access to core GP hours through the delivery of the practice access management plans.

In relation to this aspect of the service, we will engage with the public around the proposed changes, check that our previous engagement feedback is still current, and seek views on how to provide the most appropriate service in future.

An alternative service for our deprived and socially excluded population has already been commissioned. In September 2011 the PCT awarded an APMS contract to Bevan Healthcare to provide access to high quality health and social care for the most socially excluded people. They offer primary medical services tailored to the needs of people who struggle to engage with usual services and particularly those who are homeless, in temporary accommodation, refugees or asylum seekers.

They aim to provide care that recognises the social, environmental and behavioural determinants of health, linking people in with services that address these factors and emphasising the promotion of health as well as the treatment of illness. The service has recently been awarded 'Outstanding' for their provision by the Care and Quality Commission and was noted to be one of the best services of its type in the whole country. The CCGs are currently leading a re-procurement process for this APMS contract.

3.4 The CCGs will undertake the following next steps:

- The CCGs will undertake a procurement process to re-commission general medical services (GP practice services) for 4891 patients. The process will commence in June 2017 with the aim of a contract being awarded and the new contract commencing 1st November 2017. This will involve a public and stakeholder consultation process.

- The CCGs will separate out the 'enhanced primary care' service element of the current contract from the general medical services element and will engage with the public to look at commissioning enhanced access differently in the future, including increasing the capacity of services offered. This engagement will be wider than just the population that currently uses Hillside Bridge services and is likely to tie in with the engagement around extended access (6.30-8pm weekdays, plus weekend opening).

3.5 The CCGs would also like to make it clear that any changes to the services delivered from Hillside Bridge Health Centre will not affect the out of hours GP provision. If patients need to see a GP out of hours they will still access the service via dialling 111 and if appropriate will either be seen by the service at Bradford Royal Infirmary or Eccleshill Community Hospital.

4. **Options**

4.1 None

5. **Contribution to corporate priorities**

5.1 Contributes to the CCGs priorities of:

- Improving patient experience
- Improving out of hospital care
- Optimising the use of assets

6. **Recommendations**

The Health and Social Care Overview and Scrutiny Committee is asked to:

6.1 Receive this update report which details the next steps around the future of the general medical services and 'enhanced primary care' elements of the APMS contract.

6.2 Note the engagement and consultation processes which will support the future commissioning decisions regarding these services.

7. **Background documents**

7.1 Report of NHS Bradford Districts CCG and NHS Bradford City CCG to the meeting of the Health and Overview Scrutiny Committee to be held on Thursday 21 March 2013: Hillside Bridge: Primary Care Walk in Centre

7.2 Report of NHS Bradford Districts CCG and NHS Bradford City CCG to the meeting of the Health and Overview Scrutiny Committee to be held on Thursday 18 April 2013: Hillside Bridge: Primary Care Walk in Centre

7.3 Report of NHS Bradford Districts CCG and NHS Bradford City CCG to the meeting of the Health and Overview Scrutiny Committee to be held on Thursday 3 October 2013: Hillside Bridge: Primary Care Walk in Centre

8. **Not for publication documents**

8.1 None

9. **Appendices**

9.1 Appendix 1 - Ipsos MORI and Health Partnerships report 2013: Hillside Bridge Walk in Centre: How patients use the walk in centre.

Ipsos MORI
Social Research Institute

Hillside Bridge walk-in centre

How patients use the walk-in centre

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1. Executive summary

1. Executive summary

Bradford City CCG and Bradford Districts CCG have commissioned Ipsos MORI to undertake a programme of research that will explore usage of urgent care services in the city, focusing first on the Hillside Bridge walk-in centre. Ipsos MORI is working in partnership with West and South Yorkshire and Bassetlaw Commissioning Support Unit and the Health Partnership Project (HPP) to deliver the project.

This report presents the findings from the first phase of the research, which focuses on Hillside Bridge walk-in centre. The research aimed to explore how people were using the walk-in centre, and how Hillside Bridge was perceived by underrepresented and marginalised groups who were initially key intended users of the service.

The research comprised:

- four 'discovery visits' to Hillside Bridge walk-in centre, on week days and at the weekend, during which 39 short qualitative interviews were conducted with patients;
- a paper-based survey for all those who visited the walk-in centre during the two-week period of the research (Monday 12th August – Sunday 25th August). Over this period, 95 questionnaires were completed, representing a response rate of 36%; and
- qualitative research with 81 members of underrepresented and marginalised groups, including people from an ethnic minority, asylum seekers, refugees, Roma, gypsy and travellers, and drug and alcohol service users members. The research was facilitated by third sector organisations, and 18 staff from these organisations also provided information towards the research.

1.1 Perceptions of Hillside Bridge walk-in centre

Hillside Bridge walk-in centre is largely seen by patients as a back-up service for them to use when they are unable to access other health services. Due to the restricted opening hours of GP practices, patients' opinions on the primary purpose of the walk-in centre varied depending on whether they were visiting the walk-in centre during the week or at the weekend.

In general, those who visited during the weekend were more aware of the walk-in centre's function as an urgent care provider, while those who visited during the week were more likely to see the walk-in centre as the equivalent of their GP.

When patients who visited the walk-in centre at the weekend were asked about its purpose, by far the most common response was that it was a place to be seen by a GP when other services were unavailable. Alongside this belief was a widespread understanding among patients that the walk-in centre was intended to be used for urgent healthcare needs that needed to be treated before the next in-hours GP appointment was available the following week.

There tended to be an understanding among patients who visited during the week, however, that the purpose of the service was simply to provide a convenient alternative for people who found it difficult to get a GP appointment during GP practices standard opening hours.

The convenience of the service was one of the factors underpinning high levels of satisfaction with the walk-in centre among those interviewed during the discovery visits.

This work was carried out in accordance with the requirements of the international quality standard for Market Research, ISO 20252:2006.

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However, the small number of people from underrepresented and marginalised groups who had used the walk-in centre were less satisfied with the service, as a result of inability to get an appointment, waiting times, lack of access to translation services and perceived poor treatment by staff.

1.2 Use of Hillside Bridge walk-in centre

People tended to go through a fairly rational decision making process before visiting the walk-in centre. Most said they had thought about their symptoms and considered what the most appropriate service to use would be. Indeed, when deciding what health services to access, as well as rationally weighing up the different options, patients are also making judgements – whether consciously or sub-consciously – about the urgency of their condition. Three in four patients said the health condition that had led them to visit the walk-in centre that day was definitely urgent (77%). Only a small minority (10%) said that the health condition that had led them to visit the centre was probably or definitely not urgent.

In the vast majority of cases, patients would have wanted to see a GP regarding their health problem. However, it was widely perceived that it was very difficult to get GP appointments, and many stated that they had unsuccessfully tried to get an appointment on the day that they attended the walk-in centre – or that they assumed they would be unsuccessful. Most also felt that A&E services would not be appropriate given that their problem wasn't an emergency, and thought they would face long waiting times. This created a degree of uncertainty as to what to do next, as GPs and A&E were the two pillars of health and care service provision that all patients were aware of. This doubt was exacerbated at the weekend, as there was low awareness of out-of-hours GP services.

Consequently, patients using the walk-in centre were commonly referred to it via NHS helplines (particularly NHS 111), or by pharmacists, who they had contacted to try to establish what they should do next. This was particularly prevalent at the weekend when patients knew their GP would not be available. For underrepresented and marginalised groups, signposting through a third sector organisation was also mentioned as a referral route. A minority of people found the walk-in centre through internet searches or recommendations from friends or colleagues. However, the quantitative data shows that 58% of patients had used the service previously in the past year; and10% had done so six times or more, showing that some patients are using the walk-in centre fairly regularly to deal with their health concerns.

Word of mouth worked in a different way for some of the underrepresented and marginalised groups who had heard of the walk-in centre but not accessed it; they had heard negative reports from other people that had put them off using it.

The key finding is that most patients were using Hillside Bridge walk-in centre to compensate for their perceived inability to get an appointment with their GP, rather than because they weren't registered with one in the first place.

Underpinning this, the walk-in centre tended to be used by patients for whom it was local and convenient. The availability of face-to-face consultations with a clinician outside of normal working hours was strongly desired, which meant that Hillside Bridge walk-in centre was a draw for those living in its vicinity.

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1.3 How underrepresented and marginalised groups access urgent care

In general, among those from underrepresented and marginalised groups, most participants' understanding of health services were those available at a GP practice or hospital, although a reasonable number had used pharmacies and some had used NHS 111. Many participants used A+E as their default option for healthcare as it was perceived to guarantee treatment.

Use and awareness of Hillside Bridge walk-in centre among underrepresented and marginalised groups was fairly low. Those who had used the centre tended to have viewed it as a negative experience. Some participants had heard negative reports of the service from family and friends which had influenced their decision not to use it. Many workers of third sector organisations were also unaware of Hillside Bridge, which meant they were not supporting participants to attend.

Participants reported satisfaction with A&E, pharmacies and other third sector services such as Bevan House, Woodroyd Centre, Piccadilly, Unity and the Bridge Project.

Being treated with dignity and respect, access to good quality translation services, location of service and ability to just drop in and not make an appointment were all factors that underrepresented and marginalised groups cited as of high importance when choosing what health service to access.

1.4 Alternative health services

Hillside Bridge walk-in centre patients reported having used a wide variety of health services over the past 12 months. However, it appears that walk-in centre patients may have a different pattern of service usage compared with the population more generally, given high reported levels of use of A&E and lower use of GPs.

Despite the high reported level of attendance at A&E, in general, patients tended to display reluctance to attend A&E. Some said they would be unlikely to visit A&E for anything other than a genuine accident or emergency. Other patients said that they would have been persuaded to do so if they felt other health services had failed them.

Almost all patients were registered with a GP and, with the exception of securing appointments, they were generally satisfied with the service that the GP provided. There were, however, seen to be barriers to securing a GP appointment.

Awareness of NHS 111 seemed relatively high amongst patients however, patients who had used NHS 111 in the past tended to be slightly ambivalent about the service they were provided with.

GP out-of-hours services emerged as the service of which patients were least aware and some patients were unsure of what the service was intended for or whether it was available from their GP practice.

Patients' opinions about pharmacists were mixed. Some were very positive and reported routinely using a pharmacy as a first point of call to seek advice or medication before attending another health service. Others, however, were unwilling to visit a pharmacist for anything other than straightforward complaints such as a cough or cold.

A key finding emerging from the depth interviews is that, had Hillside Bridge walk-in centre been unavailable on the day of their visit, patients say they would have found it difficult to find

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an appropriate alternative. The two main alternatives patients felt there were to the walk-in centre were either to visit A&E or to wait until an appointment is available with the GP. Although many patients said they would be willing to wait until they were able to see their GP in theory, they also said that that if their condition was to deteriorate, they would go straight to A&E.

1.5 Implications of the research

1.5.1 Hillside Bridge walk-in centre patients

Overall, the patients interviewed at Hillside Bridge walk-in centre were very satisfied with the service they received. The walk-in centre appears to provide a valuable service for this cohort of patients, which raises a number of questions:

- From these patients' perspectives, what service will replace Hillside Bridge when they are unable to get an appointment with their GP, or if they believe they have an urgent care need out-of-hours?
- Related to this, if patients are using the walk-in centre essentially as a convenient replacement for their GP, should an alternative service be provided, or should these patients simply try to make a GP appointment?
- Can changes be made to the appointment systems at GP practices to address some of patients' concerns and enable them to get an appointment more easily?

If the walk-in centre function at Hillside Bridge is closed, it is unclear from the current research how many people that would affect, which will be explored further in the second phase of the research. However, the research does show that many are using the walk-in centre multiple times and these patients' needs will need to be considered.

Of the one in three patients who had only visited the walk-in centre once, these patients tended to locate the service through signposting from another health service such as a pharmacy or NHS 111. For similar patients, closing Hillside Bridge walk-in centre would therefore have minimal impact as these health services can signpost to replacement services instead. The CCGs should certainly work closely with NHS 111 and pharmacies to direct patients to the most appropriate services.

Careful thought would need to be given to the nature of replacement services. Around three in five patients indicated that, had the walk-in centre not been available, they would have gone to A&E instead (61%). Of course, there is a difference between saying this and actually visiting A&E, and so it seems reasonable to suggest that fewer than 61% will have actually done so.

This reliance on A&E as an alternative service is partly a result of low awareness of alternative out-of-hours services. With awareness of GP out-of-hours services relatively low, regardless of the outcome for Hillside Bridge, it appears that raising awareness of this service could benefit patients, so they have an option they can access where they do perceive that they have an urgent care need out-of-hours. If Hillside Bridge walk-in centre was to close, some patients who have indicated that they would have used A&E rather than the walk-in centre would access GP out-of-hours services instead if they are aware of this service.

However, this would need to be undertaken carefully: many patients who use Hillside Bridge walk-in centre do so largely for convenience, particularly because of difficulties or perceived

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difficulties make appointments with their GPs. A GP out-of-hours service needs to be seen as a service for urgent care needs only. To assist with this, one option would be to have a triage service, with patients reassured that an urgent appointment isn't needed where that is the case. There is some distrust of NHS 111 at present, but it seems patients would be more open to such advice if they were talking directly to a clinician.

This then raises the question of how people make judgements about how urgent their health need is and whether they are seeking urgent care when it is not needed. While three in four patients from the survey felt their condition needed urgent care, in the discovery visits many patients said they could have waited for a GP appointment if the alternative was A&E. The convenience of the walk-in centre combined with the urgent care need led people to the walk-in centre when they could potentially have waited instead. This suggests that their judgement or definition of urgent care is different to the CCGs' definition. If Hillside Bridge walk-in centre is closed, how will these patients be catered for? Educating people better about self-diagnosis and self-medication would help people to make these judgements, but is clearly a large task. Some form of triaging may assist with assessing whether these patients do have an urgent care need.

1.5.2 Urgent care services for underrepresented and marginalised groups

Usage research has demonstrated that those using Hillside Bridge walk-in centre tend to already be registered with a GP. Underrepresented and marginalised groups who are less likely to be registered with a GP, and one of the initial key audiences for the walk-in centre, appear to be using it less.

The research demonstrates that use and awareness of Hillside Bridge walk-in centre among underrepresented and marginalised groups is fairly low. Those who have used the centre, in contrast to the patients interviewed during the discovery visits, tended to be dissatisfied with the service. Others who had heard of the service from others but not used it personally had heard similar reports from family and friends.

This suggests that Hillside Bridge walk-in centre is not the most effective urgent care service for underrepresented and marginalised groups and that this service could be better provided elsewhere. Participants did report satisfaction with A&E, pharmacies and other services such as Bevan House, Kensington Practice, Woodroyd Centre, Piccadilly, Unity and the Bridge Project. Exploring their reasons for satisfaction enables us to identify the most important features of an urgent care service for underrepresented and marginalised groups if providing an urgent care service for them elsewhere:

- Being treated with respect and dignity: participants reported being treated disrespectfully across a number of health services at times. If services can be more targeted to specific groups using a similar model to Bevan House, this will allow staff to build up an understanding of culture and the issues facing patients, enabling them to provide a service that patients find sympathetic and therefore more comfortable using. Ideally, this would also provide some continuity in the healthcare professional the patient sees.

- Have access to good translation services: this emerged as an issue causing some heard to reach groups difficulties, particularly the Roma community, and restricting their access to health services. The research suggests that a review of how these services operate may be valuable.

- Local access: some underrepresented and marginalised groups find travel to services costly and difficult, suggesting that more local services will be easier for them to

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access (if it is possible to provide them). If more local services are not available, it is worth considering whether there are other possible solutions.

- Appointment system: some people in underrepresented and marginalised groups find it difficult to make appointments with health services. This is sometimes related to cost, sometimes to fitting it around their other commitments such as work, or at times to more chaotic lifestyles (for example, for homeless people or substance users) which make it difficult to make and keep appointments. A walk-in service may therefore be suitable for some groups – although there will be inevitable concerns about waiting times.

Many participants from the homeless and the asylum seekers groups reported that they do nothing when they are ill and wait out their symptoms to reduce or to get 'bad enough' to go to A&E. This will be explored further in the second strand of the research, but provision of a service that meets the above requirements may encourage them to access services more frequently.

Additional implications emerging from the research are:

- Signposting of services: this was a major factor affecting underrepresented and marginalised groups' decisions about where to access health services. This included signposting by third sector organisations, support services (day centres and services), pharmacies, friends, family and community members.

  This means there is scope for CCGs to work with third sector organisations, support services and pharmacies to help direct members of underrepresented and marginalised groups to the most appropriate service for them. This could help to raise awareness of some services not currently so well used, for example the GP out-of-hours service.

- Dental services: none of the Roma group were registered with a dentist and so accessed urgent care services for dental care. The CCGs could work with Roma groups and the third sector organisations supporting them to improve access to dental care.

In summary, local services staffed by people with a good understanding of the culture and issues facing patients from specific groups will begin to build trust in those organisations. Third sector organisations, support services and pharmacies can all assist with signposting people to those services.

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2. Introduction

2. Introduction

2.1 Background

Bradford City CCG and Bradford Districts CCG have commissioned Ipsos MORI to undertake a programme of research that will explore usage of urgent care services in the city, focusing first on the Hillside Bridge walk-in centre. Ipsos MORI is working in partnership with West and South Yorkshire and Bassetlaw Commissioning Support Unit and the Health Partnership Project (HPP) to deliver the project.

The use of urgent care services at present is receiving attention across the country, with patients accessing services for urgent care needs at services that may not be best suited to their needs. The CCGs therefore wanted to commission a study exploring how Bradford residents make decisions about where to access urgent care services, feeding into discussions about how the urgent care system should be designed and what could encourage patients to access services at the most appropriate place for them.

Hillside Bridge walk-in centre is one part of Bradford's current urgent care service provision. The walk-in centre is open from 2pm to 8pm, seven days a week, for people who do not have a doctor. Those who are registered with another practice can use the service between 6pm and 8pm, Monday to Friday, and between 2pm and 8pm at weekends and bank holidays. Up until September 2011 the walk-in centre had been open daily from 8am and 8pm but following a public consultation, the hours were reduced. On weekdays, patients attending the walk-in centre wait to be seen by the next available healthcare professional, while at the weekend they attend when the centre opens, make an appointment, and return later for their appointment.

While the centre is available to the general public, particular segments of the local population (mainly groups defined as 'underrepresented and marginalised') are the prime targets, particularly those not registered with a GP. However, usage research has shown that the service is not being used by the desired groups to the degree expected, while those who are registered with a GP are using the walk-in centre to a greater extent (when they could be accessing their GP). This poses questions as to how urgent care services should be designed in Bradford to meet the health needs of its diverse population.

With the forthcoming end of the current contract for walk-in services at Hillside Bridge, a public consultation on the options for the walk-in centre will take place in October 2013. The research commissioned by the CCGs therefore needs to explore in detail usage of the Hillside Bridge walk-in centre, while also providing a broad understanding of the usage of urgent care services across Bradford City and Bradford District CCGs.

Consequently, the research is taking place in two phases:

1. **Hillside Bridge walk-in centre research**: The findings from the Hillside Bridge walk-in centre research will be used to offer insight to inform the options presented in the consultation about the future of the centre. The research will also help to inform the decision that will be made following the consultation. Given that the consultation is taking place in October, this element of the research has been prioritised.

2. **Wider urgent care on Bradford research**: The urgent care research will offer a broader understanding of the usage of urgent care services across Bradford City and Bradford District CCGs. The findings of the research will help to identify possible

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interventions that could change the way patients access services. The Hillside Bridge element will feed into this as well.

This report outlines the findings from strand one – the research specifically relating to Hillside Bridge walk-in centre. Further research will then be conducted around the second strand to build a wider picture of urgent care usage in Bradford.

2.2 Objectives

This research will help to ensure that the CCGs truly understand what is driving healthcare choices, where the gaps are in its urgent care service provision, and how services can best be to designed to ensure equitable access for all patients.

In relation to Hillside Bridge walk-in centre, it will also ensure that any decisions as to how to approach the consultation on the future of the walk-in centre are evidence based, defensible and stand up to scrutiny – and, of course, are grounded in the needs of the populations the CCGs serve.

To do this, there are a number of specific objectives for the Hillside Bridge walk-in centre research. The priority research questions are:

- What do patients using the service understand to be the purpose of Hillside Bridge walk-in centre?
- In particular, when and why do people use Hillside Bridge walk-in centre and what motivates them to use it?
- Why do people use Hillside Bridge walk-in centre in non-urgent situations?
- If Hillside Bridge walk-in centre was not available, what service would they use instead?

In addition to these more specific questions about Hillside Bridge, we will also endeavour to explore issues around wider urgent care, as Hillside Bridge is one of the urgent care services offered at present. Consequently, in order for this research to feed into the broader piece of work about urgent care it is important to explore:

- How do people make decisions about where to access urgent health care?
- How are other urgent care services perceived – quality, location, availability, etc. of Accident and Emergency (A&E), out-of-hours services, GP services?
- For what health issues/complaints have people used other urgent care services?
- What do people expect when using urgent care? Are these expectations met?
- What barriers have people experienced or do they perceive to accessing urgent care?
- What would they do if they didn't know how to get help for an urgent health problem?
- What kinds of urgent care services would people want to use, and where would the services ideally be located?
- What would help people to change the way they currently access services?

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The following section will discuss how we designed a programme of research to effectively respond to these key questions.

2.3 Methodology

There were two key audiences whose views needed to be explored to comprehensively review usage of Hillside Bridge walk-in centre.

1. People who are using the service.
2. Communities of interest, or underrepresented and marginalised groups, who the walk-in centre is designed to serve but do not seem to be using the service to the desired extent.

2.3.1 Research with Hillside Bridge walk-in centre patients

Qualitative discovery visits

A key group to hear from regarding the Hillside Bridge walk-in centre is clearly those who are using the service. We therefore conducted research among Hillside Bridge patients at the time when they were accessing the service. The hypothesis was that at this time, patients would be most aware of the motivations which led them to use the service meaning that we would be more likely to gather honest and useful responses. It was also the most straightforward way of accessing people actually using the service, who would be most affected by any changes to the walk-in centre.

In order to do this, four discovery visits were conducted at Hillside Bridge walk-in centre. These visits were conducted by Ipsos MORI and the CSU. The discovery visits essentially involved a recruiter and an interviewer spending a designated period of time at the walk-in centre trying to secure short, qualitative interviews with patients. The separate visits took place both during the week and weekend to ensure that all types of Hillside Bridge user were encountered. The specific dates were:

- Wednesday 14th August, 5pm – 8pm
- Thursday 15th August, 5pm – 8pm
- Saturday 18th August, 2pm – 8pm
- Saturday 25th August, 2pm – 8pm

The recruiter approached walk-in centre patients to invite them to participate in the research either while they were waiting for their appointment (particularly on the week days) or after their appointment (particularly on weekends).

Once the patient consented to participate, the qualitative interviewer conducted a short informal interview (of between five and twenty minutes). The interviews were conducted in a room within the walk-in centre, to ensure participants had privacy and could be assured of their confidentiality. A flexible discussion guide agreed with the CCGs was used to ensure that the interviewers could respond to specific issues whilst also being able to keep conversations focussed on the project objectives.

In total across the four visits 39 interviews were completed. Across the two weekday shifts 12 were conducted, with the other 27 taking place over the weekend visits.

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Self-completion quantitative questionnaire

In addition to these qualitative interviews, all patients at the walk-in centre were asked to complete a paper questionnaire about their visit. This generated quantitative data to complement the qualitative data, and helped to provide a balanced picture of usage across a two week period (Monday 12th August – Sunday 25th August). Over this period, 95 questionnaires were completed. Data from the walk-in centre show that 262 patients had a consultation during the two-week period, representing a response rate of 36%.

2.3.2 Research with underrepresented and marginalised groups

As discussed previously, the CCGs needed to understand how primarily ‘underrepresented and marginalised’ groups perceive urgent care, why they do not tend to use the walk-in centre and how they would ideally like urgent care services to be made available to them. Where participants had used Hillside Bridge or were aware of the walk-in centre, perceptions and experiences were explored.

To deliver this element of the research, Ipsos MORI worked with HPP and the CSU. HPP and the CSU used their established network within the Voluntary and Community Sector (VCS) and community groups to schedule and conduct qualitative discussion groups with the communities of interest. These networks were often based in the heart of communities enabling access to minority ethnic, asylum seekers, refugees, homeless, Roma, gypsy and travellers, and drug and alcohol service users.

Group consultation sessions were organised and facilitated by specialist and key workers within these communities. The research questions were asked by experienced facilitators from HPP and the CSU. Ipsos MORI, HPP and the CSU worked closely together to devise and agree the discussion guide that formed the basis of all of the research with underrepresented and marginalised groups, which was also agreed by the CCGs. The discussions included posing a number of scenarios to participants of occasions on which people may need to access health services; talking through these scenarios enabled and understanding to be built of how the different groups make decisions about where to access urgent healthcare services.

Additionally, HPP and CSU spoke to a total of 18 key workers from these communities in order to obtain additional insight.

The communities included in the research, the number of people participating and the format of the qualitative discussions are outlined in the following table. Fieldwork was conducted between Tuesday 20th August and Monday 26th August.

Group	**Number of participants**			**Format**
	Total	**Male**	**Female**	
Asylum seeker group	**13**	13	0	Discussion group
Asylum seeker	**1**	1	0	Interview
Refugee & Asylum group	**16**	5	11	Discussion group
Refugee group	**8**	0	8	Discussion group
Homeless/Substance misuse group	**15**	14	1	Discussion group
Homeless people	**11**	8	3	Discussion group
Roma group	**9**	4	5	Discussion group
Homeless person	**1**	1	0	Interview
Substance misuse	**7**	6	1	Discussion group

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Total	81	52	29	

2.4 Interpretation of the data

The data from the discovery visits at the Hillside Bridge walk-in centres and the research with underrepresented and marginalised groups was qualitative in nature. Qualitative research is not designed to provide statistically reliable data on what participants as a whole are thinking. It is illustrative and exploratory rather than statistically reliable, and based on perceptions rather than realities.

Qualitative research is intended to shed light on why people have particular views and how these views relate to the experiences of the participants concerned. Such discussions are informal and allow for issues to be explored in detail. It also enables researchers to test the strength of people's opinions. This approach, in other words, facilitates deeper insight into attitudes underlying the "top of the mind" responses to quantitative studies.

Verbatim comments and case studies from the discussions have been included within this report. These should not be interpreted as defining the views of all participants but have been selected to provide insight into a particular issue or topic.

All participants were assured that all responses would be anonymous and that identifiable information would not be passed on to any third party.

In terms of the quantitative data, this is used primarily to support and add context to the qualitative findings, and tends to be presented in charts. Where percentages in this report do not sum 100, this may be due to computer rounding, the exclusion of "don't know" categories, or multiple answers. Throughout the report an asterisk (*) denotes any value of less than half of one per cent, but greater than zero.

2.5 Structure of the report

The purpose of this report is to provide an overview of the findings from the Hillside Bridge walk-in centre research. It will highlight the key themes emerging from the qualitative and quantitative research with patients using the service, as well as the qualitative research with underrepresented and marginalised groups.

The majority of the analysis contained in this report that relates to the underrepresented and marginalised element is contained in Chapter Five, with the other chapters focussing on the perceptions of patients using the service. However, where relevant, links have been made between the two strands of research. Furthermore, the 'Implications' chapter explores the overarching areas for the CCGs to consider.

At the beginning of each chapter, the key findings are summarised so that the reader can quickly gauge the key points.

The report is structured as follows:

- Chapter 1: Executive summary – summarising the key findings from the research
- Chapter 2: Introduction – providing an overview of the background to the research and how it was conducted

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- Chapter 3: Perceptions of Hillside Bridge walk-in centre – understanding of the purpose of the service and satisfaction with its availability
- Chapter 4: Use of Hillside Bridge walk-in centre – exploring the decision making process people go through when deciding to use the walk-in centre
- Chapter 5: How underrepresented and marginalised groups access urgent care – focussing on the perceptions of specific communities of interest, their urgent care needs, and how they view the walk-in centre
- Chapter 6: Alternatives to Hillside Bridge walk-in centre – reviewing patients' thoughts on what they would have done if the service wasn't available, as well as perceptions of other health services
- Chapter 7: Implications – discussing what the research means for Bradford City and Districts CCGs
- Chapter 8: Appendices – the discussion guides and quantitative questionnaire used to gather data

2.6 Acknowledgements

Ipsos MORI and HPP would like to thank Sasha Bhat, Sue Jones, Dr Piush Patel, Dr Aamer Khan and Vicki Wallace for their help and cooperation with this research.

We would also like to thank the staff at Hillside Bridge walk-in centre for their assistance that allowed us to conduct the research, in addition to all the people who took part in it.

Finally, we would like to thank the voluntary sector organisations who enabled the research with underrepresented and marginalised groups to happen:

- Bradford Action for Refugees [BAfR]
- Gypsy and Traveller Group
- Horton Housing
- In Touch Foundation
- Kurdish Group
- LACO Project
- Sharing Voices Bradford
- The Thornbury Centre

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3. Perceptions of Hillside Bridge walk-in centre

3. Perceptions of Hillside Bridge walk-in centre

This chapter explores perceptions of Hillside Bridge walk-in centre among patients using the service, in particular the perceived purpose of the walk-in centre and satisfaction with the service provided.

Hillside Bridge walk-in centre is largely seen by patients as a back-up service for them to use when they are unable to access other health services. Due to the restricted opening hours of GP practices, patients' opinions on the primary purpose of the walk-in centre varied depending on whether they were visiting the walk-in centre during the week or at the weekend.

In general, those who visited during the weekend were more aware of the walk-in centre's function as an urgent care provider, while those who visited during the week were more likely to see the walk-in centre as the equivalent of their GP.

When patients who visited the walk-in centre at the weekend were asked about its purpose, by far the most common response was that it was a place to be seen by a GP when other services were unavailable. Alongside this belief was a widespread understanding among patients that the walk-in centre was intended to be used for urgent healthcare needs that needed to be treated before the next in-hours GP appointment was available the following week.

There tended to be an understanding among patients who visited during the week, however, that the purpose of the service was simply to provide a convenient alternative for people who found it difficult to get a GP appointment during GP practices standard opening hours.

The convenience of the service was one of the factors underpinning high levels of satisfaction with the walk-in centre among those interviewed during the discovery visits. However, the small number of people from underrepresented and marginalised groups who had used the walk-in centre were less satisfied with the service, as a result of inability to get an appointment, waiting times, lack of access to translation services and perceived poor by treatment by staff.

3.1 The perceived purpose of Hillside Bridge walk-in centre

Hillside Bridge walk-in centre is an urgent care service intended to be used in situations where a response is needed before the next in hours or routine service is available. While Hillside Bridge walk-in centre is open to any member of the public, the service was intended to provide urgent healthcare for certain target groups, including those who are not registered with a GP and commuters.

This section explores what patients believe the purpose of the walk-in centre to be. As might be expected, due to the restricted opening hours of GP practices, patients' opinions on the primary purpose of the walk-in centre varied depending on whether they were visiting the walk-in centre during the week or at the weekend. Many patients who visited over the weekend had chosen to visit the walk-in centre on the Saturday because they did not feel that they were able to wait until the following Monday to speak to a health professional about

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their health condition. As such, they tended to be more aware of the walk-in centre's function as an urgent care provider.

The understanding of the walk-in centre as an urgent care provider did not feature so saliently in the interviews with patients who visited the walk-in centre during the week, who were more likely to see the walk-in centre as a convenient place to receive care during the week, particularly if they were unable to get a GP appointment or thought they would be unable to get a GP appointment.

Somewhere to be seen urgently over the weekend

When patients who visited the walk-in centre at the weekend were asked about its purpose, by far the most common response was that it was a place to be seen by a GP when other services were unavailable.

> *"You can't book an illness; illnesses just happen, they don't respect 8am till 5pm or 9am till 5pm jobs; the illness happens all the time; we've got friends and family who have suffered a hell of a lot because of this particular method that GPs have used being unavailable after hours and obviously unless things change, walk-in centres are a necessity."*
>
> Weekend patient

> *"Usually you can get appointments or get seen in the weekdays by your GP, but the thing is it's really good for the weekends where ill people can come to a place that they can be seen by doctors."*
>
> Weekend patient

Alongside this belief was a widespread understanding among patients that the walk-in centre was intended to be used for urgent healthcare needs that needed to be treated before the next in-hours GP appointment was available the following week. Many patients mentioned that, had they felt able to wait until the following week to get an appointment with their GP, they would have done so.

> *"I suppose it's for people like myself, who feel like they need to see somebody more urgently than they might have been able to see their own GP."*
>
> Weekend patient

> *"We do this when it is really, really urgent otherwise we don't come. We know that the appointments here are limited and therefore they should be left for the people who need them most."*
>
> Weekend patient

A convenient alternative to the GP during the week

As shown in the following chart, most patients who completed a questionnaire reported being registered with a GP practice (86%). This confirms that the vast majority of patients are using Hillside Bridge as an alternative to either their usual GP practice or a GP out-of-hours service. By being used in this way, the NHS is effectively paying twice for these patients to receive their care.

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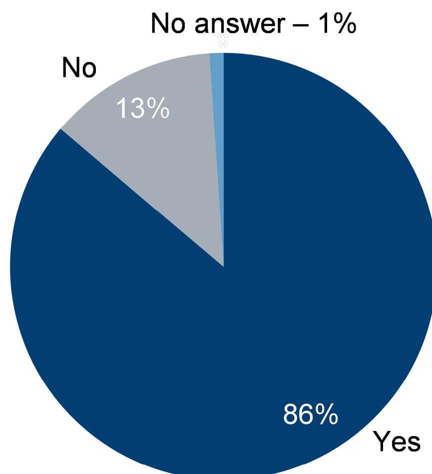
The vast majority of respondents are registered with a GP practice

Are you registered with a GP practice?



Base Users of Hillside Bridge Walk-in Centre (95), 12-25 August 2013.

Please note that findings are based on a small number of people (95) and so results should be treated with caution

Source: Ipsos MORI

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The depth interviews with patients at Hillside Bridge highlighted that, while there was a low level of awareness among patients that the walk-in centre would be useful to those who were not registered with a GP or who were visiting the area, these patients were in the minority.

> *"I thought this place was for people who didn't have their own GP, because I once had a client who didn't have his own GP, and he had a car accident, and he came to this place…So I thought it was just for people like students or people who are just not registered for a GP."*

Weekend patient

Rather, there was a belief amongst some patients that the purpose of the service was simply to provide a convenient alternative for people who found it difficult to get a GP appointment during standard opening hours.

> *"It's more convenient for people because the walk-in starts at 2 o'clock and if they come at about 1.50pm or 1.45pm they'll definitely get seen by someone. You know? So, you're not continuously calling up in the morning trying to get an appointment with your GP."*

Weekend patient

> *"I'm so busy with the housework. My mum's ill and stuff and I need to be with her 24/7. But when in the evening I've got my brothers and sisters around, so it's easier for me to like walk out the house and come and have myself checked and stuff."*

Weekend patient

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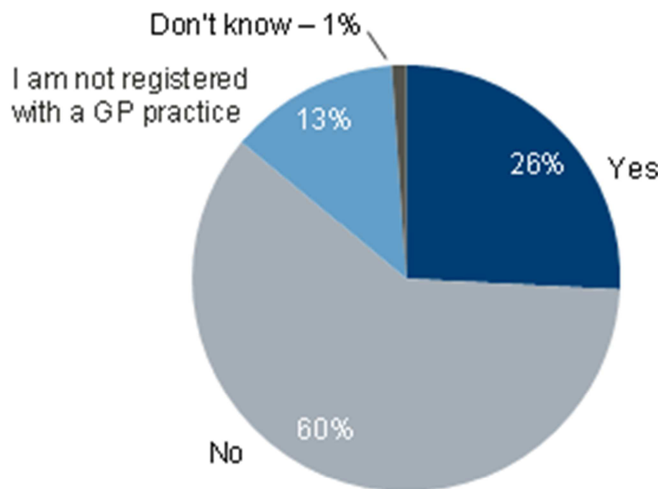
"If you struggle to get into a GP…they're there as convenience really to help when you're ill."

Weekday patient

Use of the walk-in centre as an alternative health service when patients fail to secure a convenient appointment with their GP is corroborated by the majority of respondents who said that they are unable to get a same day appointment with their GP (60%).

The majority of patients said they can't get a same-day appointment with the GP

Are you able to get an appointment with your practice if you contact them on the same day as you need an appointment?



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In some cases, respondents reported being so disenchanted with the process of securing a GP appointment that, on the occasion in question, they hadn't even tried; the walk-in centre had been their first choice of health care provider.

"I never rang the surgery in the first place because I knew they wouldn't have an appointment to give. So every time I have rung there, you know, it's "ring again tomorrow morning". The same thing happens."

Weekday patient

"I can't make a doctor's appointment. It's a bit difficult to get an appointment at my own surgery. It's a bit of a farce. So I decided to come here."

Weekend patient

In the majority of cases, patients' own GP practice would have been their first choice of service, had appointments been more readily available.

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Underrepresented and marginalised groups' perceptions of the purpose of Hillside Bridge walk-in centre

Of the 81 participants from the underrepresented and marginalised groups, 11 participants had used the centre and a further eight had heard of the Hillside Bridge walk-in centre but not accessed the service. Notably, none of the asylum seeker males interviewed were aware of Hillside Bridge.

Similarly to the patients interviewed in the discovery visits, the perceived purpose of Hillside Bridge among the participants who had used and/or heard about Hillside Bridge was to provide a service when they could not obtain an appointment with their own GP, whether due to availability of appointments or it being out-of-hours.

However, significantly, they also identified it as providing services for those who do not have a GP, sometimes because they have been unable to register; one of the key purposes of the walk-in centre.

> *"Hillside Bridge is for us [refugees] because the other doctors [referring to GPs] do not want to register us as they see us as a hassle to them. The doctors is good at Hillside Bridge but receptionist not always letting you see them."*

Refugee, female

> *"They won't accept us – receptionist told us we can't see any doctor there."*

Asylum seeker, male

A few also mentioned family planning as one of the purposes of the walk-in centre.

3.2 Satisfaction with the walk-in centre

Among the majority of patients interviewed during the discovery visits, satisfaction with the walk-in centre was fairly high. Patients were particularly positive about the convenience of the walk-in centre, which may be linked to the fact that patients tended to live nearby.

Patients also spoke positively about the waiting time for an appointment, which they compared favourably with the length of time they would have had to wait in A&E had they visited with a similar health problem.

> *"It's a really good service; I can say from the bottom of my heart that it's really good. Whether it's the GP, whether it's the walk-in centre, I'm 100% sure that I'm really happy with the service."*

Weekend patient

> *"I think that all the public really want is to be treated as quickly as possible and I think it would be a shame if places like this closed because of the eternal problem, money."*

Weekend patient

> *"I've found it very handy today, knowing a place that would be able to help me out. Every single time we've been to the A&E before, we've waited minimum of three hours, no less, and hopefully I will get seen quicker today."*

Weekday patient

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Positively, one South East Asian patient explained that one of the reasons she likes to use the walk-in centre was that staff were able to speak her language whereas, in the past, she had experienced difficulty being understood by her GP.

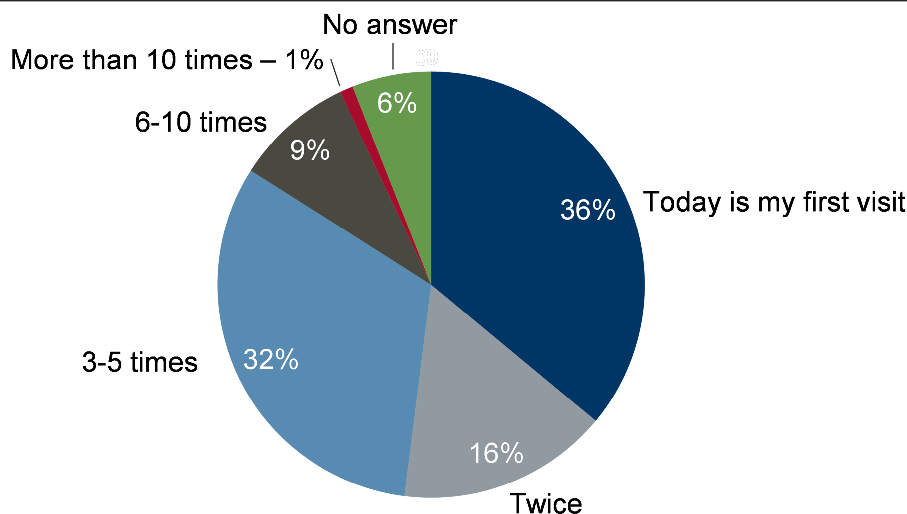
> *"My English is not very good. Sometimes I can't explain to my GP very well, when you come here the nurse and doctor speak my language and they can understand me."*

Weekend patient

The high satisfaction with the service provided at the walk-in centre was reflected by the fact that the majority of patients (58%) reported visiting the walk-in centre more than once within the past 12 months.

The majority of respondents had visited the walk-in centre previously in the past 12 months

Including today, how many times have you visited this walk-in centre within the last 12 months?



Base: Users of Hillside Bridge Walk-in Centre (95), 12-25 August 2013.
Please note that findings are based on a small number of people (95) and so results should be treated with caution

Source: Ipsos MORI

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Although opinions were generally positive, a small number of patients thought that the method by which patients were allocated appointments could be improved. One patient who was visiting Bradford from Liverpool thought that appointments should be prioritised according to the patient's need; potentially by using a system of triage, similar to that which he'd seen employed in Liverpool.

> *"That's another thing that's strange; we don't need appointments [in Liverpool]. We just walk in and say, "I need to see a doctor". It's like going to an A & E. You'll see a triage nurse. And she'll assess you. Say, "You want to be going in next". It's not like, they'll come here, its 4.30pm so the next available slot is 6.10pm.It's supposed to be a walk-in centre. Not walk in, get given an appointment and told to come back centre."*

Weekend patient

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Other patients suggested that the elderly or children should be given priority when allocating appointments, compared to other patients who were more able to wait for extended periods of time.

Although resource intensive, it is possible to envisage a number of ways in which employing a triage system could have benefits in ensuring that the walk-in centre serves its purpose as an urgent care service. It could be said that the walk-in centre is a victim of its own success – it is so convenient for patients that they feel encouraged to use it as a replacement for the GP. A triage system may not only discourage local residents from using the walk-in centre as a same-day GP service (arriving at 2pm to secure an appointment and then returning to the comfort of their own home to wait) but would also discourage patients with non-urgent complaints from using the walk-in centre as they would be subject to a longer wait for an appointment.

In contrast to this, overall satisfaction with the service appeared low among the small number of underrepresented and marginalised group participants who had used Hillside Bridge in the past year. Of all the participants who had used Hillside Bridge, very few had used the service more than once. Where participants had used the service and would return, they were more likely to use the service for their own health needs but would choose to go to A&E for family members, particularly where children were concerned, so they were in a 'safe' place while waiting to be seen.

Participants attributed their dissatisfaction partly to the long waiting times, which were seen as similar to waiting times in A&E.

> *"I waited four hours for appointment then went to A&E. I should have gone there in first place."*
>
> Roma, male

One person did acknowledge that the waiting time was to be expected with a drop-in service.

The perceived attitude and behaviour of reception staff was another source of dissatisfaction among underrepresented and marginalised group participants, with participants feeling that receptionists needed to *"listen more," "improve their working"*.

> *"The receptionist wants to know everything in front of everyone and then will give no help or way what to do next. She act like she doctor and telling me I don't need doctor. If I can get to see doctor, they are very good but it is a battle. With the children, I don't try anymore, I just go to A&E straight away."*
>
> Refugee, female

> *"You make appointment with reception, you go to appointment and they tell you, you don't have an appointment."*
>
> Refugee, female.

Some participants pointed to what they felt was a lack of respect and dignity, with participants describing situations where they were asked personal questions by receptionists in front of others and being told what to tell the doctor. Workers from the Roma community described taking a group to visit Hillside Bridge to encourage use of the service but group members had experienced the staff to be judgemental and using inappropriate communication with regards to ethnicity and culture. Many who attended the visit said they would not go back.

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Most participants were dissatisfied with the opening times of the service. Some spoke of the time changes in the past year and the difficulties for parents of more than one child caused by the removal of morning appointments. Evening-only appointments was also a cause of dissatisfaction for the Refugee and Asylum groups who had meals provided in the 6-8pm time slot.

Most participants spoke favourably about the medical service received by the doctors or nurse practitioners. Some participants experienced difficulties with language barriers between all staff at the service (medical and non-medical) and this left them dissatisfied with the service received. Three participants described situations where they were left confused and unsure of what advice and information the doctor had given them.

Of the homeless groups, only one person had used Hillside Bridge and described the service as being easy to access but their issue was they never got to see the same doctor twice.

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4. Use of Hillside Bridge walk-in centre

4. Use of Hillside Bridge walk-in centre

This chapter explores how people make decisions about accessing Hillside Bridge walk-in centre. In particular, when and why people use the service and what motivates or leads them to do so will be discussed.

People tended to go through a fairly rational decision making process before visiting the walk-in centre. Most said they had thought about their symptoms and considered what the most appropriate service to use would be. Indeed, when deciding what health services to access, as well as rationally weighing up the different options, patients are also making judgements – whether consciously or sub-consciously – about the urgency of their condition. Three in four patients said the health condition that had led them to visit the walk-in centre that day was definitely urgent (77%). Only a small minority (10%) said that the health condition that had led them to visit the centre was probably or definitely not urgent.

In the vast majority of cases, patients would have wanted to see a GP regarding their health problem. However, it was widely perceived that it was very difficult to get GP appointments, and many stated that they had unsuccessfully tried to get an appointment on the day that they attended the walk-in centre. Most also felt that A&E services would not be appropriate given that their problem wasn't an emergency, and thought they would face long waiting times. This created a degree of uncertainty as to what to do next, as GPs and A&E were the two pillars of health and care service provision that all patients were aware of. This doubt was exacerbated at the weekend, as there was low awareness of out-of-hours GP services.

Consequently, patients using the walk-in centre were commonly referred to it via NHS helplines (particularly NHS 111), or by pharmacists, who they had contacted to try to establish what they should do next. This was particularly prevalent at the weekend when patients knew their GP would not be available. For underrepresented and marginalised groups, signposting through a third sector organisation was also mentioned as a referral route. A minority of people found the walk-in centre through internet searches or recommendations from friends or colleagues. However, the quantitative data shows that 58% of patients had used the service previously in the past year; and10% had done so six times or more, showing that some patients are using the walk-in centre fairly regularly to deal with their health concerns.

Word of mouth worked in a different way for some of the underrepresented and marginalised groups who had heard of the walk-in centre but not accessed it; they had heard negative reports from other people that had put them off using it.

The key finding is that most patients were using Hillside Bridge walk-in centre to compensate for their perceived inability to get an appointment with their GP, rather than because they weren't registered with one in the first place.

Underpinning this, the walk-in centre tended to be used by patients for whom it was local and convenient. The availability of face-to-face consultations with a clinician outside of normal working hours was strongly desired, which meant that Hillside Bridge walk-in centre was a draw for those living in its vicinity.

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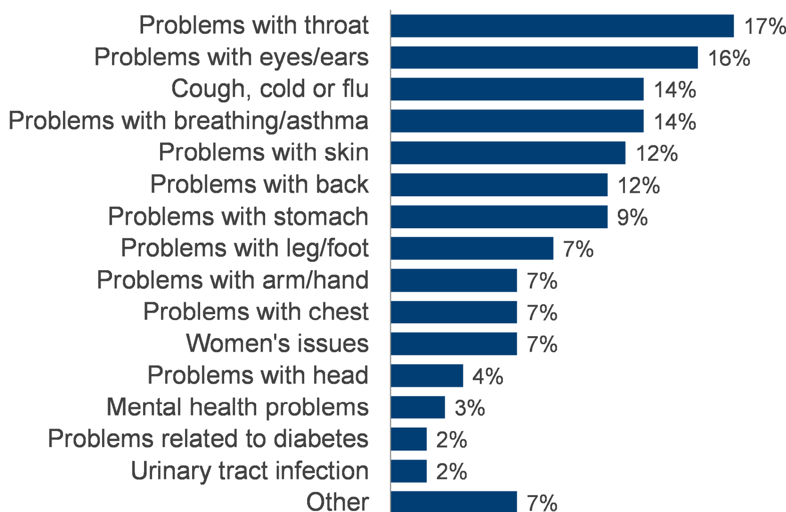
4.1 A conscious, rational decision making process

There was a great deal of variation in the health condition with which patients visited the walk-in centre, highlighting the varied needs the service is responding to, as the following chart shows.

Respondents visited the walk-in centre for a wide variety of different health conditions

What health condition or reason caused you to visit the walk-in centre today?



Base Users of Hillside Bridge Walk-in Centre (95), 12-25 August 2013.

Please note that findings are based on a small number of people (95) and so results should be treated with caution

Source: Ipsos MORI

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A key finding from this research is that the patients who attended the walk-in centre usually did so following a fairly rational decision making process. The majority were there because they were aware that their health problem was not an emergency that required going to A&E but they wanted it dealt with promptly. As a result, they had often tried to get an appointment with their GP surgery or consulted an NHS helpline such as NHS 111 to explore available options, before visiting the walk-in centre because they were referred to it, or because it seemed to them to be the only service that could deal with their issue within the timeframe they wanted.

> *"I rang the doctor's up and there were no appointments, so I rang Calverley Surgery, there were no appointments. I rang the 111 number and they took the symptoms and said "You need to see a doctor within six hours". That was their recommendation. And they gave me the Hillside address, so that's how I came to be here."*
>
> Weekday patient

> *"I wouldn't say my condition is urgent, as in the sense of in the next few hours I need some medication, but I think in the next couple of days I probably could do with having antibiotics. So I wouldn't want to book an appointment for next week with the GP because obviously I think I'd feel a lot worse by then."*
>
> Weekday patient

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Additionally, whilst participants tended not to explicitly define that they needed to attend the walk-in centre because they had an urgent care need, they did implicitly reach this conclusion by weighing up their symptoms and considering what the most appropriate service to attend would be.

> *"I think I do get migraines so I would always go to my GP about that because I know what it is and I'd want to discuss it with them at length. Whereas I think with something like cold symptoms I wouldn't really want to go to the GP for that."*

Weekday patient

> *"First of all I would look at the symptoms and see what's wrong, and then I think about where I need to go. The last time I had a chest pain I knew I wouldn't come to see the doctor, I went to hospital. I went straight there because I didn't think they would say to me that they couldn't do anything about a chest pain, so I went there myself to get it checked. But just being sick or having diarrhoea or stuff like that, I would come to see a GP. If there was no GP, then I would probably just come here and not go to hospital. So, it just depends on the symptoms, what symptoms you've got really. Something severe, go to hospital, if you've got the normal daily ones you come to a GP."*

Weekday patient

4.2 Difficulties getting an appointment with a GP

Perhaps the most consistent message that emerged from the qualitative interviews was that GP surgeries were the first option for participants when they perceived themselves to have an urgent care need. This is positive in a sense, as the Bradford urgent care pathway is designed with the intent that those registered with a GP will have their urgent care needs resolved at their surgery. However in practice, the walk-in centre was often used by patients who had not been able to get an appointment with their GP on that day – or who didn't think they would be able to get an appointment – suggesting that the pathway is not working as planned.

> *"This is the first time I've considered coming here, because I usually prefer going to my GP. Because for me they've got all my records and everything, and I'm used to going there."*

Weekend patient

> *"You have to ring within a certain time period, to get an appointment, which is a thing called a one hour window. Usually most of the appointments have gone. You can't get through to that line, because there's only one line, and there's about 50 people ringing it. And the other option is to be there on the day, at 8am, and I don't normally make it for that time, so I just leave it. If I do have a symptom, I just kind of ignore it, it usually goes away. But this is a bit serious, so I just decided to just get it sorted out."*

Weekday patient

In fact the majority of participants interviewed during the week stated that they had either called their practice and been told that there were no appointments available, or had assumed that this would be the case and had therefore looked for alternative services.

> *"I called my GP, to get an appointment, and they couldn't fit me in for six days. I wouldn't normally call them unless I really needed to see them, or it was a regular*

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appointment, but I've got a painful lump in my neck, and I'm just a bit worried about it, so I thought I'm not waiting six days, so I looked up the drop-in centre."

Weekday patient

"I never rang the surgery in the first place because I knew they wouldn't have an appointment to give. Every time I have rung there it's "ring again tomorrow morning".

Weekday patient

The following case study highlights one patient's specific story.

Case study: responding to GP appointments being unavailable during the week

A woman had been having stomach pains for a couple of days. She initially hoped the problem would pass but it persisted, and her temperature increased, so she called her GP on a weekday morning. The GP did not have any appointments until the following week so she then called NHS 111 to see if a pharmacist could help.

The NHS 111 operator informed the patient that she should see her GP. As an appointment wasn't available, Hillside Bridge walk-in centre was suggested as an option.

If the walk-in centre had not been available, the patient would have gone to the pharmacist to see if there was anything they could do to help her in the short term, and then gone back to the doctor to tell them "I need an appointment; not that I want one, I need one."

If this still didn't work, she said she would've called NHS 111 to see if there were any out-of-hour options available to her. If that didn't work she saw A&E as the only other viable option – thought it would have been a last resort.

Further to this, a few patients mentioned that they were actually registered at the GP surgery at Hillside Bridge but couldn't get an appointment. They were aware of the walk-in centre and used it as an alternative option, as they knew they were more likely to get a short notice appointment.

"I am registered at this doctor actually, so I have to ring at 8 o'clock in the morning. At times I ring at 8 o'clock in the morning and I don't get an appointment because the lines are busy. And by the time I do get through the appointments are fully taken. So, I get told to ring the next day."

Weekend patient

This was also the case for the two people from the Roma Community who had accessed Hillside Bridge. Both attended the walk-in centre with a sick child in order to be seen quickly. They had heard about the service from workers at the third sector organisation they attend. People from this community reported difficulties in getting appointments with their own GP and so they had gone to Hillside Bridge as an alternative. However, both experienced long waiting times and said they would go straight to A&E on future occasions.

It is also important to recognise that amongst those attending the walk-in centre at the weekend, there was a perception that the walk-in centre was the only service available to them. These people often noted that had their health concern needed to be addressed during

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the week, their first port of call would have been their GP practice rather than Hillside Bridge walk-in centre. However, as they knew their surgery was closed they had to seek another option.

> *"Usually I'd rather go to my GP, but today they were closed, and I definitely can't get back to work unless I get checked out. This was the only place I could get seen."*
>
> Weekend patient

> *"Because it's a weekend you can be seen by the doctors down here and get checked out and see what the problem is, get the medication etc. If you can wait until Monday or something then you can go to your own GP."*
>
> Weekend patient

These points are supported by the quantitative measure that asked patients to record their most important reasons for visiting the walk-in centre. Not being able to get a GP appointment was the most frequently mentioned driver (41% said this), whilst other common reasons such as 'opening hours are more convenient' (32%) and 'I can be seen more quickly here' (23%) are also likely to tie in with the perceived unavailability of GP appointments.

Difficulty getting a GP appointment was the most common reason for visiting the walk-in centre

What are the two or three most important reasons for why you decided to visit the walk-in centre today?

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This raises interesting questions for the CCGs as to the provision of urgent care services in Bradford. For example, very few participants mentioned the possibility of GP out-of-hours services during these discussions, suggesting there may be a gap in awareness in relation to this service. The vast majority of patients using the walk-in centre over the two week period were registered with a GP and, in theory, could have been using out-of-hours services rather than the walk-in centre at the weekend and weekday evenings.

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4.3 A&E not an appropriate service

A&E departments did not emerge as often as GP services during discussions but many participants felt that emergency services were not appropriate for their health concern, and stated that was why they had ruled out going to hospital. In most instances this was due to an acknowledgement that their condition simply wasn't an emergency and that A&E is very much a last resort for the most serious health concerns.

> *"If it's an emergency, like a heart attack, you go to hospital in an ambulance, but for minor problems you go to your doctor."*

Weekend patient

> *"The only other thing I could think of at the time was A&E, and I didn't think that was appropriate. I'd have to be very, very poorly or on the verge of my deathbed, to want to go to A&E."*

Weekend patient

However, there was also a prevalent perception that A&E services were under a lot of pressure and that as a result a patient would face long queues and waiting times of a few hours or more to be seen. Others expanded on this and thought that even if they were seen, they would not get the same level of attention.

> *"Over here at least it's guaranteed I'm going to be seen, because if I was to go a hospital I'd have to wait between two to four hours, and there's no guarantee I'd be seen because they'd probably think it's not that serious."*

Weekend patient

> *"If you go to hospital you have to wait, because they're very stretched emergency doctors, and they don't know all your history. If you go to see your doctor, obviously they know you and they know what you've had before, what tablets you've had, what antibiotics you've had."*

Weekend patient

Some explicitly stated that waiting times had been a key part of their decision making process, and they favourably compared the likely wait they would face at the walk-in centre to that at A&E. This was thought to be a particular issue at the weekend.

> *"This is a lot better than A&E because you get done here in about two hours but with A&E it's nearly five to six hours – that's how bad it is on a weekend."*

Weekend patient

> *"Every single time we've been to the A&E before, we've waited a minimum of three hours, no less, and hopefully I will get seen quicker today."*

Weekday patient

4.4 Referrals from other services

Where a GP appointment was not an option (or not thought to be an option), and A&E had been ruled out as inappropriate, patients were often uncertain about what other services

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were available. Consequently they often turned to the NHS 111 helpline for advice on what their next steps should be. Others contacted these helplines in the first instance, before even calling their GP, as highlighted in the following case study.

Case study: using helplines to navigate health services at the weekend

A male patient had a tooth abscess but their dentist was closed over the weekend. Consequently, he called the NHS 111 service who initially directed him to a dental practice in the LS7 area. He felt this was too far to travel as he didn't have a car, so the NHS 111 operator suggested contacting a local pharmacy to see if they could provide any pain relief, or visiting Hillside Bridge walk-in centre as an alternative.

He called the pharmacy to see if they could help. They weren't able to do so. Following this, the patient decided to go to the walk-in centre as their tooth was too painful to wait for a dental appointment early the following week.

He considered Bradford Royal Infirmary but felt that it wasn't enough of an emergency to go to A&E – he said he would only go there if his condition was 'dire' and did not want to add to the 'burden' or 'pressure' that A&E doctors faced.. Additionally; the walk-in centre was only a ten minute walk so it was convenient for him to get there. For these reasons, he attended the walk-in centre.

Corroborating this, one in three patients completing a questionnaire (32%) noted that an NHS helpline was one of the key factors that led them to the walk-in centre. As awareness of the walk-in centre tended to be low, the helpline was an important source of information for patients and brought the option of Hillside Bridge walk-in centre to their attention.

> *"The first thing I did was call the NHS helpline, and then they recommended this place. They also recommended my GP, but that was closed, and I wouldn't ever get an appointment anyway, so I didn't bother trying, I just came straight here."*

Weekend patient

> *"I know it's a bit of a farce getting an appointment, so I rang the NHS line, and it was getting worse, so I decided to actually to come here. I didn't even know these sorts of places existed to be honest with you."*

Weekday patient

Others went further, suggesting that the telephone services were not able to provide adequate advice for their health complaint, or that the service recommended they book an appointment with their GP – who was unavailable. The impact of this was that these patients were very keen to get a face-to-face consultation with a clinician, hence the appeal of the walk-in centre.

> *"They're asking questions about your symptoms but they don't know what they're on about really. Next time I wouldn't bother ringing 111, I'd just come straight here."*

Weekend patient

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“They didn't really advise me at all, I thought they'd talk to you about what was wrong with you or something like that, but they seemed to just be ticking boxes and boxes and boxes, just to get you to one answer at the end of it.”

Weekday patient

“I've used the old NHS Direct in the past, and the response I've had from them before is “you need to go to your GP”. It's always out-of-hours, which is why I'm ringing them in the first place, so it really isn’t helpful.”

Weekday patient

The other common source of referrals came from pharmacists. Several participants had been to a pharmacy to see whether they could provide assistance or antibiotics. The pharmacist had directed the patient to the walk-in centre if they felt they required further medical attention.

“I went straight to the pharmacist, it was getting on for six o'clock and the pharmacist said he couldn't prescribe anything. It was too late in the day to go to the GP, because the GP was closed at that point, and that's when he told me about the walk-in centre.”

Weekday patient

In the majority of these cases the walk-in centre was essentially a fall back option used by other services where patients thought GP services weren’t available, as outlined in the following case study.

Case study: the decision making process

This female patient had an issue with their leg. It was causing her some pain and limiting her mobility. She would have wanted to see her GP but it was a Saturday so there was no surgery. Furthermore, it was the Bank Holiday weekend so the earliest she could be seen would be Tuesday.

She was worried about her leg problem and therefore felt she needed to see a clinician within the next couple of days. As a result, she called NHS 111 which advised her to see someone within 12 hours. As her surgery was closed and she wasn’t aware of any GP out-of-hours services, the helpline directed her to Hillside Bridge walk-in centre.

She hadn’t heard of the walk-in centre so she considered A&E. However, the patient felt that her problem was not serious enough to warrant going to hospital, so she visited the walk-in centre and secured an appointment.

She was very happy that the walk-in centre was available and saw it as a mop-up service to deal with people who could not get an appointment with their GP, but didn’t have an emergency problem.

Referrals from other health services also fed into the decisions of refugee groups to use the walk-in centre, with some saying they had been signposted there by a pharmacist or the NHS 111 service.

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4.5 Other sources of information

In most cases where patients hadn't previously heard of the walk-in centre, patients trusted recommendations from other professionals and services rather than being told about the service by a family member. However, a few patients had found the service themselves via the internet having spoken to colleagues or friends who had heard of or used walk-in centres elsewhere – but this was only evident in a minority of cases.

> *"I was talking to somebody I know, and I told her I was feeling ill, and that I couldn't get an appointment with my GP, and she knew of a walk-in centre in Leeds, and I thought "Well, there must be one in Bradford then." I didn't think about this place in particular, until I did a search and then thought "Oh yes, I remember that."*

Weekday patient

> *"I came here once before, a couple of years ago, so I knew of it, but I didn't think of that at the time, but I went on the internet, because someone else suggested "why don't you find out about a walk-in centre"? So I just put in out-of-hours GPs in Bradford, and this came up, and I recognised it, and I knew where it was, and it would be straightforward enough to come, so that's why I came here."*

Weekday patient

A few members of refugee groups who have used the walk-in centre also mentioned having heard about the service via word of mouth. However, this also worked in a less positive way to have an impact on decision making processes. People who had heard of Hillside Bridge but not accessed the service had not done so because of the perceptions of it as *"being where you get treated badly by desk staff"* [Refugee, female]. One participant from the Roma group talked about a time when a referral was made to Social Services by Hillside Bridge staff after a visit, following which Social Services investigated but exonerated him. Although it was not clear what the concern was, it was clear that news of this had spread amongst the community and some people were now reluctant to use service for fear that the same thing might happen.

Signposting by third-sector support organisations was also a key driver for underrepresented and marginalised groups, with both workers and participants giving evidence to this. However, workers from many of the third sector organisations reported being unaware of the walk-in centre so hadn't been able to pass on the information to clients. Workers at the homeless hostels told of being contacted by health services to try to address the issue of high ambulance call out rates with their service users but had not been informed of Hillside Bridge as an alternative. Of the workers who were aware of it, some didn't signpost as they felt it was inappropriate for their client group and others had stopped giving out information due to the number of negative experience reports they had received from service users.

4.6 Understanding of the urgency of patients' health conditions

When deciding what health services to access, as well as rationally weighing up the different options, patients are also making judgements – whether consciously or sub-consciously – about the urgency of their condition. Three in four patients said the health condition that had led them to visit the walk-in centre that day was definitely urgent (77%). Only a small minority (10%) said that the health condition that had led them to visit the centre was probably or definitely not urgent.

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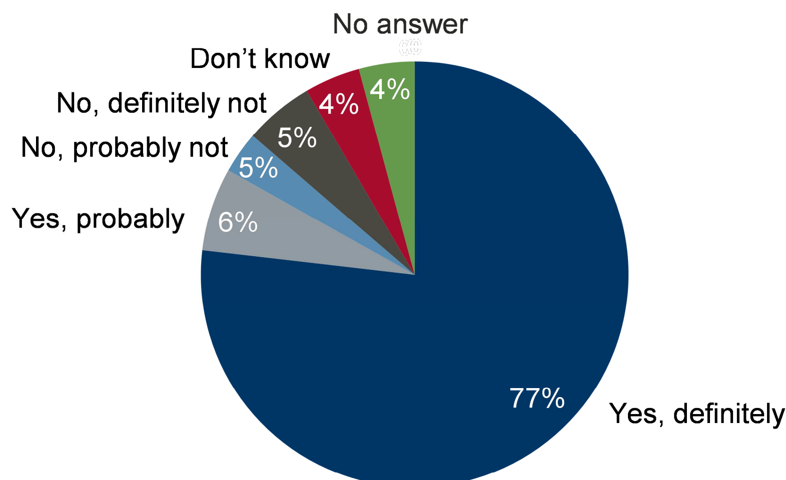
The vast majority of respondents thought their health condition needed treating urgently

Would you describe your health condition or reason for visiting the walk-in centre as urgent?



Base Users of Hillside Bridge Walk-in Centre (95), 12-25 August 2013.

Please note that findings are based on a small number of people (95) and so results should be treated with caution

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However, it is worth noting that these ratings of urgency are self-diagnosed; there is some evidence from the discovery visits that patients' conditions were not as urgent as they felt.

However, it is worth noting that these ratings of urgency are self-diagnosed; there is some evidence from the discovery visits that patients' conditions were not as urgent as they felt – or that if A&E was the only health service for them, they could have waited to see a GP instead.

One key aspect was whether their condition had deteriorated. Where this was the case, patients were more agitated and concerned, and needed reassurance from a clinician to rule out any serious or long-term implications. Indeed, for these people it appeared to be the worsening of their condition that prompted them to go to the walk-in centre. For instance, a patient who had been suffering from a migraine stated that he wouldn't usually see a clinician if he was suffering from such a problem. However, as the pain had got worse rather than improving overnight (as it had in previous instances when he'd had a migraine), he was keen to ensure it wasn't anything more serious. What exacerbated this was that he had been taking over the counter medication that had not helped, leading the patient to think he needed something prescribed from a clinician. A few other patients mentioned that over the counter painkillers hadn't had an impact on their problem as well. Their feedback suggested that this did alter their perceptions on the urgency of their problem, and was a contributory factor as to why they escalated their concerns to the walk-in centre.

However, it should be recognised that most patients did not say they were in significant pain, and, as noted previously, their decision making process appeared to be more rational than emotional. A number of patients actually felt they could have waited a few days until a GP appointment was available had they not been able to get an appointment at the walk-in centre. This ties in closely with the convenience of the service, as these patients tended to also say that the walk-in centre was very local to them, so it was worth trying.

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The factor that did seem to evoke a more emotional reaction and increase patients' ratings of urgency was when the health condition was affecting their child. In many cases, parents who had brought their child into the walk-in centre said that, had the condition been affecting them, they would have waited until Monday in order to see their GP. They were unwilling however, to "take any risks" with their children, and this had led them to seek urgent health care at the walk-in centre instead of waiting for a GP appointment.

> *"If it were me, I think I would have coped with it, but when it comes to my children, no."*

Weekend patient

> *"When it's my kids I will go out flat. If it's me I will just sit and wait for my doctors or go to hospital if it's serious."*

Weekend patient

Tackling attendance at the walk-in centre for non-urgent conditions will be difficult. It is not just a matter of raising awareness of the walk-in centre's purpose but also of educating people and raising their confidence to treat minor health conditions themselves without seeking medical attention.

4.7 A desire for a face-to-face consultation

As noted previously, a desire for face-to-face consultations with clinicians to discuss or resolve health concerns was very important to patients. They wanted reassurance about their condition and tended to worry that a telephone conversation might not be sufficient to diagnose the full extent of their problem. The potential of seeing a doctor or nurse on the same day therefore had significant appeal.

> *"On the phone sometimes I can't hear what they're saying, maybe what they're saying is completely right but they do ask quite a lot of questions and you get a bit confused and I'm frightened I might say the wrong answer. I don't hear if what they are saying is right or not."*

Weekend patient

> *"You don't know who you're talking to on the phone. I think it's confidential and you shouldn't have to discuss your symptoms, it should be with your GP rather than anybody else, do you know what I mean?"*

Weekday patient

This was especially the case where children were concerned. A number of people interviewed qualitatively had come with a child and they said the priority was to get their child seen by a doctor as soon as possible. For a minority of patients using the walk-in centre, A&E would be a viable option in these circumstances. However, given that that going to hospital could mean a long wait to be seen, the walk-in centre was viewed as a less stressful alternative for their child if it was local.

> *"He said if my son got worse to call the 111 line, but I thought rather than ringing 111 I would bring him here."*

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Weekend patient

"If the problem is with me I will wait, but if it's the children I will get the help, that's why I've come here because it's the children and not myself."

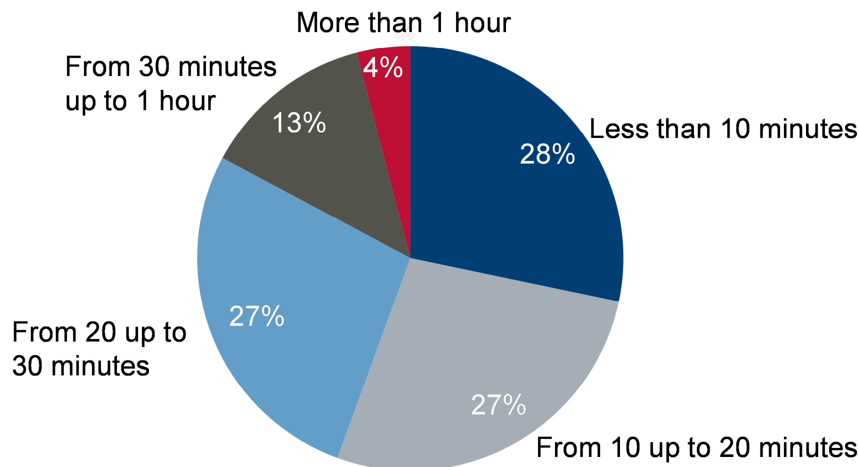
Weekend patient.

4.8 The importance of convenience

Underpinning all of the points discussed in this chapter relating to convenience, the majority of patients live locally, with 55% saying it only took them up to 20 minutes to travel to the walk-in centre.

The vast majority of respondents travelled for less than 30 minutes to get to the walk-in centre

How long did it take you to travel to the walk-in centre today?



Base Users of Hillside Bridge Walk-in Centre (95), 12-25 August 2013.

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The convenience and availability of the service were frequently emphasised by participants as central to them actually attending the walk-in centre. So, whether they were already aware of the walk-in centre or had been referred to it by another service or person, its location, availability and opening hours were determining factors as to whether it was worth trying to make an appointment at the walk-in centre or not.

"This is more convenient as it's so local, plus the opening times, because it is open at six, it's just so much more convenient for me."

Weekday patient

"It can be quite difficult to get in the GP's to book it around work. My work is quite strict about time that you can have off for things like that. So I've got to book appointments quite far in advance. So, if it is a problem that comes up like this where I get ill, then I'm likely to use a walk-in so I can do it around work."

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Weekday patient

Linked to this, the availability of the walk-in centre at the weekend was behind many people choosing to use it. This was partly due to the perceived lack of GP services at the weekend but also because some felt work and family commitments constrained them during the week, so any non-emergency health concerns had to be dealt with at the weekend.

> *"It's more easy, like Monday to Friday I'm so busy with the housework, my mum's ill and stuff and I need to be with her 24/7, but when it's the weekend I've got my brothers and sisters around, so it's easier for me to like walk out the house and come and have myself checked and stuff."*

Weekend patient

> *"It's just like a walk-in and it's really straightforward. Sometimes when you've got appointments, sometimes the timing is not good for you. And with work the timings on a Monday to Friday are really hard."*

Weekday patients

This poses a number of interesting questions: *how many of these people would have waited for a GP appointment if the walk-in centre wasn't available? What, if anything, are people who do not live in the local area around Hillside Bridge doing if they can't get a GP appointment? Do they go to A&E instead? Will the groups the walk-in centre is designed to serve attend if they have to travel to get there?* We cannot draw any firm conclusions around these questions at this stage, but the wider urgent care research will allow us to explore these issues further.

4.9 Repeat use of the walk-in centre

Whilst previous use of the walk-in centre did not emerge as a primary driver of using the service again during the qualitative discussions, the quantitative data highlighted that the majority of patients had visited it on at least one prior occasion in the past year (58%). More than one in three had not used it before (36%), but given that 10% had used it six times or more in the past year, and 32% three to five times in that period, it is clear that a significant proportion of patients are using the walk-in centre fairly regularly for their health needs,

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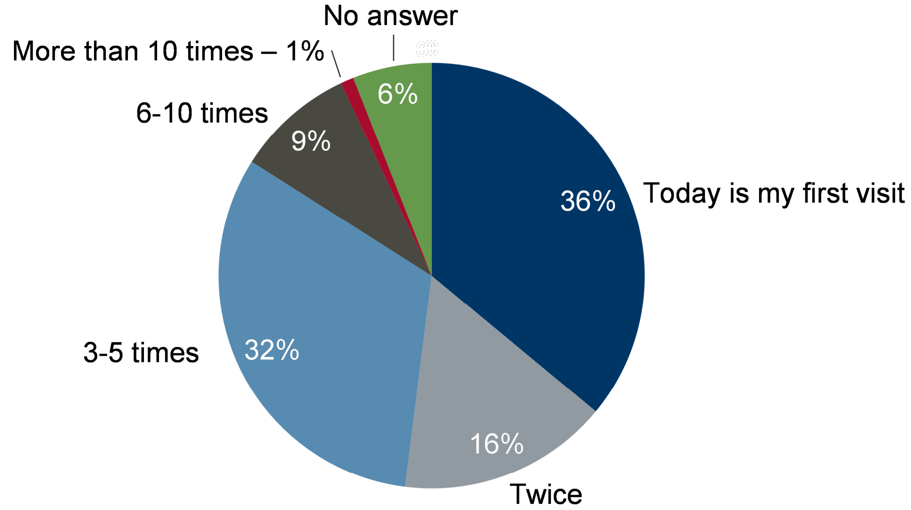
The majority of respondents had visited the walk-in centre previously in the past 12 months

Including today, how many times have you visited this walk-in centre within the last 12 months?



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5. How underrepresented and marginalised groups access urgent care

5. How underrepresented and marginalised groups access urgent care

This chapter of the report explores how underrepresented and marginalised groups make decisions about where to access care for urgent health needs.

In general, among those from underrepresented and marginalised groups, most participants' understanding of health services were those available at a GP practice or hospital, although a reasonable number had used pharmacies and some had used NHS 111. Many participants used A+E as their default option for healthcare as it was perceived to guarantee treatment.

Use and awareness of Hillside Bridge walk-in centre among underrepresented and marginalised groups was fairly low. Those who had used the centre tended to have viewed it as a negative experience. Some participants had heard negative reports of the service from family and friends which had influenced their decision not to use it. Many workers of third sector organisations were also unaware of Hillside Bridge, which meant they were not supporting participants to attend.

Participants reported satisfaction with A&E, pharmacies and other third sector services such as Bevan House, Woodroyd Centre, Piccadilly, Unity and the Bridge Project.

Being treated with dignity and respect, access to good quality translation services, location of service and ability to just drop in and not make an appointment were all factors that underrepresented and marginalised groups cited as of high importance when choosing what health service to access.

5.1 Knowledge of health services – understanding

In general, most participants' understanding of health services were services that were available at a GP practice or hospital. On further probing, a reasonable number had used pharmacies and some had used NHS 111.

The asylum seeker group only knew of pharmacies and the hospital as did the majority of the Roma group. Some participants were aware of Bevan House. Some homeless participants said they used Bevan House because they could register without a fixed address. They described the service as close and familiar, with staff who understand their complex needs. Other participants reported living out of the catchment area and therefore not being able to access Bevan House.

On exploring actions from the case scenarios, for the vast majority of participants, their default option was to dial 999. As for patients from the discovery visits at Hillside Bridge, people from the refugee groups who have children saw A&E as the best place for advice and best treatment; however for their own health needs they were more likely to use a GP or signposted service such as NHS 111 or the walk-in centre. The Roma Group used A&E but also a number reported going back to their country of origin specifically to receive medical treatment as they had waited too long to receive help here.

> *"I call for appointment with GP, they say no appointments for two weeks, I call back they say will be another two weeks for interpreter, I go to appointment, no interpreter is there so I can't see GP. After two months of same, I go to Slovakia to see doctor. I get some medication but need to see my GP here. Same thing is happening as*

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before. It has been 2 weeks and still I no get appointment, i get told interpreter will call me back but get no phone call."

Roma, female

5.2 Knowledge of health services – signposting

A major factor affecting decisions about which health services to access is the signposting underrepresented and marginalised groups receive from third sector organisations, support services (day centres and services), pharmacies, friends, family and community members.

As already noted, this word of mouth could also work in the opposite direction, for example discouraging people from accessing Hillside Bridge where they had heard negative accounts from others about the service there.

If a third sector organisation or group were unaware of a service, such as was the case with Hillside Bridge, members of that community were unlikely to use the service. This was particularly the case with the Kurdish community – mainly asylum seekers who were unaware of what services were available and key leaders of the Kurdish community would signpost people to pharmacies or A&E. This was also the case with homeless service providers as highlighted in the section above. Each person accessing a hostel has a key worker and is given a pack of information including details about local health services. At present this doesn't include information on Hillside Bridge as the workers were unaware of it.

5.3 Knowledge of health services – awareness of alternatives

In general, awareness of and experiences with alternative services such as out of hour's GP service, specific clinics, NHS 111 and pharmacy were very inconsistent. The majority of asylum seekers saw the pharmacy and A&E as the only health services available to them with the pharmacy being their first port of call. Satisfaction with pharmacies on the whole, among all participants, was very high. Participants described positive experiences of the old 0845 NHS Direct service but showed less enthusiasm about the NHS 111 service – which was perceived as "waiting to be told to go to A&E or see a GP, when I could just go myself" [Refugee, female]. Very few participants were aware of GP out-of-hours services.

A key alternative that the majority of participants had accessed was Bevan House. Again, satisfaction with this service was high, although a small number of participants described being 'de-registered' and then seeing A&E as their only alternative. In the instances where participants described being 'de-registered' by Bevan House, this was said to be due to missing appointments made or no longer living in the area.

The refugee and asylum seeker communities had no experience of specialist or specific clinics, such as diabetes, phlebotomy or sexual health, and three participants cited using urgent care services for issues related to family planning. Some members of the Roma group had heard of NHS Direct but had not heard of out-of-hours GP services. The homeless groups spoke of using and accessing drug and alcohol projects and clinics and on the whole were satisfied with the services. The homeless day shelter has a GP who visits once a week for one hour and sees six to seven clients within that time. Staff can use their discretion in booking those appointments so could use them for urgent cases/ people struggling to access health services elsewhere. There were issues and scenarios described about lack of access to rehabilitation and secondary services.

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5.4 Respect and dignity

Being treated with respect and dignity was of great importance to all underrepresented and marginalised groups. Not all participants involved in the research were registered with a GP and of those that were, very few reported having a positive relationship with them. The Roma community cited being treated with respect as one of the top two factors that would influence a decision as to whether or not to access a service.

There was a perception of trust of A&E staff over other services, but participants described being treated as 'nuisance users' and 'undesirable clients' by GPs and receptionists. Many alcohol / drug users reported feeling like they were dismissed, health condition not taken seriously, or treated disrespectfully once it was mentioned they were a user. Some of the homeless people saw GP services as being hostile and inaccessible. They felt they were viewed negatively and likely to get a poor service. Hence they were more likely to access specialist support services and third sector organisations for health advice (such as the Bridge project, Piccadilly, Sharing Voices, Horton Housing, Unity and Inreach) or go to A&E – and in some cases, to do nothing.

A homeless service user with mental health issues reported generally good experiences with health services. However, he felt that service providers didn't always deal professionally and sensitively with people presenting complex health needs. He felt those services working with such client groups should adopt a more flexible approach but instead seem to less tolerant than service providers with more standard client groups and end up being more severe with those who need more help.

The refugee and asylum groups described distressing and negative experiences with both reception and medical staff at GP practices. Participants described being misunderstood by staff and thus excluded, turned away or denied appointments. Participants described feeling like they had been spoken to in a derogatory way, treated like they were a nuisance and on one occasion escorted from the premises due to natural mannerisms and a loud voice being misinterpreted as shouting. Examples were given of being taken off patient lists when asking for explanation or clarification.

5.5 Language and translation

All members of underrepresented and marginalised groups said one of the key factors for them in accessing care was access to translation services.

Participants who did not speak English as a first language described being treated 'differently' and not being explained their health condition or having access to translation services. Some participants described having to talk about personal health conditions in front of children or family members who had to translate for them. The Roma community said at times they have had to take children out of school to provide translations for day time appointments. Workers from third sector organisations said they were reluctant to provide translation support at medical appointments in case they didn't understand or explain something appropriately and someone's health suffered as a result.

Roma groups emphasised the importance of having a translator at every appointment. They also expressed the importance of having an interpreter who is competent, has knowledge of UK medical systems, and can explain conditions, treatment and decisions. An important factor was an appropriate translator who can behave professionally. Staff present at the session recounted examples of occasions (including Hillside Bridge) when a translator was provided but displayed what they considered to be unprofessional and racist attitudes towards the Roma patient. This was understood as having come from historical relationships

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between white Slovak speaking people and the Roma community. Roma participants generally had concerns about the impact of these relationships on the quality of translation and also whether it means they are seen in a more negative light by the healthcare professional concerned.

Roma participants were concerned that health issues would become more severe and require more treatment because of late diagnosis as a result of the difficulty in accessing services. There was anecdotal evidence given of the numbers of women from the community having mastectomies to treat breast cancer because women are not accessing routine screenings because of poor communication, access or language barriers. The Roma community also said they would travel to access healthcare with good translation services; that to them, good service was a higher priority than location.

5.6 Access – proximity and transport

Location and accessibility of service are key factors for homeless service users, and drug and alcohol service users. Many have no access to a phone or money to use a phone box so need a service they can just arrive at. Due to health conditions, many are unable to walk distances longer in duration of 5-10 minutes so need a service at a central location. They are also unable to cover the cost of transport to or from a service and see calling an ambulance as a way to get to a service 'for free'. A member of staff gave an example of a client needing to visit hospital due a bad leg and when she offered him a lift he refused assuring her he'd call an ambulance as it is free. Many described difficulty in getting home from A&E, although some mentioned the journey back from A&E being 'downhill back to town' and therefore much easier. Asylum seekers and refugees also reported difficulties in both distance to travel and cost of transport to access walk in center and A+E.

The chaotic nature of people's lives when they are homeless or vulnerably housed also means that accessing GPs or health provision for ongoing health problems can prove a challenge and patients can fall out of the system, for example when waiting for referrals to consultants or between different departments.

TGP services were seen as 'closer but not helpful'.

5.7 Access – contact and making appointments

Participants mostly described experiences of getting in contact with the 'correct' service and making appointments with GPs as challenging. The appointment system was seen as 'very difficult' and 'a chance game'. Telephone access was limited for the homeless, refugee and asylum seeker groups and frustrating and distressing examples were given of attempts made to make appointments – both over the phone and in person.

The homeless groups had not used NHS 111 and only one person mentioned using NHS Direct but was unable to give a number to be called back on and hence went to A&E.

The refugee groups stated an ideal preference for accessing a local service such as GP, They felt that the GP could get to know them whereas they would usually see a different doctor each time at Hillside Bridge or A&E. However, issues around making appointments and dignity and respect led to current avoidance of this service and increased use of A&E. Participants from the refugee community felt that A&E was easier to fit around work and commitments, particularly where they had shift work or used day care support facilities during the day.

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The mental health service user was aware of NHS Direct but had never used them; he was not aware of GP out of hour's services. On further discussion, both he and the staff member present felt that this service would not be ideal if a person was suffering from poor mental health and was in need of health care, but then had to wait for a phone call from out-of-hours service, particularly during the night or when alone.

5.8 Access – opening and waiting times

All participants mentioned that waiting times for appointments at the walk-in centre and waiting times at A&E were very long. Most participants anticipated this and factored it into their decisions about which service to use. It was generally accepted that same-day appointments at GP surgeries were difficult to get and thus waiting to see if an emergency appointment or cancellation would be made available was the same as waiting for 4-5 hours at A&E.

The asylum seeker groups mentioned that the long A&E wait was a factor in their not seeking any medical advice. They would prefer to use a pharmacy but often didn't have the money to spend on pharmacy treatments.

The mental health service user talked about the difficulty with long waiting times and that it could exacerbate the situation.

Many participants said that if they were to use a service such as a walk-in centre for an urgent care need it would need to be open long hours. Many said ideally 24 hours or at least at those times when GP not available.

5.9 Health conditions – reasons for attending

Going through different scenarios, the different reasons for urgent care depended on the level of pain, perceived immediacy and whether the ill person was a child, whether or not registered with GP or dentist and relationship with GP if registered. None of Roma group were registered with a dentist, so all accessed A&E for dental related conditions. The time of day did not feature as a factor to consider for the groups.

Participants felt that they were the best judge of their symptoms, whereas reception staff would not take their symptoms seriously enough to offer same-day appointments. It was viewed that if further tests were needed then going to A&E meant that those tests could be done and time saved in the long run.

5.10 Treatment – perception of service

Bevan House, Kensington Practice, Woodroyd Centre, Piccadilly, Unity and the Bridge Project were services that people perceived as being good services. The features of these services that they described as good and appropriate were;

- Staff understood them and their circumstances and they felt they were treated with respect.
- The services were convenient to get to, their opening times and drop in clinics were in consultation with the users.
- Staff would take extra "moments" to explain services and their condition so users felt more involved, heard and in control.

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- At Kensington and Woodroyd, which are GP practices, the doctors took time out to visit local groups and used translators.

Participants perceived better services were available at A&E than at the walk-in centre or GP practices. With regard to these it was not always the treatment received once with a GP, more the perceived difficulty in getting to see a GP in first place. In some instances it was viewed that specialist and 'more professional' care would be accessed at A&E and GP services were viewed by a few people as an 'in-between' or alternative to getting 'real care'.

5.11 Treatment – received

Many participants from the homeless and the asylum seeker groups reported that they do nothing when they are ill and wait out their symptoms to reduce or to get 'bad enough' to go to A&E. Some participants described self-medicating with drugs and/or alcohol and said their health condition was a major factor in their relapse to misusing substances. This related to a lack of knowledge of where they could go. In addition to this, the homeless group talked about services being for people who had a home address, while the asylum seeker group viewed health services as being for people who had 'papers', referring to GPs asking to see their passport before they were registered.

Participants felt that services received at A&E, pharmacies, Bevan House and GPs based at the Day Shelter were accurate, satisfactory and of good quality, with high levels of trust in the skill of the healthcare professionals. They felt that their condition was understood at these services and therefore they were given the right treatment.

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6. Alternatives to Hillside Bridge walk-in centre

6. Alternatives to Hillside Bridge walk-in centre

This chapter explores patients' awareness and perceptions of health services other than Hillside Bridge walk-in centre. It also discusses the alternative services that patients reported they would use in the event that the Hillside Bridge walk-in centre had not been available.

Hillside Bridge walk-in centre patients reported having used a wide variety of health services over the past 12 months. However, it appears that walk-in centre patients may have a different pattern of service usage compared with the population more generally, given high reported levels of use of A&E and lower use of GPs.

Despite the high reported level of attendance at A&E, in general, patients tended to display reluctance to attend A&E. Some said they would be unlikely to visit A&E for anything other than a genuine accident or emergency. Other patients said that they would have been persuaded to do so if they had been unable to get an appointment with their GP and unable to access another service where they could speak to a clinician face-to-face.

Almost all patients were registered with a GP and, with the exception of securing appointments, they were generally satisfied with the service that the GP provided. There were, however, seen to be barriers to securing a GP appointment.

Awareness of NHS 111 seemed relatively high amongst patients however, patients who had used NHS 111 in the past tended to be slightly ambivalent about the service they were provided with.

GP out-of-hours services emerged as the service of which patients were least aware and some patients were unsure of what the service was intended for or whether it was available from their GP practice.

Patients' opinions about pharmacists were mixed. Some were very positive and reported routinely using a pharmacy as a first point of call to seek advice or medication before attending another health service. Others, however, were unwilling to visit a pharmacist for anything other than straightforward complaints such as a cough or cold.

A key finding emerging from the depth interviews is that, had Hillside Bridge walk-in centre been unavailable on the day of their visit, patients say they would have found it difficult to find an appropriate alternative. The two main alternatives patients felt there were to the walk-in centre were either to visit A&E or to wait until an appointment is available with the GP. Although many patients said they would be willing to wait until they were able to see their GP in theory, they also said that that if their condition was to deteriorate, they would go straight

6.1 Awareness and perceptions of other health services

As shown in the following chart, Hillside Bridge walk-in centre patients reported having used a wide variety of health services over the past 12 months. Although this indicates that patients have a high awareness of the health services that are available to them, a closer look at the data suggests that they may not be using the most appropriate health services for their condition.

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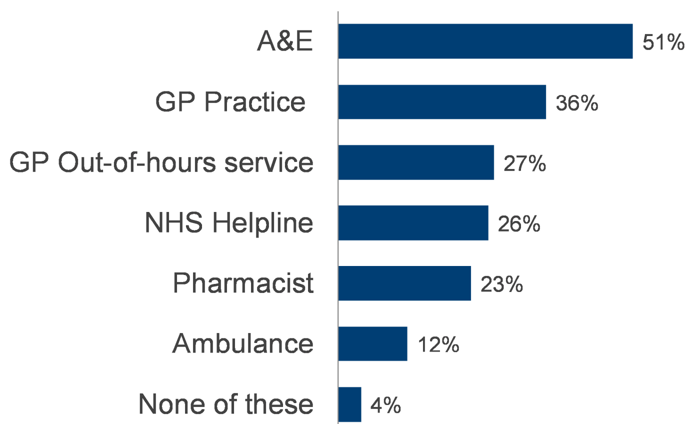
For example, half of respondents (51%) reported using an A&E department in the past 12 months. This makes A&E by far the most commonly used service; patients are significantly more likely to have used A&E in the past 12 months than, a GP practice (36%), the second most commonly used service.

GP out-of-hours services, NHS helplines and pharmacists have each been used by about one in four patients over the past 12 months (27%, 26% and 23% respectively). As these services offer healthcare for more routine health problems, it would be expected that the more patients will have used these services than A&E.

Respondents had used a wide variety of health services in the past twelve months

Which of the following health services have you used within the past twelve months?



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This suggests that patients using the walk-in centre may have a different pattern of service usage compared with the population more generally: we typically find nationally that four in five have visited a GP in the previous 12 months and one in four have visited A&E. The second strand of the research will need to compare this profile with usage across Bradford. At present, it suggests that these patients use services differently, potentially because of the difficulties they recount accessing their GP, or because they judge the urgency of their condition differently.

The reminder of this chapter will discuss awareness and perceptions of health services among Hillside Bridge walk-in centre patients as found in the discovery visits.

A&E

Awareness of A&E is nearly universal among patients. Most patients in the discovery visit interviews had used an A&E service in the past and knew what to expect from it. Despite the high level of attendance, in general, patients tended to display a high level of reluctance to attend A&E: it certainly wasn't their first choice service for most health problems. The degree of this reluctance however, and the reasons behind it, varied between patients.

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For some patients, A&E departments were seen to have a very different remit compared to primary care services such as walk-in centres, GP practices or the NHS helpline. These patients would be unlikely to visit A&E for anything other than a genuine accident or emergency, regardless of whether they had been able to access another health service, as they would feel they were using the service inappropriately.

> *"Well the only other thing I could think of was A&E, and I didn't think that was appropriate, so I'd have to be very, very poorly or on the verge of my deathbed, to want to go to A&E."*
>
> Weekend patient

> *"A&E is for proper emergency care. Like if you are going to drop dead or something; if they can't breathe or have respiratory problems."*
>
> Weekend patient

Other patients, although unwilling to use A&E for anything less than an emergency, said that they would have been persuaded to do so if they had been unable to get an appointment with their GP and unable to access another service where they could speak to a clinician face-to-face. This tended to be governed by an emotional response and was frequently the case when a parent was worried about the health of their child.

> *"A&E is the last resort. I don't like going there but when you've got a kid…it's a waste of time but you don't have a choice."*
>
> Weekend patient

Finally, there was a group of patients whose main concern with attending A&E was the inconvenience it would cause for them. This was both because of the long waiting times and also the possibility that they would not be seen at all should their health problem not be deemed serious enough.

> *"If I was to go a hospital I'd have to wait between two to four hours again, and there's no guarantee I'd be seen because they'd probably think it's not that serious."*
>
> Weekend patient

GP practice

Almost all patients were registered with a GP and, with the exception of securing appointments, they were generally satisfied with the service that the GP provided. The vast majority of walk-in centre patients said that, if possible, they would have ideally visited a GP instead of the walk-in centre. The reasons for this were two-fold; patients were both aware that the most appropriate service to seek health care from was the GP and, in some cases, they would have felt more comfortable seeking advice from a clinician who was known to them and had access to their records, rather than at the walk-in centre.

> *"I'd rather go to my own GP, this isn't even convenient, you know coming to see a GP here and you don't know who he is. So you can't even discuss things properly with them. You don't know the guy, you know what I mean, I'd rather go and see my own GP that I've been seeing for the last 20 odd years and you can open up to them."*
>
> Weekend patient

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> *"I usually prefer going to my GP. Because they've got all my records and everything, and I'm used to going there."*

Weekend patient

There were, however, seen to be barriers to securing a GP appointment; whether because there were no same-day appointments available at the patient's own GP practice, or because the patient was seeking care over the weekend and did not feel they could wait until Monday to seek health advice (often being unaware of the GP out-of-hours service).

NHS 111

Awareness of NHS 111 seemed relatively high among patients. Many patients reported having used the service in the past and those who had not used the service usually said that they were nonetheless aware of it.

Patients who had used NHS 111 in the past tended to be slightly ambivalent about the service they were provided with. Although many reported being very satisfied with the final outcome of the contact they had with the service, they were dissatisfied with the process they had to go through to get to that final outcome.

For example, some patients were uncomfortable answering a large number of questions over the phone to someone who they felt was not suitably qualified.

> *"They seemed to just be ticking boxes and boxes and boxes, just to get you to one answer at the end of it. So it wasn't really personal, you just go here, and after answering loads of questions, to actually talk about what you've got wrong with you, and a lot of the information that they were giving was quite generic."*

Weekday patient

> *"They're really good but they do ask a lot of questions and ask if you have this problem or that problem and whether you're in pain elsewhere, I find it really hard to give that straightforward answer."*

Weekend patient

A number of patients had also found that the process was sometimes drawn out and convoluted; taking far longer than it would have taken them to wait for an appointment at the walk-in centre.

> *"They said a GP is going to ring back at 8 o'clock. I waited until 8 o'clock; I didn't get a call back. So I rang again and they said they're going to find out and ring me back. And they didn't ring me back. I had to ring back again. And then, but it was like 11 o'clock by the time I got a GP call back."*

Weekend patient

Aside from the lengthy process that some patients experienced when calling NHS 111, patients were sometimes deterred from using the service because they preferred to speak to a clinician face-to-face.

> *"It was semi-useful. It was alright. Obviously you feel more reassured by actually seeing somebody and speaking to somebody about it. I know you talk to them and it's over the phone but I would prefer to see somebody in person."*

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Weekday patient

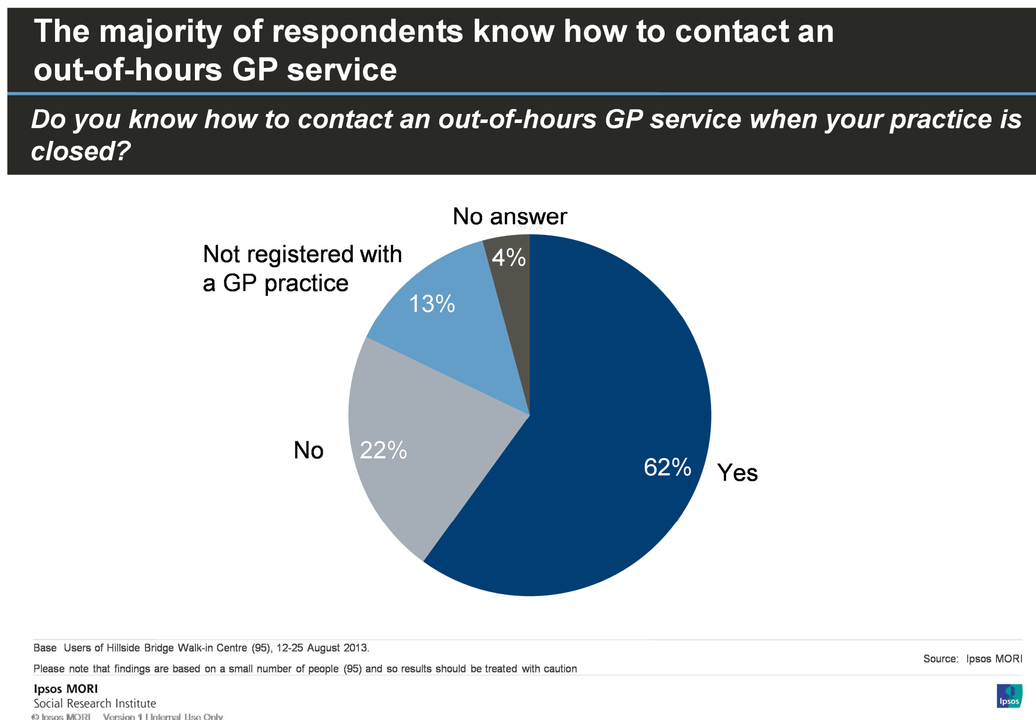
There was also a small minority of patients who viewed the NHS 111 service as akin to dialling 999; only to be used for accident or emergency situations.

> *"For me like dialling 999 or 111 - it's for when you suspect serious. I would just go to a GP really."*

Weekday patient

GP out-of-hours

As shown in the chart below , three in five respondents said that they knew how to contact an out-of-hours GP service when their practice was closed (61%).



However, from the depth interviews, GP out-of-hours services emerged as the service of which patients were least aware. Very few patients mentioned GP out-of-hours services spontaneously and, when prompted, some patients were unsure of what the service was intended for or whether it was available from their GP practice.

> *"I don't have much experience calling out-of-hours. I'm not sure whether the GP we are registered with offers out-of-hours – I have no experience of that. I suppose the walk-in clinic is similar to out-of-hours. That's what I thought."*

Weekend patient

There was a feeling among some patients that the GP out-of-hours service was to be used in emergency situations only, more urgent than those cases in which they would use Hillside Bridge.

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"We didn't ring the GP out-of-hours service because I don't like to use that unless it's a real emergency."

Weekend patient

Reflecting the confusion which seems to surround out-of-hours services, one patient did not draw a distinction between GP out-of-hours services and the walk-in centre – she saw them as interchangeable.

"The walk-in centre's a sort of out-of-hours GP really, so if it's past closing time for the GP surgery, then it's somewhere that we can come to for a limited time, I think they're open 'til 8 o'clock."

Weekday patient

Pharmacist

Patients' opinions about pharmacists were mixed. Some were very positive and reported routinely using a pharmacy as a first point of call to seek advice or medication before attending another health service.

"I went to the pharmacy just to see if I could get something over the counter, rather than come down here. Because then you know if you need to come to the doctors, don't you?"

Weekend patient

"You try the pharmacy before you make an appointment with your doctors. You don't want to be going to the doctors because you pick up a million other things."

Weekend patient

In line with this view, many patients said that they had visited a pharmacy prior to visiting the walk-in centre and, in some cases, it was the pharmacist who had referred the patient to the walk-in centre.

"It wasn't helpful because they weren't able to give us anything, but it was helpful because he told us about this centre. So that was a positive."

Weekend patient

"So today I came to the chemist and the pharmacist said that Bonjela is for teething pain and not for ulcers so they couldn't give me it. They told me to see the nurse here so they can give me something. It was good for me, she gave me information about the walk-in centre and I am satisfied to come here."

Weekend patient

Other patients, however, were unwilling to visit a pharmacist for anything other than straightforward complaints such as a cough or cold. These patients did not view pharmacists as a source of advice but saw them primarily as a source of medication. As such, without seeing a doctor first to get a prescription, they viewed the power of pharmacists as severely limited.

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“I’d go to the pharmacy if I’ve got a sore throat or stuff like that, a cough. That’s the only stuff they can give you, can’t they, pharmacies?”

Weekend patient

“A doctor is a doctor. A pharmacist is a pharmacist.”

Weekend patient

“They do know what they're talking about - it's wrong for me to say they don't. But obviously they can't give you the antibiotics or something like that.”

Weekend patient

“I only refer to the pharmacist if I've got a prescription from the GP, so it's literally to go and collect something. Today was the first time I walked in and asked for their advice. So it's literally you know, just a collection point.”

Weekend patient

6.2 Alternative services to Hillside Bridge walk-in centre

A key finding emerging from the depth interviews is that, had Hillside Bridge walk-in centre been unavailable on the day of their visit, patients would have found it difficult to find an appropriate alternative.

As shown in the chart below, the majority of patients (61%) said that, had the walk-in centre been unavailable on the day of their visit, they would have gone to A&E instead. Around one in five (19%) said that they would have called an NHS helpline while fewer than one in ten (seven per cent) would have waited to get an appointment with their GP. Only six per cent said that they would not have contacted another health service.

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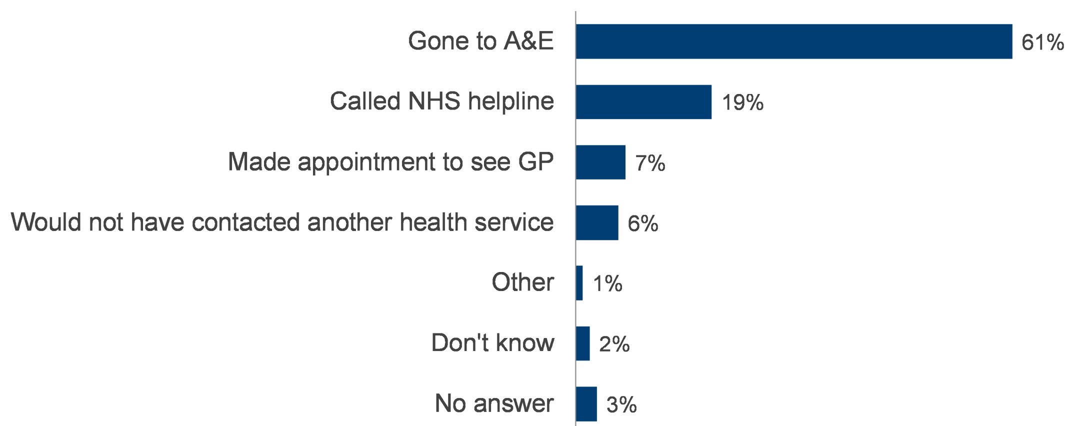
The majority of respondents say they would have gone to A&E if the walk-in centre had been unavailable

What do you think you would have done today if the walk-in centre was not open?



Base Users of Hillside Bridge Walk-in Centre (95), 12-25 August 2013.

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The depth interviews with patients painted a similar picture. Many patients we spoke to in the interviews said they would not have waited for a GP appointment had Hillside Bridge walk-in centre been unavailable or considered using any other service; they would have gone straight to A&E.

> *“I would have ended up taking him to A&E because, from past experience, it just escalates and then he has such a bad time.”*
>
> Weekend patient

> *“I would have thought that I would have no alternative but to go to A&E; and I know it’s very unpopular to do so, but I didn’t want to wake up dead!”*
>
> Weekend patient

It is interesting to note that almost all patients who said that they would have visited A&E did so with a degree of remorse. They often mentioned that they were aware that using A&E in their situation was inappropriate but that they could see no other alternative. As has been mentioned previously, this was particularly the case for parents who, being unwilling to take any risks with their children’s health, were more likely to resort to A&E in spite of their reservations about using it.

From the depth interviews, it seems that more patients than the survey data indicates would have waited until they were able to get a GP appointment. It is worth noting that we were able to challenge participants on this in the interview, whereas when completing the survey it is easier for patients to say they would do this when, in reality, they may not do so. Many patients said that, had the walk-in centre been unavailable, this would have been their course

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of action. Many patients, particularly those who would not consider using A&E for anything other than a genuine accident or emergency, saw no other alternative to this.

> *"I would have just waited until I could go back to the doctor and try telling them I need an appointment; not that I want one, I need one."*
>
> Weekend patient

> *"I think I would have waited till tomorrow, because with my surgery, before 8 o'clock, you might get an appointment."*
>
> Weekday patient

However, many of those who said they would have waited until they could see their GP qualified it by saying that, if their health situation was to deteriorate, they would go to A&E.

> *"If the condition is stable and they were able to wait for my GP, then I would have to wait for two days, wait Saturday and Sunday and see the GP. If the condition is getting worse then I'm afraid I would have to go to hospital."*
>
> Weekday patient

> *"Well there are two things; I'd either have gone to accident and emergency if it was really hurting or just grin and bear it until I could get somewhere."*
>
> Weekend patient

Given the large number of patients who say that they are unable to get an appointment to see their GP on the same day, it seems likely that some of the patients who had the intention of waiting for an appointment with their GP would therefore have ended up attending A&E.

A relatively small number of patients said that they would call NHS 111. This tended to be seen as an alternative, though relatively inconvenient, route to getting an appointment with a GP.

> *"I'd have probably rang 111, you know, the NHS… try and get an appointment there, somewhere. It'd be difficult, because with having four children as well, you've got to wait for them to ring you back and then you've got to wait longer for an appointment as well, so it's a bit harder, so it's easier for me."*
>
> Weekday patient

> *"Well, if I couldn't have found a place today I was going to ring NHS Direct. A lady gave me the number at a chemist in Skipton so I would ring them to try and fit me in at a GP."*
>
> Weekend patient

Considering the high awareness of the NHS 111 service among patients and the high proportion who have used it in the last year (26%), few said they would use the service as an alternative to the walk-in centre. Among those who have used the service, satisfaction with the outcomes tend to be high. It is regarding the process of using the service where patients are less positive. It could therefore be suggested that the reluctance to use this service is because patients need the reassurance which is gained by speaking to a health professional face-to-face rather than by telephone.

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There were no mentions of using a GP out-of hours service as an alternative to the walk-in centre. As discussed earlier in this chapter, GP out-of-hours services are the service which patients were least aware of and patients are often unsure of what the service was intended for and whether it is available from their GP practice.

In summary, the two main alternatives to the walk-in centre, as perceived by patients are to visit A&E or to wait until an appointment is available with the GP. Although many patients said that, in theory, they would be willing to wait until they were able to see their GP, they also said that if their condition was to deteriorate, they would go straight to A&E.

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7. Implications

7. Implications

Having described the findings from the research, this chapter draws out the implications for Hillside Bridge walk-in centre and for urgent care more broadly.

7.1 Hillside Bridge walk-in centre patients

Overall, the patients interviewed at Hillside Bridge walk-in centre were very satisfied with the service they received. The walk-in centre appears to provide a valuable service for this cohort of patients, which raises a number of questions:

- From these patients' perspectives, what service will replace Hillside Bridge when they are unable to get an appointment with their GP, or if they believe they have an urgent care need out-of-hours?
- Related to this, if patients are using the walk-in centre essentially as a convenient replacement for their GP, should an alternative service be provided, or should these patients simply try to make a GP appointment?
- Can changes be made to the appointment systems at GP practices to address some of patients' concerns and enable them to get an appointment more easily?

If the walk-in centre function at Hillside Bridge is closed, it is unclear from the current research how many people that would affect, which will be explored further in the second phase of the research. However, the research does show that many are using the walk-in centre multiple times and these patients' needs will need to be considered.

Of the one in three patients who had only visited the walk-in centre once, these patients tended to locate the service through signposting from another health service such as a pharmacy or NHS 111. For similar patients, closing Hillside Bridge walk-in centre would therefore have minimal impact as these health services can signpost to replacement services instead. The CCGs should certainly work closely with NHS 111 and pharmacies to direct patients to the most appropriate services.

Careful thought would need to be given to the nature of replacement services. Around three in five patients indicated that, had the walk-in centre not been available, they would have gone to A&E instead (61%). Of course, there is a difference between saying this and actually visiting A&E, and so it seems reasonable to suggest that fewer than 61% will have actually done so.

This reliance on A&E as an alternative service is partly a result of low awareness of alternative out-of-hours services. With awareness of GP out-of-hours services relatively low, regardless of the outcome for Hillside Bridge, it appears that raising awareness of this service could benefit patients, so they have an option they can access where they do perceive that they have an urgent care need out-of-hours. If Hillside Bridge walk-in centre was to close, some patients who have indicated that they would have used A&E rather than the walk-in centre would access GP out-of-hours services instead if they are aware of this service.

However, this would need to be undertaken carefully: many patients who use Hillside Bridge walk-in centre do so largely for convenience, particularly because of difficulties or perceived difficulties make appointments with their GPs. A GP out-of-hours service needs to be seen as a service for urgent care needs only. To assist with this, one option would be to have a

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triage service, with patients reassured that an urgent appointment isn't needed where that is the case. There is some distrust of NHS 111 at present, but it seems patients would be more open to such advice if they were talking directly to a clinician.

This then raises the question of how people make judgements about how urgent their health need is and whether they are seeking urgent care when it is not needed. While three in four patients from the survey felt their condition needed urgent care, in the discovery visits many patients said they could have waited for a GP appointment if the alternative was A&E. The convenience of the walk-in centre combined with the urgent care need led people to the walk-in centre when they could potentially have waited instead. This suggests that their judgement or definition of urgent care is different to the CCGs' definition. If Hillside Bridge walk-in centre is closed, how will these patients be catered for? Educating people better about self-diagnosis and self-medication would help people to make these judgements, but is clearly a large task. Some form of triaging may assist with assessing whether these patients do have an urgent care need.

7.2 Urgent care services for underrepresented and marginalised groups

Usage research has demonstrated that those using Hillside Bridge walk-in centre tend to already be registered with a GP. Underrepresented and marginalised groups who are less likely to be registered with a GP, and one of the initial key audiences for the walk-in centre, appear to be using it less.

The research demonstrates that use and awareness of Hillside Bridge walk-in centre among underrepresented and marginalised groups is fairly low. Those who have used the centre, in contrast to the patients interviewed during the discovery visits, tended to be dissatisfied with the service. Others who had heard of the service from others but not used it personally had heard similar reports from family and friends.

This suggests that Hillside Bridge walk-in centre is not the most effective urgent care service for underrepresented and marginalised groups and that this service could be better provided elsewhere. Participants did report satisfaction with A&E, pharmacies and other services such as Bevan House, Kensington Practice, Woodroyd Centre, Piccadilly, Unity and the Bridge Project. Exploring their reasons for satisfaction enables us to identify the most important features of an urgent care service for underrepresented and marginalised groups if providing an urgent care service for them elsewhere:

- Being treated with respect and dignity: participants reported being treated disrespectfully across a number of health services at times. If services can be more targeted to specific groups using a similar model to Bevan House, this will allow staff to build up an understanding of culture and the issues facing patients, enabling them to provide a service that patients find sympathetic and therefore more comfortable using. Ideally, this would also provide some continuity in the healthcare professional the patient sees.

- Have access to good translation services: this emerged as an issue causing some heard to reach groups difficulties, particularly the Roma community, and restricting their access to health services. The research suggests that a review of how these services operate may be valuable.

- Local access: some underrepresented and marginalised groups find travel to services costly and difficult, suggesting that more local services will be easier for them to

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access (if it is possible to provide them). If more local services are not available, it is worth considering whether there are other possible solutions.

- Appointment system: some people in underrepresented and marginalised groups find it difficult to make appointments with health services. This is sometimes related to cost, sometimes to fitting it around their other commitments such as work, or at times to more chaotic lifestyles (for example, for homeless people or substance users) which make it difficult to make and keep appointments. A walk-in service may therefore be suitable for some groups – although there will be inevitable concerns about waiting times.

Many participants from the homeless and the asylum seekers groups reported that they do nothing when they are ill and wait out their symptoms to reduce or to get 'bad enough' to go to A&E. This will be explored further in the second strand of the research, but provision of a service that meets the above requirements may encourage them to access services more frequently.

Additional implications emerging from the research are:

- Signposting of services: this was a major factor affecting underrepresented and marginalised groups' decisions about where to access health services. This included signposting by third sector organisations, support services (day centres and services), pharmacies, friends, family and community members.

  This means there is scope for CCGs to work with third sector organisations, support services and pharmacies to help direct members of underrepresented and marginalised groups to the most appropriate service for them. This could help to raise awareness of some services not currently so well used, for example the GP out-of-hours service.

- Dental services: none of the Roma group were registered with a dentist and so accessed urgent care services for dental care. The CCGs could work with Roma groups and the third sector organisations supporting them to improve access to dental care.

In summary, local services staffed by people with a good understanding of the culture and issues facing patients from specific groups will begin to build trust in those organisations. Third sector organisations, support services and pharmacies can all assist with signposting people to those services.

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8. Appendices

8. Appendices

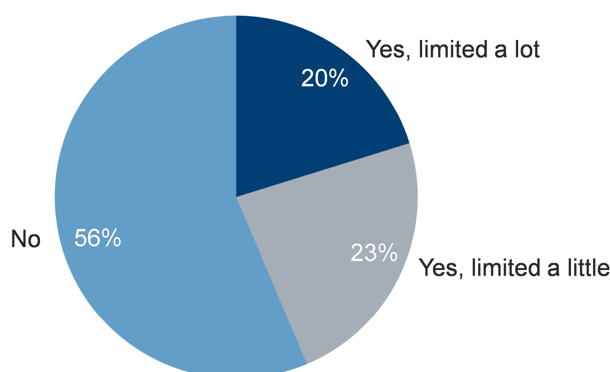
8.1 Demographics

This section briefly outlines the profile of those who completed the survey questionnaire.

The majority of respondents did not have an existing health problem or disability that limited their day-to-day activities (56%).

The majority of respondents did not have a long-term health condition

Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?



Base Users of Hillside Bridge Walk-in Centre (95), 12-25 August 2013.
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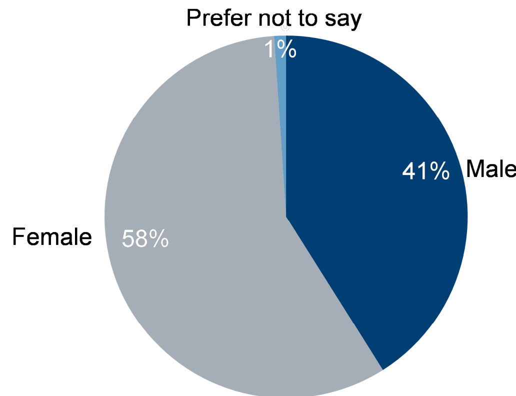
Looking at demographic information, more women than men appear to visit the walk-in centre (58% vs. 41%), whilst, indicatively speaking, a greater proportion of 25-34 year olds attended than other age groups (25% of respondents were in this age bracket).

More women than men visited the walk-in centre

Are you . . .?



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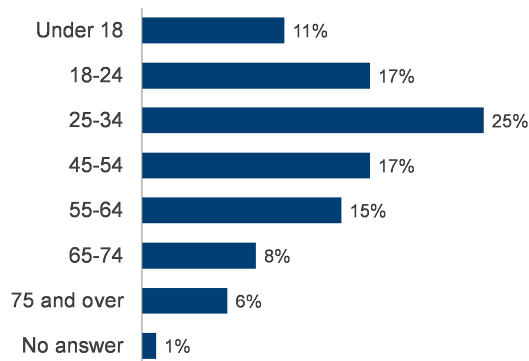
A high proportion of 25-34 year olds visited the walk-in centre

How old are you?



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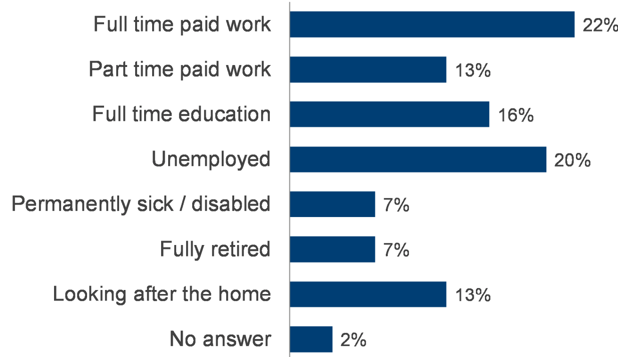
There appears to be a spread of people with different working statuses attending the walk-in centre.

Respondents have a variety of different working statuses

Which of the following best describes what you are doing at present?



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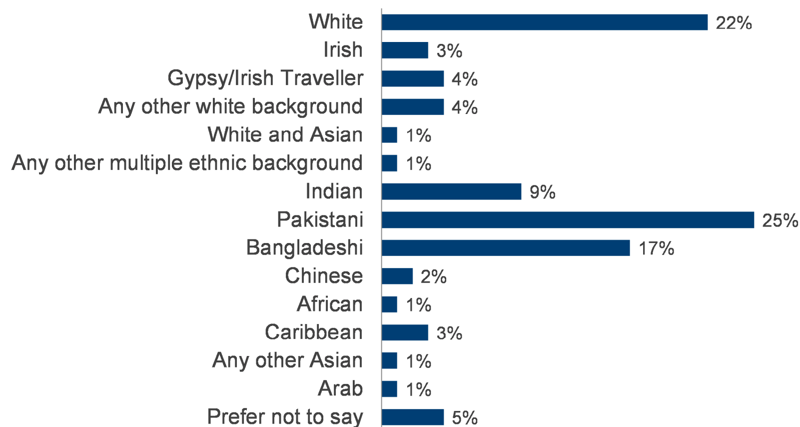
Additionally, there is diversity in terms of the ethnic backgrounds of patients returning questionnaires, with Pakistani (25%), White (22%) and Bangladeshi (17%) people most commonly responding

Respondents have diverse ethnic backgrounds

What is your ethnic group?



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Report of Airedale, Wharfedale and Craven CCG to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 9 February 2017

AA

Subject:

ACCESS TO PRIMARY MEDICAL (GP) SERVICES IN AIREDALE, WHARFEDALE AND CRAVEN.

Summary statement:

This paper is intended to provide the Health and Social Care Overview and Scrutiny Committee with an updated position relating to access to primary medical services in Airedale, Wharfedale and Craven. It builds on the report received by the committee in February 2016.

As advised previously in 2016 NHS England (NHSE) is responsible for commissioning primary medical care within Airedale, Wharfedale and Craven and is responsible for the quality of the services they commission. However, the CCG has a responsibility to support NHSE to discharge its duty to secure continuous improvement in the quality of primary medical care service which includes improving access.

In 2016 the CCG has applied for full delegated responsibility for the management of primary care medical functions that are currently carried out by NHS England (NHSE) from April 2017. The application is being considered by NHSE and the CCG is working closely with the NHSE West Yorkshire Area Team to put the appropriate agreements in place for the delegation of functions in preparation for April 2017.

The CCG continues to work with patients and stakeholders to improve the quality of all services they commission and to progress development and commissioning of New Models of Care, to improve people's experience of care, including access to professionals such as general practitioners.

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E-mail:
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Portfolio:

Health and Wellbeing

1. Summary

1.1 NHS England (NHSE) is currently responsible for commissioning general medical care. However it is anticipated that from April 2017 this responsibility will be devolved to the CCG. There are three level of involvement in co-commissioning primary medical care:

Level 1 Greater involvement
Level 2 Partial delegated responsibility
Level 3 Fully delegated responsibility

1.2 Airedale, Wharfedale and Craven CCG are currently 'level 1' and so are responsible for greater involvement in commissioning primary medical care services with NHS England. However the CCG has applied for 'level 3' involvement from April 2017. NHSE West Yorkshire Area Team Co Commissioning Scrutiny Group agreed on 4th January 2017 to formally recommend that the application from AWC for fully delegated responsibility be accepted. The NHS England Commissioning Committee will consider those recommendations at its meeting on 8th February 2017. Final Public Approval of Delegation to CCGs will take place at the NHS England Board meeting at the end of March 2017.

1.3 In view of this, ultimate responsibility for the quality of general medical care including GP access for the past 12 months has remained with NHS England. However, the CCG has responsibility to support NHS England (NHSE) to discharge its duty to secure continuous improvement in the quality of primary medical services and the CCG is also working closely with the West Yorkshire Area Team in preparation for delegated functions from April 2017.

1.4 The CCG considers a range of information when reviewing peoples experience of primary medical care, this includes the quality monitoring system for general practice which NHS England operate and share with CCGs, the national patient experience survey and local intelligence gathered through a range of feedback mechanisms.

1.5 Primary care remains under significant and growing pressure. Demand for consultations continues to increase, recruitment and retention of the workforce is fragile. Funding is reducing, particularly for practices which have a personal medical services contract (as NHS England continues with their approach to reduce funding for this type of contract). This is a national issue and is not confined to local services. Impact assessment also indicates that the proposed local authority budgets reductions are expected to impact on health services and so the whole health and social care infrastructure is under pressure.

1.6 The CCG has continued to develop new models of care; this involves a new more proactive tailored approach to care and so is intended to have a positive impact on peoples experience and access to care.

1.7 Going forwards the implementation of new models of care will continue as part of AWC journey towards a single place based accountable system of care for its population. Our aim is to establish a system of care in which provider organisations collaborate to manage the common pool of limited resources available and work together as one system to improve health and care for the whole population.

1.8 An Accountable Care programme has been established to deliver this vision. The programme has joint governance structure with representatives from all parts of the system and improving peoples experience and access to care will be integral part of the design and implementation of 'Accountable Care Airedale'.

1.9 This paper briefs the Health and Social Care Overview and Scrutiny Committee on the issues and challenges the system faces which impact on access to primary medical care, the CCG's approach in supporting quality improvement and provides a summary of initiatives in place to improve patient access to services.

2. Background

2.1 AWC CCG vision and strategic objectives

Whilst improving primary care access is not a separate objective for AWC CCG it is implicit in the new models of care being commissioned and in the overall CCG vision. The vision of the CCG is to commission 'proactive, co-ordinated person centred care'. Strategic objectives are to commission models of care that will address physical, psychological and social needs to:

- Reduce reliance on reactive emergency and urgent care through more planned and proactive model of services
- Change the mind-set of professionals to promote active participation in health and wellbeing of the individual
- Change the mind-set of the public so they become an active participant in their health and care
- Deliver the pledges as set out in the NHS constitution

The CCG Principles are:

- No one in hospital unless their care cannot be delivered safely in the community 24/7
- No one discharged to long term care without the opportunity for a period of enablement
- 24/7 access to and delivery of co-ordinated care, which is needs driven and not about age, condition or location
- AWC CCG is a national 'Pioneer' site and so is at the forefront of developing and implementing new models of care.

3. Report issues

3.1 GP and Primary Care Workforce:

The GP Forward View published in April 2016 highlights the workforce pressures facing general practice and outlines plans to sustain and transform general practice. Much of the detail regarding how to access the support outlined in GP forward view is still being worked through and the CCG continues to work closely with NHS E and our member practices to review and develop the quality of primary care services which includes GP access in line with the GP Forward View and to progress new models of care.

The CCG has developed our plan outlining how we will deliver the GP Forward View. This has been submitted to NHS E and work is continuing to develop detail further and establish robust action plans to support delivery. The plan has been developed in conjunction with our member practices and we will continue to engage with them to refine and enhance our plans further.

The workforce issues highlighted in the previous report to the committee continue although some progress has been made by way of workforce development planning.

Attracting new entrants at sufficient numbers is recognised as a nation issue. This is impacting upon practices ability to recruit and retain GPs and other clinical staff, even where investment in new staff is possible. The GP workforce isn't keeping pace with the growth in medical consultants posts or population growth hence increasing pressure on existing GPs.

GP training schemes are not at capacity, 79% of places are filled. However for every new GP trained one, one retires or leaves, so in reality the status quo is maintained rather than any increase in GP's. GPs are a limited commodity and all providers are 'fishing in the same pond' and attempting to recruit or secure GP services in order to provide a range of services. For example, to replace retiring GPs, provide extended opening in practices, and to establish GP led urgent care centres and GP Out of Hours services.

The increase in workload and growing demand is contributing to low morale within the GP workforce and practice in general, this is influencing career changes, moving abroad, retirement, early retirement . For example, 20% of current GP workforce are over 55 and so eligible for retirement and a number of younger GPs are so demoralised they are considering emigration. This reduction in GP workforce combined with fewer trainees coming through and choosing general practice as a career is resulting in a 'ticking time bomb'. This drives the need to consider alternative approaches for supporting people, utilising skills and resources from a diverse workforce, working differently to reduce dependence on GPs alone.

The CCG is part of the West Yorkshire Accelerate Zone (WYAZ) for Extended Access. Extended Access is defined in the GP Forward View planning requirements as 8am -8pm Monday to Friday and weekend provision to meet local population need. As an accelerator site we have the opportunity to access some additional support and test out what our model for extended access may look like, as part of phased approach to deliver the requirements as laid out in GP Forward view by 2019/20. This means that AWC will be delivering some extended access in 2017/18. This will undoubtedly impact further on some of the workforce issues highlighted above and we are currently working with our member practices to explore what extended access could look like in AWC.

3.2 GP Access and Patient Satisfaction within AWC
The full results of the national survey at a practice and CCG level are publically available on the internet through the GP Patient Survey website.

https://gp-patient.co.uk/surveys-and-reports

The GP survey is an England-wide survey, providing practice-level data about patients' experiences of their GP practices.

The GP patient survey measures patients' experiences across a range of topics, including:
- Overall experience
- Ease of getting through to the GP surgery on the phone
- Overall experience of making an appointment
- Booking appointments
- Waiting times to see or speak to a GP/Nurse
- Waiting times at the surgery
- Confidence and trust in the GP and nurse
- Practice opening hours
- Out of hours services

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
- Data is published annually during July.

However, given the consistency of the survey across organisations and over time, it can be used as one indicator of quality. It can also be considered alongside other sources of information such as feedback from patient participations groups, local surveys, contacts made via patient advice and liaison services (PALs), complaints and the friends and family test, to develop a fuller picture.

3.3 Assessment of the AWC CCG GP Patient Experience Survey published in July 2016:

The July 2016 publication is based on surveys completed between July to September 2015 and January to March 2016. This is the most recent publication available as the frequency of reporting has now changed to once a year. The next survey will be published in July 2017. The results for AWC CCG are based on 1,865 completed surveys, giving a response rate of 45%, higher than the national response rate of 39%.

Key areas are highlighted below:

Overall experience of GP surgery	85% of patients in AWC stated that their overall experience of the GP surgery was very good or fairly good. This is in line with the national figure which was also 85%. This is slightly down on last year's score of 87%. This trend is not unique to AWC CCG practices, assessment of other areas indicates a reduced level of satisfaction from patients overall. Looking at a practice level, the level of satisfaction ranges from 96% to 40%. There is one particular outlying practice within AWC CCG where just 40% of patients indicated good overall experience. The contract fort his practice has recently been re – procured and a longer term provider has now been secured. The new contract is supported by an outcomes based specification. An element of funding is associated with improving patients experience and further engagement work with the local community. This is intended to incentivise service improvement and increased satisfaction with care and access for this practices population.
Access to GP services (by phone)	68% of AWC patients stated that it was easy to get through to someone at the GP surgery on the phone. This is slightly below the nationally average of 70%. The practice range in this category is from 27% to 94%. Ten practices saw satisfaction levels above the 70% national average in this category. The CCG is working with 6 outlying practices to support improvement. N.B. The increased uptake of on-line booking of appointments is expected to help reduce the volume of calls practice experience and so make it easier for those who choose to make their appointment by phone to get through to the practice.
Booking appointments	The CCG is in line with the national score of 85% of people saying that the last time they wanted to see to speak to a GP or nurse they were able to get an appointment. 12% stated that they weren't able to get an appointment. The practice range within the CCG is 47% to 95%. With one exception all

	practices score above 65% in this category. The outlier is the practice mentioned previously and the new contract includes incentives to help improve performance in this area.
Overall experience of making an appointment	73% of patients rated their experience of making an appointment as good. This proportion had risen slightly from 71% last year, and is in line with the national figure. The practice range within the CCG is 25% to 93%, with the practice with the lowest rating the one that has seen issues across other categories.
Waiting times to see or speak to a GP/Nurse	57% of AWC patients stated that they saw or spoke to a GP/Nurse either on the same day or on the next working day. 14% stated that they had to wait for a wait for a week or longer. This compares favourably with the national figures where 48% were seen/spoken to on the same or next working day. This figure has also increased from 54% in July 2015.
Impression of Waiting times at the GP surgery	59% of AWC stated that they felt they didn't have to wait too long at the GP surgery for their appointment. This was in line with the national figure of 58%. The practice range within the CCG is from 18% to 84%. The outlier is the practice mentioned previously and the new contract includes incentives to help improve performance in this area.
Confidence and trust in the GP	92% said yes that they had confidence and trust in the GP they saw or spoke to at their last appointment, a figure which was the same nationally. The practice range within the CCG is from 65% to 100%. Again the lowest scoring practice was the one that has scored lowest in previous categories.
Confidence and trust in the nurse	86% said yes that they had confidence and trust in the nurse they saw or spoke to, a figure which compares well to the national average of 84%. The practice range within the CCG is from 70% to 96%. Again the lowest scoring practice was the one that has scored lowest in previous categories.
Satisfaction with the practice's opening hours	74% of AWC patients said they were satisfied with the hours the surgery is open, a proportion that is slightly below the national average of 76%. The practice range within the CCG is from 55% to 86%. The practice with the lowest satisfaction level is again the same practice to have seen the lower scores across other categories.
Out of Hours GP services	61% of patients said their overall experience of out of hours GP services was good. This is below the national average of 67%, and has also fallen from the 67% reported last year. This service is commissioned on a West Yorkshire footprint with services delivered at both Airedale Hospital (co-located with A&E) and Skipton General Hospital.

3.4 Local Intelligence

In addition to the NHS E quality monitoring system, the CCG also assesses intelligence gathered through a variety of mechanisms such as feedback from patients and carers, Patient Advice and Liaison Service (PALS), Patient Network Groups, Patient Participation groups, complaints and Healthwatch. Along with other data sources such as engagement with local forums and CQC feedback this intelligence is regularly collated and shared with practices as primary care dashboard. This dashboard is also shared with the CCG Clinical Quality and Governance Committee who are responsible for identifying appropriate actions to ensure feedback is acted upon. The dashboard has been and will continue to be developed in conjunction with our member practices.

3.5 System Wide Pressures

There are increasing pressures on not just GP practices but the health and social care system as a whole which also impacts on GP access:

- A&E
- GP Out of Hours
- Intermediate Care
- Social care
- Care Homes
- Local Authority budget reductions

A&E attendances from AWC patients are up 3.8% across all providers when comparing the period April to November 2016 with the period April to November 2015. At Airedale only, A&E attendances have increased by 2.5% when comparing the same period. This has resulted in increased pressures, with Year To Date (YTD) only 91.4% of all patients attending A&E being seen within 4 hours with the national target set at 95.0%. At the same time last year the figure stood at 95.9%. This compares to a national increase of 3.7% between the period April to November 2016 and period April to November 2015 (MAR data – England).

The number of GP OOH appointments has reduced over the last year. Between April to November 2015 there were 12,399 appointments, compared to 12,184 between April to November 2016, this is a reduction of 1.7%. This decrease is encouraging as one of the core aims of the CCGs Enhanced Care schemes is to reduce the number of OOH appointments.

Further pressures are evident across the secondary care and social care setting, with non-elective (specific acute) admissions across all providers up 2.5% when comparing April to November 2016 with April to November 2015 though the national increase for non-elective admissions when comparing April to November 2016 to April 2015 was 3.6% (MAR data – England). However, the numbers of patients in North Yorkshire with a Delayed Transfer of Care almost doubled from 433 (Nov 14 to Oct 15) to 792 (Nov 15 to Oct 16).

Running alongside funding constraints and levels of historic investment in primary care, these issues increase pressure and the ability of practices to meet growing demand. In recognition of this the CCG has instigated several initiatives to support improvement.

3.6 Patient Need and New Models of Care

As reported previously to the committee there is a limit to the number of people a practice can see each day. GPs have a duty to ensure suitable care is provided determined by need and they make necessary arrangements to ensure urgent cases are attended to in a timely fashion. This does not always meet patients' definition of need and so expectations are not always met.

The range of initiatives reported last year are underway, all of which will directly or indirectly support improved access to GPs or access to alternative support for individuals as appropriate, determined by their needs.

- Complex Care
- Enhanced Primary Care
- Pharmacy First
- Health Navigators
- Increased self-management and prevention
- Urgent Care Centre (Additional Primary Care capacity collocated with A&E at times of increased demand Friday – Monday)

- Primary Care Quality Improvement initiatives and participation in NHSE improvement network
- Extended Practice Opening

3.7 AWC Approach to developing New Models of Care

3.7.1 Complex Care:
For individual with more complex needs new models of care have been commissioned. These will ensure that individuals holistic needs are taken into account. Needs assessment will take account of individuals physical, psychological and social care needs and a tailored pro-active plan of care will be put in place to provide a pro-active approach, thereby reducing the need for urgent care or escalation of need. This will free up more GP time for those with less complex needs as the complex care team respond to individuals on their case load.

The new model of care for people with complex needs includes a personal support navigator (PSN) function. This has been jointly commissioned and funded by health and social care. CBMDC have led on the development of this role commissioning a VCS consortium to deliver this new approach. The PSN function is intended to 'bridge the gap' between health and social care systems and individuals, enabling individuals to engage with personalised planning and feel supported to self-manage, self-care and achieve their personal objectives. The PSN will provide an advocacy service and act as a first point of contact for individuals thereby changing current behaviours and ideally reducing demand on GP time and other services through an alternative approach.

Following a successful proof of concept phase this model of care for individuals with more complex needs has now been commissioned on a longer term basis. Work continues to refine and embed the service further and is supported by robust evaluation processes including patient feedback that will continue to assess the impact of the service and to support delivery of improved outcomes for individuals.

3.7.2 Enhanced Care:
In addition the CCG has commissioned a new approach to care for those with additional needs who have not yet become complex. This is called enhanced care. This too provides a pro-active approach to care and is intended to prevent needs escalating. It provides additional resource and capacity to support general practices thereby contributing to improved access to practices and professionals within the practice. Under this scheme practices are given the opportunity to come together to design their own schemes to deliver improved outcomes for individuals. This approach is intended to test new approaches thereby promoting an innovative culture and transformational change. Going forwards it is anticipated that work will continue to dovetail the complex and enhanced models of care and increase collaborative working across the patient population to tailor care around patients as their needs change.

3.7.3 Self-Care and Prevention:
A programme of work is being undertaken to support uptake of self-care and self-management. This includes training for health professionals and tools, techniques, access to resources, advice and support to enable individuals to take control and manage their own condition.

3.7.4 Working with an Enhanced Skill Mix
Through initiatives undertaken practices are testing how working with different professionals and individual can enhance the patient experience and improve access. The personal support navigator has been mentioned in section2.8.1 however the range of professional extends to working more closely with community pharmacists,

physiotherapists, physician associates, social workers, nurses with advanced skills as part of the integrated practice team.

A closer working relationship with the voluntary sector has resulted in an increased awareness of voluntary and community services (VCS) available to support individuals and an increased level of 'signposting' to these services. We are working closely with the VCS 'hub' to monitor the impact on local services.

4. Next Steps

4.1 Strategic Objectives.

Airedale, Wharfedale and Craven's strategic objective to commission models of care that will address physical, psychological and social needs will deliver new models of care. Through developing new models of care practices are encouraged to work at a 'Federation' level to fully exploit and realise the opportunities economies of scale present.

4.2 Accountable Care System:

As a system the CCG is leading on establishing an accountable system of care for our patient population to ensure that when people need access to care and support it will be available to them through proactive, joined up health, social care and well-being service. Primary Care are critical to this work, as the first point of contact for many individuals and are viewed as the 'lynchpin' of care and will form the foundation of an accountable system of care. As our journey towards an accountable care system continues this will involve engagement activities to seek the views of individuals, their families and carer's, and access to care will be a critical component of this.

4.3 Co-Commissioning:

The CCG expects to undertake level 3 co-commissioning from 1 April 2017. The CCG is currently in the process of putting arrangements in place to take on fully delegated functions. With this the responsibility for primary care experience and access to services will be devolved to the CCG.

4.4 Outlying Practice:

Within the CCG there is one practice that is an outlier. The experiences their patients report 'skew' the overall CCG results due to the significant variation in experience being reported when compared with other practices. In light of this the CCG has been working closely with NHSE England and following a recent re-procurement exercise a longer term provider has now been secured. A robust specification for the new services has been developed which clearly addresses the nature of the practice population and the challenge of improving experience. A range of outcomes linked to these areas have been included in the new specification, regular contract monitoring arrangements are in place and the CCG continues to work closely with the new provider to ensure these areas are being addressed.

4.5 Transformation Funding:

The CCG is exploring every opportunity to secure additional external funding to support transformation and development of primary care services. This includes support and submission of a range of expressions of interest for the NHS E GP Resilience Fund and a bid to national Pioneer programme for PSN role in enhanced care. As part of West Yorkshire Accelerate Zone (WYAZ) for Extended Access we have secured additional financial support to progress extended access over the next year and have submitted a further application against the accelerator hub capital bid.

5. Recommendations

The Health and Social Care Overview and Scrutiny Committee is asked to receive and note this update.

6. Background Document

None

7. Appendices

None

City of Bradford MDC
www.bradford.gov.uk

Report of NHS Bradford City CCG and NHS Bradford Districts CCG to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 9 February 2017

AB

Subject: ACCESS TO PRIMARY MEDICAL SERVICES IN BRADFORD:

Summary statement:

NHS Bradford City CCG and NHS Bradford Districts CCG continue to work with patients and stakeholders to improve the quality of all services they commission and to fulfil their statutory duty to improve the quality of primary medical care.

This paper also describes initiatives that our primary care providers are undertaking to improve access, including how they are engaging patients in the process.

The paper also describes the challenges in maintaining sustainability of the service in the face of the nationally mandated funding review, increasing demand and workforce challenges.

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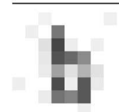
Health & Wellbeing



1. Summary

1.1 This paper describes initiatives that our primary care providers are undertaking to improve access, including how they are engaging patients in the process.

1.2 The paper also describes the challenges in maintaining sustainability of the service in the face of the nationally mandated funding review, increasing demand and workforce challenges.

2. Background

2.1 The CCG reported last year that they were undertaking a financial review of all primary medical service contracts. The review was completed and the CCGs implemented funding changes from April 2016. For some practices this will mean a reduction of funding and this will be a phased reduction over a period of 5 years.

2.2 Recognising that the traditional model of general practice is unlikely to be sufficient to deliver its objectives, NHS England is supporting the development of new ways of providing and commissioning services. In taking this forward the CCGs developed a 5 year primary medical care commissioning strategy, this has been widely consulted on with partners and stakeholders.

2.3 One of the key priorities within the strategy is to improve access to primary medical services, including our intention to commission extended hours provision. It also includes a requirement to improve the offer of digital access and improve access to technologies that promote self-care and prevention. The strategy will also encourage delivery of primary care at scale and deliver high quality primary medical services.

2.4 The contract requires practices to provide essential services within core hours (8am to 6.30pm Monday to Friday). GP practices are required to deliver services within this period but there are no clearly defined standards. It is regarded that this should be something that the provider defines, ensuring that they meet the needs of the patients. In support of this the CCGs in Bradford have issued a “Position Statement on Opening Hours”, so that practices are aware of the requirements under the contract.

2.5 GPs and practices continue to be under unprecedented pressure, with an increasing number of practices struggling to maintain existing services in the face of financial pressures, falling staff numbers and rising demand. It continues to be hard to retain GPs and increased numbers are retiring early, there is also an increase in GPs wanting to work part-time. Practices in Bradford are therefore reliant on a GP locum workforce.

2.6 In measuring patient’s satisfaction with GP opening the CCGs are required to use the GP National Survey. This is a real challenge in Bradford as we have poor response rates.

3 Report Issues

Key elements

3.1 Improving Access

3.11 The funding review has meant that contracts are of more equal value and have resulted in a redistribution of existing funding across primary medical care. One of the aims of the review has enabled the CCGs to commission practices to undertake a more formal assessment of how they offer access to patients.

We asked practices to work with their Practice Participation Group (PPG) in agreeing an access plan. In year one the CCGs wanted to see that practices were engaged with the process and were actively using their PPG as a conduit to seek the views the people they serve and influence how services are delivered.

Some examples of the kinds of activity practices included within their plans were:

- newsletters to improve communication with patients
- reducing DNAs (did not attends), as this can waste appointments
- improvements to telephone systems to help patients get through more easily
- implementing a triage system so those patients needing an appointment can get one and others can be supported to self-care or access other support where required
- promotion of self-care to patients, via events, notice boards and printed material so they feel more confident to look after themselves for minor ailments, which may not require an appointment with a clinician
- coaching patients on how to register for online services, to make and cancel appointments
- encouraging more patients to provide feedback via the national survey, the Friends and Family Test, or via practices' own satisfaction surveys
- working with schools and community groups – working with young people to gain their views and get them more engaged with the practice, supporting them to lead healthier lives
- first aid training and peer support for new parents
- referring patients in to social prescribing initiatives which may provide other sources of support not always found at the practice – e.g. advice on benefits and financial matters, self-care, leading healthier lives, exercise, emotional support, support for carers, support groups for people with long term conditions, reducing loneliness.

The most recent results of the national GP patient survey data (Jan to March 2016, published in July 2016) indicate that patients who gave a positive answer to the question: *"Overall, how would you describe your experience of making an appointment?"* responded as follows:

England average	73%
Bradford City average	56%
Tower Hamlets (comparator CCG to City)	*65%*
Bradford Districts average	64%
North Kirklees (comparator CCG to Districts)	*68%*

This represents most recent published data. The CCGs await a further report in January for the period July to September. In comparing the above results with the previous year there has not been any reduction or increase in satisfaction.

It however should be noted that there was a slight increase in the response rates.

Bradford City Response Rate	14.6% (2015)	20.4% (2016)
Tower Hamlets		*23%*
Bradford Districts Response Rate	26% (2015)	36.1% (2016)
North Kirklees		*37%*

The CCGs in 2017 will commission extended access for people that reside in Bradford. This will be on a phased basis with full population coverage by 2020. The CCGs are working with general practice on how this would be delivered. The intention is to offer additional access from 6.30pm to 8pm, Monday to Friday. There will be weekend cover but the hours are subject to our understanding the needs of patients. The model of delivery is required to support our primary medical care commissioning strategy and will be required to be delivered within a financial envelope.

3.2 Working at scale

Our primary medical care commissioning strategy supports practices working at scale and as a result we are therefore beginning to see practices working more closely, in order to share resources. As the CCGs have delegated commissioning rights and completed the equitable funding review we are able to give practices contract advice, we are therefore seeing an increase in networks of practices, practice mergers and federated working.

The CCGs have applied for funding issued to NHS England under the GP Resilience Scheme. The intention is that this funding would provide practices with organisation development opportunities, legal advice and funding to merge clinical systems. There is also an opportunity to look at how practices may employ staff that would work across a number of sites.

3.3 New Models and Workforce

The CCGs know that different model of improving access to patients within primary care would suit a particular practice population and that, through creative review of skill mix and perhaps wider utilisation of the voluntary and community sector, unwarranted demand on the clinicians within the practice could be reduced. The CCGs are therefore facilitating groups of practices to share their learning from this exercise.

The CCGs have throughout the year incentivised and therefore tested some incentives that would reduce inappropriate demand on clinicians:

- Social Prescribing - We have a number of practices that are piloting social prescribing. This is a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. ‘co-produce’ their ‘social prescription’. The aim is that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector (VCS).

- Practice Health Champions – We have a number of practices that are creating a ‘community centred practice’ through volunteering and patient involvement.

- Pharmacy First – This is a scheme where patients that would normally access their GP for free prescriptions for minor ailments are able to access a community pharmacist. The scheme is being accessed by an average of 1010 patients per month (Bradford City) and 588 patients per month (Bradford Districts) in 2016. It is important to note that not all practices patients are accessing this service, the 10 ten highest practices generate 81% (Bradford City) and 68% (Bradford Districts) of the activity. The CCG has reviewed the scheme and as the activity shows 75% of those accessing the service are children. The CCG has therefore amended the scheme from January 2017 to include children only. There will be a further review of the scheme, this will ensure that it is in line with the CCGs strategy to develop self-care and prevention initiatives.

- Physio First – scheme where patients can self-refer to a physiotherapist, these schemes are currently being evaluated

- Clinical Pharmacists – there are new roles emerging in primary care, one role is the clinical pharmacist. There is a national pilot and in Bradford we were successful in accessing funds and resources to support this.

- Training – there will be training in place for front line staff within primary care to sign-post people to appropriate voluntary and community sector services.

4. **Next steps**

4.1 Bradford City CCG and Bradford Districts CCG will continue to develop the *"Standard access offer to patients"* ensuring that Patient Participation Groups are engaged in this process and enable practices to share learning.

4.2 The CCGs will commission an extended access offer this will commence in Bradford in 2017. This will include a plan to phase in to full population coverage by 2020.

4.3 The CCGs will continue to work with general practice to support them in providing high quality provision that is sustainable, testing new roles and initiatives that will improve access for patients.

5. **Contribution to corporate priorities**

6.1 Contributes to the CCGs priorities of:

- Improving patient experience
- Out of hospital care
- Use of assets

6. Recommendations

The Health and Social Care Overview and Scrutiny Committee is asked to:

6.1 Receive and note the Clinical Commissioning Groups' commitment and actions taken to improve access to appropriate primary medical services.

6.2 Receive and note initiatives within Bradford that are being developed that will impact the primary medical service offer to Bradford residents.

7. **Appendices**

7.1 Bradford CCGs position statement on opening hours

NHS Bradford City and NHS Bradford Districts CCG's position statement with regard General Practice opening hours

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1. Background:

The former Bradford and Airedale PCT issued a position statement for practices in relation to the practice opening times. As a result of the Bradford CCG's taking on full delegated rights for commissioning primary medical services the CCG's would like to reiterate this existing position statement.

The aim is to ensure that we have consistently of access applied to all practices (with the exception of extended access service at Hillside Bridge where the core opening hours are 2.00pm to 8.00pm 365 days a year)

The original position statement was presented to YORLMC for consideration at the NHS BA/YORLMC liaison meeting held 19 May 2010. At that meeting it was resolved that YORLMC considered NHS BA's Position Statement relating to practice opening hours to be acceptable.

2. Definition of Core Hours:

In the GMS, PMS and APMS contracts used within Bradford Districts and Bradford City CCG's "core hours" means the period beginning at 8.00am and ending at 6.30pm on any day from Monday to Friday except Good Friday, Christmas Day or bank holidays.

3. Provision of services within core hours:

By issuing this position statement the CCG's are not introducing new or changing any existing contractual requirements, the GMS, PMS and APMS contracts already make clear that:

The Contractor must provide essential and additional services at such times, within core hours, as are appropriate to meet the reasonable needs of its patients, and to have in place arrangements for its patients to access such services throughout the core hours in case of emergency.

4. Local agreements:

Whilst the contracts require practices to have in place arrangements for its patients to access services throughout the core hours in case of emergency and to meet their reasonable needs, the core hours defined can be agreed individually with PMS practices and included in a separate schedule of the Agreement. This allows local negotiation and agreement of hours when the practice is allowed to be closed during core hours. Bradford Districts and Bradford City CCG's would normally only expect this to be applied for protected learning time or where as part of a local PMS negotiation a practices has extended their core opening hours.

5. Open reception:

The position of Bradford Districts and Bradford City CCG's is that **practices will ideally be open at all times** during core hours.

"Open reception" means that patients are able to come into the practice building and deal with a receptionist in person, for example to gain access to a clinician for urgent or emergency care or assessment, to pick up a prescription or make or cancel an appointment. It does not mean that a surgery or clinic has to be running at that time however; patients who present in person in need of emergency care should expect to be able to access appropriate care through self presentation.

6. Protected Learning Time (Referred to locally as "Practice Based Learning (PBL)" and "Protected Learning Time (PLT)":

In accordance with our CCG learning and development frameworks practices should currently close for a minimum of twenty hours per annum for protected learning time.

Ideally, even during PLT, a patient should be able to self present by attending reception to access care in an emergency situation. Relying on patients accessing care by telephone alone is not ideal. Not all patients have access to a phone and may therefore present at the practice in person. The position of Bradford Districts and Bradford City CCG's is that it is preferable for patients presenting in person not to be met by a locked door as this does not allow access to services in case of emergency.

However, we accept that there will be times when a practice wishes to include all staff in learning events and as such wish to close reception during PLT. In this instance practices are required to clearly advise patients how to access services during this time and consideration given to how a patient without a telephone will access care.

7. Access to a clinician:

The CCG's accept that there may be occasions when a GP or suitably qualified clinician is not on the premises, however practices are still responsible for patients during core hours even if there is no clinician present on the premises (thus practices are still required to have arrangements in place for patients to access services in case of emergency). We would therefore still expect clinical advice to be accessible, for example by telephone through the 'on call' GP. Using the earlier example of a person self presenting, the receptionist would be able to access the GP by phone on their behalf, hence meeting the practices contractual requirement in this regard.

8. Branch Surgeries:

The CCG's accept that some practices have branch surgeries which have shorter opening hours, and this is acceptable, as long as at least one of the practice's premises are open through the core hours.

9. Extended Hours

A number of practices in both CCG's offer extended hours through the Extended Hours Directed Enhanced Service (DES). The DES guidance states that:

Extended hours access must be provided on a regular basis in full each week including providing sickness and leave cover and should also ensure that its patients are aware of any cancellation of

extended hours sessions, which should normally be discussed and agreed with NHS England in advance, including any arrangements for re-provision.

As both Bradford City CCG and Bradford Districts CCG have delegated responsibility for primary medical care commissioning, any changes to the extended opening hours should be agreed with the relevant CCG. The guidance states that commissioners:

Are obliged to consider any proposals for the arrangements of extended hours access put forward by a practice in accordance with the time limits and exceptions detailed below. This consideration should not be delayed unreasonably nor should commissioner agreement to such proposals be unreasonably withheld. Consideration does not have to be given by commissioners, nor do decisions have to be made where:

a) the practice has not submitted a written proposal within 28 days of the commissioner offer to enter an arrangement under the DES directions or;
b) the practice has not provided any information requested by the commissioner in order to make a decision as to whether the proposal to enter into arrangements under the DES directions meets its requirements.

When a bank holiday, Christmas Day, Boxing Day, New Year's Day or Good Friday occurs on the day which the practice would normally offer extended hours, the practice may wish to request a move of these hours to another day within the period. This must be done in writing at least 28 days in advance of the proposed date to the respective CCG and a written decision from the CCG will be returned to the practice.

10. Sub contracting arrangements:

Whilst access to services during core hours remains a contractual responsibility for each contract holder we accept that for operational reasons some practices choose to make arrangements to sub contract provision at certain times. Commonly referred to as 'wrap around', this usually applies to periods such as 8.00am to 8.30am or 6.00pm to 6.30pm. In instances where contractors wish to make arrangements for care for their patients to be provided by an alternative provider our preference is that reception remains open. If the practice does close during this period we expect practices to be clear to patients about how they access services. Our judgement regarding whether patients are clear about how to access services will be made by considering reported patient experience, complaints and reports. This will influence any changes to future position statements.

11. In summary:

Bradford Districts and Bradford City CCG's expect practices to demonstrate compliance with their contractual requirements by having open receptions through which patients can access care during core hours 8.00am to 6.30pm. An exception will be made for closures during agreed PLT time and wrap around periods as long as practices clearly advise patients how they access care during this period.

12. For practice consideration:

Practices are encouraged to consider the implications of this position statement and take any relevant action, this may include:

- Dissemination of information; to ensure practice managers, GPs and relevant staff members are aware of the CCG's position with regard interpretation of primary care contracts in the context of core hours, opening hours and expectations regarding patient access

- Review opening hours; has the practice assessed their current provision and made any necessary adjustments to opening hours and staffing levels to ensure contractual requirements are met?

- Review of information on NHS Choices re opening hours; is it up to date and are patients aware of opening hours (including extended opening)

- Review of PLT; does the practice maintain a record of hours closed for PLT which would enable them to demonstrate, if asked, that this amounts to minimum of 20 hours per annum in line with CCG policy.

- Review of patient information. Are patients clear about how to access services if the practice reception is closed, for example during PLT or wrap around period

If a practice has any concerns regarding their ability to meet their contractual requirements with regard opening hours, or any other issue, they are encouraged to contact a member of the primary care team to discuss, and where appropriate, agree an action plan and timescale to address issues raised.

City of Bradford MDC
www.bradford.gov.uk

Report of the City Solicitor to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 9 February 2017

AC

Subject: Health and Social Care Overview and Scrutiny Committee Work Programme 2016/17

Summary statement:
This report presents the work programme 2016/17

Parveen Akhtar
City Solicitor

Portfolio:

Health & Wellbeing

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1. **Summary**

1.1 This report presents the work programme 2016/17.

2. **Background**

2.1 The Committee adopted its 2016/17 work programme at its meeting of 14 July 2016.

3. **Report issues**

3.1 **Appendix 1** of this report presents the work programme 2016/17. It lists issues and topics that have been identified for inclusion in the work programme and have been scheduled for consideration over the coming year**. Appendix 2** lists items for inclusion in the work programme that have not yet been scheduled.

4. **Options**

4.1 Members may wish to amend and / or comment on the work programme at **Appendix 1** and **2**.

5. **Contribution to corporate priorities**

5.1 The Health and Social Care Overview and Scrutiny Committee Work Programme 2016/17 reflects the ambition of the District Plan for ‘all of our population to be healthy, well and able to live independently for a long as possible’ (District Plan: Better health, better lives).

6. **Recommendations**

6.1 That the Committee notes the information in **Appendix 1** and **2**

7. **Background documents**

7.1 Constitution of the Council

8. **Not for publication documents**

None

9. **Appendices**

9.1 **Appendix 1** – Health and Social Care Overview and Scrutiny Committee work programme 2016/17

9.2 **Appendix 2** – Unscheduled items for inclusion in Committee’s work programme 2016/17

Democratic Services - Overview and Scrutiny

Appendix 1

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 2nd March 2017 at City Hall, Bradford. Chair's briefing 15/02/2017. Report deadline 17/02/2017.			
1) Accessible Information Standard	Details to be confirmed	Alec Porter	
2) Working Better Together 2: Mental Wellbeing in Bradford District and Craven: A Strategy	Strategy and initial action plans	Helen Hirst / Bev Maybury	
3) Community mental health services	Report to include information on pressures on the service and the outcomes of the review looking at recovery and early intervention.	Mark Trewin / Debra Gilderdale	Resolution of 4 Feb 2016
Thursday, 23rd March 2017 at City Hall, Bradford. Chair's briefing 08/03/2017. Report deadline 10/03/2017			
1) Care Quality Commission	12 month update on inspection activity in the District	Rachel Bowes	resolution of 3 March 2016
2) Respiratory Health in Bradford and Airedale	Report to cover the high level areas outlined in the 'Bradford Breathing Better' programme and to include an update on self care	Andrew O'Shaughnessy	resolution of 3 March 2016
3) Great Places to Grow Old programme	Update	Lyn Sowray	resolution of 3 March 2016
4) Update on the progress made by Airedale and partners enhanced health in care homes Vanguard	Update	Helen Bourner	resolution of 24 March 2016
Thursday, 6th April 2017 at City Hall, Bradford. Chair's briefing 22/03/2017. Report deadline 24/03/2017			
1) Outcome Of Consultation On The Proposed Change To Bradford Council's Contributions Policy For Non-Residential Services	Update including consideration of ways to improve consultation with vulnerable groups.	Bev Maybury (Bev Tyson)	resolution of 8 Sept 2016
2) Safeguarding Adults	Details to be confirmed	Bev Maybury	
3) Vision for the Department of Health and Wellbeing		Bev Maybury	resolution of 26 Jan 2017

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Democratic Services - Overview and Scrutiny
Scrutiny Committees Forward Plan
Unscheduled Items

Health and Social Care O&S Committee

	Agenda item	Item description	Author	Management comments
0	111 service / out of hours primary care	Update on performance and previous resolution around tagging of patient notes and promotion	Commissioners (Greater Huddersfield CCG)	
0	Independent Complaints Advocacy Team (ICAT) Bradford & District	Annual update	Andrea Beever	
0	Children's mental health	Sub committee to be convened to consider 'Help today's youth to help tomorrow's Bradford'	Contact: Heather Wilson	
0	Home B - Residential Care Home	Consultation to decommission Home B - Residential Care Home	Lyn Sowray	
0	Diabetes	Details to be confirmed	Public health / CCGs	
0	Domiciliary Care	See resolution of 21 Jan 2016	Bernard Lanigan	

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