



## Strategic Delivery Plan for Primary Care Engagement

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Stoke-on-Trent/North Staffordshire CCGs

Research & Insight

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## Contents

Executive Summary.....	2
Background .....	5
Plan & Methodology .....	5
Objectives.....	5
Methodology.....	6
Quality plan .....	10
Findings .....	11
Appointments .....	12
Access to additional services .....	17
Reasonable adjustments.....	18
Continuity.....	20
Locality and access.....	21
Patient records.....	25
Customer care.....	26
Patient centred care .....	27
Information, advice and guidance .....	28
Positive regard for general practitioners.....	29
Staffing resource .....	30
Extended hours .....	32
Change management.....	33
Relationship with secondary care.....	34
Conclusions .....	35
Recommendations .....	37
References .....	38
Appendices on following pages .....	38

## Executive Summary

Engaging Communities Staffordshire (ECS) is an independent, community interest company that delivers Healthwatch Staffordshire.

ECS is primarily concerned with engagement with the local community surrounding the provision of health and social care in Staffordshire, the wider West Midlands region and beyond. The company provides a subscription service for partner organisations. We develop practical recommendations to improve services and replicate good practice, based on robust evidence collected from the voice and experience of service users and staff.

Our reports are designed to be transparent, clear, and easily accessible that create sustainable improvements in the delivery of services.

On this occasion ECS/Healthwatch Staffordshire have been commissioned, with Healthwatch Stoke-on-Trent, by the CCGs in North Staffordshire and Stoke-on-Trent to carry out public engagement around their proposed Primary Care Strategy.

There were a range of engagement activities undertaken and these aimed to ensure that traditionally harder to reach members of the community were also given a voice. To that end there was a specific focus on going out to groups that represented the nine protected characteristics. Respondents to the engagement identified a number of areas that they felt could be improved and these developed into key themes for consideration in the implementation of the strategy.

A key theme for participants was in relation to accessing appointments at the GP and the length of time they had to wait for an appointment in particular. This was also an issue for dentistry but to a lesser degree. Access to some additional services was an issue for some participants with GPs being seen as a barrier in some circumstances, particularly in relation to mental health services. There was a view that there was an unwillingness to make such referrals. A more prevalent issue was having to be referred back to services that have been accessed in the past. It is suggested that there needs to be a reconsideration of access routes in such circumstances.

Participants with particular needs such as disability or language issues raised concerns about being able to access services on an equal footing. There were marked issues for some in being able to physically access services because of a lack of adjustments and others where a lack of interpreters means they cannot communicate effectively. It became clear during the engagement activities that there were different levels of service in different localities. This is recognised within the strategy and needs to be a key consideration. There needs to be a recognition when planning locality footprints of travel routes and availability of transport in order to access services. It is not enough to simply group geographically close localities together.

Participants held the belief that records should be shared between providers and this sharing would enable better joined up working from the point of view of the patient. The concept of having a care co-ordinator with the patient at the centre was welcomed. However, there were concerns about how this could be resourced to ensure that there is meaningful care planning.

GPs were viewed as a principal source of information, advice and guidance but that was not always forthcoming. The internet was also being used as a source of information and there may be scope to develop this further as a source of early intervention. However, there are also a large number of people who do not feel confident using the internet or do not have access and therefore they require the means to seek advice and support from medical professionals in a different way.

GPs were generally positively regarded by respondents but were recognised as being under pressure. There were concerns raised about the recruitment and retention of GPs in particular and how the strategy was to be delivered without more GPs and other medical professionals.

The concept of extended hours and seven day working was raised in relation to people who are working being able to access GP appointments at times were convenient for them. It was not an issue for any other primary care services but there were concerns about the availability of advice out of hours and the service provided through 111.

It was often difficult to differentiate between primary and secondary care in the feedback as they are viewed as being part of the same system. Therefore, it is welcomed that the strategy looks towards working more closely with secondary care and delivering some services in a

community setting. However, there have been instances where there has been poor information sharing between the two and this would need to be resolved to allow the strategy to work effectively.

The strategy was broadly welcomed but there were concerns about how the change was to be managed and how it would bring together different providers to work together effectively when other initiatives have failed in the past. It was also felt that there had been a lack of communication with the public prior to this point and there needed to be a continued public voice during the implementation of the Primary Care Strategic Delivery Plan.

## Background

Stoke-on-Trent and North Staffordshire CCGs have been working together to develop a strategic delivery plan for primary care. There are multiple challenges facing primary care at present, particularly around workforce issues in the North Staffordshire/Stoke-on-Trent areas. The CCGs are therefore committed to addressing these by developing a plan that tackles the key issues, works with practices, patients and wider stakeholder groups and is sustainable in the longer term.

The plan has now been developed in draft form and indeed has formed the basis for wider work across Staffordshire that is being fed into the pan-Staffordshire Transformation Programme, “Together We’re Better”. However, for the CCGs in the north of the county delay is not an option. Already other factors are influencing the development of health care provision in the north, including strategies to treat people closer to home (My Care, My Way - Home First), and the introduction of greater multi-disciplinary working. To this end, the CCGs are committed to engaging with the local population as soon as possible to gain their insights on the proposed plan.

The CCGs held discussions with the two Healthwatch bodies in the area - Healthwatch Stoke-on-Trent and Healthwatch Staffordshire. The two Healthwatch are committed to promoting, supporting and advising the engagement work and undertook this as part of their Healthwatch service. In addition, the CCGs commissioned the two Healthwatch organisations, to carry out the engagement work and provide an evaluation report.

## Plan & Methodology

### Objectives

Overall the objective of the engagement and research was to gain community feedback on the proposed plan, including insights from harder to reach seldom heard groups, as well as the general public. The intention is that the feedback that has been gained and is contained in this report will inform the further development of the plan and its implementation.

## Methodology

There were a series of public engagement events across the Stoke-on-Trent, Newcastle under Lyme and Staffordshire Moorlands areas. There were a total of six events that took place during February and March 2016.

Location of event	Date of event	Total number of attendees
<b>Burslem, Stoke-on-Trent</b>	2 February 2016	7
<b>Longton, Stoke-on-Trent</b>	10 February 2016	20
<b>Bentilee</b>	16 February 2016	17
<b>Newcastle-under-Lyme</b>	16 February 2016	26
<b>Biddulph</b>	23 February 2016	17
<b>Leek</b>	1 March 2016	28

A wide range of promotional and marketing activities were undertaken across Stoke-on-Trent and North Staffordshire including:

- Poster and flyer distribution
- e-poster distribution
- PPG/GP practice promotions
- CCG website and newsletters
- Library promotions
- Direct mailshots via both Healthwatch Stoke-on-Trent and Healthwatch Staffordshire membership databases and network contacts
- Social media campaigns on Facebook and Twitter
- Press release and coverage on BBC Radio Stoke
- Paid advertisement in The Sentinel
- Articles in both Healthwatch newsletters in printed and on-line versions
- News feature and promotion via both Healthwatch websites
- An on-line booking platform on both Healthwatch websites supported by their CRMs

The public events included interactive table discussions in order to gather feedback from participants. A dot democracy was also undertaken following the table discussions designed

to identify what themes were the most important to participants. The CCGs provided scenarios for the table discussions to work through and these are attached as Appendix 1.

The events format was included in advance and followed the format below:

15 min	Introduction to the day  Presentation: Introduction to the Strategy by Dr Emma Sutton detailing the starting point, context and direction of travel and inviting patient contribution to inform.	Healthwatch Staffordshire or Healthwatch Stoke-on-Trent  Dr Emma Sutton
20 mins	Questions from the public	
45 mins	Facilitated sessions with scenarios/archetypes provided to identify different types of patients with different needs.	Facilitators and audience workshops
20 mins	Facilitated session asking people to reflect on the needs of different people discussed in previous session and then apply themselves to answering the following questions about what is proposed: <ul style="list-style-type: none"> <li>• What does what is proposed feel like to you as a patient?</li> <li>• What is right about it?</li> <li>• What's missing or hasn't been thought through?</li> <li>• In the global scheme of things what is important to you?</li> </ul>	Facilitators and Audience
15 mins	Feedback with top 2 priorities from each table	Facilitators
5 mins	Thanks and next steps	Chair or Emma Sutton

In addition to the six public events there were a series of focus groups to reach a diverse range of service users and particularly those seldom heard and those from the nine protected characteristics. In addition to the formal focus group sessions, a series of drop in sessions was also undertaken across Stoke-on-Trent and North Staffordshire with the aim of gathering more feedback from hard to reach groups and communities.

Location	Date	Number attending	Type of engagement	Protected Characteristic
<b>Scope/Aiming Higher Together (Children)</b>	11 January 2016	11	Focus group	Disability/Age
<b>City Mosque (Males)</b>	22 January 2016	87	Engagement	Religion/Race/Gender
<b>Caudwell Children Charity</b>	27 January 2016	11	Engagement	Disability/Age
<b>Young at Heart group</b>	1 February 2016	45	Engagement	Age
<b>Voices-homeless/multiple conditions</b>	5 February 2016	5	Engagement	Age/Gender/Race/Religion
<b>Nash Dom- Eastern European</b>	11 February 2016	6	Drop-in	Race
<b>City Mosque (females)</b>	19 February 2016	50	Engagement	Religion/Race/Gender
<b>Staffordshire Buddies (LGBT)</b>	23 February 2016	22	Engagement	Sexual Orientation
<b>Transgender support group</b>	2 March 2016	8	Engagement	Gender Reassignment

Location	Date	Number attending	Type of engagement	Protected Characteristic
<b>Partnership Housing Customers</b>	22 January 2016	4	Focus group	Disability
<b>LD floating support customers</b>	27 January 2016	3	Focus group	Disability
<b>Biddulph Rethink</b>	1 February 2016	5	Focus group	Disability
<b>Penny Bank House</b>	3 February 2016	3	Drop in/surveys	Age/Gender/Disability
<b>Lyme Brook</b>	5 February 2016	1	Drop in/surveys	Age/Gender/Disability
<b>Children's centre, Staffordshire Moorlands</b>	9 March 2016	31	Drop in/surveys	Age/Pregnancy and Maternity
<b>Children's centre Newcastle under Lyme</b>	11 March 2016	50	Drop in/surveys	Age/Pregnancy and Maternity
<b>Headway North Staffs</b>	9 March 2016	6	Focus group	Disability
<b>Headway North Staffs</b>	18 March 2016	5	Focus group	Disability

To fit alongside the public events and focus groups ECS in collaboration with Healthwatch Stoke-on-Trent, developed and distributed a public survey both in paper format and via web links to an on-line survey, to support people who could not attend the public events in

giving their views and contributing to the thinking around primary care strategy development plan and delivery of services. In total there were 543 surveys completed.

Using both Healthwatch Staffordshire and Healthwatch Stoke on Trent networks, the surveys were distributed to a wide range of stakeholder organisations and support groups and particularly those who have a role in engaging and supporting hard to reach communities and those who are representative of the 9 Protected Characteristics and demography.

The survey can be found at Appendix 2

## Quality plan

ECS has a responsibility to ensure that the evidence and insight it creates is of high quality and aligned to best practice across the industry. Research ultimately provides the evidence on which sound decisions should be made, which is why it is important to state how quality was ensured during this project.

The Evidence & Insight Team underpins its research activities by applying the Market Research Society Codes of Conduct, which allows us to demonstrate that we are credible, fair and transparent. ECS is now a company partner and accredited by the Market Research Society.

ECS also adheres to a strict data protection policy to ensure that:

- Everyone handling and managing personal information internally understands they are responsible for good data protection practices
- There is someone with specific responsibility for data protection in the organisation
- Staff who handle personal information are appropriately supervised and trained
- Queries about handling personal information are promptly and courteously dealt with
- The methods of handling personal information are regularly assessed and evaluated
- Necessary steps are taken to ensure that personal data is kept secure at all times against unlawful loss or disclosure

ECS also have firm guidelines for data storage, data retrieval, data security and data destruction. There is also a strict process in place should a data breach occur (which includes containment and recovery, assessment of ongoing risk, notification of breach, evaluation and response).

To further ensure the quality of the final report, an internal peer review process is initiated to ensure that the report is fit for purpose before submission. Where data is not robust it is statistically suppressed to prevent disclosure.

## Findings

The public engagement events considered a number of scenarios provided by the CCGs but the participants were able to choose to tell of their own experiences and consider what would make the experience more positive under the new strategy. Many of the issues that have been raised are reflected in the themes that follow, however, it was felt that some of the patient stories were important to capture.

The first participant scenario concerned the care of a three year old boy with asthma. His parents manage their child's condition themselves but did not know about some of the services that they could access. They commented that when they see a doctor they prefer to see their own doctor but if this means that they have a long wait they will see anyone. However, when they have an urgent appointment the focus is on treating the symptoms rather than the underlying causes. It was felt that under the new strategy there was an opportunity for them to have more support and guidance to manage their son's condition. They felt that they would benefit from having access to information before they see a Doctor, fitting in with the aims of early intervention.

The second participant scenario was in relation to an individual who is deaf and had experienced an emergency admission. Following discharge they have had no follow up or support. He said of his situation:

*'Now it's just me and my wife, so how do we know what to do? I feel completely clueless.'*

They have no knowledge of assistive technologies that could help them, and they felt that when they were given information they needed to be given practical demonstrations and visual examples as leaflets did not have enough information. They raised the issue that not everyone uses IT and so there should not be a great reliance on it to convey information, advice and guidance. As a deaf individual he raised issues with communication and not being able to access an interpreter easily, sometimes having to rely on paper and pen to communicate in appointments. There were issues around confidentiality with information often being given to family member first to convey to him and this mean he felt that he was not treated equally.

*'I want to feel on an equal standing as others.'*

The third patient story demonstrated how people can find themselves being referred around the system because of a lack of knowledge both on the part of the patient and the professionals working within the health service. It was a relatively simple matter of a broken hearing aid but took a multitude of referrals. The participant went to their practice in Biddulph and was referred to Endon, from there they were referred to Kidsgrove. The participant raised issues around being able to travel to the appointments as transport links between Biddulph and Kidsgrove are not direct. The issues around being able to travel to appointments are raised within the themed analysis that follows. However, there needs to be consideration within the concepts of locality working of accessibility and transport links to services.

An interim report was submitted to the CCGs that identified work that had been undertaken to that point and the emerging themes from the engagement activity. As the engagement progressed those themes were developed and expanded on, with some themes such as language barriers becoming part of wider themes. (See Interim Report at Appendix 4)

## Key Themes

### Appointments

When asked how experiences of primary care could be improved the key suggestion of participants was in relation to being able to get an appointment. Participants were principally concerned with how long they had to wait for an appointment, particularly a

routine appointment. Some participants said that they regularly waited up to three weeks to see a GP.

*'You make an appointment, I've got three weeks wait.'*

*'It's normally two or three weeks.'*

Additionally, some said that they had also experienced long waiting times to see a practice nurse. Participants in a focus group in Biddulph reported that they had a lengthy wait to see a practice nurse.

*'It's a fortnight to see the nurse.'*

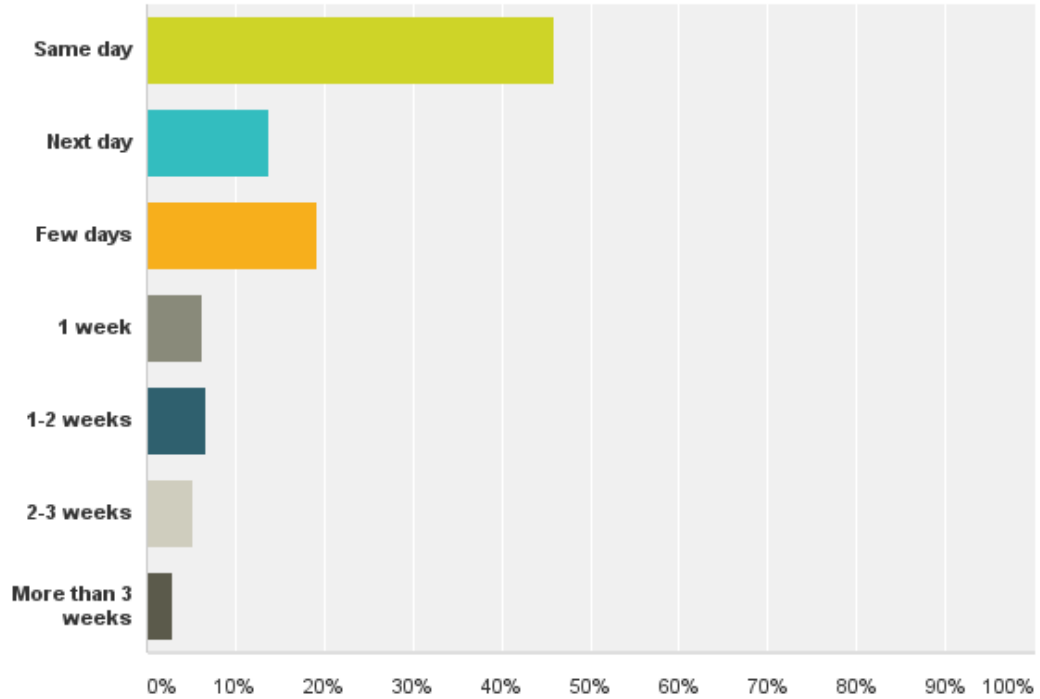
However, respondents to the survey were asked how long they had waited to see a GP the last time they had made an appointment. The percentage of people waiting for over three weeks was relatively small at just under 3% and 45.6% said that they had been seen the same day as they had called and asked for an appointment. This is reflective of findings from previous Healthwatch work in Stoke-on-Trent and Staffordshire<sup>1</sup> where there were higher numbers who were seen the same day than had waited for long periods of time for an appointment.

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<sup>1</sup> Healthwatch Shropshire; Healthwatch Staffordshire; Healthwatch Stoke-on-Trent; Healthwatch Telford and Wrekin. GP Access Study; 2015.

## Q2 When you last visited the GP how long did it take for you to get an appointment?

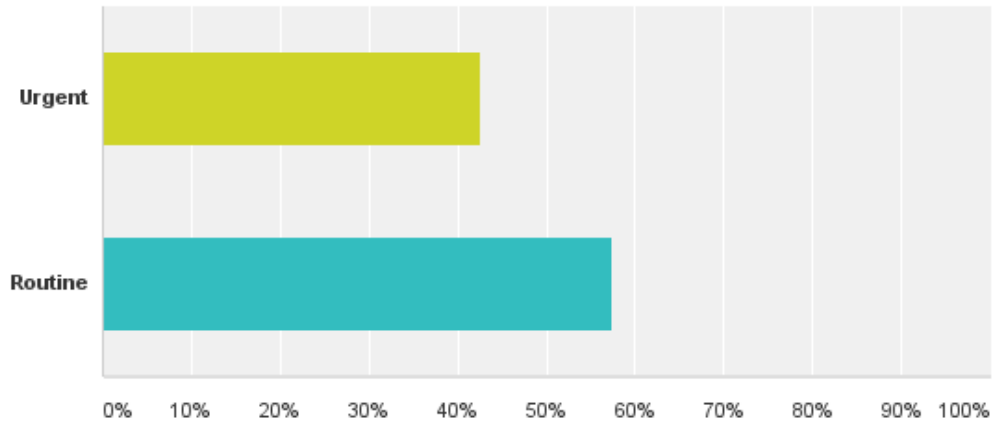
Answered: 519 Skipped: 6



They were also asked whether their appointment had been routine or an urgent appointment and there was a lower percentage of people considering their need for an appointment to be urgent than the percentage who were seen the same day.

### Q3 Was the issue urgent or was it a routine appointment?

Answered: 517 Skipped: 8



Survey respondents were asked what they considered to be a reasonable time to wait for a routine appointment. Whilst some said that they would want to be seen the same day or the next day, most did expect to have to wait for longer than they would for an urgent appointment. The acceptable length of time to wait varied widely between one week and three weeks, but the most frequent suggestion was a wait of no longer than a week.

For this survey respondent, they suggested that an improvement that could be made was around how soon they could get an appointment.

*'Having a routine appointment within a week rather than waiting for three weeks.'*

Although not specifically mentioned as an aim of the Primary Care Strategy, it is clear that for participants in this research, being able to get an appointment with a GP in what they consider to be a reasonable time period is a key priority.

In keeping with the finding that a higher percentage of people had been seen the same day than any other group on the survey, a number of participants commented on difficulties in being able to book advance appointments and needing to ring on the day of the appointment. Whilst this appointment system may be effective for many people,

participants referred to problems getting through on the telephone and not being able to get an appointment on the day that they needed it.

*'If you ring to book in the future you're always told you need to ring on the day you want the appointment. The problem is that at 8am every morning the phones are jammed and if you wait until later all the appointments go too soon.'*

*'Be able to book appointments which are requested by the doctor as a repeat (e.g. if the doctor says he needs to see you in two weeks, be able to make an appointment). At the moment they say they can't make an appointment in advance and you need to ring on the day.'*

It was suggested by some people that being able to book a routine appointment in advance would be an improvement to the service that they received. This would also potentially ease some of the pressure on the telephone systems that came in for a large amount of criticism. Although all practices are supposed to be providing on-line access it is difficult to see how a same day appointment system can work with an on-line booking system.

Research participants also commented on the need for some appointments to be longer than the 10 minutes employed by most practices. 56.94% of respondents to the survey had a long term condition and for those who are managing more than one long term condition it is often the case that a 10 minute appointment does not give them an opportunity to discuss their issues. There was also variation between the length of time participants thought an appointment was and this varied between practices. Urgent appointments are often shorter than routine appointments and this may account for the discrepancy.

*'Longer time, 10 minutes may not be enough for some cases.'*

*'Ten minutes isn't always enough time to talk to my GP about my health issues. They only operate on ten minute appointments and there is a sign on the reception that you can only talk to the doctor about one issue. My health condition is such that many things overlap into different areas of my body.'*

*'Variable length appointments - bespoke to patient issues. Often have multiple problems but just an eight minute appointment.'*

Being able to give longer appointments would enable a more holistic approach to treating patients. Although this facility is available it is not always communicated to patients and so people are not accessing double appointments when they have more complex issues. It was observed that at the Midway in Newcastle-under-Lyme patients are made aware of appointment lengths and that they can book a double appointment should they feel it is necessary.

As there was an awareness amongst some respondents of the pressures that practices are under there were suggestions of alternative appointment types that could be employed including telephone consultations or in some cases on-line consultations via Skype. When asked what would make access easier survey respondents suggested alternatives.

*'Telephone consultations and on-line consultations.'*

*'Skype appointments.'*

Whilst there were a limited number of people suggesting these options it does mean that there is some appetite for alternative methods of consultation. It would also mean that for those who are simply seeking advice or guidance on managing their health they would not need to go into the surgery. It is accepted that these methods are not suitable for all appointment types and that they do still take up appointment time. However, telephone consultations, in particular, can be quicker to undertake than a face to face appointment.

#### Access to additional services

GPs were seen as being a route to accessing other services and sometimes this was not as effective as it might be. Survey respondents were asked about delays in being referred to other services and the impact that delays have had on their health. Where there had been delays these were usually ascribed to delays with secondary care. However, there were some people who saw delays as being due to their GP and that they had not communicated with them effectively.

*'Still waiting referral and absolutely no communication with me to reassure me that referral has been made or what the waiting time currently is. This will inevitably mean I have to*

*chase unnecessarily in order to satisfy myself that the referral has indeed been made. It has now been eight weeks since my visit and I have received no further contact or information.'*

There were also similar feelings in terms of being able to access mental health services with GPs being seen as a barrier to being able to access mental health care and being ill equipped to treat mental health issues. A focus group was held with people with mental health issues in Biddulph and they felt that there was:

*'Significant lack of referrals to mental health services.'*

Some participants from a focus group of people with physical disabilities gave examples of issues re-accessing services that they had previously used and needed to access again.

*'I had the same problem with my AFO. I haven't been in touch with the Orthotics for a few years, so they said you need to be referred back from your GP again. So I just got back in touch with my GP and they referred me back to the hospital. All good again, just took a bit longer.'*

In these circumstances they had to be referred again by their GP. Whilst the participants did not see this as a major issue other than it slowing the process down and being a nuisance in terms of having to get to their GP if this is replicated in higher numbers it becomes an issue in terms of time and money for the NHS. Where people have accessed another primary care service by referral from their GP and are likely to need to access it again, it makes more sense for them in future, to be able to access it directly without the requirement to revisit their GP for a further referral.

### Reasonable adjustments

As part of the engagement activity, focus groups took place with people who have physical disabilities. They spoke of difficulties with accessing particular services due to their needs, but there was also contrast in the experiences of people with similar needs. This suggests that there is a lack of access for people with specific needs and as such some people are not getting the care that they need.

One participant told of how he is a carer for his wife and because of her disabilities she requires hoisting on to a chair or a bed. This has meant that she cannot access a dentist or be examined by her GP.

*'Yeah, because she's got to be hoisted, so if she wants an examination at the doctors they can't do it, because they don't have the facility to hoist. Which I think they should have, they should have a portable hoist, that they can use to hoist people about but they haven't.'*

Despite asking for home visits by the GP these are not forthcoming on most occasions despite her issues with access at the GP practice. This contrasts with the experience of a different carer living in a different part of North Staffordshire. Her husband has access to a range of primary care services at home and these are co-ordinated by their GP.

If it possible for this to happen with one GP practice and the associated primary services such as dentists and opticians, why is it that similar adjustments cannot be made by another practice in North Staffordshire?

Parents with disabled children also gave examples of where their contact with GP services have been made unnecessarily difficult. For those who have children with additional needs around learning disability they reported that delays in the waiting room can make the situation difficult as the child becomes distressed and their behaviour escalates. The GP practice are aware that the child has additional needs but the receptionist still books appointments for later in the day when there are more likely to be delays. Whilst it is accepted that there are occasions when a later appointment cannot be avoided it would be better for all concerned if there could be more flexibility in how the appointments are approached, such as offering a home visit. Parents in a similar position who responded to the survey said that they felt there should be better access to their GP because of their situation.

*'On the day appointments to be available, knowing we have children with disabilities.'*

Again there is a contrast between experiences with others reporting that adjustments are made for their child due to their being long term patients and that there are notes on the GP system that they need adjustments.

Participants in the public events in Stoke-on-Trent raised that they sometimes had issues with language barriers and that access to interpreters could be difficult. This however, was not reflected in any of the other feedback with it not being raised at focus groups or within the surveys this was a key area of concern from those who represent the Protected Characteristic of Race and Religion.

However, similar issues were raised by participants in the Newcastle public event who were deaf and were unable to access suitable interpretation services, particularly at short notice. These areas of concern are particularly relevant in the context of the NHS England Accessible Information Standard which will be fully implemented from July 2016.

The issues raised about reasonable adjustments may be addressed through practices working together to address physical access issues where they cannot be overcome in one practice, however, there needs to be regard for where services are delivered and ensure that people can get there easily. This would help to ensure that 'all patients will have the same access to the primary care team and the range of services on offer.'

### Continuity

Participants expressed that being able to see the same GP was important to them. It should be remembered that 56.84% of survey respondents said that they had a long term condition and some of the focus group participants had long term conditions or disabilities such as mental health problems or brain injuries. For those with ongoing health conditions that continuity is more likely to be a preference than for someone who only accesses the service sporadically for unrelated matters. However, as the numbers of people who have at least one long term condition is growing nationally, continuity of care is also likely to grow in importance.

When asked what would improve their experience of accessing their GP practice a large number said that being able to see their named or preferred GP would be an improvement.

*'GP got to try and know their patients. It's like every time you are seen by a different doctor.'*

People said that continuity was important to them because it gave them confidence and built a trusted relationship with their practitioner.

*'I would like to see my named GP. Seeing different doctor's makes for inconsistency.'*

*'I would prefer to see the same doctor every time as you build confidence with them.'*

For one participant, she was able to give examples of how being able to access the same GP each time for her husband had meant they had a positive experience. Their GP acted as their main point of contact.

*'There's one person that comes out on a regular basis so she knows what's working well, what's not working well. If she looks at him so can get a good feel of how he is and she said it's important to have the same person because other people see different things that are from a different perspective. They might look at him as a whole and think he needs to be hospitalised, you know what I mean, where in fact he might be on a fantastic day, you know what I mean kind of thing, so it's very important to see the same. For confidence as well to feel reassured isn't it as well.'*

This is the kind of service that most people would have liked but arguably their needs are not severe enough for this type of approach to be taken.

The strategy's aims of having the GP as being the care co-ordinator would be welcomed by patients if that meant that seeing the same GP each time they accessed the practice. However, it is difficult to see how this could be achieved. It will need to be communicated to patients what is possible and how the co-ordinator role will work in practice. Participants in the public events suggested that the co-ordinator role need not be a clinical role but does need to be properly resourced in order to ensure that it is effective.

### Locality and access

Throughout the engagement activities it became apparent that there are differences in being able to access services depending on whereabouts the participant lived. Whilst it might be expected that there would be differences between North Staffs and Stoke-on-Trent as they fall under different CCGs, and that is not to condone the differences, this was not the case with some glaring differences between different areas within North Staffs CCG footprint.

Participants in Newcastle-under-Lyme and Staffordshire Moorlands talked about very different service experiences, in terms of access to services and appointments. For instance, for a participant in from Leek, she reported that she had services coming to her home to treat her husband.

*'A lot of our services are provided at home though. Like opticians will come to the home, hearing tests will come to the home.'*

This is in contrast to another carer whose partner had similar needs who cannot access a GP appointment for her or a dentist appointment.

*'Well it's trying to get someone to come out and do it at home all the time. Yeah, because at the end of the day they can't provide the service that they're supposed to.'*

Some participants recognised that there were disparities in the experience of the GP practice and they wanted everyone to have the same level of experience as they did, that is that everyone had access to a good GP.

*'Equitability across different GP services. Each to be as good as ours.'*

It was not possible from the survey responses to see where those who had very good experiences lived specifically but certainly in the focus groups those with the best experiences lived in the Moorlands.

However, this was not the case when considering access to dentists with participants from the Moorlands telling how there were issues with being able to access dental appointments on the NHS. Participants gave feedback that due to lack of access to NHS dentists and emergency dental services further reliance was placed on accessing other NHS services for help, advice and treatment i.e. GP practices, walk in centres and A&E.

*'It's hard to access dentist services.'*

People living in Stoke-on-Trent were able to discuss the relatively good access to services they had through the health centres that are in the City. This was particularly in relation to the health centre at Cobridge and being able to access a range of services through that one location.

*'I found that since the Cobridge Health Centre's been there, it's helped me, cos I go there for my blood tests, found out that I've got hearing problems, so they saw to my hearing aids there as well. So they are a good idea, having these local health centres because the specialists do come to the health centres on certain days.'*

This is not replicated in Newcastle-under-Lyme and one participant spoke about having to use the hospital to access a lot of services, such as x-rays, that were available at health centres in Stoke-on-Trent. They cited that Newcastle had Bradwell hospital but that it is limited to providing only blood tests in their experience.

*'We've got Bradwell Hospital but they haven't got half the services there which they could have, like x-rays. Be easier for us.'*

It is the case that physiotherapy is available at Bradwell hospital as well but there may be scope to extend the services available.

Furthermore, access to walk-in centres differs across the two CCGs, although they are available to residents from both areas. Although there is the Midway practice in Newcastle this does not really constitute a walk-in centre in the same way as the Haywood or Hanley walk in centres. The service is appointment only and this is not clear to many residents who believe it to be a walk-in centre in the same sense as elsewhere. It was observed that once appointments have been used up for the day patients are re-directed to Hanley Walk-In Centre which for some would be problematic in terms of travelling there. Additionally people were being directed there without them checking that the other centre would be able to assist the patient. Patients were unsure of what their options were for out of hours care and when they were unable to access appointments were unsure where to turn to next. There is scope for ensuring that when people are re-directed they are fully informed of their options in relation to the needs they have presented.

For the people who live in the Moorlands there is no equivalent walk in centre available to them and this lack is felt by some people who live there.

*'Rural areas would really benefit from a walk in centre.'*

Although it is accepted that it would not be possible to replicate all services in every location there does need to be an understanding of how services being delivered a distance away can impact on the patients. For people who do not have their own transport being able to access appointments can be particularly problematic and time consuming. In the public event in Biddulph it was pointed out that poor transport links meant that people could not access services that were closest geographically and this needs to be a consideration when deciding the locality footprints.

Difficulties with being able to access public transport means that some people are dependent on hospital transport in order to get to appointments.

*'There's not enough wheelchair spaces on the buses, they prioritise pushchairs over buses.'*

*'I've had to wait over an hour and a half for a bus.'*

This is another area where there appears to be difference in being able to access the transport and a difference in experience. One participant believed that they could only access the non-urgent patient transport provision from NSL via their GP practice and needed to be referred, another was able to access it directly simply by telephoning.

*'You've got to make your arrangement for your travel, through your doctor again.'*

*'Well, I access patient transport, they arrange for me to come here and back on the days that I come...so they just gave me the number. Since then I've arranged my transport a few times...I just phone up, and so all you need is your NHS number then they can put you on the system.'*

Ultimately they are both accessing exactly the same service. Additionally, one of those service users knew that there were due to be changes to the service in July but the other did not. This shows that there has been a lack of communication with service users about changes that could potentially affect them. Participants who have access to transport via their carers said that their disability benefits paid for the car and should they lose that benefit they would be left with no transport and a dependence on hospital transport again.

*'Because it all comes down to cost anyway, and if all the money's not there you can't do it. I mean, I have a disabled car for [name], they start taking money off us, I wouldn't be able to run the car.'*

*'It's the same for us, we couldn't afford the car...I'd have to rely on the authorities, the ambulance to get to appointments, and there'd be extra cost there for the NHS because I'd still have to and from appointments.'*

Although the CCGs have no power over the benefits that people with disabilities receive it is important for them to be aware of the potential impacts of cuts on individuals and try to mitigate their impact in terms of being able to access health services.

The strategy aim to deliver improved services that are equitable across the area would help to overcome some of the perceived and real inequalities of access in relation to locality. There needs to be consideration of how localities come together and where services are delivered in terms of sensible transport links and options for individuals. For those in rural areas in particular there are issues with being able to access the services, but equally there can be similar issues for more urban areas where public transport is not directly available.

### Patient records

The sharing of patient records was a recurring theme with participants who explained that as they moved around the healthcare system they would expect their records to be available to whoever they were seeing. One carer told how he had to be responsible for explaining what treatment his wife had already received as when they moved from one service to another her records did not follow her. This put him under pressure to remember and record all her treatment but it also affected his faith in the professionals treating her.

*'And you've got to start filling forms out again to explain exactly what she's got. I thought, well if you read her records from the other department, you should know what's wrong with her...why should I have to tell each department all this, they should already be on record each time. They should know these things.'*

*'Do they know what they're on about?'*

Participants struggled to understand why their healthcare practitioners did not have access to medical information about them when technology should be enabling it to happen.

*'It seems an unnecessary responsibility or pressure on him, where he's got to start passing information, which in this day an age of 2016, with computers being around since 1995, surely it should be all on there.'*

The lack of communication was seen as being an issue between doctors at the same practice as well as with other service providers and for some this would be an area for improvement that would make a difference to their experience of primary care.

*'Better communication between doctors in the same practice and between GP and hospital.'*

It was not the case that information is not always shared. One carer gave the example of her husband having been in hospital as an emergency admission and her GP practice contacting them because they had been made aware.

*'Whenever we go, for instance he was in the hospital last Saturday...so soon as the GP service opened we had a phone call off the doctor to make sure he was ok because he had had a hospital admission.. so obviously they get something.'*

However, it is not clear how much information had been shared. The same lady gave an example where her GP had shared information with her optician that had meant they were aware of her disabilities and were able to make adjustments for her to access her appointment. This practice was given as an example of positive practice on more than one occasion and it does beg the question why they can get it right and so many others cannot.

### Customer care

Participants raised some issues that can be termed customer care, mainly these concerned their interactions with receptionists at GP practices.

*'Receptionists should be happier and more pleasant - they have a customer facing job no matter how difficult and should make the patient feel important.'*

There was a view that receptionists did not make access to a GP easy and acted as a barrier to access on occasions. Where patients had additional needs that they felt needed to be

taken into account they were not always listened to. Whilst it is recognised that reception staff are easy targets for the frustrations that participants had experienced the customer service role performed could be expanded and improved upon. It has already been mentioned that receptionists can help to ensure that patients access the best practitioner for their particular issue as long as it is carried out in the right manner.

Being listened to was something that participants talked about not simply in terms of their interactions with the reception staff but also with medical staff. Participants wanted to be accepted as being knowledgeable about their own health and where relevant that of their children. One survey respondent showed their frustration when asked how GP services could be improved and said that they should be listened to more.

*‘Take more notice when patients actually tell them.’*

#### Patient centred care

At the public events there was discussion about the need for personalised care plans that are genuinely personalised and not simply a tick box exercise. For some people their experiences of care plans were not positive and that they failed to meet the needs of the patient. People with long term conditions felt that their care plans were condition specific and this was problematic where there were co-morbidities. In addition to this whilst the care plan may be taking care of the person’s medical needs currently they are failing to effectively deal with social care needs that impact on a person’s well-being.

To be effective the care planning and co-ordination role to be undertaken by GPs needs to encompass being able to refer to social care services and have enough authority to be able to ensure that access is as quick as it needs to be.

Where care planning and communication is effective it can make a difference to the patient’s life and provide them with reassurance.

*‘My husband had a co-ordinating nurse. This service is very useful and he feels any problems he has support.’*

It was broadly supported as a concept by participants but there were concerns about implementation and the resource to do it.

### Information, advice and guidance

Survey respondents were asked where they went to get information, advice and guidance on managing their health. The most frequent response was that they used their GP for this but many also used the internet as a source of information, all be it with some caution. Some also said that they asked family for help but qualified this by explaining that specific family members were also medical professionals.

It is clear that respondents felt that their GP or practice have a role in helping them to understand and manage their medical conditions.

*'May be they could explain more about the illness things to me. Let me get clearer.'*

*'A specialist to go through would be good and explain it in layman's terms.'*

However, this expectation is not always met, particularly for those with more complex needs. Focus group participants said that there was no-one at their practice that they could go to who could explain things to them and as such they relied on the voluntary sector group they attended to explain things to them.

*'If I need stuff explaining I bring it here.'*

However, once again, this was not the case for everyone, with one participant telling us that her practice has helped her to understand her husband's health condition.

*'Like they could explain it a hundred times and they make sure you are fully aware and you can ring up and you can get telephone advice.'*

As it is apparent that people use their GP for advice, even if they find it lacking on occasion, there needs to be provision for this without it preventing access for those needing urgent care. Whilst the need for appointments may not always be avoided there is scope for approaching this in a different way, making use of the internet and linking to GP websites in order to remove some of the fear and uncertainty from on-line advice.

In terms of more complex patient specific advice practices would benefit from making knowledgeable staff available to explain and advise on issues. In the specific example from

the focus groups this role was undertaken by the co-ordinating, named GP but she also works as part of a team so this role could be given to a member of the nursing team.

The aims of the strategy to improve the provision of information, advice and guidance in order to improve wellbeing are broadly supported by participants as they see the GP practice as a principle source of information and would like to see more of it. It will be important to ensure that all staff at practices are able to provide accurate signposting and also that where people can access the voluntary sector they are helped to do so. However, there also needs to be an understanding that services in the voluntary sector require funding to operate.

### Positive regard for general practitioners

Participants in the focus groups and respondents to the survey were asked to describe their experience of their GP in one word. The majority of respondents used positive words such as 'good' and some used words such as 'brilliant' and 'fantastic'.



*'GP is excellent. Active PPG and GP really makes you welcome. Please don't change anything!'*

Where less positive words were used they were often explained in terms of struggling to access the GP or long waiting times.

Very few respondents felt that their experience of using their GP was irredeemably poor, with most seeing a poor experience as being symptomatic of wider pressures on the system.

### Staffing resource

Participants saw a lack of staff, particularly of GPs, as a major reason for issues within primary care and suggested that recruiting more GPs would mean improvements to their experiences of primary care.

*'The practice is two GPs down, therefore, filling these vacancies as soon as possible would have a very positive effect.'*

This was also the case with dentists with some participants raising issues with being able to access dental appointments easily. This was particularly raised as an issue in Biddulph but there were some issues with dentist access in Newcastle under Lyme.

*'More NHS dentists.'*

Participants saw the use of locums as being detrimental to their experience accessing their GP, with a lack of continuity being a major issue. A number of survey respondents suggested that there needed to be less reliance on locums.

*'Extra GP, not a locum.'*

*'More doctors that can stay in post not a locum.'*

The use of locums is not ideal for the patient experience and neither is it cost effective. Additionally, people questioned how the suggested improvements in the strategy could be delivered if there was not a change in the recruitment situation in Stoke-on-Trent and North Staffordshire. A comment was made at a public event on the strategy:

*'Sceptical that the required number of GPs would be available in the new system, if they're struggling now - how therefore, would it be delivered?'*

It is recognised that one of the reasons for the strategy is to address the recruitment issues but the comments to show that people would like to see something more specific about how the CCGs aim to address this issue in both the short term and the long term.

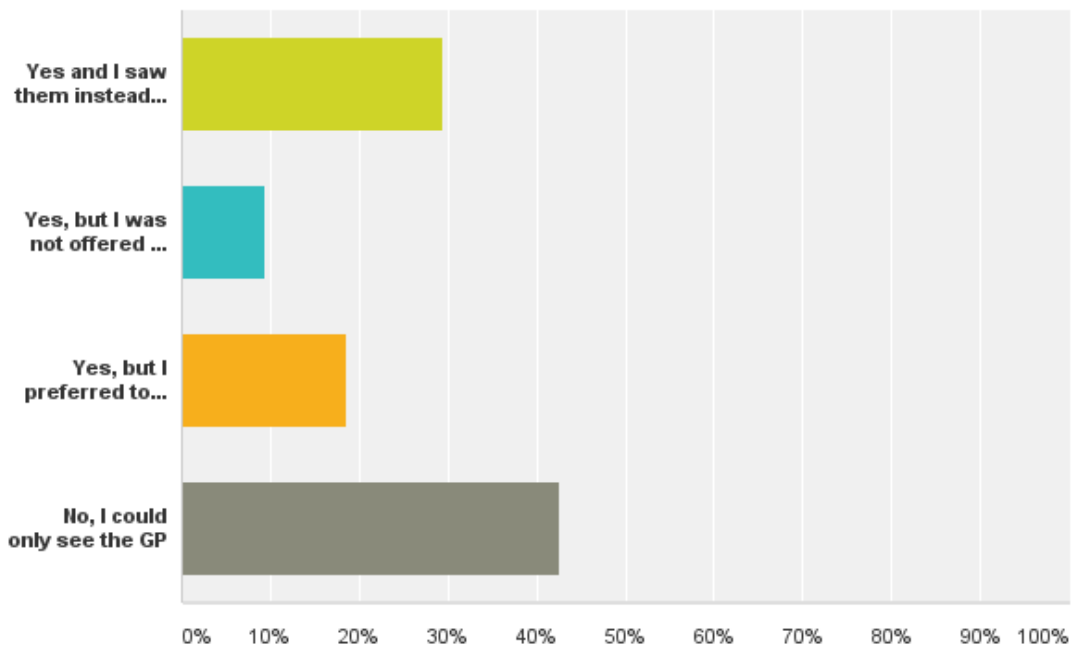
Although people spoke about seeing other types of practitioner they were still wedded to the idea of seeing a GP in the main. Survey respondents were asked if on the last time they accessed their practice they had been offered an appointment with anyone other than a GP.

Although 80% of respondents said that they would be willing to see a practice nurse rather than a GP and 54.17% said that they would consider seeing a GP Registrar, when asked about who they had seen 42.18% said that they could only see a GP with their issue.

However, almost 30% did see a practitioner other than a GP but a further 10% felt that they could have seen someone other than a GP but were not given the option. This is potentially a missed opportunity to reduce the pressure on GP appointments and make use of other practitioners within the surgery.

### Q11 Could you have seen a practitioner, such as a practice nurse, rather than a GP?

Answered: 490 Skipped: 35



As at many practices receptionists do not ask the reason for wanting to see a GP there is a missed opportunity to make greater use of practitioners other than a GP specifically. However, it is also the case that receptionists who do ask receive a great amount of criticism for overstepping their professional limits. There are specific training courses available for receptionists to carry out basic triage to decide the most appropriate practitioner or alternatively using a nurse based triage service at the point of contact for same day appointments in particular may be successful in ensuring that people only see a GP if it is necessary and are able to see a nurse, for example, where it is appropriate. This would help to ease some of the pressure on GPs in the short term.

#### Extended hours

People responding to the survey talked about the need for GP practices to be more flexible in their opening hours, particularly in relation to accommodating the needs of people who work during traditional opening hours.

*'Offer out of hours appointments. I work long hours during the week and phoning in to get an appointment is not possible, then trying to get a planned appointment to fit in with work commitments is almost impossible.'*

Comment was also made about practices closing on a Thursday, which is reflective of the traditional half day closing in Newcastle-under-Lyme and Stoke-on-Trent.

*'Opening hours. Cannot understand why it has to shut on a Thursday afternoon.'*

It is clear that this is a source of frustration for some respondents and does mean that week day access is to an extent limited.

The comments made suggest that respondents would be supportive of seven day opening, however it would need to be monitored in relation to who is using the additional hours and its effectiveness. The experience of some practices in neighbouring East Cheshire through the Prime Minister's challenge is that additional opening is proving less effective in terms of access and not being utilised by people who are at work during traditional opening hours. (ECS/Healthwatch Cheshire East, 2016).

A number of participants raised issues with accessing out of hours care and this is a recurrent theme through all the engagement methods. Whilst out of hours care is not the main concern of this engagement it became clear that issues with being able to access a GP out of hours was impacting on the patient experience of healthcare. There was a view that when using 111 patients are not receiving appropriate advice and this was impacting on the pressure on secondary care.

*‘Out of hours/111 point to A&E unless it is very straightforward.’*

People attending the public event at Burslem commented that the current system for out of hour’s access was too confusing and this is an area that needs to be further considered. It may not be within the scope of the strategy as it stands but is an area for further exploration.

#### Change management

Participants in the public events were broadly supportive of the aims of the primary care strategy but there were concerns about how the change would be managed. People said that there had been numerous proposed changes in the past but that unless major stakeholders such as GPs were on board it would fail. Participants raised the need to bring different parts of the NHS services together to enable them to work together more effectively.

*‘Delivery is dependent on the fragmented services working together.’*

It is also arguable that secondary care providers also need to be involved as part of the changes otherwise it will not achieve its aims, particularly in light of the perceived failings of secondary care to communicate effectively with primary care providers.

Engagement with patients will be important to change management and those attending the public events were clear that they wished to continue to be involved in shaping the delivery of the strategy. For some participants they felt that communication up to the point of the engagement events had been lacking and that they should have been involved before

that point. Some participants also felt that it was difficult to understand what would actually be different for them from the strategy.

*'Understanding what will actually be different under new models. What will be physically different?'*

This suggests that there needs to be more explanation and engagement in order to develop the implementation and gain patient buy-in.

### Relationship with secondary care

It is clear that many participants do not differentiate between primary and secondary care in terms of how they view their experiences. For some participants they found it difficult to talk about primary care as opposed to their poor perceptions of secondary care in hospitals. However, comments made by participants generally did demonstrate that issues in secondary care were impacting negatively on people's experiences in the community.

Participants were asked about whether they had experienced delays in being referred by their GP to other services. On the whole where people said they had experienced a delay and provided more detail as to why this was they saw the delay as being caused by delays in secondary care rather than being because the GP had been too slow in making the referral.

*'Allow them to have easier access and better contact with other services. They want to do all they can for me, but are held back by the lethargy and lack of communication from other services.'*

Where a referral has been made and there is a waiting list there is often no communication with the patient, or ongoing support, it may be that there is a role for the GP whilst patients are waiting to access secondary care and where in order to speed things up there are some things that the GP could carry out rather than waiting to see a specialist. This would be a positive outcome from the Strategy proposal to provide more acute services in the community.

Others spoke about being discharged from secondary care services back home and there being no follow up to check on their health or communication with their GP about their ongoing needs. A parent with a disabled child in Stoke-on-Trent told of an experience

around poor communication following discharge from Birmingham Children's Hospital with the Health Visitor.

*'No support. Luckily there was no dire consequence from the lack of follow up from community care.'*

Discharge processes could be improved for patients if the primary care practitioner was part of the discharge process and able to follow up any issues.

## Conclusions

Engagement was undertaken through a range of methods including public events, a survey and focus groups in order to give a wider than normal opportunity for the public to feedback on the Primary Care Strategy and raise their key concerns in accessing services. The principles behind the strategy were welcomed on the whole and there are synergies between the concerns that people raised and what the strategy aims to address.

Access to appointments was a key theme for the feedback from participants with people wanting to have shorter waiting times for appointments. Although the focus was on GPs on the whole there were also issues with accessing dental appointments for some people.

GPs are the gateway to a number of services and can be seen as a barrier to being able to access them, this was particularly the case in terms of accessing community mental health services. There were also situations where re-referrals have to be made for some services such as orthotics where there is an ongoing need to use the service again. It would be beneficial to consider the referral pathways to services to remove unnecessary duplication.

There were clearly issues for those who had physical and disabilities in being able to access services whether physically accessing a service or having the service come to their home. However, there were clear differences in access with some practices in other areas being able to deliver services tailored to the patients' particular needs. There were also communication difficulties that affected access for people with language issues or who were

hearing impaired. There is clearly a need to ensure that services are accessible to people with additional support needs.

It is clear that there are a key differences in the provision of services in different localities and it is welcomed that the strategy recognises that there are differences of quality and access that need to be addressed. When developing the locality footprints there will need to be a recognition that travel can be problematic even between geographically close locations.

The concept of a core co-ordinator role in practices is welcomed but there are resource concerns in terms of how it will be delivered whilst there are recruitment and retention issues in practices. There needs to be work undertaken in terms of sharing patient records to enable this to be more effective. There was positive regard for GPs and there were concerns that the issues with recruitment would mean that the strategy would prove undeliverable. Although the strategy aims to resolve some of the issues it is not clear how that would be achieved.

Change management emerged as a theme with broad support for the principles of the strategy and its vision but there were concerns about how it would be managed. It was recognised that in order to be effective there needed to be a change in the way that services currently work together and that it will be a difficult task to bring together GPs and other providers of primary and secondary care to deliver the strategy.

A theme throughout the engagement was that people welcomed the opportunity to give their views on how primary care is to be delivered in North Staffordshire and they saw this as the beginning of their involvement. There is a need to ensure that communication and engagement continues and involved patients and the wider public, as well as GPs and PPGs directly.

## Recommendations

To further inform the ongoing development of the Primary Care Strategic Delivery Plan, the following recommendations are made for consideration by the North Staffordshire and Stoke on Trent CCGs:

1. Appointments systems should be reviewed and consideration given to employing triage systems in order to alleviate same day pressure on services. Ensure that staff delivering the system are fully trained and understand what they are delivering and ensure that appointment options and methods are fully communicated to patients.
2. Consider mapping referral routes for services and consider how the need to be referred via a GP can be reduced. Consider direct access for previous service users to reduce the re-referrals which can reduce the need for GP appointments.
3. When mapping locality footprints ensure that local travel provision is considered to ensure that services are accessible to people who use public transport. This may mean that geographically close areas are not mapped together due to poor provision.
4. Map practices that are offering 'best practice' in order to ensure that there is parity of service and that the best are replicated rather than a 'race to the bottom'.
5. Develop specific plans for the recruitment and retention of GPs and other medical professionals in order to ensure that there are the resources for the delivery of the strategy.
6. Ensure that there were further engagement opportunities for the public to have a voice in the development and delivery of the strategy. Ensure that opportunities for engagement are widely communicated and include 'seldom heard' groups.
7. Undertake further engagement on out of hours care and 111 services to understand where there are gaps in provision and how to alleviate pressures on secondary care as a result of those service failures.

## References

Engaging Communities/Healthwatch Cheshire East- GP Access Study; to be published 2016

Healthwatch Shropshire, Healthwatch Staffordshire, Healthwatch Stoke-on-Trent and Healthwatch Telford and Wrekin; GP Access; 2015

## Appendices on following pages

## Clinical Scenarios Illustrating the Benefits of Primary Care Transformation

### 1. Primary Care Promotes Independence

**Example:** George is 78 and lives alone. He had a heart attack five years ago but has recovered well and has been taking his medication regularly. He has noticed that recently he has become short of breath when climbing the hill to the shops.

#### Goal of Primary Care Transformation

Increase life expectancy and reduce inequality

Enhance quality of life and improve health outcomes for people with long term conditions

Enabling self – management so that patients and carers have the information necessary to better manage their own health

The majority of care provided in the community

Enabling people to stay well and live healthy lives

Improved use of technology

#### What Might Happen Now

George makes a routine appointment to see his GP, who examines him and finds some symptoms of heart failure. He is referred to a cardiologist and waits around a month to be seen. The cardiologist recommends further tests, which require George to go back and forward to the hospital a number of times over the next few weeks. During this time his breathing deteriorates and he is no longer able to shop for himself. Eventually the cardiologist confirms heart failure and prescribes a change to George’s medication. He is referred to the community heart failure nursing team who visit him several times over the following weeks to adjust his medication.

This process has taken more than four months, during which time George has lost some of his independence and the confidence to go to the shops alone.

#### What Will Happen in Future

George’s GP uses the e-referral service to find the most appropriate pathway to help him. This suggests she emails a copy of the ECG to a referral management centre for advice, and within 48-hours this has been reviewed by a cardiology GPSI (GP with special interests) who recommends that George has a 24-hour ECG and is referred to the community cardiology service. George’s GP sends an online referral to which all the appropriate clinical information is automatically added. She arranges for her practice nurse to fit the surgery’s 24-hour blood pressure machine and the results are transmitted securely to the community cardiology service.

George is seen two weeks later at a neighbouring surgery where the community cardiology service is based. The GPSI examines him and reviews his test results, and after seeking any necessary advice from one of the consultant cardiologists, diagnoses heart failure while George is still at the clinic.

He is referred to the community heart failure nurses who visit him within a week and liaise with the GPSI regarding changes to his medication. George has his own blood pressure monitor and a set of scales at home, and regularly telephones (or texts) these results to the community nurses who are able to adjust his medication every few days. They continue to visit to provide advice and support.

This process has taken less than two months and George has not lost any of his independence or confidence.

## 2. Co-ordinated Multi-agency Support Leads to Better Outcomes

**Example:** Ellen is 28 years old and lives alone. She has suffered from low mood, poor concentration and loss of motivation over the last 6 weeks but this has become a lot worse recently. Yesterday she suffered from a panic attack at work and was sent home. This morning she feels low, anxious and overwhelmed. She feels like she cannot cope any more.

### Goal of Primary Care Transformation

Community, mental health and social care are integrated in a multispecialty community provider’s model.

Care is personalised to the needs of the patient

Support is given to help patients navigate across the health and social care system

Effective use of the Voluntary sector to enable recovery

Integrated IT Systems with individual care records being shared

### What Might Happen Now

Ellen makes a routine appointment with the GP who suspects a new diagnosis of depression. They discuss treatment options and agree a combination of talking therapies (via IAPT) and medication. The referral to IAPT is done by giving Ellen a slip of paper with a contact telephone number and website details and she is asked to make this call that day. As the GP has some concerns he has asked Ellen to return later in the week on a pre-booked appointment for review. She is signed off work.

Over the next 48 hours Ellen gets much worse. She cannot even start to contemplate ringing the number that she was given and when she rings back to the GP surgery is told that all the routine appointments for the day have gone and she cannot see the same GP as previously. She is offered an emergency slot with the GP on call. At this appointment, she expresses thoughts about self-harm and says she has bought tablets with the thoughts of taking on overdose. The GP refers to the crisis team to arrange acute support. This takes some time to arrange and before they get back in touch with Ellen she has rung 111 for advice. They refer her to A+E where she is seen by the RAID team in the department. Eventually she is referred to the crisis team and IAPT.

Though the GP attempted to ‘safety net’ Ellen, the deterioration of her condition meant that she saw a different GP and was inappropriately signposted to the accident unit before she had the appropriate support that she needed.

### What Will Happen in Future

Ellen’s GP diagnoses depression and agrees a referral to IAPT. This is done electronically by the GP whilst Ellen is still in the surgery. A pre-booked appointment is given for review but Ellen is also given a contact email address for the GP and information about using the practice nurse triage system should she deteriorate before then.

When she gets worse, Ellen emails the GP who is able to arrange a review appointment with him and identifies that the support of the crisis team is needed. This is also done electronically with an immediate response to inform the GP who will contact Ellen and when. She leaves the surgery secure with this information.

The crisis team provide acute support that day and the IAPT team arrange to see her in a neighbouring practice the next day. The work with IAPT identifies some underlying issues and the practice based health navigator is used to access appropriate voluntary sector services.

All have appropriate access to a shared care plan that Ellen is also able to access and enter information onto.

### 3. Integrated Response Enables Home Based / Community Support

**Example:** Elsie is a 96 year old lady who's only relative is her son, James, who lives an hour away and works full time. She lives alone and is increasingly frail. She has several health conditions including blood pressure, chronic kidney disease and has had 'mini-strokes' which lead to her balance being poor.

#### Goal of Primary Care Transformation

- To ensure that people receive the right care in the right place at the right time
- Everyone works together to provide proactive, high quality and coordinated care.
- The majority of care provided in the community
- Care is designed around you and your Carer's needs.
- Integrated IT communication solution between all health and social care providers

#### What Might Happen Now

Elsie suffers from a water infection that makes her off colour and stops her drinking so well. She rings her son who contacts the surgery for a home visit. The GP visits and organises some investigations (blood and urine tests) via the district nursing team by faxing a request to their office. This takes another day and the results are seen the day after.

By this time, Elsie has become unsteady and fallen. She has a care call alarm which alerts her son but as he cannot attend, an ambulance is called. They assess her with limited history and no access to her medical records and take her to the acute hospital where she is admitted. On the ward, her discharge is delayed as her mobility is less good and it is decided that carers are now needed. This assessment takes 4-5 days and in this time Elsie develops a chest infection. She is eventually admitted to a community hospital for another 2 weeks then discharged home with a care package. She never regains her previous level of functioning.

#### What Will Happen in Future

Elsie is known to the integrated practice team and has a shared care plan on a patient portal that can also be accessed (with Elsie's consent) by her son. This plan identifies scenarios where Elsie is at risk and outlines the actions to take. This may include stopping certain medication during acute illness and prompts early contact to the surgery. This contact initiates a visit by the most appropriate member of the integrated team- often a community nurse. The decision to arrange tests is communicated directly and performed the same day with access to the results via the electronic results system.

Social care is integrated with health such that an early assessment is triggered and carers introduced to support the acute episode of care. Domiciliary care is aligned to primary care. Voluntary sector health navigators are also integrated and signpost useful additional services to complement the social care package. A GP trained as a specialist in frailty and geriatric medicine will assess Elsie if needed and link with Elsie's own GP and the hospital geriatrician as needed to agree a plan.

Health and social care use a single care plan that is shared with Elsie and her son.

Elsie remains at home and regains nearly all her previous level of functioning.

#### 4. Integrated Working for Patients with Complex Needs Enables Continuity of Care and Reduces Crisis

**Example:** Alice is 64 and has COPD. She lives with husband. Her condition was successfully managed until around 6 months ago but since then has had three admissions.

##### Goal of Primary Care Transformation

Rapid access to specialist advice and care when its needed

Health care records are available to all the people who provide care so that everyone who needs to know, knows is familiar with the patient and their needs.

Improved use of technology e.g. telephone triage / on line appointments records

##### What Might Happen Now

Alice attends the practice nurse for review of her COPD following her most recent admission. The nurse checks her inhaler technique and compliance with her medication. They develop and agree a COPD self-management plan and the nursed prescriber provides rescue/ stand-by medication. She refers her to the GP for a review.

Alice sees the GP a week later who modifies her medication and refers her to both pulmonary rehabilitation and a tier 3 community clinic. This appointment is another 4 weeks and in that time Alice has another exacerbation and calls 999. She is taken to A+E and admitted.

##### What Will Happen in Future

Alice is already identified as high risk of admission due to her medical history and recent admissions using the practice risk stratification tool and invited in proactively for review. This practice is part of a 'care bundle' for COPD that GPs have adopted as part of quality improvement work. The review will consider factors that may have contributed to the change in her control including mental health and social issues

At the review, the nurse updates her COPD self-management plan and agrees actions with Alice. This is then uploaded onto the patient portal. Rescue medication is prescribed and onward referral made to the COPD community team who review the patient in a nearby practice within a couple of weeks. Alice has direct access to the team via mobile, Skype and face to face consultation and regularly uploads her PEFr and oxygen saturation results to her records via the portal and telehealth. This team combines specialist nurses and hospital consultants supporting generalists in the community and is quickly responsive to subtle changes in her condition.

If Alice has an exacerbation, she can follow her self-management plan but if uncertain can access any member of the extended team who will have access to the plan and can support her. This allows Alice the confidence to manage her condition at home.

## 5. Improved Access to Care

**Example: Sharon is a working mother with a five year old daughter, Justine. Justine has had a high temperature for 24 hours and Sharon is becoming very worried. It is now Sunday lunchtime.**

### Goal of Primary Care Transformation

Improved health education

7 Day access across the healthcare system EG Bury Easy GP Project

Improved use of technology e.g. telephone triage / on line appointments

Health care records are available to all the people who provide care so that everyone who needs to know, knows is familiar with the patient and their needs.

Single point of access for urgent cases

Providing fast responsive services with a view to preventing avoidable emergency admissions and A+E attendances

### What Might Happen Now

Sharon rings her usual GP number and is automatically directed to 111. She is advised to see a doctor the same day and is referred to the out-of-hours service. An appointment is given at the centre at Campbell Road. This is not close to home and Sharon has to book a taxi to get there- by this time Justine is very hot and fractious. Justine is seen by a GP who has no access to her medical records and is prescribed some antibiotics. Sharon then has to find a pharmacy that is open.

That evening, Justine develops a rash. Sharon is anxious and calls 111. Because of the fever and rash she is advised to go to A+E. This time Sharon is worried and calls an ambulance. She is referred to the children's assessment unit who diagnose a viral illness and a rash likely caused by antibiotic allergy. Sharon had forgotten about this allergy when she saw the OOH doctor earlier.

### What Will Happen in Future

Sharon rings her usual GP number and is automatically diverted to local nurse triage with access to Justine's medical records. She can see that Justine is a frequent attender with viral illnesses and that she has an allergy to penicillin. The nurse takes a full history and checks that Sharon has followed appropriate self-care advice. As she has not done so, she initially sign posts to the local pharmacy who are offering a minor ailment scheme. The pharmacist provides paracetamol for Justine.

The nurse triage rings Sharon back after a couple of hours to check on Justine's progress. As she is still unwell and unsettled despite appropriate self-care, she arranges for a review appointment at the GP hub. This is staffed by local advanced nurse practitioners, physician's assistants and GP's and is situated in a GP surgery close to home.

Justine is reviewed by the nurse practitioner and a viral illness diagnosed. Sharon feels reassured but a review with hospital at home team is also arranged that evening in case the situation changes. All the information is entered into Justine's medical record at the time of the consultation.

## 6. Primary Care Promotes Patient Choice

**Example:** Helen has inoperable ovarian cancer. She lives with her husband and has had extensive discussions with family, her oncologist and her GP about her end of life care. She is adamant that she wants to die at home and wants her symptoms to be effectively managed to enable her to achieve this goal.

### Goal of Primary Care Transformation

Care is personalised to the needs of the patient

Patients and carers of all ages are empowered to take an active part in their own care

Enabling self – management so that patients and carers have the information necessary to better manage their own condition

The majority of care provided in the community

Improved use of technology

### What Might Happen Now

Helen develops symptoms of abdominal pain in the night. Her husband is concerned and rings the surgery number and is put through the 111. A home visit is arranged by the OOH service. The visiting doctor takes 4 hours to arrive- by this time it is 3am and Helen is quite distressed. The doctor has no access to her medical records. A prescription for pain killing medication as an injection is agreed and Helens husband rings a relative to come and sit with her whilst he tries to find a pharmacy to provide this. Once the medication is collected, the family wait again for a district nurse to arrive to administer it.

This process takes several hours, causing distress to Helen and her family. Admission is not unusual in this situation.

Some weeks later, Helens condition has deteriorated further. She now has a syringe driver managing her pain and is comfortable. Though the family has had night sitters on some occasion they are told about this on a day to day basis and this night they do not have cover. During the night Helen stops breathing and her husband rings 999. As there is no paperwork in the home, the ambulance crew attempt to resuscitate Helen unsuccessfully. Her husband is distraught.

### What Will Happen in Future

Helen and her husband discuss an end of life care plan with the integrated practice team. This single document is used by the whole team including health, social care and the hospice team and a copy is present in the home and in electronic form via the patient portal. This is shared with the ambulance service, OOH and acute trust as needed for direct patient care.

The GP has prescribed appropriate ‘stand by’ medication for in the home and completed authorisation sheets to allow a clinical team member to administer it if needed. The plan describes situations for use of such medication and Helen has a number to call for the community nurses 24 hours a day- this is supported by a co-ordinated palliative care service.

When Helen develops abdominal pain, her husband calls the community nurses who come and administer appropriate pain medication. This takes no more than a couple of hours.

As Helens condition deteriorates, night sitters are made available every night the family need them. End of life discussions have been handled in a sensitive manner but provide the appropriate support and documentation to prevent unnecessary intervention or admission. Helen dies peacefully at home.

**7. Improved Access to Care**

**Example:** Paul is 45 and works in the middle of Newcastle. He injured his knee last night playing football and it has been hurting all morning at work.

**Goal of Primary Care Transformation**

Improved health education

7 Day access across the healthcare system EG Bury Easy GP Project

Improved use of technology e.g. telephone triage / on line appointments

Health care records are available to all the people who provide care so that everyone who needs to know, knows is familiar with the patient and their needs.

Single point of access for urgent cases

Providing fast responsive services with a view to preventing avoidable emergency admissions and A+E attendances

**What Might Happen Now**

Paul has seen that there is a ‘walk-in’ centre at a GP practice close to work so decides to go there during his lunch hour. He arrives and asks to see a GP but is informed that these appointments have to be booked in advance and have now all gone. He tries to ring his own practice but they have now closed as it is a Thursday afternoon.

Paul does not understand the options available and so attends the A+E department, losing an afternoon at work.

**What Will Happen in Future**

Paul accesses an appointment on-line when he gets home from football. This allows him to be seen at an acute access hub within his community. There is access to his medical records and the expertise to manage acute illness and minor injury including suturing and simple fracture diagnosis and initial management.

Paul picks a time that is convenient to him and is seen after work.



Primary Care Survey 2016

Primary Care Services Survey 2016

**Stoke-on-Trent and North Staffordshire Clinical Commissioning Groups (CCGs) have been working together to develop a strategic delivery plan for primary care services including GP medical services, practice nurses, pharmacists, dentists, opticians and so on and how these services should work together with other care providers including community services (e.g. district nurses and mental health services) to ensure that patient care is co-ordinated effectively. The CCGs are therefore, committed to addressing all these areas by developing a plan that tackles the key issues, by working with practices, patients and wider stakeholder groups. They have asked Healthwatch Stoke-on-Trent and Healthwatch Staffordshire to support the public and patient activities to inform this development.**

**Below is a survey designed to gather your views on primary care services which will be used to inform the key areas for development of services within the delivery plan. We would be grateful if you could take a few minutes to complete it. If you would like help completing the survey please contact either Healthwatch Stoke-on-Trent on telephone number 01782 683080 or Healthwatch Staffordshire on 0800 051 8371, who will be happy to help.**

1. When was the last time you visited your GP?

- This week
- This month
- 1-2 months ago
- 2-3 months ago
- 5-6 months ago
- More than 6 months ago
- 3-4 months ago

2. When you last visited the GP how long did it take for you to get an appointment?

- Same day
- Next day
- Few days
- 1 week
- 1-2 weeks
- 2-3 weeks
- More than 3 weeks

3. Was the issue urgent or was it a routine appointment?

- Urgent
- Routine

4. How would you describe your experience of your current GP services in one word?

5. How soon would you expect to be seen by a GP for a routine appointment?

6. What ways does your GP practice offer for making an appointment e.g. by phone, on-line, open surgery, on the day appointments, booking appointments in advance?

7. Please suggest below how your GP services could be improved for patients, carers and families, based on your current experiences.

8. Are you willing to see a different type of practitioner than a GP?

- Only GP
- Practice Nurse
- Healthcare Assistant
- GP Registrar (GP in training)
- Pharmacist (practice based)

9. How often have you been to the GP in the last 12 months?

10. What was the reason for the number of visits?

e.g. felt unwell, routine visit, medication review

11. Could you have seen a practitioner, such as a practice nurse, rather than a GP?

- Yes and I saw them instead of the GP
- Yes, but I was not offered an appointment with a different practitioner
- Yes, but I preferred to see the GP
- No, I could only see the GP

12. Do you have a long term condition?

- Yes
- No

13. Where do you get information, advice and guidance to help and support you in maintaining and managing your health and well-being?

3

14. Do you consider that you have experienced delays in getting a referral from your GP to other services?

15. If yes do you feel that this had an adverse effect on your long term health?

16. Where in North Staffordshire/Stoke-on-Trent do you live?

4

### 1. Before Starting

- Ensure the room is conducive to promoting discussions.
- Make sure you (the facilitator) set the tone for discussions and put the group at ease
- Ensure that every participant is given a chance to air their opinions (including the quiet ones)
- Make sure you monitor time closely and allocate enough time to each question.
- Inform people that they have a right to leave the group at any time

- Set ground rules: switch mobile phones off, everything will remain confidential, only one person to speak at a time, there is no right or wrong answers etc.
- Capture all observations including non-verbal body language and morale

## 2. Introduction

<i>Activity INTRODUCTION (if appropriate)</i>	
<b>Guidance</b>	<ul style="list-style-type: none"> <li>• <b>Spend no more than 5 minutes on this activity</b></li> <li>• Welcome the Group                             <ul style="list-style-type: none"> <li>○ Thank them for attending</li> <li>○ Invite them to sit wherever they wish</li> <li>○ Remember the points above</li> </ul> </li> <li>• Introduce the purpose and context of the focus group                             <ul style="list-style-type: none"> <li>○ Explain who HW Staffordshire and Stoke on Trent are</li> <li>○ Explain how the project came about</li> <li>○ Explain the format and duration of the focus group session</li> <li>○ Explain how the information will be fed back to the CCGs</li> </ul> </li> <li>• Explain how the information will be recorded                             <ul style="list-style-type: none"> <li>○ Inform them that a note taker will be recording the information</li> <li>○ Inform them that no names will be recorded or comments attributed to any individuals</li> <li>○ Explain how information will be analysed and used</li> </ul> </li> <li>• Make introductions                             <ul style="list-style-type: none"> <li>○ Introduce yourself and co-facilitator</li> <li>○ Ask group to introduce themselves (if they are happy to do so but no obligation)</li> </ul> </li> <li>• Ask if anyone has any questions before you start</li> </ul>
<b>Observations</b>	<i>(Capture questions and observations here)</i>

## 3. Semi structured interview script

<i>Question DESCRIBE YOUR EXPERIENCES OF YOUR GP services currently</i>	
<b>1</b>	
<b>Guidance</b>	<ul style="list-style-type: none"> <li>• <b>Spend no more than 15 minutes on this question</b></li> <li>• Ensure everyone contributes</li> </ul>

	<ul style="list-style-type: none"> <li>• You May want to consider and ice-breaker question here. Something similar like “Describe your experience of your current GP services in one word”. You can then use these words to start a discussion further explore peoples experiences. Might just help open people up and get them talking.</li> <li>• Prompts:             <ul style="list-style-type: none"> <li>○ Think about services, environment, access to services.</li> <li>○ Co-ordination of services and any follow-up appointments, referrals etc.</li> <li>○ What positive/negative things can you mention?</li> <li>○ Do you get the care and/or information and advice that you need?</li> <li>○ Are you given help to keep healthy?</li> <li>○ Do staff treat you with dignity and respect?</li> <li>○ Do you feel safe?</li> <li>○ What works well (e.g. communications, range of services available, patient engagement, signposting, help and advice)</li> </ul> </li> </ul>
<b>Feedback</b>	

**Question** *HOW COULD THE SERVICES BE IMPROVED FROM YOUR EXPERIENCES?*  
2

- Guidance**
- Spend no more than 15 minutes on this question
  - Ensure everyone contributes
  - Prompts:
    - Timely and appropriate access to appointments with GPs

	<ul style="list-style-type: none"> <li>○ Availability of appointments with other health professionals eg. practice nurse, nurse specialist</li> <li>○ Integrated, joined up approach to care pathways and interventions ie. across different services eg. mental health, referrals to acute sector, physio.</li> <li>○ More services available within the GP practice setting or co-located eg. LTC reviews; phlebotomy services.</li> <li>○ Improved support eg. – peer support/groups and advice for mental health, LTCs, physical/sensory disabilities, etc.</li> <li>○ Signposting to information and appropriate support services.</li> <li>○ Clear, easy to understand information available.</li> <li>○ Being supported to manage my own health and wellbeing.</li> </ul>
<p><b>Feedback</b></p>	

**Question 3** *HOW CAN ACCESS TO PRIMARY CARE SERVICES BE IMPROVED FOR PATIENTS, CARERS AND FAMILIES.*

<p><b>Guidance</b></p>	<ul style="list-style-type: none"> <li>● <b>Spend no more than 15 minutes on this question</b></li> <li>● Ensure everyone contributes</li> <li>● Explain the context of what we mean by access to services</li> <li>● Prompts:             <ul style="list-style-type: none"> <li>○ Appropriate and timely appointments and referral to other services eg. mental health, secondary care, community services.</li> </ul> </li> </ul>
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	<ul style="list-style-type: none"> <li>○ Timely follow up treatments, appointments</li> <li>○ Co-ordinated communications and understanding of information across different services</li> <li>○ Accessible for those with physical/sensory disability</li> <li>○ Support at the right time and advice for people when needed</li> <li>○ Information and advice that is easy to understand and is explained properly</li> <li>○ More services available within the GP practice setting</li> <li>○ More information and choice</li> <li>○ Help to navigate the system</li> </ul>
<b>Feedback</b>	
<b>Question 4</b>	<b>HOW CAN DELIVERY PRIMARY CARE SERVICES BE IMPROVED FOR PATIENTS, CARERS AND FAMILIES.</b>
<b>Guidance</b>	<ul style="list-style-type: none"> <li>● <b>Spend no more than 15 minutes on this question</b></li> <li>● Ensure everyone contributes</li> <li>● Explain the context of what we mean by delivery of services</li> <li>● Prompts:             <ul style="list-style-type: none"> <li>○ Appropriate and timely appointments and referral to other services eg. mental health, secondary care, community services.</li> <li>○ Timely follow up treatments, appointments</li> <li>○ Co-ordinated communications and understanding of information across different services</li> <li>○ Accessible for those with physical/sensory disability</li> <li>○ Support at the right time and advice for people when needed</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ Information and advice that is easy to understand and is explained properly</li> <li>○ More services available within the GP practice setting</li> <li>○ More information and choice</li> <li>○ Help to navigate the system</li> </ul>
<b>Feedback</b>	

<b>Activity</b> <i>FOCUS GROUP CLOSE</i>	
<b>Guidance</b>	<ul style="list-style-type: none"> <li>● <b>Spend no more than 10 minutes on this question</b> <ul style="list-style-type: none"> <li>○ Summarise key findings for each question</li> <li>○ Seek clarification on any ambiguous areas</li> <li>○ Offer a last opportunity to provide any additional comments</li> <li>○ Thank them for their support and input</li> <li>○ Reassure them that we will keep all info confidential and non-attributable</li> <li>○ Inform them of next steps</li> <li>○ Leave email / phone number in case they think of anything else of use</li> <li>○ Close meeting</li> </ul> </li> </ul>
<b>Feedback</b>	

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Stoke-on-Trent/ North Staffordshire CCGs

Strategic Delivery Plan for Primary Care

Engagement

Interim Update Report

February 2016

## 1. Background

Stoke-on-Trent and North Staffordshire CCGs have been working together to develop a strategic delivery plan for primary care. There are multiple challenges facing primary care at present, particularly around workforce issues in the North Staffordshire/Stoke-on-Trent areas. The CCGs are therefore committed to addressing these by developing a plan that tackles the key issues, works with practices, patients and wider stakeholder groups and is sustainable in the longer term.

The plan has now been developed in draft form, and indeed has formed the basis for wider work across Staffordshire that is being fed into the pan-Staffordshire Transformation Programme, Together We're Better. However, for the CCGs in the north, delay is not an option. Already other factors are influencing the development of health care provision in the north, including strategies to treat people closer to home (My Care, My Way - Home First), and the introduction of greater multi-disciplinary working. To this end, the CCGs are committed to engaging with the local population as soon as possible to gain their insights on the proposed plan.

The CCGs have held initial discussions with the two Healthwatch bodies in this area – Healthwatch Stoke-on-Trent and Healthwatch Staffordshire. Both Healthwatch are committed to promoting, supporting and advising the engagement work, and will do this as part of their Healthwatch service. In addition, the CCGs have expressed interest in commissioning the two Healthwatch to carry out the engagement and the ensuing evaluation report.

In December 2015 a proposal was submitted to the CCG by ECS (attached) supported by Healthwatch Staffordshire and Healthwatch Stoke-in-Trent in its delivery, which was approved with a commencement date of January 2016 and completion of the engagement activities and evaluation report by end of March 2016.

## 2. Objectives of the Engagement and Research

Overall, the objective of the engagement and research is to gain community feedback on the proposed plan, including insights from harder to reach and seldom heard groups, as well as the general public. The intention is that this feedback will inform the further development of the plan, and its implementation.

### 3. Details of the Engagement and Update on Activities

- 3.1 CCG to provide scenarios – some already provided but may need more. These should explain what will be different for patients, and will look at it from the perspective of different groups of patients.

CCG did provide a series of scenarios (attached) but have also provided flexibility within the public events for participants contributing to the table discussions, to offer their own stories of care pathway experiences which were then discussed within the table groups and with support from the table facilitators were captured on flip charts. This flexible approach has proved valuable in promoting debate and discussions and participants having ownership of the discussion topic(s). This was particularly important when facilitating a group of participants with a profound or partial hearing loss who were then able to explore in more detail the issues that were important to them in relation to both positive and negative aspects of their experiences.

- 3.2 There will be a series of public engagement events across the Stoke-on-Trent, Newcastle-under-Lyme and Staffordshire Moorlands areas with a likely geographical spread of:

- 3 across Stoke-on-Trent – Stoke North, Stoke Central and Stoke South
- 1 in Newcastle-under-Lyme
- 2 in Staffordshire Moorlands – location to be decided eg. Biddulph, Leek, Cheadle.

6 public events were scheduled across Stoke-on-Trent and North Staffordshire locality areas and at the time of writing, 5 public events have been delivered as follows:

### Healthwatch Stoke on Trent

Tuesday 2<sup>nd</sup> February 7 attendees

Fellowship Room, Swan Bank Methodist Church, Burslem.

Wednesday 10<sup>th</sup> February 20 attendees

Central Hall, The Strand, Longton.

Tuesday 16<sup>th</sup> February 17 attendees

Bentilee Neighbourhood Centre, Stoke-on-Trent.

### Healthwatch Staffordshire

Tuesday 16<sup>th</sup> February 26 attendees

King Room, Borough Arms Hotel, Newcastle-under-Lyme.

Tuesday 23<sup>rd</sup> February

Function Room, Biddulph Town Hall, Biddulph. 17 attendees

The remaining event is taking place on Tuesday 1<sup>st</sup> March at Staffordshire Moorlands District Council Offices, Stockwell Street, Leek which currently has 28 people registered to attend.

There has been positive feedback regarding the events and particularly the event in Biddulph where participants were keen to show their appreciation for having an event in their local community.



20 mins	20 mins Questions from public	
45 mins	45 mins Facilitated sessions with Scenarios/Archetypes provided to identify different types of patients with different needs.	Facilitators and audience workshops
20 mins	20 mins - facilitated session asking people to reflect on the needs of different people discussed in previous session and then apply themselves to answering the following questions about what is proposed: <ul style="list-style-type: none"> <li>• What does what is proposed feel like to you as a patient?</li> <li>• What is right about it?</li> <li>• What's missing or hasn't been thought about?</li> <li>• In the global scheme of things what is most important to you?</li> </ul>	Facilitators & Audience
15 mins	Feedback with top 2 priorities from each table	Facilitators
5 mins	Thanks and Next Steps	Chair or Emma Sutton

The format of the public events largely followed the outline above with Healthwatch facilitating the co-ordination of the events and support on the day including registration, welcome and introductions; explained the format of the event and particularly our approach in terms of flexibility of the programme sessions ie. if more time was needed for Q&A, less on scenarios, etc. and again this was co-ordinated by ECS/Healthwatch staff. ECS/Healthwatch provided facilitators for the events to support the interactive table discussions and gathering feedback from participants and feeding back at the end of the session. ECS also produced the facilitator briefing (attached) to ensure all facilitators understood their role on the day and provided a consistent approach to delivery across the events.

A dot democracy was also undertaken following the table discussions designed to identify which themes were the most important to participants gathered from the 4 questions asked in session 2 of the events. Each participant was provided with 3 sticky dots/stars and asked to put them against the key themes and findings which were the most important to them (up to a maximum of 3) but could put all 3 against one theme if that's how important it was to them.

Following the discussions and dot democracy exercise, the facilitators on each table agreed with participants which were the top two priorities and key messages they would like to feedback to the whole group.

### 3.4 In addition to the 6 public events, it was agreed that there should be a series of focus groups to

reach a diverse range of service users and particularly those seldom heard and those from the 9 protected characteristic groups. It may be that some of the focus groups will be jointly across both Healthwatch Staffordshire and Healthwatch Stoke-on-Trent areas as it would be best if they were complementary to the localities and communities. Both Healthwatch organisations have key contacts with stakeholder organisations supporting those hard to reach communities and worked together to identify possible areas for support in the delivery of the focus groups. It was envisaged that 6 to 9 focus groups would be delivered across North Staffordshire and Stoke-on-Trent.

A template for the focus groups was developed by ECS in consultation with Healthwatch Stoke-on-Trent (attached) to ensure a consistent approach to the delivery of the focus groups across a range of service users but with flexibility to tailor this to specific audiences.

In addition to the formal focus group sessions, a series of drop-in sessions has also been undertaken across Stoke-on-Trent and North Staffordshire with the aim of gathering more feedback from hard to reach groups and communities and the table below shows the activities undertaken to date. Further focus groups and drop-ins are

being delivered in the first 2 weeks of March, the feedback from which will be incorporated into the final report produced by ECS.

**9 protected characteristics and hard to reach focus groups, engagement and drop-ins summary to date:**

**Healthwatch Stoke-on-Trent**

11/01/2016 Group	Scope/Aiming Higher Together  (Children)	11 people	Focus
22/01/2016 Engagement	City Mosque (Males)	87 people	
27/01/2016 Engagement	Caudwell Children charity – families	11 people	
01/02/2016 Engagement	Young at Heart Group	45 people	
05/02/2016 Engagement	Voices – homeless/multiple conditions	5 people	
11/02/2016	Nash Dom – Eastern European	6 people	Drop-in
19/02/2016 Engagement	City Mosque (females)	50+ people	
23/02/2016 Group	Staffordshire Buddies (LGBT)	22 people	Focus
2/03/2016 Group	Transgender support group	8 people	Focus

**Healthwatch Staffordshire**

22/01/2016 Group	Partnership Housing customers	4 people	Focus
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27/01/2016 Group	LD floating support customers	Focus
28/01/2016	Refugee and Asylum seekers	Drop-in
01/02/2016 Group/Drop-in	Biddulph Rethink	Focus
03/02/2016 in/surveys	Penny Bank House	Drop-
05/02/2016 in/surveys	Lyme Brook	Drop-
Tbc group/drop-in	Children's Centre, Staffordshire Moorlands	Focus
Tbc group/drop-in	Children's Centre, Newcastle-under-Lyme	Focus
Tbc group/drop-in	Children's Centre, Kidsgrove	Focus
Tbc	Headway, North Staffordshire	Focus group

In addition to the above, there are a further 3 or 4 focus groups which will be delivered in March.

3.5 To fit alongside the public events and focus groups ECS, in collaboration with Healthwatch Stoke-

on-Trent, developed and distributed a public survey both in paper format and via weblinks to an online survey, to support people who could not attend the public events in giving their views and contributing to the thinking around the primary care strategy development plan and delivery of services. People were also able to call the respective Healthwatch teams on their contact numbers for help in completing the online survey via the telephone or if they had any queries.

To date, 219 surveys have been completed and there are still more completed paper surveys to be gathered in.

Promotion of the surveys was supported through the various mechanisms outlined at 3.2 above.

- 3.6 Completion of face to face surveys has also been supported by both Healthwatch organisations and their volunteers who have been keen to help in talking to patients at drop-in sessions, engagement events and activities and at a range of GP Practices. Support was provided from the CCG and CSU in sending out a letter to all PPG Chairs in Stoke-on-Trent and North Staffordshire inviting them to contact their respective Healthwatch organisations with expressions of interest in hosting survey sessions within their practices. To date, the following practices across Stoke-on-Trent and North Staffordshire had expressed an interest in doing so:

### **North Staffordshire**

Alton Surgery, Alton.

Tardis Surgery, Cheadle.

Keele Practice, Keele University.

Park Medical Centre, Leek.

Midway Centre, Newcastle-under-Lyme.

### **Stoke-on-Trent**

Cobridge Health Centre

[Apsley Surgery](#)

[Cobridge Surgery](#)

Trinity Surgery Blythe Bridge

Hanley Health & Wellbeing Centre

Hartshill Surgery

Orchard Surgery Norton

Shelton Health Centre

Norfolk Street surgery

Five Towns surgery

### Summary of emerging themes

Engagement activities are continuing but in parallel to this, the ECS Research and Insight Team have started the analysis phase of the feedback received to date from the various engagement approaches. ECS agreed with the CCGs that an interim report would be produced to give an update on both the range of engagement activities undertaken to date and any emerging themes from feedback provided.

### Primary Care Strategy Survey Themes

The themes below are based upon the qualitative responses from the Primary care survey.

Themes	Comment
Waiting times	The survey showed that 35% of respondents had seen their GP on the same day as requesting an appointment on their last visit. However 4% said that they had waited for more than 3 weeks.
Expectations of waiting times	Expectations on waiting times varied but it was the case that most respondents expected to wait no more than a week for any kind of appointment. A large number wanted to be seen the same day or within a few days of requesting an appointment.
Positive regard for surgeries	When asked to describe their experiences of their GP practice the responses were largely positive with most saying that their GP was good or excellent. However, there were some less positive responses such as being rushed or not listening but these were in the minority.
Appointments	Respondents suggested that there needed to be more appointments available in order to reduce the times that they have to wait to be seen. There was the suggestion that there should be more advance appointments available in order to reduce the need to have a same day appointment when it wasn't medically necessary.

Extended hours	Respondents suggested that there should be access at weekends, specifically on a Saturday and that it should be on an open access basis. There should also be more early morning and late evening appointments available for people who are working and cannot take time off in the day.
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Themes	Comment
Resource	A number of respondents raised concerns that doctors had left from their practices and that they had not been replaced. It was suggested that at the very least there should be replacements for those that had left. It was also suggested that there should be more GPs generally in order to make access to appointments easier.
Length of appointments	Appointment lengths are seen as inadequate particularly for those with multiple conditions. Appointments often overrun which then impacts on waiting times in the surgery. People feel rushed in their appointments and said they didn't have time to talk about all of their concerns.

### Public event themes

The themes below are based on the analysis of two of the public events that have taken place up to 23<sup>rd</sup> February.

Themes	Comments
Joined up services	There was emphasis on service providers communicating with one another in order to provide seamless services to patients. There was a need to have continuity of service and a reduced need to repeat the same information more than once. IT was identified as needing to be joined up in order to support service delivery.
Language barriers	Language barriers were seen as a barrier to accessing services and a concern in service provision. This included barriers for deaf people using BSL and the difficulties in accessing translation services.
Patient centred approach	There was discussion about the need for personalised care plans and that these should be genuinely personalised and not a tick box. There is a need to look at the whole person and not simply their condition in isolation.
Information, advice, guidance and support	There were a number of comments in relation to the need for more information and support. This was in terms of understanding what services were available but also in terms of the self-management of healthcare.
Change management	Whilst plans were broadly welcomed there were concerns about how the change would be managed. There was a need to ensure that all stakeholders - particularly GPs were on board with the changes.

### Next Steps

- The final public engagement is taking place on 1<sup>st</sup> March in Leek.

- A number of further survey sessions in GP practices are being delivered with support from Healthwatch volunteers in early March.
- The on-line survey will remain live until end of March.
- The remaining focus groups targeting hard to reach communities are being completed by mid-March.
- The final research and evaluation report will be produced by end of March 2016.

## Conclusions

The CCGs' intention is that this feedback and final report will be used to inform the further development of the strategic delivery plan, and its implementation. From this period of engagement and consultation some clear themes are already emerging and it is clear that these are commonly shared across different localities and communities.

In terms of the future development of the strategic delivery plan and implementation plan, it would be beneficial to demonstrate the ongoing commitment to patient and public involvement in those developments with further planned phases of engagement going forward. A key theme from discussions at the public events has demonstrated the need for ongoing communications, updates and involvement of the public so that they can understand how their contributions have informed, shaped and supported the development of plans going forward as well as being kept informed of service changes and what this means for them.

We would suggest that the CCGs consider an ongoing programme of public and patient engagement throughout the strategic development of primary care services.

As can be seen above, another common theme emerging is that of accessible, clear and timely information and communication and barriers. In light of the NHS England Accessible Information Standard being implemented (see below) it is crucial that the development of the strategic delivery plan and any subsequent implementation plan include measures to address this.

## Implementation of the standard

By **1 September 2015** all organisations that provide NHS or publicly funded adult social care must have started to prepare for implementation of the Accessible Information Standard.

This includes:

- Assessing current systems and processes; and
- Developing and commencing roll out of a local implementation plan.

By **1 April 2016** all organisations that provide NHS or publicly funded adult social care must identify and record information and communication needs with service users:

- At the first interaction or registration with their service
- As part of on-going routine interaction with the service by existing service users.

By **31 July 2016** all organisations that provide NHS or publicly funded adult social care must have fully implemented and conform to the Accessible information Standard.

We would suggest that the CCGs consider a further programme of engagement on these specific issues.

In response to a request from the CCGs, ECS and Healthwatch organisations agreed to include additional drop-in and survey sessions at the two Walk-in Centres in Hanley and Newcastle-under-Lyme with a focus on the GP service provision only. However, this discussion did highlight the need to undertake some further targeted engagement work specifically around the provision of GP Out of Hours services/111 as an integral part of the wider primary care service landscape. Issues around access to mental health, dental and pharmacy services have also been raised during this engagement phase and the CCGs may wish to consider a wider programme of further public and patient engagement on the broad range of primary care services that are integral to the development of the implementation plan.

ECS and Healthwatch organisations would be keen to work with the CCGs in the development of further and ongoing engagement plans.

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