The second

Community Values Panel

Talking about urgent and emergency care

An independent panel for Cambridgeshire and Peterborough

Contents

Key Findings	**3**
About the panel	**5**
Urgent and emergency care	**8**
Appendices	**21**

Key Findings

30 local people from across Cambridgeshire and Peterborough joined a Community Values Panel to have a say on funding local health services.

The panel was set up by the people who plan and buy health services in our region – Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). It was supported by our Healthwatch.

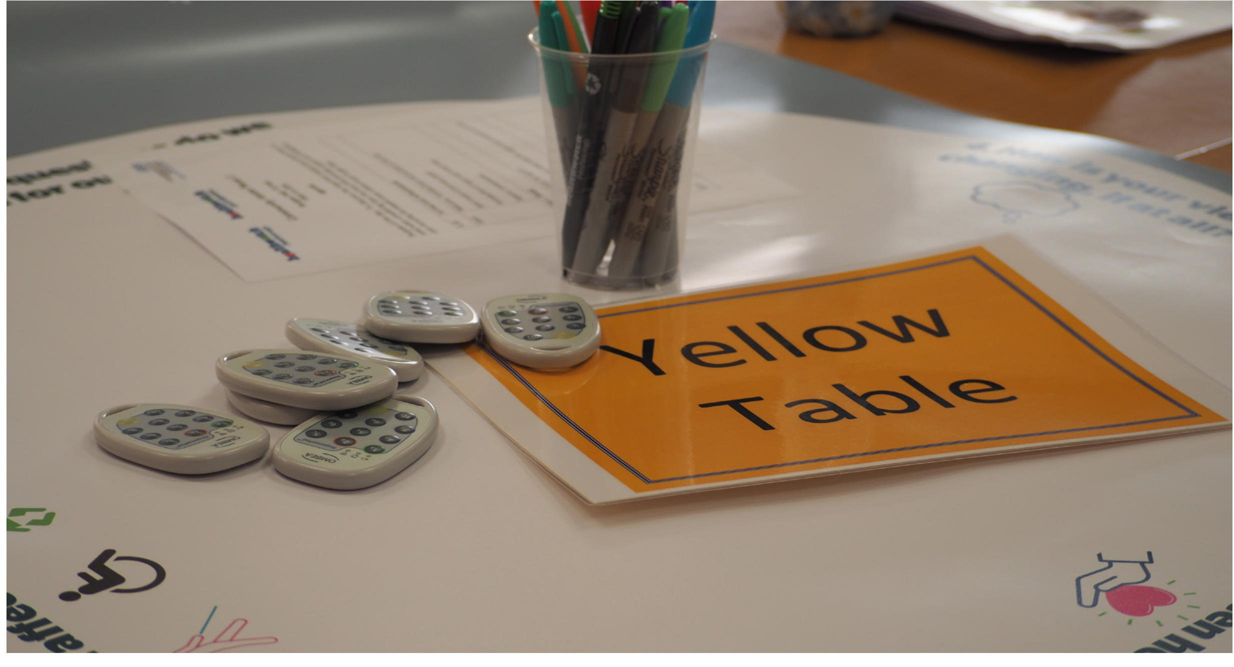
The panel met twice in the autumn of 2019 to help the CCG work out what's important to local people. This report includes the outputs of the second panel meeting on 19 November in St Ives.

Panel two

On the day, 29 panellists helped the CCG think about care in our Accident and Emergency Departments. They wanted to know if people should be redirected to other NHS services if they arrive at A&E but do not need emergency treatment.

They heard from experts at the CCG who told them about:

+ The range of NHS services that provide urgent and emergency medical treatment. And how NHS 111 helps guide people to the right service.
+ How much it costs the NHS to provide these services.
+ The increasing number of people using urgent and emergency services.



What the panellists thought

Panellists were asked to vote on how much they agreed or disagreed with the following statements at the start and then again at the end of the day. We wanted to see how their views changed after finding out more about the issue.

Statement 1: We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency.

At the start of the day, most of the panellists agreed with the statement. Only four panellists told us that they were either unsure or disagreed. At the end of the day all the panellists who voted agreed with this statement.

Statement 2: You should always be seen at A&E if you go there and you should not be turned away.

The vote on the second statement suggested less certainty. At the start of the day, only half of the panellists agreed that people should always be seen if they went to A&E.

There was a small change in the vote at the end of the day when fewer panellists were 'unsure'. Slightly more panellists agreed with the statement and slightly more panellists disagreed. The conversation about the outcome of the vote on the second statement was particularly interesting.

Panellists talked about the significance of the different terminology used in each statement. And how they felt about people being 'turned away' - which they didn't like - as opposed to 'redirected'. This highlighted important issues about how people would be redirected, by whom, and in what circumstances.

Shared values

During the day the panellists got involved in a variety of discussions and activities. These encouraged them to consider what was important to them in relation to using emergency and urgent care services.

At the end of the event, the panellists decided their values, in order of priority, were:

+ Most in need first.
+ Access to information.
+ Access to the expert.
+ Access to a range of services.

About the panel

About the Community Panel

The Community Values Panel was set up and run by our local Healthwatch, and independently facilitated by Phil Hadridge of idenk. It is funded by Cambridgeshire and Peterborough Clinical Commissioning group. The Panel is a part of the CCG's Big Conversation asking people:

+ What they value most, and
+ What changes could be made to the way people access and use health services.

The panel workshops aim to find out which values the panel prioritises when considering a particular part of our local health service in challenging financial times.

30 panellists were selected to reflect the diverse demographic characteristics of the population in Cambridgeshire and Peterborough. This was based on age, gender, and district of residence. The selection also aimed to reflect the area's disability, ethnicity, sexuality, long-term conditions and caring profile.

More information about the role of the panel, the selection of panel members and how each panel works is included in the report of the first panel workshop - 'The first Community Values Panel - Talking about the availability of over the counter medicines on prescription', also published in January 2020.

Picture shows one of our panellists.

How the panel meeting was structured

Each panel meeting followed the same format with some variations in the methods used to capture panellists' discussions.

This was:

+ Topical questions described.
+ A vote on questions to test panellists' divergence on the topic.
+ Experts, specialists in the topic, explaining context.
+ Structured discussion in small groups.
+ Further scenarios explored.
+ Facilitator exercise to identify community values – what matters, and how people prioritise them.
+ Repeat vote on the topic to explore changes in the panellists' views.
+ Summary, evaluation and closing business.

All panellists were paid £50 for each four-hour workshop and reasonable travel costs. The funding included covering the cost of taxis for panellists with sensory impairments and learning disabilities.

Details of how we reflected the CCG population in the membership of the Community Values Panel is shown in Appendix 1.

Facilitator exercise to identify community values – what matters, and how people prioritise them.

+ Repeat vote on the topic to explore changes in the Panel view and for individuals.
+ Summary, evaluation and closing business.

Feedback from the CCG representative/s and the local experts was welcomed.

The evaluation forms and the facilitator-led team debrief informed the design and practicalities for the second workshop. A summary was shared with the panellists.

About the second panel workshop

29 panellists attended the second Community Values Panel. Most had also attended the first one. The few who couldn't come to this session were substituted with people who similarly reflected the demographic profile of the Cambridgeshire and Peterborough area.

We improved the format of the second panel based on feedback from the panellists after the first event.

They liked:

+ The input from experts.
+ Using voting buttons.
+ And the way the table discussions had been run.

We made it better by:

+ Spending less time introducing people.
+ More time in discussions.
+ And by using a smaller room so we didn't need a sound system.

Picture shows one of our panellists.

Urgent and emergency care

A&E departments in all our hospitals are very busy. A&E staff often struggle to see people with urgent needs as quickly as they would like.

The purpose of the second panel was to discover the values the panel members have in mind when they consider which urgent and emergency care service people should use.

The day started with everyone meeting the other panellists again and new panellists introduced themselves. Panellists told us they had enjoyed working with the people on their table at the first workshop and welcomed the opportunity to meet them again. And work mostly in the same groups.

The next conversation reminded everyone of the ground rules agreed at the first panel, for the way the panellists, facilitators and experts would work together.

Panellists were given the opportunity to try out their voting devices again with a brief quiz related to the day's topic.

They were asked:

+ What number would you ring if someone in your family has chest pains and breathing problems?
+ Where would you go if someone in your family has sprained or broken their ankle?
+ What number would you ring if you are feeling unwell but are not sure if it's an emergency?
+ Are you confident that you know the difference between an urgent health need and an emergency?
+ Do you know where to go for more information?

The responses to these questions immediately stimulated conversations.

Panellists were confident in their responses to the first three questions. Although a significant number of people were unsure about the most appropriate route to treatment for chest pain or a broken ankle.

Interestingly, 26 of the 28 people responding to the third question knew that they should ring 111 if feeling unwell and unsure if it is an emergency, showing that people had absorbed the messages about using NHS 111.

When asked did you know the difference between emergency and urgent care, panellists were nearly evenly split between 'yes' and 'I'm not sure'. Two people said 'no' they were not confident they knew the difference .

In response to the last question about seeking information, more than half the panellists who responded - 16 out of 27 - said they were unsure or didn't know where to go for information.

Where did the panel stand on the topic of the day?

Panellists were asked to vote on two statements at the start of the day.

Statement 1: We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency.

A	Strongly agree	15	56%
B	Agree	8	30%
C	I'm not sure	1	4%
D	Disagree	3	11%
E	Strongly disagree	0	0%
	Total	**27**	**100%**

Most of the panellists agreed with the statement. Only four panellists told us that they were either unsure or disagreed with this statement.

Statement 2: You should always be seen at A&E if you go there and you should not be turned away.

The vote on the second statement was more ambiguous. This time only half of the panellists agreed that people should always be seen if they went to A&E. Panellists talked about how they felt about the term 'turned away' and were concerned about how this would happen in practice.

What the experts said

Jessica Bawden, from the Clinical Commissioning Group, explained the role of the CCG in contracting health services for local people. And told them about the 'Big Conversation' initiative to hear what people have to say about affording health services in difficult financial times.

She outlined in principle the different urgent and emergency services and which service people should most appropriately use when they feel unwell. She acknowledged that the range of services varied across the area and that choice of service could be complicated.

Experts Dr Andrew Anderson a local GP and the clinical lead for urgent and emergency care, and Mr Vaz Ahmed, A&E Consultant, Addenbrooke's Hospital, gave more details about the pressure on services. See Appendix 2 for the slide set used.

We heard that

+ Calls to NHS 111 have been increasing year on year.
+ Since July 2018, patients have been able to use 111 online.
+ More people are using urgent and emergency care services every year. The biggest increase is in A&E, where there's an average extra 44 people a day.
+ Roughly 15% of people attending A&E departments locally on weekdays could be treated appropriately elsewhere. This was higher at weekends.

Picture shows one of our panellists.

What we heard from our panellists

Panellists had differing levels of awareness of the range of emergency and urgent care services available.

Everyone was familiar with A&E departments. And many panellists had had direct or indirect experience of using A&E departments at the hospitals across the area and beyond.

Fewer people were aware of Minor Injury Units (MIU), Walk in Centres, and Urgent Treatment Centres (UTC).

We heard a range of comments based on panellists' direct experience of these services.

"Better than nothing" - Wisbech MIU

"Speedy", "Excellent, can't praise it enough", "It's comforting to know that it is near by" - Ely MU

"Very fast", "Excellent" - Doddington MIU

"Quite good", "Only open limited hours" - St Neots walk in centre

A lot of panellists commented on the confusion caused by:

+ Services with different names operating across the area.
+ Different opening hours.
+ And differing in what treatments are provided.

Most panellists were unaware how GP extended hours worked in their local area.

Many panellists didn't know the difference between the functions of an MIU and an UTC.

Panellists were unaware that NHS 111 was also available to the public as an online app and a web page. They were interested to know more about how these worked.

Questions from the panellists

Panellists had lots of questions for the experts.

"When there is so much pressure on A&E why was the out of hours service in Chesterton closed?"

"Why is there no other service other than what is offered on the Addenbrooke's site?"

"Does the MIU/UTCs being open affect the workload at the A&E departments?

"Why are some people sent to A&E post discharge when the minor issue could probably be dealt with by community health services?"

"How do the emergency and urgent care out of hours services handle the additional needs of people with learning disabilities?"

"Is there really not enough staff to meet the demand? There needs to be greater flexibility to attract people to stay in NHS employment, or to return "

"Addenbrooke's works like a magnet sucking people into A&E first. Couldn't there be a wider range of services spread across the city and surrounding areas?"

"A&E departments are not the best place for treating emotional and mental health problems. We need different services"

"Services need more funding. How can we lobby for a fairer funding settlement for this area?"

"What happened to GPs 24 hour duty of care?"

"What are people told now at the point of triage if staff feel they are using the service inappropriately"

"Would a more even spread of MIUs across the area help manage demand?"

What the experts said

All the experts acknowledged that there was need for greater consistency around services. This included:

+ Where they were based.
+ The opening times.
+ And the range of treatments.

They also said:

+ Locating different services together, like the out of hours' service on the Addenbrooke's Hospital site, helps make best use of limited resources. Especially staff.
+ More work was needed to make sure that some procedures could be provided in the local community.
+ There was now a wider range out of hours' support for people in mental health crisis.
+ Adjustments to funding services to reflect population growth were slow and small. And do not reflect real population growth.
+ Redirecting people to alternate services 'at the front door' of A&E departments was difficult.
+ But encouraging people to phone first, e.g. to NHS 111, would provide an opportunity to redirect people to the best service to meet their needs.
+ Providing urgent care within GP extended hours' services would reduce pressure on A&E departments.
+ However, many patients still don't know about alternatives to using A&E departments.

In response to what they heard

There was a wide range of responses from panellists to what they heard from the experts. This is what some of the panellists told us.

"Services need to be more 'hard nosed', some people are just time wasters"

"People need better information and signposting"

"People living and working in a 24-hour culture want to be seen NOW"

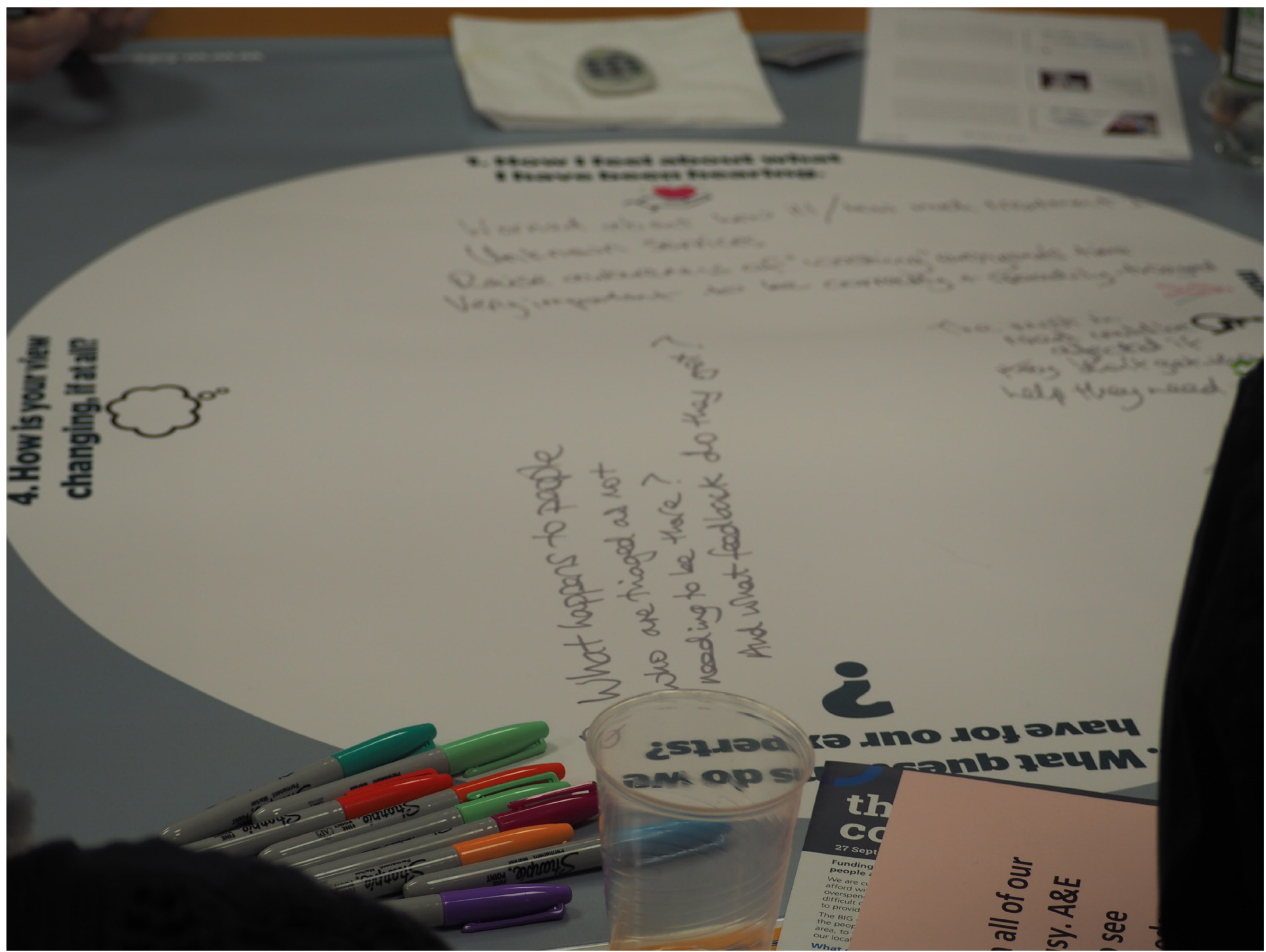
Exploring the issue in more detail

The panellists took part in facilitated conversations at four tables to explore the topic in more detail.

What they talked about:

+ How they felt about what they'd been hearing.
+ What sorts of people would be most affected by possible changes in practice.
+ If they had any questions for the experts.
+ If their views were changing at all.

Panellists were encouraged to record their feelings, views and questions on posters and sticky notes on each of the tables. Appendix 3 records these.



Picture shows notes from the panellists as they took part in this section of the day.

What they said:

- Those that have access to wider range of services appreciate them.
- But there were concerns about how people may be redirected, where to, and by whom. People didn't want to be 'turned away', but maybe redirected.
- There was a lack of knowledge about what services are available and where they are.
- Inconsistencies between different services gets in the way of people using them.
- Limited and varying opening hours restricts how much people can use services.
- Concerns about a growing emphasis on encouraging people to use phone and online-based services.
- There's a need for more and better advertising to inform people of the best service for their treatment.

The panellists' experiences of using services

In our next conversation, we encouraged our panellists to think about their own decision to seek emergency and urgent care services. Drawing on their own experience, what had helped them get that service, and what was difficult.

Did they notice any information gaps? Could they suggest any improvements which may have helped? Each table talked about one of each of the services and panellists were able to move to a table they felt best suited their experience or interest if they wished.

The topic tables were:

- A&E.
- NHS 111.
- MIU/Urgent care services / Walk in centres.
- GP out of hours' services.

We reminded panellists that they should only share experiences that they felt comfortable talking about.

Themes identified and how panellists felt

Panellists liked:

+ How easily they could use NHS 111 via the phone or an app. However, some people weren't sure when they should call 999 or 111, and wondered if there were too many emergency numbers.
+ That it was easy and reassuring to use local urgent and out of hours' services, such as the MIUs.
+ Local services could help them avoid long waits at A&E.

Panellists didn't like

+ That they sometimes had a long wait for a call back from NHS 111.
+ That it was hard to decide which service they should use.

Picture shows notes from the panellists as they took part in this section of the day.

Panellists felt:

- There should be more awareness campaigns about the range of services available to meet people's differing health needs, including out of hours' concerns and emergencies.
- Patients should be asked routinely if they had used NHS 111 when they go directly to a service.
- Concerned about homeless people and people from Gypsy, Roma and Traveller communities who may not be able to telephone services first.
- There needed to be a wider skill set in the staff working in alternative urgent care services.

Appendix 4 gives more information about these conversations.

Which values are most important?

The panellists' next activity was to try to think about what was important to them when using emergency and urgent care services. Each table had a set of nine cards representing values relevant to the day's topic.

Panellists talked together to try to find agreement about how important each value was. They represented this by ordering the cards into a diamond shape. with the most important values at the top and the least important at the bottom.

The values they talked about were:

- Access to range of facilities.
- Prevent further harm.
- Access to the expert.
- Most in need first.
- A safe place to go .
- Convenient – good use of my time.
- Efficient services.
- Access to information and advice.
- Equal opportunities.

Some panellists thought that some of the values were intrinsic in how the services should be provided. For example, all the services should be assumed to be a safe place to go. And equal opportunities was the natural outcome of most in need first.

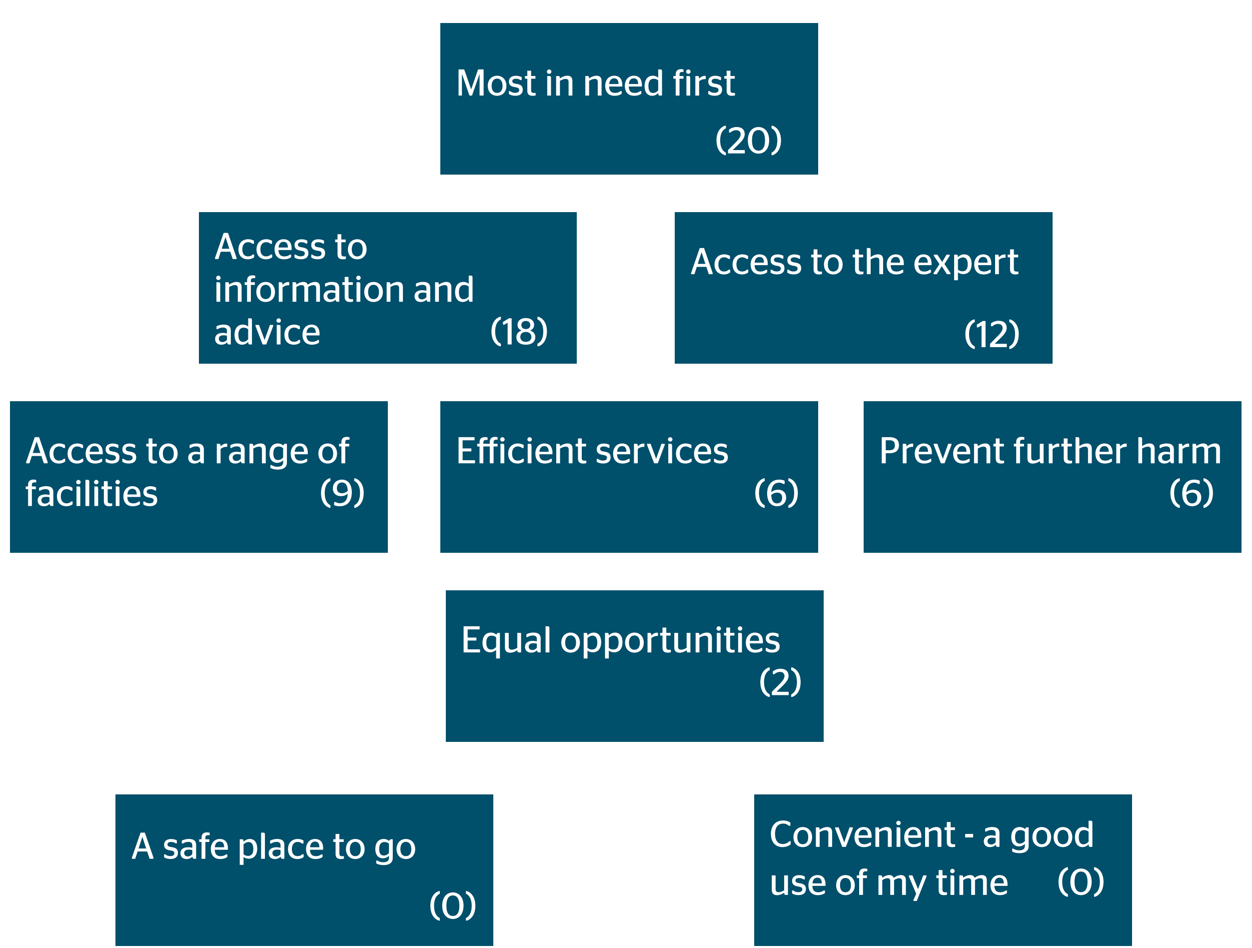
Some panellists wanted to make additions to the list. An additional two values were added by panellists:

+ Meet my health needs.
+ Quality of assessment.

The exercise generated a lot of conversation. Finding consensus was difficult. Each table shared its experience of trying to order the cards. We heard that panellists had found it easier to agree on what was less important, and to some extent on the values they would place in the 'middle' of the diamond.

In the final step in this activity, all the panellists were given three stickers to put on the final set of values, to rank their importance overall. The number on each of the boxes indicates how many stickers were put on the respective card. Two of the cards ('convenience, a good use of my time' and 'a safe place to go') had no stickers added to them.

This is how the panellists ranked the cards



Repeating the panel votes

At the end of the day, the panellists voted again on the two statements related to the day's topic.

The first vote took place before the experts introduced the topic and the second vote at the close of the session.

Statement 1: We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency.

		First Vote	Second vote
A	Strongly agree	15	21
B	Agree	8	6
C	I'm not sure	1	0
D	Disagree	3	0
E	Strongly disagree	0	0
	Total	**27**	**27**

The second vote showed panellists more firmly supporting the statement. Following the presentations and conversations, everyone who voted now agreed with the statement.

Statement 2: You should always be seen at A&E if you go there and you should not be turned away:

		First vote	Second vote
A	Strongly agree	10	9
B	Agree	4	6
C	I'm not sure	5	2
D	Disagree	3	5
E	Strongly disagree	6	5
	Total	**28**	**27**

The vote on the second statement showed less change. Fewer panellists were 'unsure'. Slightly more panellists agreed with the statement and slightly more panellists disagreed. The conversation again indicated the significance of the different terminology used in each statement with 'redirected' as opposed to 'turned away'.

Rounding off the day

We wanted to know how the panellists felt about the topic and conversations which they had taken part in. They were asked to pick out a photograph from a selection which they felt resonated with how they felt. Some of the panellists shared their choices with us.

They expressed the energy and enthusiasm they had felt, although one panellist said she felt 'quite disturbed' as she felt the experts 'had a different view of the world'.

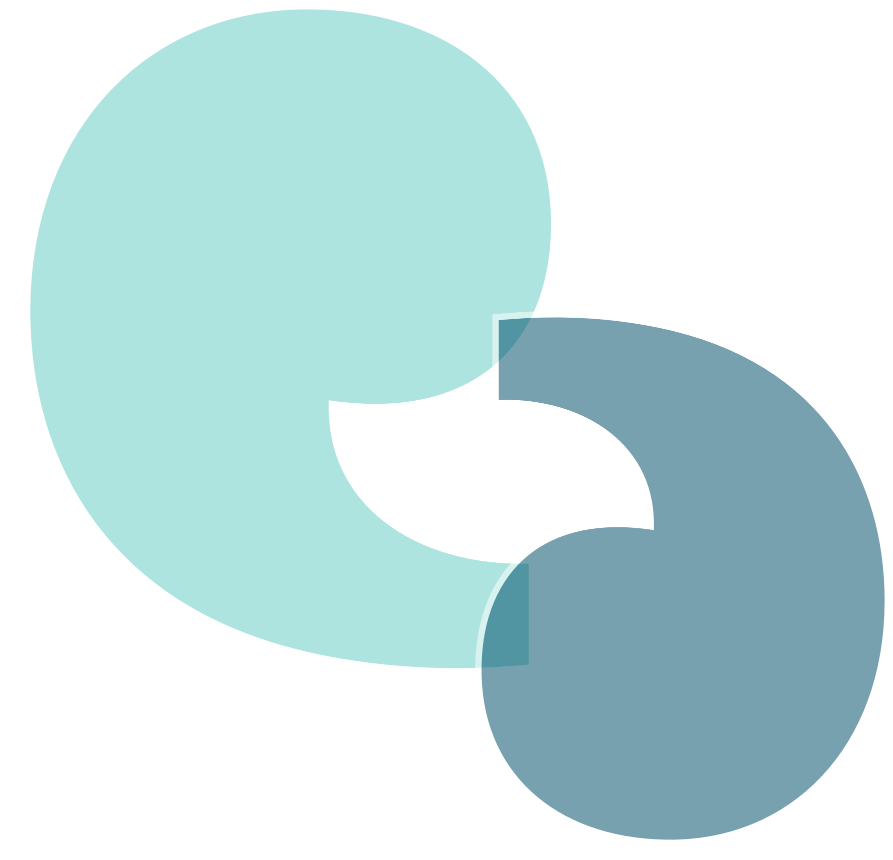
Panellists felt they had learnt a lot. They expressed how much they had enjoyed the session again and told us that they would look forward to potentially more panel meetings in 2020.

The panellists told us in their evaluation forms that they had valued the opportunity to talk with the experts who they felt were interested to hear what they had to say.

Four panellists volunteered to read the reports to check that they reflected their experience of the day.

Picture shows one of our panellists.

Appendices



Appendix 1

Reflecting the population in the CCG area – the percentages and panel makeup.

Gender	Female	Male
Percentage in local population	50%	50%
Number of panellists	15	15

Which district or city people lived in	Cambridge	East Cambs	Fenland	Hunts	South Cambs	Peterborough
Percentage in local population	15%	10%	12%	20%	19%	24%
Number of panellists	4	3	4	6	6	7

Age	15 to 24	25 to 44	45 to 64	65+
Percentage in local population	15%	33%	31%	21%
Number of panellists	5	10	9	6

Sub-categories in population	Carers	Disability or long-term condition	LGBTQ+	Minority ethnic community
Percentage in local population	12%	20%	10%	10%
Number of panellists	4	6	3	3

Appendix 2 - CCG presentation slides

NHS Urgent and emergency care

In Cambridgeshire and Peterborough we have:
Urgent treatment and Minor Injury Units

- Peterborough Urgent Treatment Centre at The City Care Centre
- Wisbech Minor Injury Unit at North Cambs Hospital
- Ely Minor Injury Unit at Princess of Wales Hospital
- Doddington Minor Injury Unit at Doddington Community Hospital
- St Neots Walk-In Centre

Accident and Emergency Departments:

- Addenbrooke's Hospital
- Hinchingbrooke Hospital
- Peterborough City Hospital

NHS Urgent and emergency care

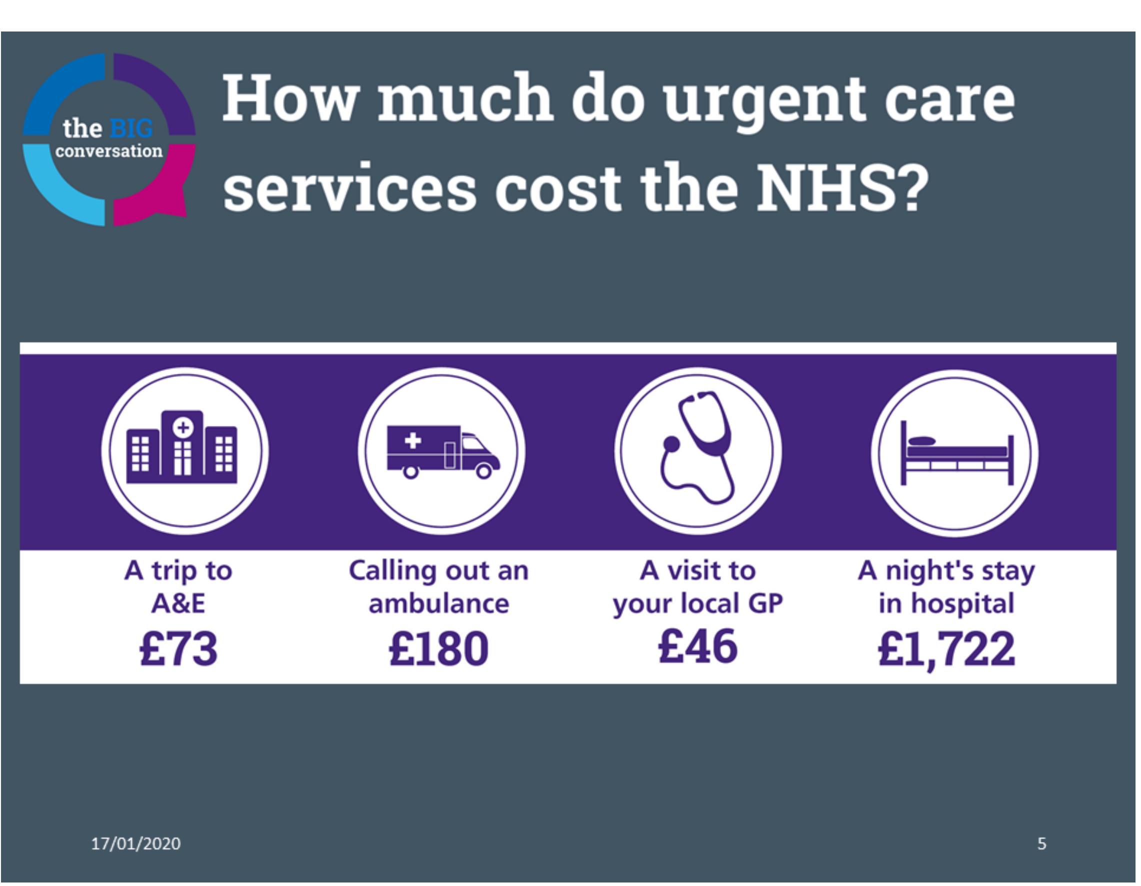
AND we have:

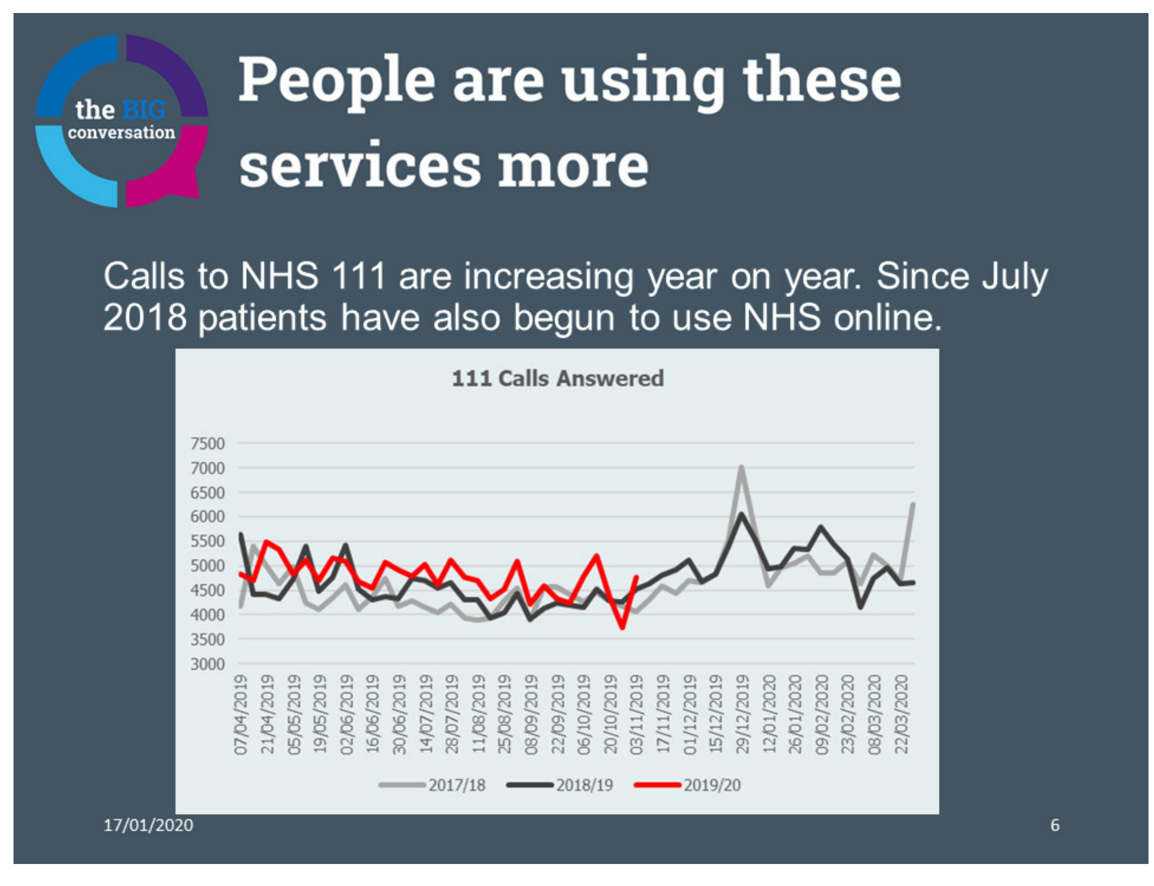
- NHS 111, including GPs and clinical advisors
- GP Out of Hours services
- GPs supporting the front door of A&E
- GPs supporting our Minor Injury Units
- Extended Access to GP appointments

It's sometimes hard to know where to go.

NHS 111 is here to help.

17/01/2020 4


the BIG conversation
How much do urgent care services cost the NHS?
A trip to A&E
£73
Calling out an ambulance
£180
A visit to your local GP
£46
A night's stay in hospital
£1,722
17/01/2020
5


the BIG conversation
People are using these services more
Calls to NHS 111 are increasing year on year. Since July 2018 patients have also begun to use NHS online.
111 Calls Answered
7500
7000
6500
6000
5500
5000
4500
4000
3500
3000
07/04/2019
21/04/2019
05/05/2019
19/05/2019
02/06/2019
16/06/2019
30/06/2019
14/07/2019
28/07/2019
11/08/2019
25/08/2019
08/09/2019
22/09/2019
06/10/2019
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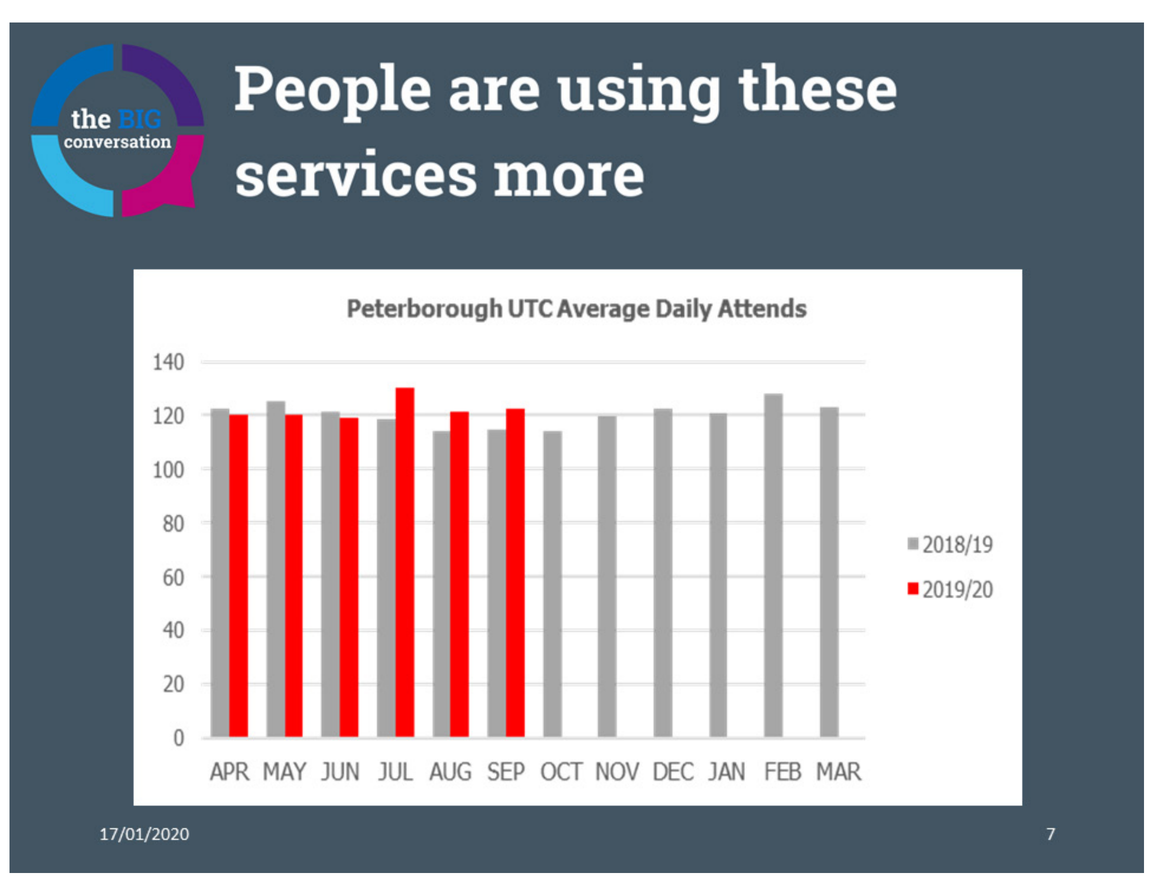
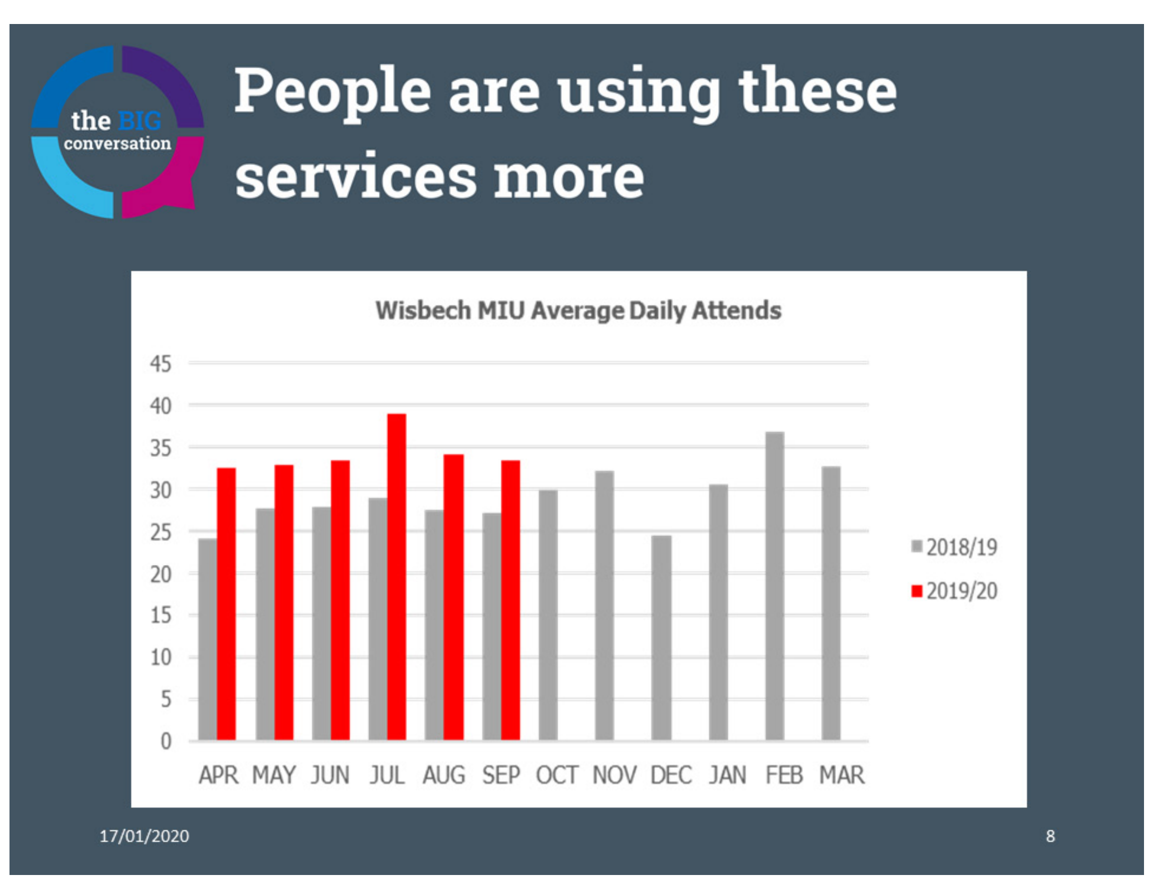

the BIG conversation
People are using these services more
Peterborough UTC Average Daily Attends
140
120
100
80
60
40
20
0
APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR
2018/19
2019/20
17/01/2020
7


the BIG conversation
People are using these services more
Wisbech MIU Average Daily Attends
45
40
35
30
25
20
15
10
5
0
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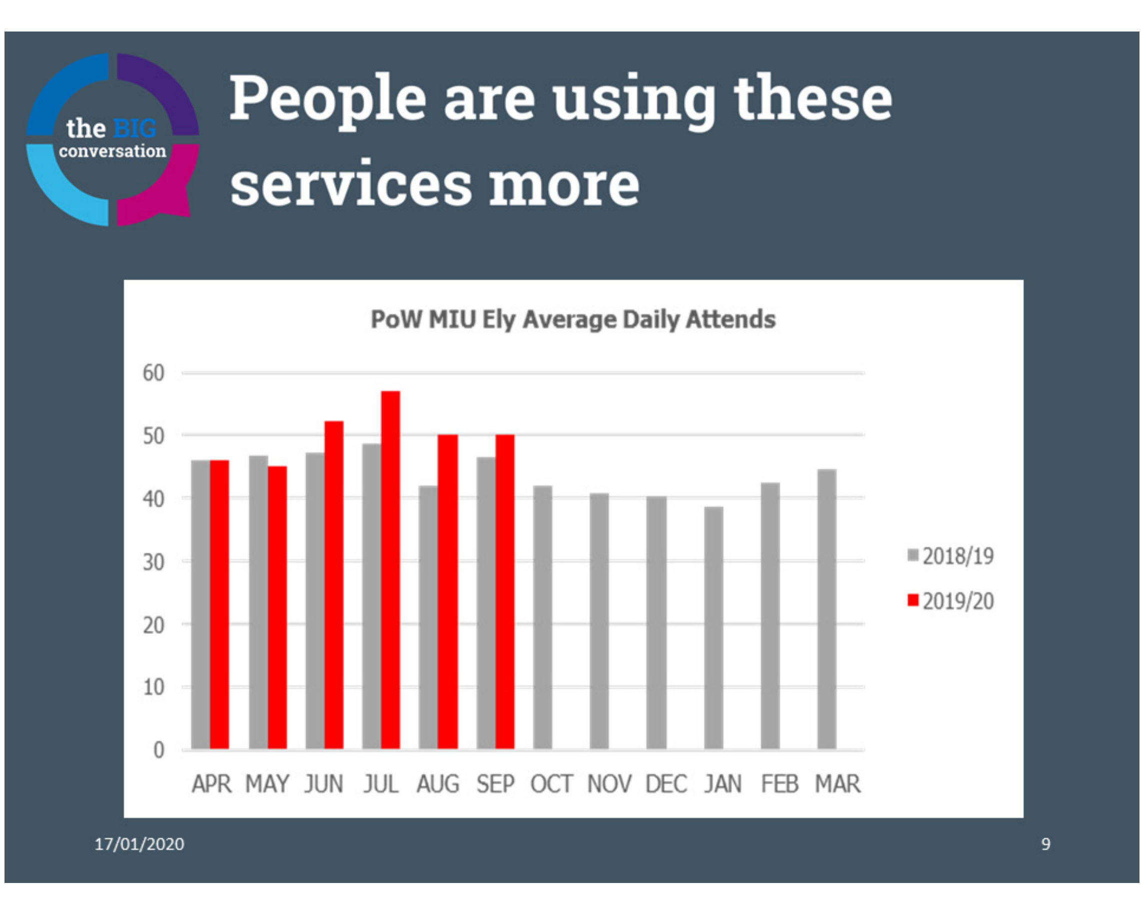
2018/19
2019/20
17/01/2020
8


the BIG conversation
People are using these services more
PoW MIU Ely Average Daily Attends
60
50
40
30
20
10
0
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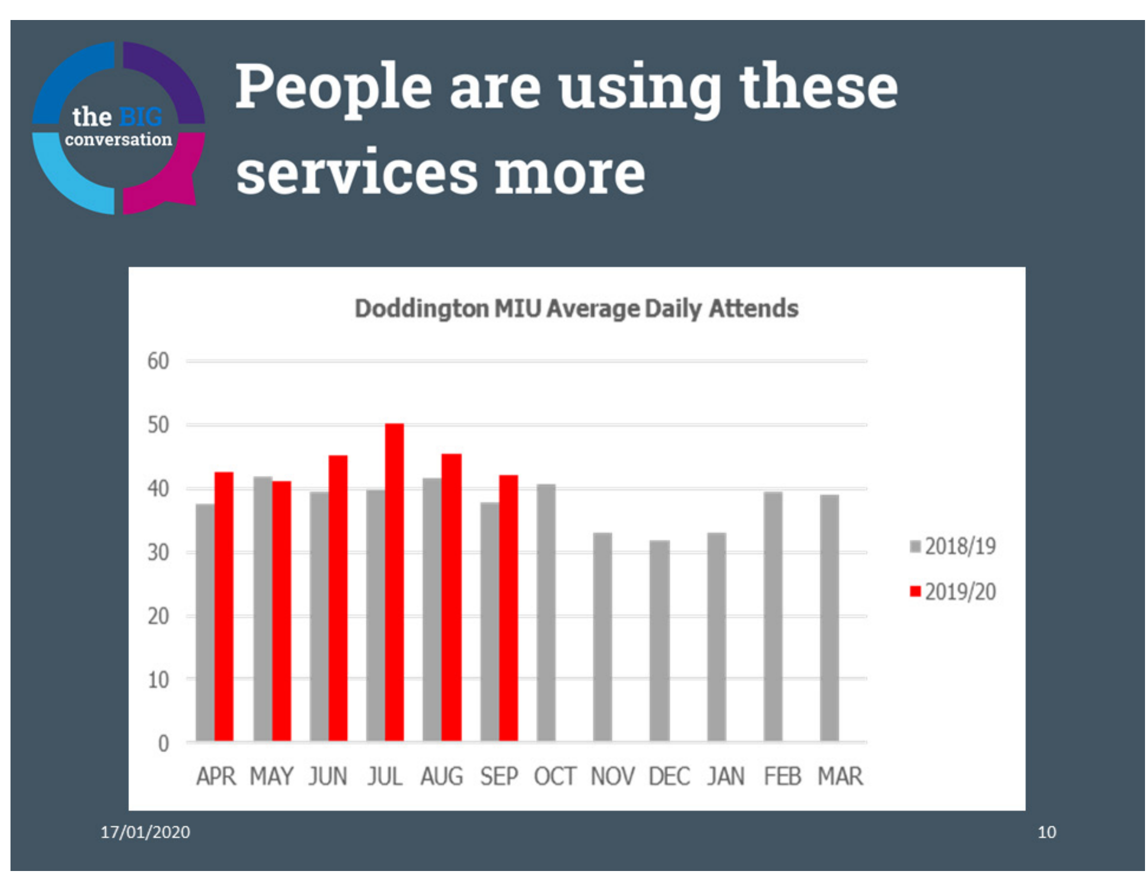
2018/19
2019/20
17/01/2020
9


the BIG conversation
People are using these services more
Doddington MIU Average Daily Attends
60
50
40
30
20
10
0
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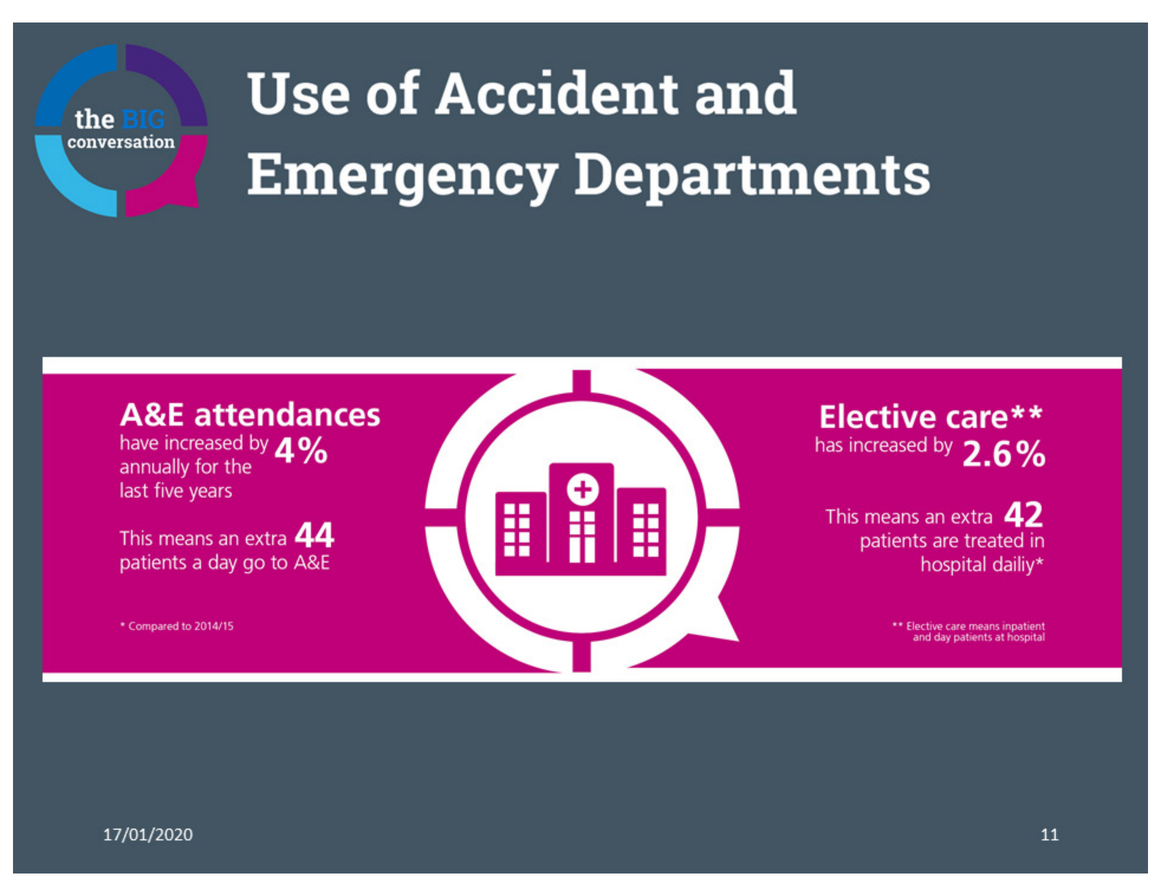
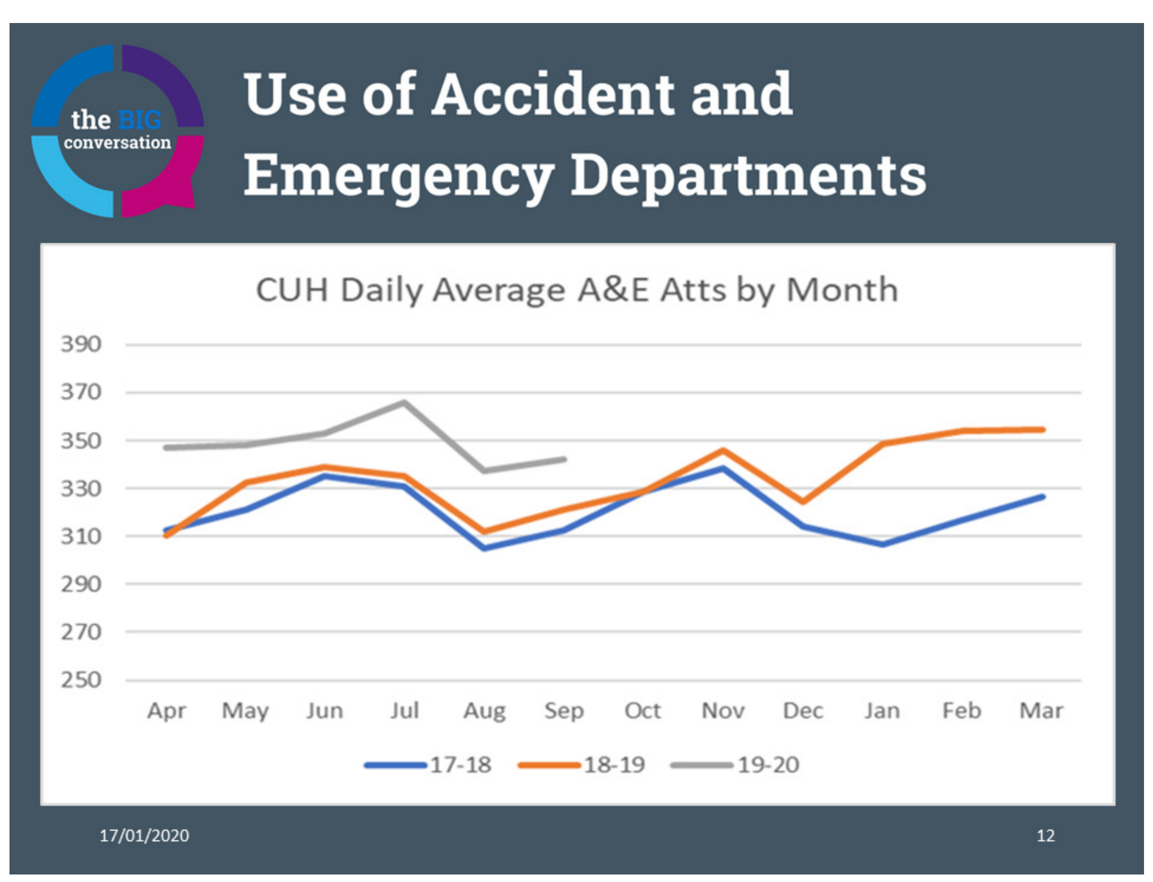
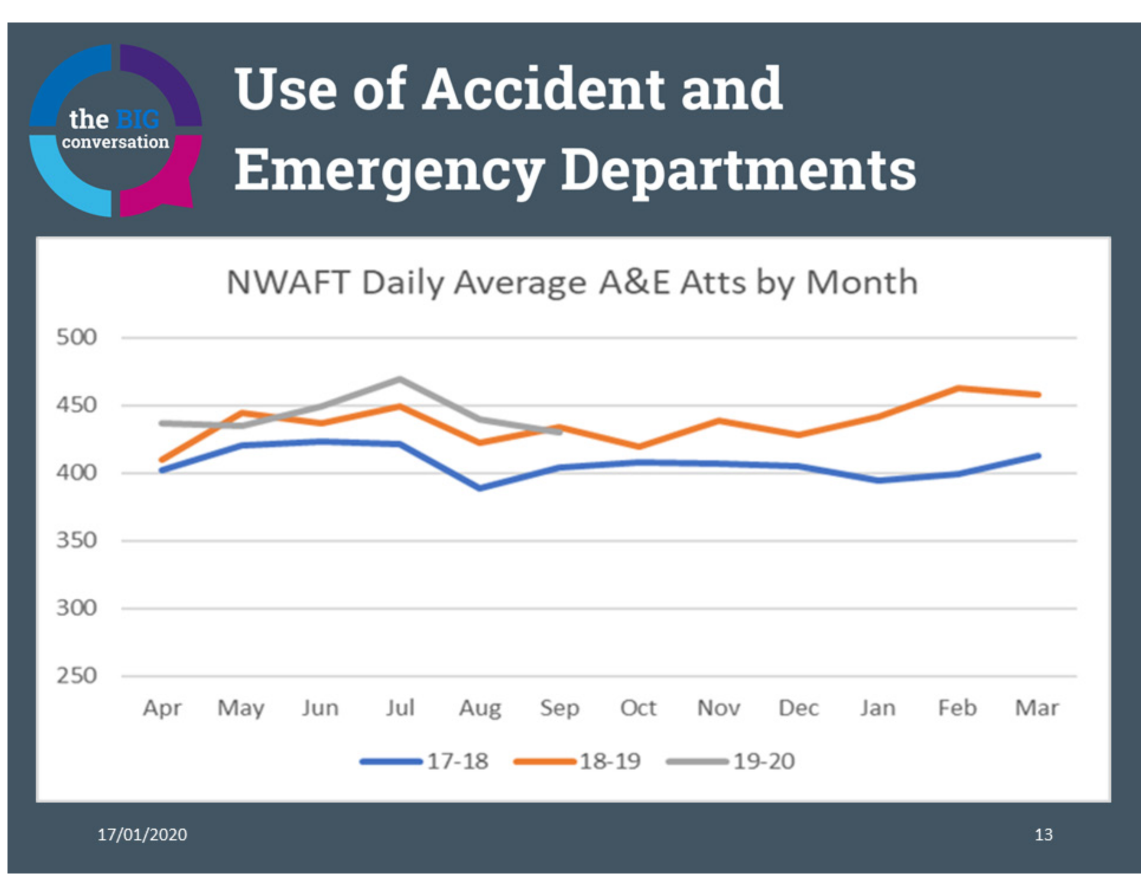
2018/19
2019/20
17/01/2020
10


the BIG conversation
Use of Accident and Emergency Departments
A&E attendances
have increased by 4%
annually for the last five years
This means an extra 44 patients a day go to A&E
* Compared to 2014/15
Elective care**
has increased by 2.6%
This means an extra 42 patients are treated in hospital dailiy*
** Elective care means inpatient and day patients at hospital
17/01/2020
11


the BIG conversation
Use of Accident and Emergency Departments
CUH Daily Average A&E Atts by Month
390
370
350
330
310
290
270
250
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
17-18
18-19
19-20
17/01/2020
12



NWAFT - North West Anglia Foundation Trust. This trust runs Hinchingbrooke Hospital and Peterborough City Hospital.

CUH - Cambridge University Hospital Foundation Trust. This trust runs Addenbrooke's Hospital and the Rosie Hospital.

Appendix 3 - Summary of table posters

Question	What people said
How do I feel about what I have been learning?	+ Worried about how ill I am / how much treatment I need. + Unknown services. + Raise awareness of 'wasting everyone's time'. + Very important to be correctly and speedily triaged . + Public health info for people who have unhealthy lifestyles.
What sort of people will be most affected by these ideas?	+ The most in need could be affected if they don't get the help they need. + People who don't use IT/mobile phones might be disadvantaged. + Cambridgeshire lacks mobile signal in many places. + Worries about long ambulance waits – people abusing ambulance service (i.e. calling an ambulance when they could have called a taxi or a driver).
What questions do we have for our experts?	+ What happens to people who are triaged as not needing to be there and what feedback would they get? + Would more MIUs help? Take pressure off? Already? Is there a way they could?
How is your view changing, if at all?	+ Advertise NHS app. – could counteract 'Google effect'. + Something like the advert with the chaps in moustaches (directory services).

Question	What people said
How do I feel about what I have been learning?	+ Surgical procedure in Addenbrooke's – then other services send you back to A&E. + It's very complex. + At weekends, feel there are no options but A&E. + Worried about A&E wait. + Worried about turning away – always see at triage. Education and information needed. + Worried about ambulance estimate (cancer centre, collapse, short transfer, 8 hour).
What sort of people will be most affected by these ideas?	+ Elderly. + Low IT skills. + Vulnerable groups.
What questions do we have for our experts?	+ Support for people with learning disabilities in A&E. + Paramedics don't want to call an ambulance.
How is your view changing, if at all?	+ Good recent use of 111/A&E. improved view. + Interesting to hear about booking systems. + Better view of 111 – much improved, would use.

Question	What people said
How do I feel about what I have been learning?	+ Pleased to be living in Peterborough – localisation of services is a great idea for Cambs, don't take the services away from P'Boro'. + Education. More GP hours, NHS is a 24/7 service not just for weekdays. + I'm happy I live in Peterborough. + If they don't need to be in A&E, the correct thing is to turn them away.
What sort of people will be most affected by these ideas?	+ 111 – is ?? to the questions they ask and patients can ??? things. 999 – A&E. + People who struggle for transport -if they get a lift to A&E but then turned away, they may have to wait too long there to go to other facilities. + Elderly, don't want to call 999 so call 111 when they are actually ill. Youngsters call 999 when they don't need to – educate. + Some elderly people don't know they are acutely ill.
What questions do we have for our experts?	+ How can you and us lobby for fairer funding for this area? + Why don't GPs open 24/7? + What plan do you have to open an MIU in Cambridge?
How is your view changing, if at all?	+ Redirect, not turn away. + Where can I go? How do I find out? + People do not know about services outside of A&E. + Confused about where to go – told off for going to the wrong place.
Other comments	+ NHS 111 option 2 for mental health is failing + Broken bones – a long wait to look at x-ray by a doctor. Why not have a rapid access doctor who can discharge etc?

Question	What people said
How do I feel about what I have been learning?	+ Addenbrooke's growth + Addenbrooke's takes everyone - site is horrendous, overcrowded and poor access. Use out of centre area. + Addenbrooke's – overloaded/access/parking + Correlation between opening hours of walk in services and A&E- impact on demand. + Cost of real estate v cost of skills. + Thread of today's discussion – GP GP GP, not enough about extending NHS 111 service. Young/in work etc most use mobile apps all the time. Educate them to use 111 instead of GP.
What sort of people will be most affected by these ideas?	+ People not registered with GPs – how many? + Ability to travel/accessibility /parking. + Many people are not registered with GPs – Addenbrooke's A&E is only service for them.
What questions do we have for our experts?	+ Why have GPs at A&E when there are highly qualified nurses around?
How is your view changing, if at all?	+ More dynamic and informative advertising of the 111 service. Currently just not at a sufficient level of public comprehension. Get Saachi & Saachi type approach to up its awareness. + Flexibility for workforce – older staff returning to work/ bank staff. + Could have mobile units like breast screening units for walk in? Put a Walk in in Cambridge, for out of hours, e.g. at Trumpington P&R. + Green cross code – knew all about it as adults and children – excellent advert. Something similar to inform and educate. Was memorable and interesting.
Other comments	+ Manage the sense of expectations 'I've paid my NI'/Need to revise old cottage hospital concept based at GP. – become MIU, -empty bed blocking at Addenbrooke's, - place for low hours contract staff to return to work. + GP services, some can offer same day, - 5 min,- regular appointments still 4-6 weeks. Not available out of hours, not where I live, - referral to 111 or Addenbrooke's.

Appendix 4 - summary from table discussion

NHS 111

What helped	What was difficult
+ Ease of use – phoning. + NHS online web access. + Easy to remember phone number.	+ Lack of information. + Wait for call back was too long. + People don't know which is the right number. 999 or 111. + Some people call 111 when they need 999 and vice versa.
Any Information gaps	**Improvements?**
+ Big gaps in information. + Info for 111 app, education/info. + More advertisement on services, e.g. TV ads and leaflets. + Neighbours talking, 'Oh I used the 111 service and it was rubbish,' to someone who hasn't used it, automatically thinks it'll be bad and not call. + Too many numbers for emergency / health.	+ Gypsy communities who travel and homeless communities have no GPs or cannot always access it so use A&E. + Inaccurate / not up to date information online. + Encourage surgeries to be active on local chat mail and social media to advertise preferred contacts e.g. 111 and online. + Educate! + 111 at the door – 'Have you called 111?' + Education – advertising in roadshows in shopping centres, GPs.

Out of hours' care

What helped	What was difficult
+ Time of day/Bank Holiday. + Not sure if emergency or urgent. + Advice from out of hours' services avoided long trip to A&E – able to treat as guided over the phone. + Reassurance.	+ Questionnaire (algorithm) to access OOH very long. + Wrong prescription – too much pressure / training skills?
Any Information gaps	**Improvements?**
+ Couldn't use it if don't know it exists – thought Cambridge shut. + Access to OOH advice on phone.	+ Awareness campaign + Extend hours. + Skill set of OOH staff.

A&E

What helped	What was difficult
+ I knew I was really ill. GP no help, operation next day. + Caring attitude. + Paramedics inspired confidence.	+ If surgical procedures – 'told must go to A&E'. Knowing if it is A&E you should visit, especially out of GP hours. + No empathy shown for people with learning disabilities - lack of understanding. + Ambulance patients in same queue as walking. + Told need to go to A&E – no ambulance available –'find a lift'.
Any Information gaps	**Improvements?**
+ 111 can direct you to the more appropriate service. + Telephone number for A&E – encourage you to ring. + Lack of knowledge of local options.	+ Investment in staffing – getting staff in the right place. + Phone triage in A&E – awareness. Clear phone number. + Clear guidance – how to get communication. + Re-look at shift patterns – all emergency staff.

MIU / Walk in

What helped	What was difficult
+ Local – reassurance + Quick	+ Not one near me. + Not knowing opening hours. + Weekend closed. + Glass wall between CCG areas and hospital catchment areas on boundaries.

Any Information gaps	Improvements?
+ Didn't know about them and opening hours. + Awareness of who (age) and what conditions can be treated.	+ Sales pitch for MIUs. + Distribution of staff? + Get skilled people in – workforce initiative + Pop up clinics for long term conditions (like breast screening units in car parks)

Picture shows panellists talking about their experience of using services - this was the table that talked about NHS 111.

Picture shows panellists voting on what values were most important to them.

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