Reviewing urgent care options for the public in Plymouth
Early insights

1. Introduction

Urgent care is defined as the 'range of responses that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care needs and appropriate prompt response to that need' (*Direction of Travel for Urgent Care: A discussion document,* 2006).

In Plymouth each year many people access urgent care options, some figures by way of background include:

- 38,000 ambulance activations
- 17,000 visits to the minor injury units
- 70,000 visits to the emergency department
- 30,000 calls to NHS Direct (plus greater numbers to online estimated)
- 60,000 out of hours services contacts

In the last few years opportunities have been taken to increase urgent care options, using a mix of national drivers, target delivery and opportunities, but there is a pressing need to take stock of the current position and consider what the landscape needs to look like over the next few year. We need to deliver the challenging economic requirements, but more importantly respond to public and service concerns that the system is confusing for the public.

Locally concerns have been raised about duplication in service delivery, not only increasing costs unnecessarily but also overlapping existing provision of care, in an unhelpful way. There is constant expectation that we educate the public to choose well in terms of urgent care, but it is complex with subtle differences between the various options, which hinders clear decision making for the person in search of urgent attention.

The need to articulate the vision for urgent care.

The approach taken by the urgent care leads in the last eighteen months has been to work on a programme which created some head room for the community. The pressure created for managers and clinical teams to respond to failed performance targets meant the need to focus all attention on the immediate system failures, and the expectation was at this point in the cycle of work, we would take stock of the services and start to think more strategically about urgent care options, the engagement of primary care and the future model.

The QIPP process has encouraged us to press on describing a range of projects and options for the next couple of years but it is really important that we take some time now to:

- Describe what urgent care may look like in a few years time in Plymouth

- Ensure organisations understand what the picture may look like so they can position themselves to respond
- Create a more meaningful service configuration for the public.

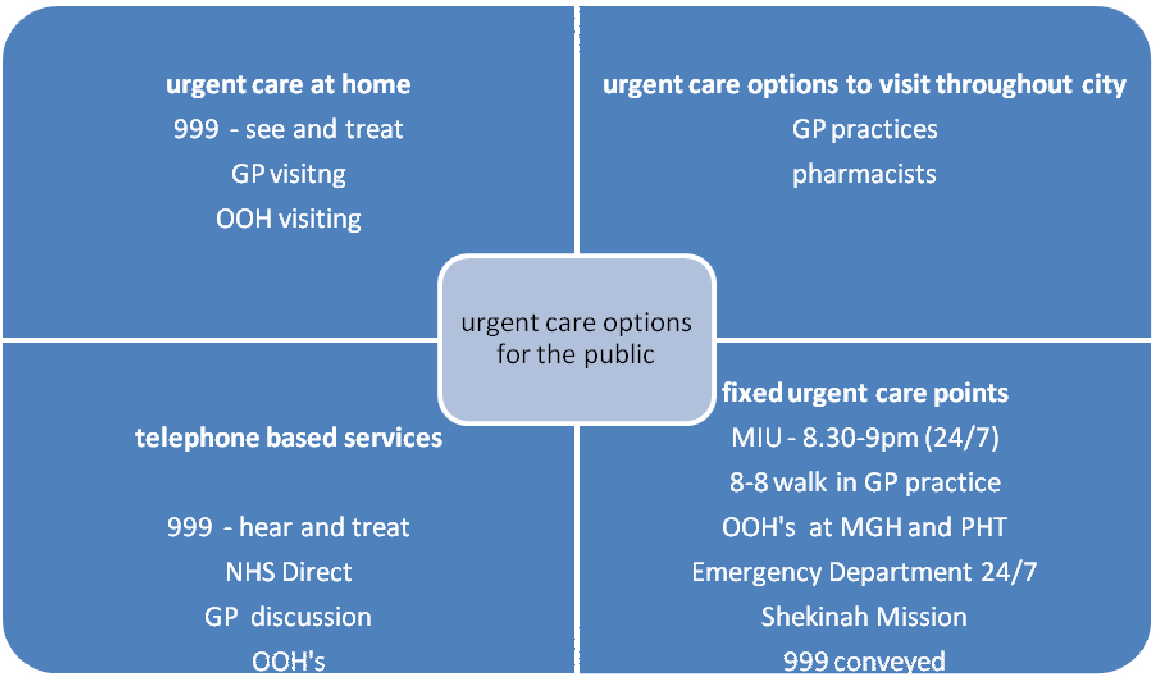
2. What should our overarching principles be?

It is important to remember that over 80% of all urgent care activity is generated by the public using their own interpretation of what urgent means to them. Most people when asked as part of focus groups or surveys understand a separation of emergency and urgent. They can easily differentiate between life threatening situations and those issues which need quick responses i.e. don't fit into our usual planned service responses, therefore we should be concentrating far more of our efforts in considering urgent care options from the person's perspective. People generally understand the role of accident and emergency (emergency departments) but not all the other myriad of options for them to consider.

The diagram below describes all the options open to an individual. There is a duplication of provision and a confused picture, and there should be no surprise that the person may default to those which they are more confident of understanding (or have more knowledge of –advertising and TV are powerful educators).

In considering principles for urgent care the following phrases or issues come to mind:

- Simplicity
- Collaboration between clinical teams
- Consistency of approach between same named providers
- People able to exercise informed choice



Horizon scanning

3.1 Consistency of offer

Locally and nationally the confused picture is recognised and there is expectation that by the end of this year March 2011, the national Czar and Leads for emergency and urgent care will issue service models which clearly define what should be expected at each tier of services. This is known as the consistency of offer approach, so for example wherever a person travels in the country they should be able to understand what is meant by a minor injury unit and understand what is available.

This is going to be a huge challenge as services are often developed to meet local needs and be moulded in with existing service provision and needs assessment, but there is going to be a national attempt at clarifying some of the confusion, which may be quite successful at high level but be less successful at more local developed diverse service level.

3.2 Three digit number

The recent White Paper has reinforced a direction of travel for the development of a non urgent three digit number which can be used for people who do not want an emergency response but do need to get help and advice. There is duplication with some of the work undertaken by NHS direct but the difference is expected to be the actual links with services, e.g. pilots in the North book a GP appointment or an emergency dental appointment for the person ringing. The first full service goes live this week and the demand and capacity issues are of concern for all as the level of use is uncertain. However the new Minister has signalled his desire to press on with the roll out as soon as possible. The evaluation is going to be fed back monthly to assess impact and feed out to services.

The NHS in Plymouth has submitted a joint bid with SWAST our ambulance provider and NHS Direct to pilot the three digit number service in the South West (combining seven PCT areas as well). We expect to hear by April if successful as a pilot and any caveats to the development.

3.4 Capacity Management System (CMS) and NHS Pathways

On behalf of the seven PCT's SWAST our ambulance services are rolling out the implementation of a Capacity Management System (CMS) – (March 2011) this year which will assist with the redirection of people who call asking for an ambulance but should be using other patient facing urgent care services. This also provides an overall community activity web based system (OHA) which will replace the resilience dashboard people will recall we used over the last winter with good effect.

The call handling changes will be linked with NHS pathways which is an NHS funded and developed algorithm process to direct people to the right options of care. It has been tested in the UK with over 2.5million sets of data with no adverse responses. Clinically it is overseen by a group of the Royal Colleges. A briefing note is available and can be shared.

This is seen as a critical piece of underpinning work to get people to match with the right service delivery. In the North East where it has been running some time, in over 10% of calls an ambulance is not sent and in a face to face pilot being run in

Blackpool some 25% people are being offered different options to that which they had chosen. There is the potential for our entire patient facing urgent services to implement this as well as referral hubs, so that for the same set of symptoms the person always gets the same response.

3.4 Long term condition management

Much of the more pressing work for the urgent care work plan focused around our own processes across the community with good effect, but in the last six months has turned more 'upstream'. Rather than just dealing with the urgent cases as they present, projects and pieces of work which are being initiated to reduce the risk of the person's condition deteriorating. Whilst recognising that people with a long term condition are nearly always likely to have a exacerbation and possible crisis, our system for planning and managing these needs to become far more robust. The role of long term condition management is critical to 'turning off the tap' of unplanned urgent and emergency care and is more possible and predictable than may be imagined. We are therefore very closely watching the impact of the LTC work plan, particularly in relation to

- Combined predictive modelling (planned to go live April 2011)
- Long term condition matrons (increased city wide cover February 2011)
- Care planning (business case complete by May 2011)
- Information prescriptions
- Telehealth (business case complete by March 2011)
- End of life advanced care planning (Roll out of plan to offer preferred place of care planning by March 2011)

Whilst this is the priority linkage for the urgent care work, each programme of work has an interdependency which we need to ensure we maintain to support reducing the spend in urgent care and redirecting it to other more planned interventions.

3.5 Primary care development

Earlier this year the urgent care leads met with Sentinel shareholders to discuss urgent care and to gauge interest in extending their role into influencing how the urgent care resources are spent. There was interest and support in being more involved in urgent care and some good agreements were reached around implementing advance care planning for end of life, RAPA and the clinical referral hub. There was longer discussion trying to understand why and how urgent care could be more contained within the community and some indicators of the areas of important work which essentially provided confidence for primary care that they were working in an integrated way with other clinical teams to deliver the best care and not to feel they were holding high risk cases on their own.

Areas of future work which were identified and have been picked up through various QIPP strategic improvement priorities included

- Accessibility to health care of the elderly consultants to provide advice and support with complex frail elderly people, especially the mix of physical and cognitive problems
- Support for improving care in care homes
- Greater integration and reconnecting with district nursing teams, therapist and social services

The white paper signalling the development of GP consortia and lead for commissioning is currently being debated to understand what this means for Plymouth, there is a huge potential to influence urgent care choices, and already the development of the clinical referral hub for urgent care (mirroring the elective hub) has directed work to offer options for different community based services and ambulatory care.

Many further discussions are needed with Sentinel to explore how we commission urgent care for the future.

The role of primary care itself in delivering urgent care options needs to be explored, the access targets are being disbanded in their current form, but despite the greater access available to primary care for the public in the last few years with 8-8, extended opening and the target delivery of 48/24 hours, there doesn't appear to have been a resultant drop in out of hours contacts or contacts with other parts of the urgent care system. The work around the PMS review, national contract discussions and the impact of the review of out of hours (Dr Urbani driven) needs to be incorporated into to the urgent care developments.

3.6 Trauma accreditation

We must not forget the pivotal role that Plymouth Hospitals Trust plays in the wider urgent care network. As a tertiary centre for neurosciences, burns and plastics and renal care already, the trust is well placed and expected to be accredited as a regional trauma centre, the only one south of Bristol. This will mean a change in travel and flow of patients around the region, particularly in relation to Somerset and a slight increase in trauma cases is anticipated if this accreditation goes through. This means that locally that however much we manage to decrease ED attendance by the local population there will be workforce requirements and a level or responsiveness required which will challenge us in reducing costs. We will already see the impact of some of the cross boundary flow changes in October this year when the bypass arrangements commence for PPCI for patients from Torbay at certain times of the week.

4 What services/contract could be affected?

By just reviewing the range of services which provide urgent care for people in Plymouth and the surrounding area (page 2) there is potential to explore if duplications in provision are leading to greater confusion and also increased costs.

Proposed way forward

5.1 Opportunities

The urgent care leads still need to work on specific tasks which help to streamline the processes for urgent care and also take opportunities when they arise.

Each year as we plan for winter ways of improving service delivery are consolidated and moved on. This year for example further improvements included:

- Intermediate care services for people with mild cognitive impairment which allows them to have further assessment take place in a non acute setting.
- Domiciliary care being commissioning in partnership with the local authority through brokerage
- Develop of the end of life co-ordination centre and consolidation of contractual arrangements

There are often options for improving urgent care pathways but this does need to be done in the context of a longer term plan. In developing new options there may well be the need to explore different contractual mechanisms, and a radical review of the provider /commissioner relationship and also that of providers working together in very different approach.

5.2 Public and patient involvement

It is critical in developing options for the future that the public are involved; we have messages already about the confusing and muddled service delivery, but have not yet asked in any detail

- Which services do you particularly value and why?
- What influences your decision making in Plymouth?
- What would be a simpler model to understand.... and if this means reducing the numbers of options down how would this be received?

It is critical because of the nature of the urgent care that where we consider changing service models the public are part of the conversations from the outset so that they can work through the options and arrive at the same solutions as the clinicians and managers. The loss or change of urgent care options are newsworthy and can be subject to political and public knee jerk responses, which could cause significant delays in making changes.

There have been some innovative approaches in other parts of the country where models and options have been mocked up to enable patients to walk through, these have led to considerable changes in models of care, which looked sensible from clinical perspectives as they created economies of a scale, but were only worthwhile where the patient knew where they should be!

While Patient and Public Involvement (PPI) has become increasingly common in many parts of NHS organisations, it has, as yet, played little role in urgent care

settings. This is because of the special challenges that involvement presents in the context of urgent care.

Unlike almost all other areas of healthcare, there is no stable or consistent patient or service user group that can be 'owned' by urgent care. Therefore, there is no ready-constituted group that can be called upon to be involved except in ad hoc ways. And we will need to create this locally.

Work has already started with LiNKs to explore options as not only do we need to work towards the future but also need to incorporate patient experience into today's work, whilst there is considerable improvements in target delivery, there is still too many indicators that patients don't always receive a good or the best experience.

5.3 Clinical collaboration

It is fair to reflect that clinical and organisational tensions have been apparent in the urgent care network over the past few years, not helped in all cases by the contractual flow of resources between commissioners and providers. Considerable effort has been expended by managers working with clinical teams to try to limit the potential and actual perverse incentives in the system, with some success in preventing the breakdown of relationships but not always managing the financial flow as well as desired!

There have been many successes in managing the system more effectively, but also a number of pieces of work which have not been entirely successful but have been valuable learning lessons for the community around collaborative working, governance, respecting each other's clinical skill sets etc, which are a firm foundation for moving forward. An early discussion paper for clinical teams to debate the various options for the single point of access for the front door of Derriford has been shared and can be shared wider if of interest. There are a number of different models to consider and over the next couple of weeks this debate will be enhanced by visits to other acute sites to learn the lessons.

The need to performance manage the system very tightly over the last eighteen months has meant the relationships and fora have not been correctly constructed to facilitate the clinical debate, but this is shifting again, with projects such as the clinical referral hub which is entirely clinically driven and a new move to separate out and undertake this piece of strategic work re-engaging organisations and clinicians throughout.

5.4 Financial appraisal

The urgent care community are challenged by a mismatch between contractual activity charged for and true understanding of demand and capacity in the system in relation to the use of secondary care services, which is being addressed. A quick analysis of all services, suggests further scrutiny is warranted to be confident that contracts and thus resource are duplicating. This is reinforced when reviewing how activity is funded and paid for in secondary care, where there have been significant reductions in time spent by patients, but the contractual mechanisms have not reflected the gains, but in some cases have penalised commissioners.

There is a need to map all financial flows for urgent care across the community, be clear about what is provided in each case and determine value for money, strip out unnecessary and confusing duplication and ensure we pay accurately for what is provided. We also need to understand how the system can be used to incentivise developing good patient centred care and practice, which sometimes penalises one organisation for doing the right thing.

6. Conclusion

It is really important that we take stock of the urgent care options open to us as a whole. There is the potential to shift care significantly and make changes to a number of contracts which would lead to a simpler and better understood landscape for the public. It does however need some time to consider the options and work through these will our local population, to be convinced that the changes will provide better outcomes and more cost effective use of urgent care. A proposed work plan to take this forward is currently being developed.

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