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**A Strategy for the Commissioning of**  
**Urgent Care Services**  
**for NHS Birmingham East and North PCT**  
**2009-2014**

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## **Executive Summary**

The Urgent Care Commissioning Strategy outlines a 5 year plan and vision for the development of Urgent Care services for the population of NHS Birmingham East and North (NHS BEN). It describes how urgent care services will meet the diverse local needs and ensure the right mix of workforce, skills, leadership and facilities are in place to deliver integrated, high quality and personalised urgent care services to individuals. Key goals include making access to all urgent care services easier, improving responsiveness, reducing waiting times, simplifying the patient journey and ensuring patients are always seen by the professional best able to meet their needs.

Nationally the focus on urgent care services has shifted from the achievement of national targets and standards to developing more patient centred services. This will only be achieved through an integrated model of urgent care where existing and new providers work together for improved patient outcomes, delivering services in settings that are more convenient to the people that use them.

Within NHS BEN there have been a number of initiatives to improve urgent care services for patients including the development of an urgent care centre, out of hours diversion to primary care services in A&E and ambulance diversion schemes. Despite these initiatives, local urgent care services still lack integration and are complex for patients to navigate.

It is important to recognise when planning and implementing new models of urgent care, in reality patients will enter the system at a variety of access points most convenient for them. The principle that the system is responsible for ensuring that the patient is seen and treated by the most appropriate professional in the most appropriate setting needs to be upheld. Relatively little is known about what motivates individuals to call on particular urgent care services or what communities value as the important features of these services but recent evidence gained from the Urgent Care Project Focus Groups, suggests patients are confused with the different services, find opening times and availability of services confusing and are unclear about the most appropriate access points for urgent care. The provision of good information to the public and patients about how local urgent care services operate is extremely important in enabling people to use the most appropriate services for their needs.

This strategy sets out a framework for the development of Urgent care services with the following key objectives:

- Developing and supporting self care - where appropriate

- Developing an integrated model across primary and secondary care providers and other partner organisations with consistent services and pathways
- Providing simple access including a Single Point of Access, choice and quality urgent care for patients as close to home as is safe as possible.
- Supporting clinical leadership across the urgent care system
- Developing capacity across the urgent care system to deliver new integrated models of care.
- Enhancing GP Access for Urgent Care

The benefits and outcomes of a more integrated urgent care system will be more consistency in urgent care pathways, less waiting and more local services for patients.

## **1 Introduction and Scope**

This paper outlines the commissioning strategy for urgent care for NHS Birmingham East and North PCT. The definition of urgent care in the Direction of Travel for Urgent Care (DOH 2006) will be applied throughout this strategy. Urgent care *“is 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 their carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need.”*

The range of urgent care providers considered within the strategy are the A&E departments at Heart of England Foundation Trust (HEFT), the Urgent Care Centre in Kingstanding, the Walk in Centre in the City Centre, GP practices in hours, Badger and Primecare GP out of hours providers, NHS Direct, West Midlands Ambulance Services, Mental Health teams, PCT provider services including Intermediate Care, Assertive Case Mangers and District Nurses, Dentists, and Pharmacists.

The scope of this strategy is limited to the above though it is acknowledged partnerships and supportive services for urgent care exist with Birmingham City Council Adults and Communities. The strategy is complimentary to the PCT strategies on long term conditions, planned care, childrens services, mental health services and end of life services and so does not cover these in any detail.

The strategy includes:-

- A vision and strategic framework for urgent care commissioning in BENPCT area
- Information on local health needs, current services and planning for future needs
- National and local commissioning drivers
- Stakeholder and patient feedback.
- Objectives and strategic plan for urgent care.

There are three important interlinking issues that are embedded and woven within this strategy, equality, diversity and sustainability. The PCT as a public body is required by the various equality legislations, to ensure the services commissioned and provided by the PCT do not discriminate against people on the grounds of race, religion and belief, age, sexuality, disability and gender. The PCT acknowledges different people will have different needs that need to be taken into account, for example the requirement for translation services. To address the equality and diversity requirements for the PCT, a full Equality Impact Assessment has been undertaken and can be found in appendix 1.

Sustainable development is: "development which meets the needs of the present without compromising the ability of future generations to meet their own needs" (Brundtland Commission definition in *Our common future* report to UN, 1987). Essentially about developing and maintaining a good quality of life for us all and enable future generations to do the same. Appendix 2 sets out the principles for sustainable development.

## 2 Vision and Strategic Aims

The vision for future urgent care models need to be driven by patients' needs and preferences-providing care as close to home as is safe to do so, managing demand through appropriate care pathways and ensuring provision of services in primary care is complemented by secondary care provision when necessary. Demand for urgent care is relatively predictable and so it follows provision can be planned.

The strategy for urgent care is underpinned by the following aims:

- To provide urgent care services that support self care where appropriate
- To simplify the way high quality care is accessed by patients in the place most appropriate to their needs
- To improve responsive
- To integrate all providers in their approach to care delivery
- To meet diverse local needs
- To deliver high quality personalised care.

### 3 Strategic Context

The Urgent Care Strategy is informed and influenced by national policy and the vision for urgent care as laid in the most recent key documents:

- **World Class Commissioning**

The vision and competency framework of World Class Commissioning (WCC) launched by the Department of Health (2007) set out how improvements in commissioning will lead to better outcomes for patients that *'Add life to years and years to life'* with *'better health and well being for all, better care for all and better value for all'*. This strategy presents a way forward for urgent care that incorporates the key competencies in WCC including how the PCT will locally lead the urgent health care agenda for its community in collaboration with local clinicians, the public, users and partners to promote improvement in the quality of services and outcomes for patients.

- **Investing for Health Programme (IfH)**

The PCT is actively engaged in the development and delivery of the SHA Investing for Health programme. The programme has reinforced the focus and legitimacy of the PCT core purpose and approach. The IfH programme has 5 strategic themes that will underpin future strategy and developments within the urgent care system:

1. Full engagement in self care and health improvement
2. Improving quality and safety of health services
3. Care closer to home
4. Sustainable services which ensure access to safe services
5. Organisations that are fit for purpose and resilient

- **Direction of Travel for Urgent Care**

The Direction of Travel for Urgent Care (DOH 2006) provided a shift in focus from the achievement of national standards to developing patient centred urgent care services, responding to what patients and the public tell PCTs they want from urgent care. The document is based on six key principles intended to address the concerns of service users. The learning from the consultation document went on to inform the NHS Next Stage Review (Department of Health 2008a).

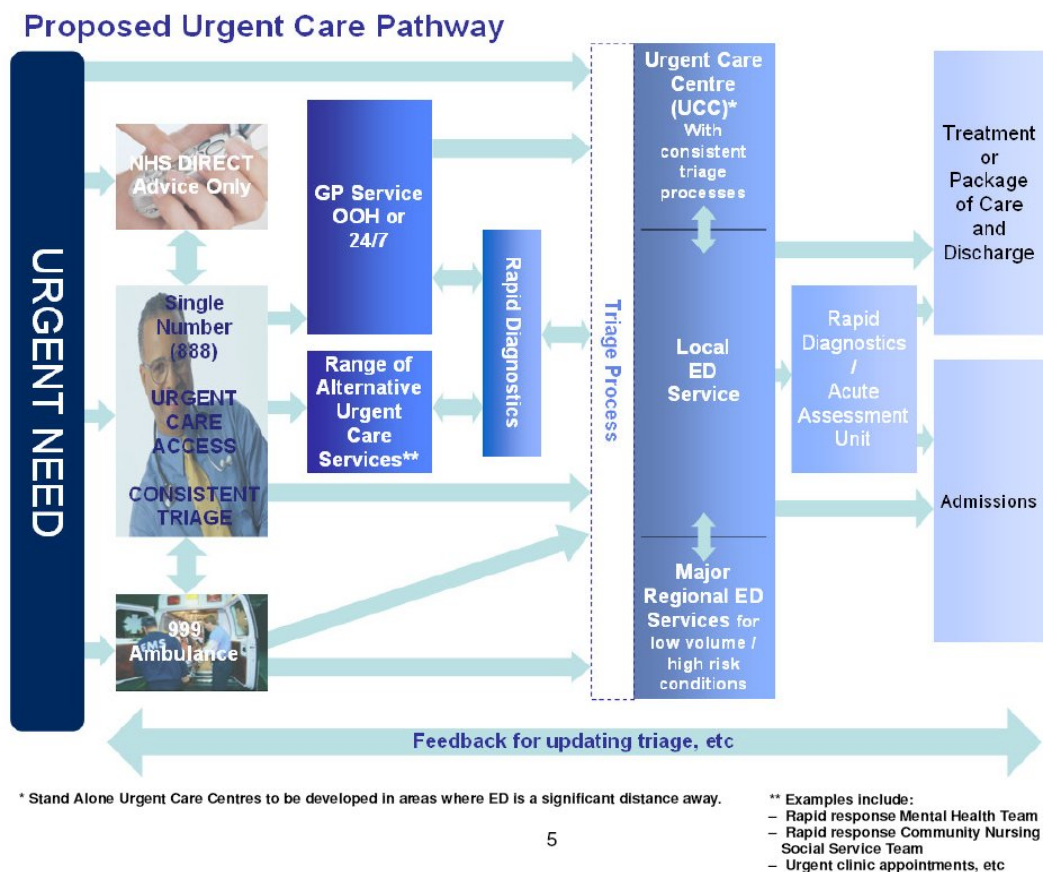
- **The NHS Next Stage Review**

The review sets out a vision for Urgent Care where *every member of the public should be able to expect integrated local services that provide access to urgent care, 24 hours a day and 365 days a year* (NHS Next Stage Review: Our vision for primary and community care, 2008)

The acute care pathway stream, led by West Midlands SHA, has developed the recommendations for the NHS review and set out how urgent care services will achieve the vision through:

- A single point of access - potentially an 888 number available around the clock which would assess people's needs (triage). Currently people are often unsure what to do or where to go if they think they have an urgent care need.
- Common assessment for urgent care wherever the patient accesses the service including within urgent care centres.
- Better provision of information to the public combined with education and alternative support services in the community to enable self care.
- Increased quality of care, patient and staff satisfaction because of the streamlined access to appropriate urgent care services.
- Increasing the number of patients being assessed and treated at or close to home, increasing the numbers receiving rapid diagnostics.

A summary of the West Midlands SHA proposed pathway for urgent care is shown below.



- **Not Just a Matter of Time**

In September 2008, the Commission for Healthcare Audit and Inspection reported on their review of out of hours GP Services, A&E services, urgent care centres, emergency ambulance services, urgent GP services delivered during usual surgery opening hours and NHS direct.

Birmingham East and North PCT were amongst the 27% of PCT's who were rated as "better performing".

A series of recommendations to improve urgent care services were made following the national review including:

- PCTs should ensure they have a clear plan for the delivery of integrated urgent and emergency care services that are easier for patients to navigate and make the best use of resources.
- Patients and the public need to be fully engaged in plans for the future of services, this has been developed further with the DOH producing a guide for Patient and Public Involvement in Urgent Care (DOH 2008c).
- PCTs should ensure that they are making effective use of information to monitor and improve urgent and emergency care services. This should include 'whole system' measures of outcomes and patients' experiences, from initial contact to resolution of their problem.
- The Department of Health should review what national action they can take to support integration across urgent and emergency care services and simplify how these services are accessed. This should include supporting the planned pilots of a single telephone number for urgent care, ensuring consistency in terminology, targets and standards across services and reviewing how targets should evolve to support integration of services.

## **4 Local Strategic Context and Drivers**

### **4.1 PCT Strategic Direction**

The PCT has a clearly stated core purpose as set out in the Strategic Plan (BENPCT 2008a) of 'Working in partnership to tackle inequalities and improve health and wellbeing of local people'. The PCT holds four audacious goals which provide the core framework for investment and development:

- To be so responsive to the population we serve that no one waits for the quality care they need;

- That the health and wellbeing of the population will have improved so much that people will enjoy 10 more years of healthy life;
- That people regard us as the first choice organisation to work with and for;
- Our communities will be the most involved, informed and empowered in the country.

The goals are underpinned by strategies that drive the delivery of the PCT objectives:

- Promoting health and empowering People
- Extending Working Together for Health
- (B)RISK processes-Bold, Redesign , Investment, Sustainability, Knowledge
- Consistently fit for purpose-People, Buildings and IT.

Specifically for urgent care, the strategic plan sets out that emergency activity has remained stable over the last couple of years, against national growth of some 8% pa, not least as a result of the redesign of community nursing services within the PCT's own provider arm.

However, there has been growth in emergency activity at HoEFT and West Midlands Ambulance Service during 2008/09. Initial demand and capacity analysis suggests that the increase should be manageable within existing capacity. However it suggests an emerging lack of resilience in local systems, which have declared that 'an unplanned admission is a systems failure'.

### **PCT Strategic Plan**

The strategic plan sets out a number of initiatives for Urgent Care:

- PCT investment will expand the successful nurse-led urgent care team to deliver a second Urgent Care Centre in Washwood Heath. This will address the ad hoc use of A&E for minor conditions by the local population and surrounding areas, applying the learning from Kingstanding, which has repatriated urgent activity to the local area and created alternative access points to care for a vulnerable community.
- Redesign of key services including in planned care, urgent care, and long term condition management will increase choice and flexibility of delivery, maximising access across the PCT.
- By March 2013 9,700 accident and emergency attendances will be seen in the second urgent care centre.
- By March 2013 some 7,500 admissions will no longer be required due to the commissioning of increased community capacity for people at the end of their lives, increased community rehabilitation. Increased telephone and

assistive technology based support. This will be 13% if current emergency admissions and will mean a reduction in hospital beds.

### **PCT Commissioning Strategy (BEN PCT 2008b)**

The PCT Commissioning Strategy (BENPCT 2008b) provides a framework for commissioning focused on: improving health and wellbeing, securing access to a comprehensive range of services, improving the quality, effectiveness and efficiency of services, increasing choice for patients and achieving best value with resources together with the best possible outcomes for patients.

Commissioning takes place at different levels appropriate to the services and pathways being commissioned. This includes at practice based commissioning level, PCT level, through the Birmingham specialised commissioning team and jointly with the local authority.

A range of initiatives have been prioritised in line with the Strategic Plan and Commissioning Strategy, a number of these support primary care management of patient's urgent care episodes through increased capacity and responsiveness of primary care services.

#### **Best practice in Long-Term Conditions management through:**

- Birmingham Own Health,
- Integrated Model for Assertive Case Management and District Nursing.
- Secondary Care and Primary Care 'Working Together for Health' in for example diabetes care, heart failure and COPD.

These services ensure that patients have care plans in place that provide timely response to their urgent needs and then return patients to planned pathways without the need for A&E transfer.

#### **Comprehensive Intermediate care services:**

Expanding roles, provision and capacity for intermediate care services in primary care. Partnership working with health, social care and voluntary organisations. These expanded services have more capacity to support targeted work to reduce urgent and unplanned admissions to hospital and facilitate early discharge.

#### **End of Life Care Services:**

- Redesigning care pathways for all patients identified as suffering from an advanced disease from which they will die.
- Increasing capacity for end of life care services in the community and so reducing emergency hospital admissions, enabling more patients to die at home.

This approach ensures more patients die in their place of choice with adequate planned services to support them in primary care reducing urgent admissions through A&E at the end of life.

### **Access to Diagnostics:**

- Direct access diagnostics for GP's available at secondary care and independent sector provision.
- Access to X-ray for Urgent Care Staff
- Direct referral pathway to the early pregnancy assessment unit (EPAU) for patients attending the UCC with problems in early pregnancy

Furthermore, rapid access to diagnostics outside of the acute hospital setting will support current and developing urgent care providers to provide complete episodes of care in primary care.

### **Local Urgent Care Centre Provision:**

The Urgent Care Centre (UCC) at Kingstanding meets the needs of a deprived community. A second facility is planned during 2009 for the Saltley area. Further walk-in facilities will be available in the new PCT health centre in Erdington during 2009/10, and within the Sheldon Heath new build, scheduled for opening 2011/12.

Patient satisfaction with these services is high and evidence demonstrates the service provides much needed capacity for urgent care and primary care services in an area of deprivation.

The need for future developments in Urgent Care Centres will need to be considered within a fully integrated model that takes account of the needs and preferences of the local population. The use of predictive modelling to understand where best to locate services for those most in need requires further work but early indicators suggest a further area of high demand in the Sheldon Heath, Castle Vale and Kitts Green area of the PCT.

### **Ambulance Service:**

West Midlands Ambulance Service (WMAS) are working with the PCT and local health economy on two diversion schemes created to reduce demand at A&E departments and provide care closer to home for patients:

- Diversion of appropriate patients to the Urgent Care Centre in Kingstanding
- An alternative pathway that diverts appropriate patients calling ambulance services with primary care problems to OOH GP service providers to provide primary care interventions at: treatment centres, urgent care centres, in patient's homes (if they are housebound) or by telephone to support self care.

### **Out of Hours Providers**

The PCT has operated an A&E diversion scheme supported by Badger OOH provider at both Heartlands and Good Hope sites for three years. The scheme diverts patients presenting with primary care problems from A&E to the onsite OOH provider in the out of hours period. The scheme supports reduced waiting for patients and enables the A&E departments to concentrate on appropriate cases and achieve 4 hour waiting targets.

Both Badger who cover 74 of BEN practices and Primecare who cover 8 practices are supporting the ambulance diversion scheme pilot referred to above.

**Urgent Care Project:**

BENPCT is leading a piece of work across the Local Health Economy to test out an integrated model of urgent care that rewards providers on quality outcomes rather than activity. The project has scoped a range of measures aimed at ensuring the national tariff as currently constructed does not act as a barrier to redesign and integration of urgent care services at a local level. This includes scoping local alternatives to the national tariff for A&E and supports integration of urgent and emergency care services in line with local priorities.

The project is now at a stage where two options have been agreed in principle, by the Programme Board for testing. Both services will start in April 2009 and will be initially tested for 12 months.

NHS Birmingham East and North PCT will develop and lead the implementation of a Primary Care Discharge Unit (PCDU) admission avoidance scheme at Good Hope Hospital to test a model which will focus on reducing medical short stay admissions. The PCDU will be led by a senior GP and will be supported by a multi disciplinary primary care team including intermediate care, drug and alcohol workers, social workers, therapists, assertive case managers and admission avoidance nurse. The unit will afford the opportunity to ensure enough time is available to plan comprehensive and co-ordinated discharge without restrictive four hour target penalties. The team, which includes support from South Staffordshire PCT, will work with A&E staff to ensure swift and co-ordinated advice, diagnosis and treatment for primary care patients including assessments by community teams where necessary and appropriate onward referrals for a full discharge package of care if required.

Solihull NHS Care Trust will lead the development and implementation of the second option, which will provide a Primary Care Nursing Service to support care homes in managing their patients. This option will be tested in Solihull and two care homes have been identified to take part in the trialling of this option. The service will endeavour to provide increased management and treatment of conditions presented by the residents, provide early intervention in an appropriate setting, avoid unnecessary hospital admissions and provide education, advice and support to care home staff. Clear links with GP practices and full integration with Solihull's Single Point of Access will be created and maintained as a fundamental part of this service.

The learning achieved from both models will be shared across the local health economy.

## 5 Profile of BENPCT Residents

NHS Birmingham East and North PCT serves a population of 440,844 (as at end Jan 09) people across 17 wards across the eastern half of Birmingham City Council. The registered population is similar in its profile of to that of the city as a whole. The population of NHS BEN has grown by 1.8% since 2001 compared to 3% to the city. Birmingham is a relatively young city, each year it has over twice the number of births as it does deaths. However, outside of Bordesley Green and Washwood Heath, BEN is relatively under represented in 18-34 year olds, and over represented in 75-85+ with high utilisation of health services.

White British is the single largest group at 66.7% of the population, and the PCT is culturally diverse with over 22% of the population self reporting a non white British background. Washwood Heath has a 70% Black and ethnic minority population while Sutton, Four Oaks has only a 5% ethnic minority. There is also disparity in gender: a total of 51.7% of residents are female.

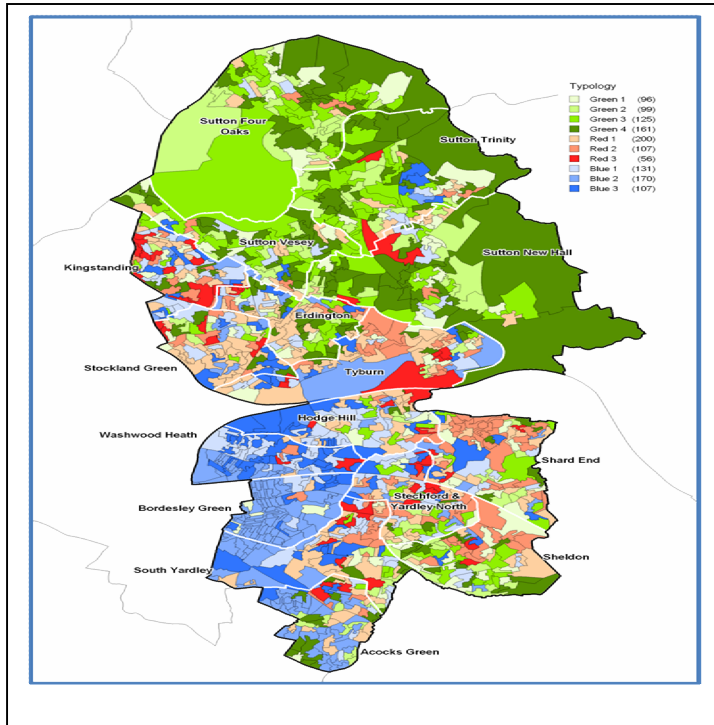
Overall the 2007 Index of Multiple Deprivation ranked Birmingham as the 14<sup>th</sup> most deprived local authority in Britain, and half of the city's 10 priority fall within our area. The rank of income scale placed Birmingham as the most deprived in terms of income and employment. Approximately 22% of the working population is unemployed. Unemployment is most highly concentrated in the deprived wards including Kingstanding, Washwood Heath and Shard End. Over 20% of the population, concentrated in the Sutton Constituency are well established career professionals or successful white collar older families.

Within the PCT there is an over 6 year difference in the average life expectancy in the 6 miles from Washwood Heath to Sutton town centre.

The vast majority of the PCT population use Heart of England Foundation Trust to access A&E services. The rate at which individuals access A&E across the wards of the PCT varies quite considerably and highlights the requirement for full data segmentation and predictive risk modelling to fully understand the differences in utilisation.

Data segmentation has been used by the PCT to identify high intensity users with long term conditions who would benefit from planned support from an assertive case manager to prevent urgent care episodes. Many more opportunities for targeted intervention of particular groups through data segmentation and social marketing exist and will be undertaken specifically for Urgent Care Services. This will be explored further through the work of the PRIME project (Programme for Relationships, Intelligence, Metrics and Equality).

Recent evidence from a bespoke segmentation model for health inequalities within BEN, can be used as a foundation for public health planning and marketing interventions in the longer term. The map below details the health typologies experienced across NHS BEN.



Overall, there are representative streams appearing in each ward. Stream 1 (Green) accounts for the majority of output areas with Sutton Four Oaks, Sutton New Hall, Sutton Trinity, Sutton Vesey and Sheldon and for urgent care specifically, accounts for higher rates of admissions for strokes and lower rates of emergency admissions. Output areas within Bordesley Green and Washwood Heath predominately belong to stream 3 (Blue) which incorporate higher rates of admissions for

complications of pregnancy and birth and lower rates of A&E attendances. Stream 2 (Red) appears to have a large proportion of output areas in Erdington, Shard End, Tyburn, Stechford & Yardley North and Stockland Green and experiences higher rates of A&E attendances, higher rates of emergency admissions, and higher rates of excess bed days.

Population density also has an impact on the output areas but upon superficial analysis, areas such as Kingstanding, Castle Vale and Falcon Lodge all have high levels of deprivation and therefore high urgent care activity. Further details of the Health Typologies and detailed breakdown of the colour streams can be found in the Health Typologies Analytical Phase document held by the PRIME Project team.

## 6 Review of the Evidence

### 6.1 Direction of Travel for Urgent Care (DoH 2006)

Lattimer et al (2006) conducted a literature review on out of hospital urgent care in order to inform the Direction of Travel for Urgent Care document (DOH

2006). The key messages from the evidence were grouped under workforce and skill mix, assessment and triage and treatment and referral.

### **6.1.1 Workforce and Skill Mix**

- Nurses substituting for doctors in out-of-hours care, walk in centres, minor injuries units and general practice can deliver care that is safe and of equal quality in relation to a sub-set of clinical conditions. *Laurant et al (2004)*
- Emergency Care Practitioners (paramedics and nurses) working in ambulance trusts, walk-in centres and general practice out-of-hours services are reducing hospital attendance and admission. *Mason et al (2007)*
- Patients are uncertain about the variety of role titles and what they mean. *Barnes et al (2004), Bunn et al (2006)*

### **6.1.2 Assessment and Triage**

- Up to 50% of patients have their care managed over the telephone out-of-hours. Practice Nurses can manage over 40% of requests for same day appointments in general practice by telephone. *McKinstry et al (2002)*
- Telephone assessment of Category C ambulance calls identifies patients less likely to require emergency department care and reduces ambulance dispatch rates. *Dale et al (2003)*
- Patients managed by telephone either by GPs or nurses are more likely to re-consult about the same problem. Nurses are more likely than doctors to recommend follow-up, albeit appropriately. *Bunn et al (2006)*

### **6.1.3 Treatment and Referral**

- Emergency Care Practitioners carried out fewer investigations, provided more treatments and were more likely to discharge patients home than the usual provider (an ambulance trust, a GP led out-of-hours service and a walk in centre). *Mason et al (2007)*
- Appropriate transport of patients by ambulance crews to treatment centres rather than EDs may have positive effects on ambulance job-cycle times and improve patient satisfaction, but many schemes are at an early stage of development. *Mason et al (2007)*
- Multidisciplinary models of intervention that include social care staff show promise in the care of older people including risk identification and admission prevention; in the care of people with mental health problems and in engaging frequent service users. *Macleod et al (2003)*

In summary, the review of the literature highlighted growing evidence of new roles, new ways of working, new ways of commissioning and delivering services in urgent care in the UK in response to a number of drivers for change. The drivers include policy requirements to improve local services for patients, the need to prepare for the future where GP resource may be more constrained and the need to make best use of resources. The evidence on the outcomes of many of these changes is limited both in the number of studies and the robustness of design. The pace of organisational change has ruled out the

opportunity for before and after studies. However, it is becoming clearer from the international agenda Grol et al (2006) there is a need for service integration at local or regional levels and a move away from services working largely as separate components.

## **6.2 BEST PRACTICE REVIEW**

In addition to the DoH Direction Travel for Urgent Care literature review, the Urgent Care Project commissioned an independent review of local, national and International best practice around Urgent Care, extracts detailed below. The review including full references is available at [www.warwick.ac.uk/go/edwaits](http://www.warwick.ac.uk/go/edwaits).

### **Improving patient flows – right place, right time**

- High users of the ED are usually high users of primary care, it is not commonly substitution in this group.
- Good continuity of primary care reduces ED usage.
- Open access to primary care ( including OOH) reduces ED attendance
- Walk-in centres & NHS Direct have not been demonstrated to change flows.
- Phoning for advice before going to the Emergency Department may reduce attendances.
- There is no evidence around the effects on waiting times of general practitioners working in emergency departments.
- Primary care filtering at the front door of the ED may reduce emergency department attendance but may be unsafe
- Triaging out of the emergency department can reduce numbers but more work is required to verify the safety of such systems.
- No evidence that NHS Direct significantly changes flows or reduces ED attendance
- It is possible to divert some 999 calls to advice lines but safety is not known.
- The role of paramedics/ECPs in either discharging patients from scene or deciding on appropriate destinations has not been adequately studied to confirm its safety and effectiveness, except in a specialist role with elderly patients combined with a prolonged training programme
- Specialist nurse care in heart failure, COPD and DVT can reduce hospital admissions.
- Nurse practitioners are safe and effective but their effect on flows is unknown
- The role of other health care professional in emergency care needs evaluation
- Patient education is of unproven benefit in most areas except chronic disease management.
- Attendance by the elderly, those with chronic disease and those with multiple attendances may be reduced by various interventions, trials are needed in this area, including the role of social workers.
- Senior staff may reduce admissions and delays.

- Triage is a risk management tool for busy periods; it may delay care.
- Fast track systems for minor injuries reduce waits.
- Observation wards may reduce length of stay and avoid admission.
- There is a lack of evidence of innovations in bed management.
- There is a lack of evidence about innovations to reduce delayed discharges from hospital.
- Co-payment systems reduce attendances but may equally reduce attendances by those requiring emergency care.
- There is no evidence on how reimbursement systems may help to incentivise best care in the NHS funding system.

## **Reducing unplanned hospital admissions**

A range of initiatives were explored to identify those that may reduce unscheduled admissions. There is some evidence to suggest that the following initiatives may reduce unplanned hospitalisations and readmissions:

### **Self-management education and self-monitoring**

- Group visits to primary care for those with chronic disease
- Broad managed care programmes and care from specialist nurses
- Integrating social and health care
- Multidisciplinary teams in hospitals and after discharge
- Discharge planning
- Nurse –led clinics to review chronic disease patients and frequent users
- Telecare and Telemonitoring
- Short stay units and clinical decision units in the ED for specific conditions
- Hospital at home for children

**There is some evidence that the following may reduce length of stay:**

- Self-management education
- Telecare
- Multidisciplinary teams in hospital
- Discharge planning and bed management may reduce length of stay
- Home hospitalisation
- Educating professionals
- Specific Geriatric emergency departments

**In addition these interventions may reduce length of subsequent hospital stays:**

- Targeting people at high-risk
- Self-management education
- Telemonitoring

- Multi-disciplinary teams in hospital and after discharge
- Nurse-led clinics and nurse-led follow up
- Targeted assertive case management
- Targeted proactive home visits.

### **Lessons from Kaiser Permanente** *(provided by Chris Crisafulli, KP South California)*

KP has stated that their key successful changes were:

- Short stay and clinical decision units where patients can be worked up, observed and stabilized prior to discharge.
- Physicians trained and committed to low hospital utilization, i.e. higher rather than lower threshold for admitting a patient. One element that facilitates that is not to have a surplus of hospital beds available.
- Crisis team for psychiatric patients.
- Discharge planning

For patients coming to the emergency department:

- 50% of our ED visits are for low acuity injuries and illnesses. Of those 50% about 60% of them tried and were unable to get an appointment with their primary care physician. Having a primary care physician and being able to see that primary care physician is the most effective way to prevent ED visits. One of our strategies we employ in the winter time when we naturally expect more URI and therefore ED visits, is to open up more primary appointments.
- Having an efficient Fast Track system for the low acuity patients is an absolute must. Otherwise delays in discharge will clog up the ED.
- A state-of-the-art accredited nurse advice system called "KP OnCall". Algorithms allow RNs to recommend at least five dispositions; Home care, Urgent appointment in PC, Emergency visit or 911 ambulance pick-up. It allows us to direct patients to the appropriate level of care at the right time to the right place. This centre serves over 4 million people. We are unsure of how many of our southern california population utilize this service but we do know that outside claims costs have been reduced.
- Three other important areas to focus on the reduction of Lab and Radiology turn around time and consultant response times.

### **6.3 URGENT CARE (A practical guide to transforming same-day care in general practice)**

A recent report commissioned by the Department of Health and provided by the Primary Care Foundation (2009), confirms that practice capacity is critical in determining practice's ability to improve patient's experience of urgent care. A number of recommendations were highlighted as part of the report and suggest that by offering ongoing resourced support for practices to improve urgent care can bring major benefits across the system.

If surgeries can manage urgent care as early as possible in the patient's journey, the workload and costs for the rest of the NHS will be reduced. In addition, better management of urgent care requests can lead to a substantial reduction in attendance at A&E and emergency hospital admissions. The evidence from the

report goes on to confirm that four factors are key in providing high quality urgent care; Access, Speed of initial response, Capacity, Assessment (by receptionist or call handlers and clinicians).

Specific actions points are recommended and include;

1. Access – Ensure patients with urgent conditions will receive timely care however they access the service.
2. Matching capacity and demand – Ensure processes minimise avoidable peaks in demand including telephone demand and capacity.
3. Reviewing Capacity – Make sufficient appointments available to meet demand from patients.
4. Capacity for same-day and advanced appointments – The balance of book ahead to same-day appointments (including other options such as telephone consultation or other responses) should be matched to the pattern of demand.
5. Responding to urgent cases – reviewing how the practice would identify and respond to a range of urgent cases.
6. Training – Review receptionist training to ensure that the front line teams understand and use the right processes to identify and handle urgent calls.
7. Deadline for assessment – define practice’s own standards for the length of time from patient first ringing to assessment by a clinician (telephone or face-to-face)
8. Deadline for intervention – define practice’s own standards for the length of time until appropriate clinical interventions or hand-offs take place where a clinician has assessed the case as urgent.
9. Quality – Carry out regular audits of the process for urgent care to review the quality and consistency of telephone response.
10. Home Visits – Any patient or carer who requires an urgent home visit should be offered a rapid assessment by a clinician.

## **7 Patient Views/Experiences**

Patient and public feedback remain high on the PCT agenda and patient consultation events were held to ensure the views of our patients are incorporated in Urgent Care. Eleven patient focus groups were held as part of the Urgent Care project and “The Big Conversation” event, where 16 focus groups were recruited from across the PCT area to give views on health services. Feedback themes are detailed below:

### **Appointments**

- People commented that difficulty getting a GP appointment meant they attended A&E instead.
- Many people commented that having to call on the day of an appointment is frustrating; the restrictions placed additional stress on the emergency appointments.
- Those that had a good service from their GP prefer not to go to the hospital.

### **Make Access Easier**

- Expand access and availability of walk in services.
- Ensure everyone can easily make a same day appointment at their GP surgery.
- Extend GP opening times.
- Encourage people to register with a GP.

### **Raise Awareness**

- Re-educate people to develop understanding of what services are available
- Target hard to reach communities
- Raise awareness of services provided at walk in centres and urgent care centres, NHS Direct and Pharmacies.

### **Accident and Emergency Services**

Many respondents complained about waiting times exacerbated by what they saw as non urgent cases attending A&E, *“the problem is that people are abusing it. Most of the people in there don’t need to be there and half of them are only there because they can’t get an appointment at the doctor”*.

### **Local Urgent Care Centres/ Walk in Clinics**

In principle respondents liked the idea of accessing minor acute services locally. Advantages were: no parking fees, better for older people, who may find a longer journey more arduous, imagined shorter waiting times, less intimidating environment especially important for children also less hospital attendances could impact positively on infection rates.

A number of queries raised were around what could be treated and how patients would decide where to go, A&E or local service.

Concerns were raised about lack of access to existing records and non users were unclear as to what one can legitimately present with at a walk in centre. There were concerns that provision of emergency facilities might impact negatively on existing GP services making it more difficult to obtain a routine appointment.

### **Single point of Access for Urgent Care**

The respondents were largely opposed to a single call number because of their experiences with general call centres. They felt this service may duplicate services offered by NHS direct. However some respondents felt

there would perhaps need to be some way to direct patients to the most appropriate source of help especially given the advent of Local Urgent Care Centres.

## **8 Stakeholders views**

A stakeholder event was held by BENPCT as part of the urgent care project in September 2008. There was also a health economy wide event held as part of the Darzi NHS review in November 2007. Many of the themes put forward by local stakeholders are mirrored in the publication *Direction of Travel for Urgent Care* (DOH 2006) and there is fairly widespread agreement on key themes between patients and other stakeholders.

### **Access**

- Primary Care services require 24 hour local access 7days a week.
- Access to social workers and social care 24/7 so services are consistent
- General Surgery Admissions and General Admissions need 24/7 clinical cover.
- Ease of access, equitable and needs not desire led

### **Integrated services**

- Clear and simplified pathway and knowledge so as patients know where to appropriately access.
- An integrated health care system - no more primary and secondary care services. Reinvent the United Health Service.
- Stop using money as the driver for change, pooled resources across the health economy with joined up services.
- Don't create financial disincentives or use it as a barrier for good practice.
- Safe high quality care benchmarked, better coordinated with better choice.
- Building bridges to bring GP's on side to work with secondary care as a joint force.

These stakeholder views are consistent with recent papers by Chris Ham espousing the benefits of clinically integrated NHS care, Ham 2008.

### **Public Education and Information**

Information on:

- The effective use of health services-clarifying the role of the NHS.
- The fact all things are possible but not all things are beneficial.
- Why we need to centralise emergency care to provide a better service.
- Use all forms of communication, advertising, websites that the local diverse community will relate to, to provide information on services.

### **Data**

Better data, coordinated integration of IT but securely held.

## Workforce Development

- Engage workforce in changes to get their buy-in.
- Access to the right equipment and up-to-date technology.
- Broader skills and better representation of the local community in our wider workforce.
- Investment in staff so less turnover.

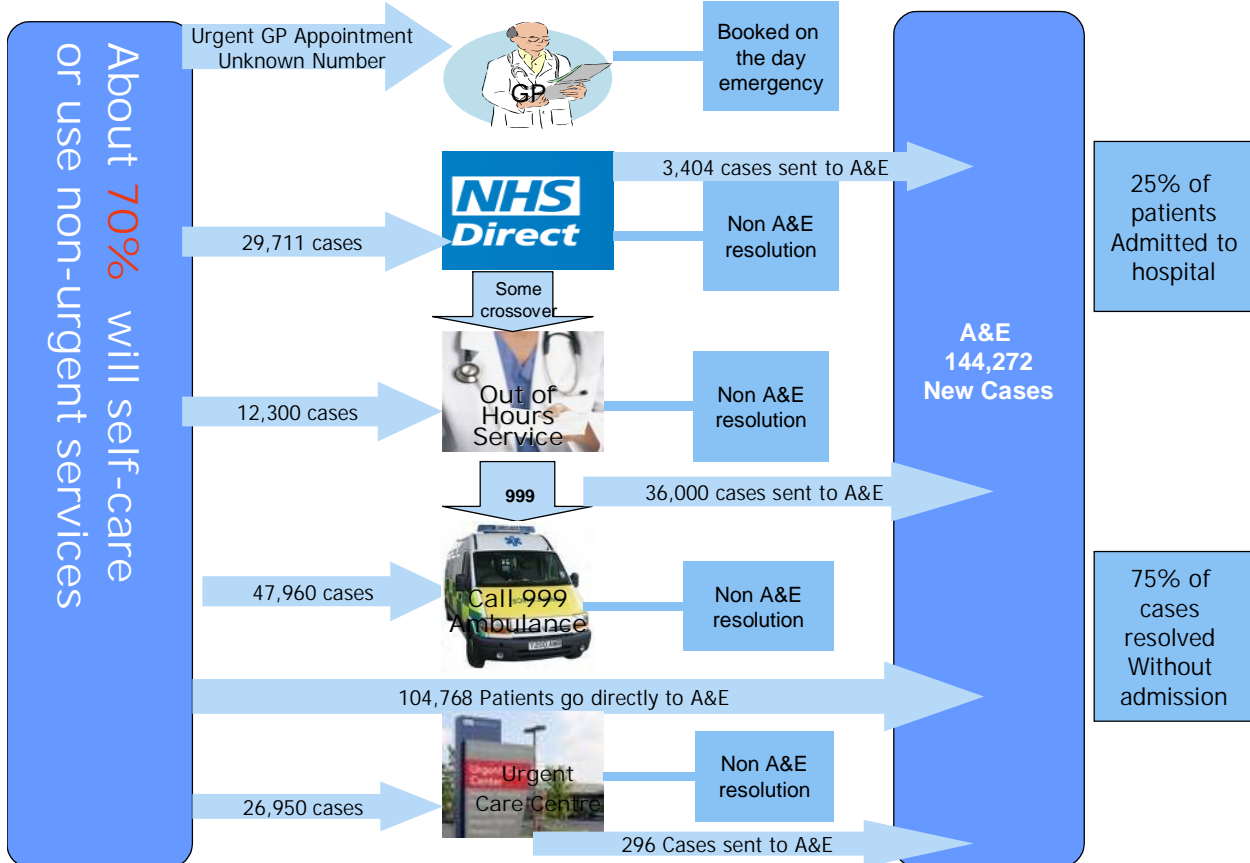
In summary, the stakeholders support an integrated system for urgent care with good access and information on services for patients. There is a desire to remove the disincentives for integration put in place by payment by results and to achieve better working between primary and secondary care. Sharing of data and better workforce development are seen as key to improvement.

## 9 Profile of Urgent Care Services

### 9.1 The Urgent Care System is wider than just A&E

#### Urgent Care System

Emergency care pathways, West Midlands, 2008. Figures represent a 12 month period in BEN PCT.



### 9.2 The Cost of Urgent Care

Urgent Care activity accounted for £98.7m spend for NHS BEN during year 2008/09. A&E activity and emergency admissions account for a massive 78% of the overall spend as detailed below:

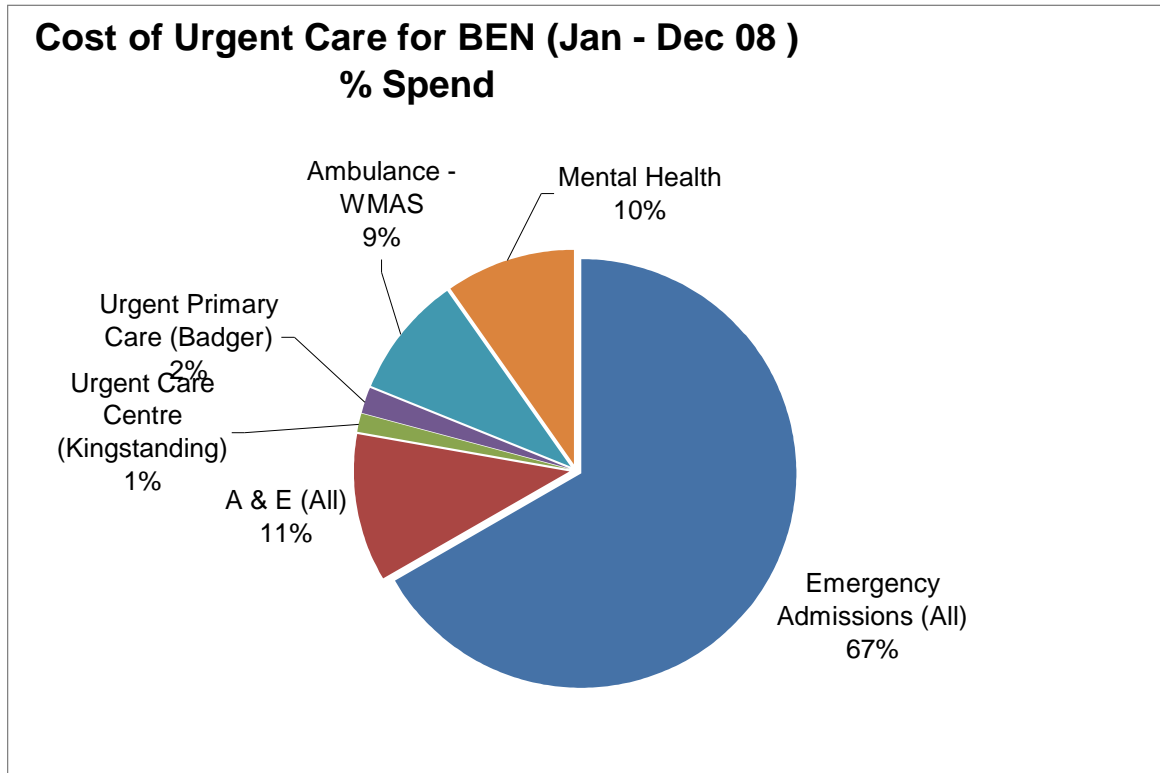


Fig 1 Cost of Urgent Care for NHS BEN

Table 1 below demonstrates the activity at secondary care trusts nationally for the population of NHS BEN from Jan 08 to Dec 08. In addition, the table details the total activity and costs incurred for the NHS BEN population for both A&E attendances and emergency admissions.

**BEN PCT**  
**Urgent Care Activity and Cost**  
**Jan - Dec 08 (All Providers)**

Provider	A&E		Emergency Admissions	
	A&E Count	A&E Cost	Admissions	Total Cost
HEART OF ENGLAND NHS FOUNDATION TRUST	118,189	£ 8,946,398	31,784	£ 58,614,368.60
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	15,570	£ 1,077,710	2,177	£ 3,869,599.48
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST	6,102	£ 405,974	1,270	£ 1,460,074.86
UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST	2,493	£ 201,554	540	£ 893,434.18
WALSALL HOSPITALS NHS TRUST	648	£ 50,633	106	£ 210,833.55
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	212	£ 15,762	39	£ 66,372.84
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	271	£ 21,791	48	£ 60,939.61
SOUTH WARWICKSHIRE GENERAL HOSPITALS NHS TRUST	104	£ 8,160	20	£ 46,894.57
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	58	£ 4,769	16	£ 36,491.45
GEORGE ELIOT HOSPITAL NHS TRUST	123	£ 10,183	14	£ 32,767.41
DUDLEY GROUP OF HOSPITALS NHS TRUST	162	£ 9,273	22	£ 24,836.90
Others	340	£ 23,451	436	£ 616,120
<b>Total</b>	<b>144,272</b>	<b>£ 10,775,658</b>	<b>36,472</b>	<b>£ 65,932,733</b>

Table 1 Total A&E attendances and Emergency Admissions for NHS BEN

Heart of England Foundation Trust is the main provider of A&E and Emergency Admissions for NHS BEN residents, attendances at HEFT account for 81% of all emergency activity. The table below demonstrates the % split of activity between

the three Heart of England Foundation trust sites for the 118,189 attendances in the table above.

A&E	Heartlands	Good Hope	Solihull
<b>Emergency Admissions</b>	48%	45%	7%
	45%	50%	5%

Table 2. % split of NHS BEN activity for Heart of England Foundation Trust

The rate at which individuals access A&E across the wards of the PCT vary quite considerably as illustrated in the table below. The average % of activity over all localities is 26% of the locality population, therefore only Sutton and Kingstanding experience below average activity.

Locality	Population	HIGH COST	STANDARD	MINOR	Grand Total	Total % activity for population
Bordesley Green, South Yardley & Acocks Green	78,816	7,724	3,191	12,075	22,990	29
Kingstanding	62,776	5,299	3,252	6,195	14,746	23
Sheldon, Stechford, Shard End & Yardley North	64,850	7,014	2,570	9,213	18,797	29
Sutton	110,827	8,902	5,120	10,632	24,654	22
Tyburn, Erdington & Stockland Green	59,996	5,545	3,431	6,716	15,692	26
Washwood Heath & Hodge Hill	64,280	5,457	2,761	10,856	19,074	30
<b>Grand Total</b>	<b>441,545</b>	<b>39,941</b>	<b>20,325</b>	<b>55,687</b>	<b>115,953</b>	26

Table 3. Locality specific attendances at A&E at Heart of England FT April 2007 to March 2008

Furthermore, there are a range of common conditions that result in A&E attendances as detailed in the table below although consideration must be given to the 58040 records that have been un-coded.

Diagnosis	Total
BLANK (Non recorded)	58040
DISCHARGED FOR ASSESSMENT IN PRIMARY CARE CENTRE	2715
Sprain and strain of lower limb/ankle	1233
NON ORTHOPAEDIC TRAUMA - MINOR HEAD INJURY	1107
Chest pain, unspecified	1085
Unspecified injury of head	732
GASTROENTEROLOGICAL - ABDOMINAL PAIN ? CAUSE	723
SPRAIN/SPRAIN - LOWER LIMB – ANKLE	627
CARDIO-VASCULAR – CHEST PAIN ? CAUSE	618
Other and unspecified abdominal pain	594

Top 10 Most Frequently Presented Conditions at A&E October 2007 to November 2008

Many of the A&E attendances go on to be unplanned admissions Table 4 shows the top ten specialities for unplanned admissions.

Specialty	No of Emergency Admissions
300 General Medicine	22247
100 General Surgery	3035
420 Paediatrics 1	2700
340 Thoracic Medicine	2675
430 Geriatric Medicine	2515
110 Trauma and Orthopaedics	2182
502 Gynaecology	2114
320 Cardiology	1088
350 Infectious Diseases	709
101 Urology	600

**Table 4 Emergency Admissions 2007/08**

### **Ambulatory Care Sensitive Conditions (ACS Conditions)**

The West Midlands' PCTs spent £128m on the 19 Ambulatory Sensitive Care Conditions in 2006/07 and £133m in 2007/08, which was 16% of the total emergency spend in each year. In 2006/07 and 2007/08, NHS BEN were among the three highest PCTs in the region having the most ACSC spells, spending over £11m on ACSC. When the results were weighted, NHS BEN continued to be one of the three highest spenders in 2007/08. This confirms the extent of the issues for the local population and the need for the PCT to focus an emphasis on providing care and managing illness and disease in primary care. Effective health promotion can also play a key part in preventing the onset of ACSC.

During April to July 2008, NHS BEN total spend for Emergency activity totalled £25m of which 18% of the overall spend was related to ACSC.

ACS conditions include; Angina, Asthma, Cellulitis, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Convulsions and epilepsy, Dehydration and gastroenteritis, Dental conditions, Diabetes complications (This covers Diabetes A-C in the ICD9 list), Ear, nose and throat infections, Gangrene, Hypertension, Influenza and pneumonia, Iron deficiency anaemia, Nutritional deficiencies, Other vaccine preventable, Pelvic inflammatory disease, Perforated/bleeding ulcer and Pyelonephritis.

## **9.3 Accident and Emergency Departments**

### **9.3.1 Acute Sector**

There were significant challenges in 2007/08 and more recently 2008/09 has seen the urgent care system severely challenged with worsening performance of the 98% target for all patients to be able to attend and discharged from A&E within 4 hours. Commissioners have been working with HEFT to jointly resolve the issues including increasing capacity for step down beds, additional

intermediate care capacity and increased use of primary care based urgent care facilities, for example ambulance services use of the Urgent Care Centre.

A significant amount of demand and capacity work has been undertaken both in 2007/08 and 2008/09, to understand the root cause of the problems related particularly to A&E attendances and flow through of patients at Heartlands and Good Hope Hospitals. From the data available, it demonstrates that demand for urgent and emergency care did not increase during 2007/ 08, however length of stay did increase across the two hospitals by one and half days. This created significant pressures on bed capacity and meant that the flow of patients was blocked at some points which resulted in patients numbers backing up and it resulting in problems for the Ambulance Service in relation to turn round times.

The winter period of 2008/09 has seen similar problems with flow of patients and increasing attendance at A&E during a cold winter and flu outbreak.

### **GP Call Handover Service**

GPs are also able to contact HEFT with patients they want to receive assessment or admission. A dedicated line (previously bed bureau) takes the call direct from the GP and arranges assessment or admission. This has proved a valuable service for frail elderly patients requiring assessment and diagnostics without admission.

### **9.3.2 Accident and Emergency Diversion Scheme**

During evenings and weekends an A&E diversion scheme operates at all HEFT sites any patients presenting with primary care problems are automatically directed to Badger Out of Hours GP located within the department. Activity has grown in this scheme whilst A&E attendances are consistent.

<b>Attendances</b>	<b>2006/07</b>	<b>2007/08</b>	<b>2008/09</b>
<b>A&amp;E Diversion</b>	<b>5064</b>	<b>11,690</b>	<b>12159</b>

Table 5. Badger A&E Diversion Scheme

### **9.3.3 GP Services**

There are currently 82 GP practices within NHS BEN with a total registrant list size of 440,844 (as at end Jan 09). GP's provide urgent care within the hours from 8.30am to 6.30pm. Currently 57 practices provide some extended hours at weekend or evenings under an enhanced service scheme.

Out of hours GP services are provided by two main providers Badger and Primecare. 36 practices have opted out of providing 'out of hours' cover and the PCT commissions Badger to provide this service. The remaining 46 practices continue to organise their own out of hours cover using either Badger( 38 practices) or Primecare (8 practices).

During the out of hours period in 2008 31,535 calls were made to Badger and Primecare.

### **9.3.3 Dental Care**

All patients registered with dentists in BENPCT area are able to access urgent and emergency treatment by contacting their dentists, on their usual number, which will give them an emergency dentists contact number. All unregistered patients can access emergency dental services via NHS direct.

### **9.3.4 Pharmacy**

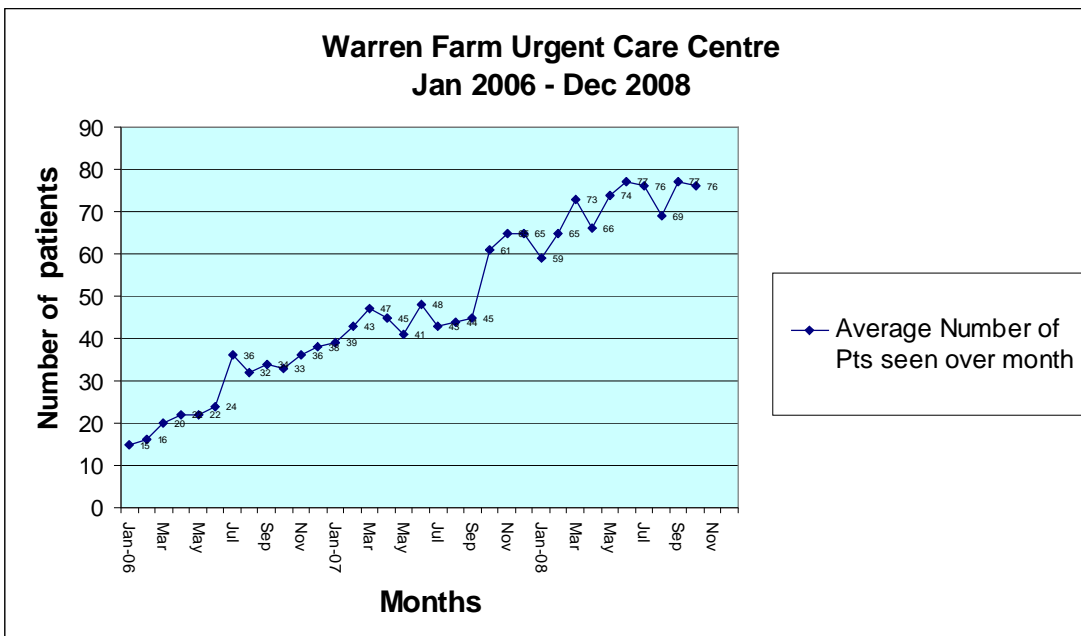
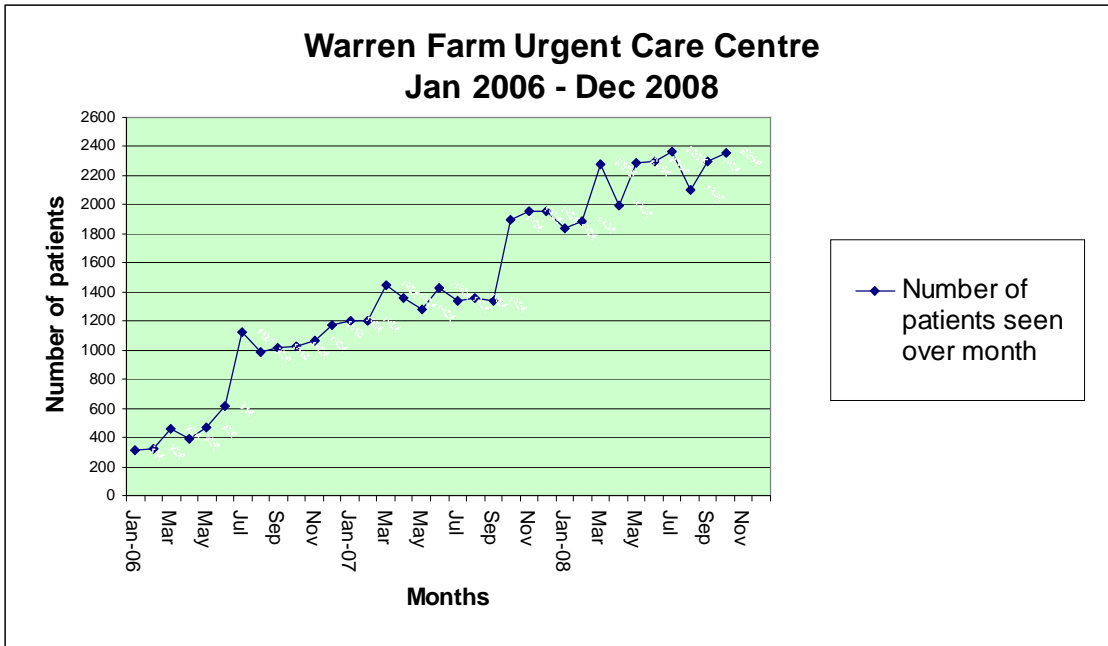
There are 100 community pharmacies within the BENPCT area, six of which provide a minimum of 100 hours opening a week. Three pharmacies open (voluntary) for an extended period opening until 10pm seven days a week. Three additional pharmacies open until 10pm Monday to Friday but with more limited hours at weekends.

### **9.3.5 Community Services**

Community services for Urgent Care are provided by BENPCT operations directorate which includes district nursing (available 7 days 24 hours a day), Assertive Case Managers and Intermediate Care teams both available 7 days per week. Both Assertive Case Managers and Intermediate Care teams provide an assessment service in both Heartlands and Good Hope Hospital A&E departments as well as community based services.

### **9.3.6 Urgent Care Centre**

The urgent care centre at Kingstanding opens seven days a week and provides a walk in urgent care service to the local population. During the winter pressures, the PCT supported the funding of an extended team at the Urgent Care Centre in Kingstanding to increase capacity and therefore utilisation by both patients but also ambulance crews diverting patients from A&E to the UCC. The graphs below details the steady rise in activity experienced at the Urgent Care Centre, including a high peak in activity during December 2008.



### 9.3.7 Mental Health

Mental health services are provided by Birmingham and Solihull Mental Health Trust with access to emergency teams available in the out of hours period both in a primary and acute care settings. There is significant investment in primary care mental health services to provide access to support and treatment to individuals who experience mental health difficulties within their GP surgery or community setting. The focus of primary care mental health services is to provide rapid

access to interventions and treatment in a setting close to home that is as ordinary as possible thus reducing stigma.

A liaison psychiatry service operates from Birmingham Heartlands Hospital (BHH) and is delivered through a multidisciplinary team model. The team provides assessment and advice regarding psychiatric and psychosocial aspect of care of the patients in the hospital. The team will also act as a primary contact with the Psychiatric service at Birmingham and Solihull Mental Health NHS Trust (BSMHT) and will incorporate and work closely with the deliberate self-harm Social Worker from the Social Care and Health Department at BHH.

### 9.3.8 Walk in Centre

The Walk in Centre in Birmingham City centre also provides urgent care services for BENPCT residents. BENPCT residents currently account for approximately 20% of the 35,000 attendances at the Walk in Centre each year.

The Birmingham PCT Partners have recently appointed a new provider for the Contract for the provision of services and it is anticipated that the new provider will take the WiC forward to provide improved patient satisfaction, greater access and integration with other services and the continuation of a valued service for Birmingham patients.

### 9.3.9 Ambulance Service

West Midlands Ambulance Service dispatched ambulances to 47,962 incidents across NHS BEN during 2007/08 and activity is expected to be in excess of 55,000 incidents for 2008/09.

Whilst it is entirely appropriate to dispatch ambulances to emergency situations such as road traffic accidents and heart attacks many calls to the service are not in need of emergency ambulance services. Around 23% of the calls were for non life threatening and non urgent (Cat C) calls, commissioners are working with the ambulance service to redefine the model of future services and to ensure the alternatives to A&E available in primary care are utilised more. Currently the number of patients who are not actually transported by ambulance following a visit from the service is 25%. Through better utilisation and coordination of alternative pathways where appropriate the non conveyance rate is expected to increase to 40% over the next 3 years.

Category	A (Response in 8 mins)	B (19 mins)	C (30 mins)	Total
Call Volume	15,766	21,372	10,824	47,962

Table 6. WMAS Activity 2007/2008

West Midlands Ambulance service (WMAS) is finding it increasingly difficult to deliver improved response times and achieve challenging call connect times across the BENPCT area. Commissioners are driving forward plans with WMAS to develop a workforce that is trained in additional assessment and clinical management skills that allow them to manage patients differently to the traditional ambulance response that is over reliant on accident and emergency departments. However, this requires the PCT to have in place easily understood and accessible onward referral pathways that are co-ordinated across boundaries.

### 9.3.10 NHS Direct Activity

NHS Direct are nationally commissioned by the Department of Health to provide a single telephone and web facility 24 hours per day, 365 days per year. When patients call with specific health problems, NHS Direct Health Advisors triage patients and refer callers to either a Nurse Advisor or in some cases patients may be fast tracked to 999 Emergency Services and A&E Departments.

For NHS BEN patients alone, NHS Direct have taken 29,711 calls in the period Jan-Dec 2008. Of these calls, a high proportion of calls have resulted in referral to another healthcare provider including Ambulance, A&E, Pharmacists, Dentist, Walk in centres and the patients own GP.

The chart below shows the outcomes of the calls received by NHS Direct for NHS BEN patients during October to December 2008. Activity shows that 44% of all calls received in that timeframe, were referred on to other healthcare services with 33% given self care advice and a further 23% of calls having no further action required.

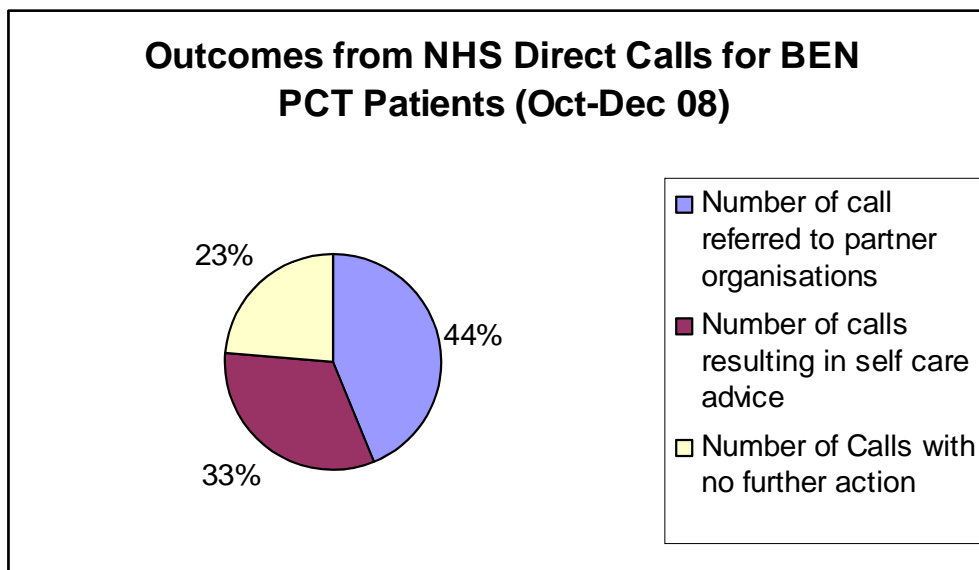


Chart 1. Outcomes from NHS Direct Calls for NHS BEN Patients (Oct-Dec 08)

### 9.3.11 Recently commissioned for CAT C Calls

In response to winter pressures and the increase in activity during December 2008, the out of hours providers were temporarily commissioned by the PCT to provide the Category C diversion scheme during the “in hours period” in addition to the out of hours. This resulted in an increased CAT C diversion with 142 calls diverted in the first 10 days of operation. However, on 21st December 08, the Department of Health commissioned NHS Direct to deal with the national increase in activity for Cat C calls which has resulted in a dramatic decrease to 26 CAT C calls handled by the out of hours providers during period 22.12.08-25.01.08. Commissioners are currently reviewing both models and will decide on the best model for Cat C diversions to be implemented from April 2009.

## 10 Challenges and Issues

The current urgent care system faces the following challenges to meet the needs of current and future populations:

1. Service needs to be more patient focused. No such thing as an inappropriate attendance, services need to redesign to provide an appropriate response.
2. There is a lack of integration in urgent care services leading to fragmented and variable care – needs consistent assessment across services.
3. The public are unsure what to do and where to go when they have urgent care needs – urgent care services need co-ordination, a single point of access will help.
4. There is a lack of self care information and alternative options available to the public.
5. There is a perception that there is excessive and inappropriate use of A&E departments and ambulance services by patients with problems and minor illness that could be dealt with in primary care. This requires co-ordinated alternative pathways easily accessed supported by a single point of access.
6. Evidence and findings from patient consultations and the visioning event, have highlighted a lack of sufficient access to urgent on the day appointments at GP practices which can often result in A&E attendances, therefore a clear need to focus on GP access is required.
7. Inadequate IT systems exist that do not support patient pathways and facilitate safe communication of patient information.
8. Current financial arrangements do not provide the right incentives.
9. Inadequate provision of primary care facilities with adequate diagnostics.

## **11 Objectives of the Urgent Care Strategy**

The principle objective of the urgent care strategy is to set out how the PCT will commission urgent care services to meet the needs of present and future populations, providing the highest quality care in the most appropriate setting making best use of resources. It will do this through the following objectives:

1. Develop consistent and coordinated urgent care pathways and clinical models of urgent care that will best meet the diverse needs of all BENPCT residents as close to patients homes as possible.
2. Expand the provision of primary care urgent care services including urgent care centres with access to diagnostics in primary care and primary care presence within accident and emergency departments.
3. Enhance GP Access for Urgent Care across NHS BEN.
4. Provide patients with good information and education programmes that support self care and promote the use of alternative support services.
5. Simplify the way high quality and safe care is accessed by patients in the place most appropriate to their needs including supporting a single point of access for urgent care that holds real time information on capacity within the system.
6. Enhance Clinical Leadership across the PCT and providers to ensure the objectives of the urgent care strategy are realised.

Whilst there are levels of urgent care need and services that are more appropriately placed to meet those needs, it is recognised that patients access urgent care at various levels of the Urgent Care pyramid, as shown in Fig 2 below. Many patients access self care in the first instance and progress onto the different levels of Urgent Care as appropriate; the model allows patients to access the urgent care system at any stage during the process with the exception of Specialist A&E Services which can only be accessed via ambulance.

## The Urgent Care Needs Pyramid

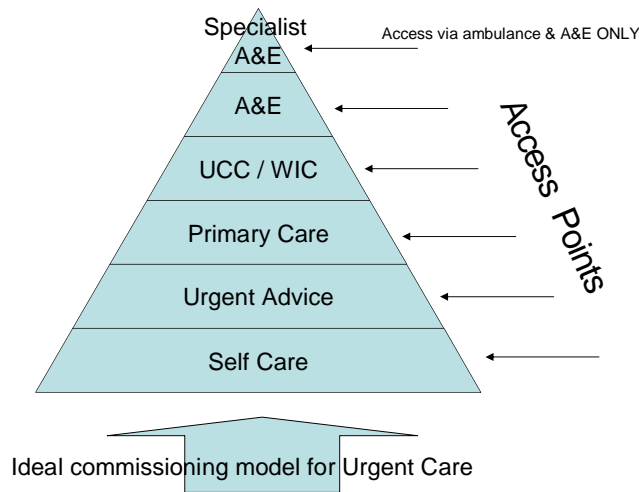
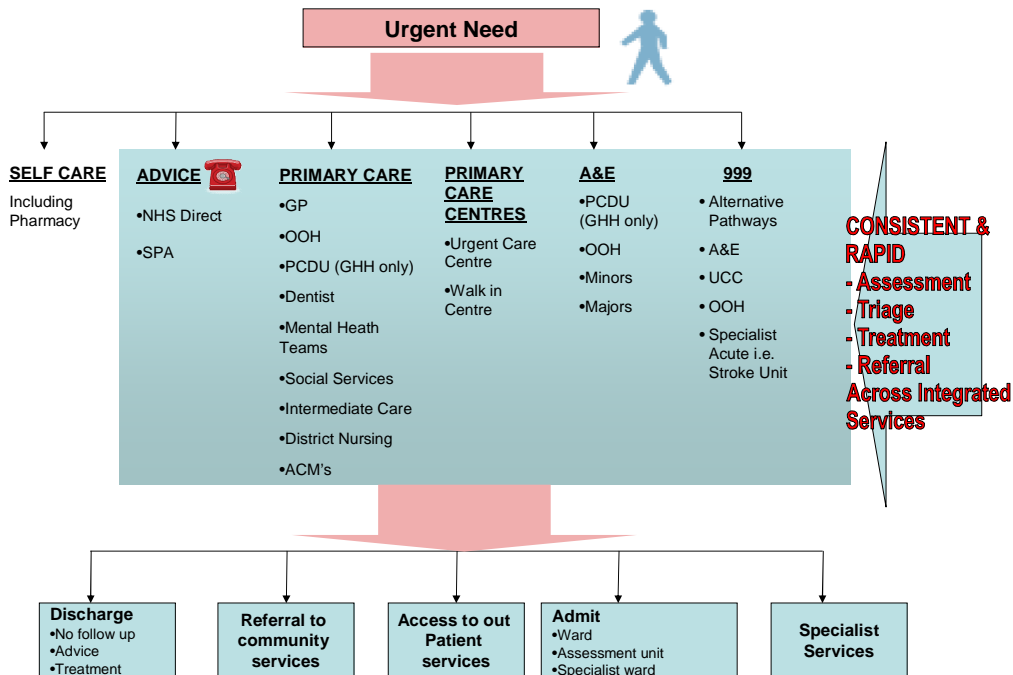


Fig 2. The Urgent Care Pyramid

The model recognises the multiple access points that patients choose to take and makes an appropriate urgent care response with **consistent and rapid assessment, triage, treatment and referral at all points**. Integrated services and care pathways will ensure patients that require referral to another service will experience a seamless transfer as detailed in Fig 3 below.



Fig

3. The Urgent Care Model – Consistent and Rapid Assessment, Triage, Treatment and Referral across Integrated Services.

## 12 Strategic Plan for Commissioning Urgent Care Services

### **12.1 Developing consistent and coordinated clinical models of urgent care including clinically integrated pathways that will best meet the diverse needs of all BENPCT residents and simplify the patients journey through urgent care.**

This will involve developing a work stream across all urgent care providers that has responsibility for developing clinical pathways and models of care irrespective of the access point where the same consistent, rapid assessment/triage and treatment processes and pathways apply.

Models of care and care pathways need to be agreed through clinical partnerships and in collaboration with patients so as they are understandable to both and reflect best evidence and outcomes. Pathways will be developed to ensure care is provided as close to home as possible.

This approach is patient/public focused and relies on clinicians to first see and treat and then educate patients, if appropriate, for future access of urgent care, planned follow up and includes lifestyle checks. This work stream will be informed by and build upon the progress made in the urgent care project as documented below:

The PCT, in collaboration with partners across the Local Health and Social Care economy has been working on the Urgent Care Project which is a programme of work that commenced in April 2008, 'To design and test a new urgent care system in Birmingham East & North and Solihull together with a reimbursement system which will incentivise providers in the best interests of patients'. The final options will test out a vertically integrated urgent care system that moves towards more planned arrangements and demonstrates clear benefits to patients.

Five goals were identified for the project and include:

- Goal 1 - To understand the system of providing urgent care in the Birmingham East & North and Solihull area by working with 9 different practices in the area; this included a diagnostic assessment-the aim was to get a clear picture of how the existing system works in order to identify areas for development. This included visiting stakeholder organisations, mapping the current services and patient flows.
- Goal 2 – To understand the cost to both commissioners and providers of providing those services, where they can be identified at a specific identifiable patient level; projecting future demand and developing a better understanding of the financial baseline and existing contracts.

- Goal 3 – To design new ways of providing urgent care in those localities; This included Vision Sharing-to ensure stakeholders including patients and the public are were engaged at an early point, to agree the future service model principles, desired patient outcomes and any constraints.

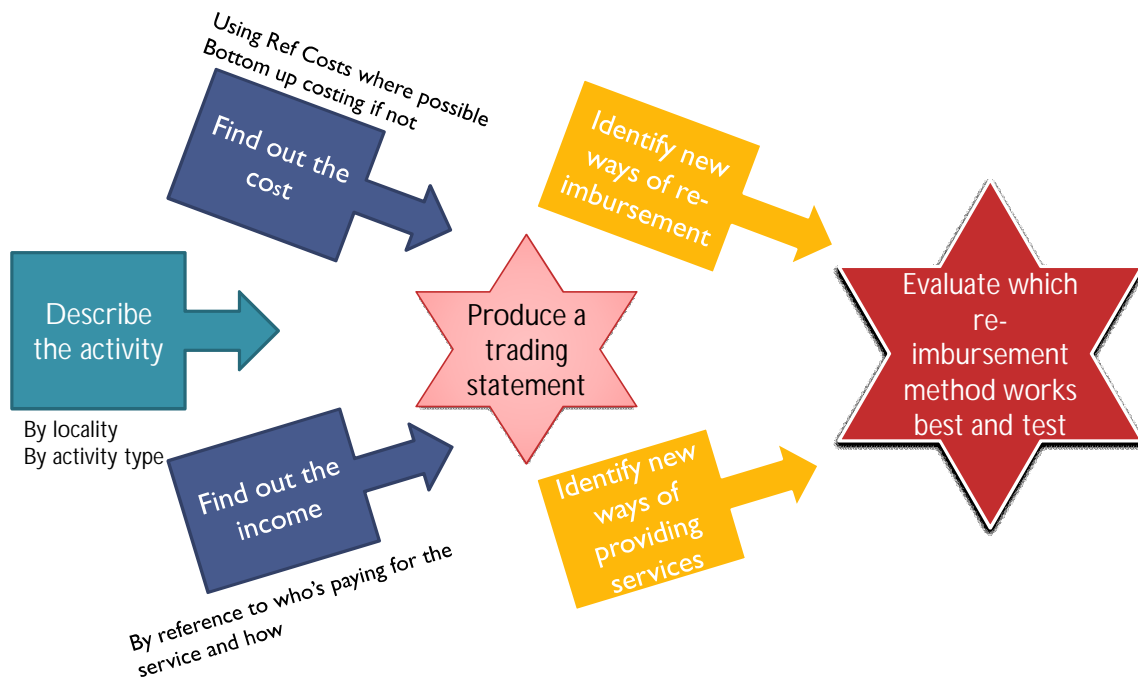
Patient focus groups, patient forums and patient representatives on the programme board have enabled good engagement. All stakeholders were involved in creating the vision and options for improvement.

Best practice review to learn from local, national and international work undertaken by Warwick University.

- Goal 4 – To design new ways of reimbursing urgent care providers which incentivise behaviours in the best interests of the patient and the commissioner of care; This included model development and this utilised the knowledge from the three earlier phases and began the process of designing the new operational model, the care pathways, the payment incentive system, commissioning arrangements and ICT support.
- Goal 5 – to test and evaluate both the new ways of provision and the reimbursement method to establish which would be the recommended approach. The two favoured schemes the primary care discharge unit and support to care homes will be tested from April 2009 for a twelve month period.

This programme of work has and continues to require full stakeholder engagement on each of the workstreams, good programme management and two-way communication. A programme board with representation from Directors of each stakeholder organisation and patient representatives continues to oversee the integrated project.

This can be shown schematically as follows:



### **12.2 Expand the provision of primary care urgent care services including urgent care centres with access to diagnostics in primary care and primary care presence within accident and emergency departments.**

During the extensive patient consultations, respondents liked the idea of accessing minor acute services locally and to make access easier by expanding access and availability of walk in services. BENPCT currently commissions one urgent care centre at Warren Farm in Kingstanding with limited direct access to diagnostics at Good Hope hospital. Future plans include the development of a second urgent care centre in the Saltley area, a third within the new PCT Health Centre in Erdington and a fourth within the Sheldon Heath new build.

All of these future developments need to be considered as part of the fully integrated urgent care system and will have access to diagnostics with X-ray and ultrasound as a minimum.

### **12.3 Enhance GP Access for Urgent Care across NHS BEN**

GP practices across NHS Birmingham East and North vary in the availability of appointments for patients. Some practices offer urgent on the day appointments for urgent matters or telephone triage, and others offer fixed appointments or walk in services, but the detail of the exact booking arrangements is not routinely

collected. In addition, in 2008/09 and 2009/10, the Quality and Outcomes Framework (QOF) have provided key incentives as a result of patient experience/satisfaction surveys relating to their own GP Practices ability to provide access to appointments within 2 working days or to book in advance of 2 days (QoF indicators PE 7 & PE 8).

A theme from the patient consultations, visioning event and evidence reviews all support the need to make access to GP appointments easier for urgent on the day appointments as this can result in reducing A&E attendances.

To support GP practice's specifically around urgent access, the PCT should support practices with recurrent resources, expertise and advice in reviewing and improving their process for handling requests for same-day urgent care. Consideration must be given to the key recommendations given as part of the Urgent Care report created by the Primary Care foundation (Carson, *et al* 2009) with each area a key focus.

#### ***12.4 Provide patients with good information and education programmes that support self care.***

Patients and stakeholder comments have confirmed the need to focus on raising awareness for patients to understand the urgent care system and what is available as alternatives to A&E. In addition, Patients have asked us to focus on hard to reach communities.

We plan to build on successful local initiatives that support self care including Birmingham Own Health, Case Management for long term conditions and the Expert Patient Programme. Further extension of other professional roles e.g. pharmacists role in urgent care provision will also be explored. All staff involved in urgent care will have a responsibility for promoting healthy lifestyles with patients.

Local education campaigns on accessing the right care in the right place at the right time will be further developed following the successful campaign in 2007/08. This will be supported by the development of a directory of urgent care services for patients.

The Insight Information tool transfers A&E patient information to GP practices within 24 hours. This will enable practice staff to support patients with primary care problems to access care in more appropriate settings and allow practices to view benchmarked data on patient activity at A&E departments.

#### ***12.5 Simplify the way care is accessed by patients in the place most appropriate to their needs.***

We need to simplify the process for patients that will enable better understanding of services available for urgent care need and how best to access services. This will be supported by patients experiencing consistent triage and care pathways across services wherever they are accessed. Inline with National guidance and

patient and stakeholder comments, a Single Point of Access will support patient education providing clear information and access to services most appropriate to patient needs.

The feasibility of a single number for access to urgent care needs to be scoped together with the development of a directory of services that holds real time information on capacity of all elements of the urgent care system.

## **12.6 Clinical leadership**

All of these plans require clinical leadership across all services. Much of this is already in place across existing networks such as the Emergency Care Network and through Working Together for Health. This will be enhanced further as the strategy is implemented further.

# **13 Supporting Work Streams**

## **13.1 Workforce**

Moving services closer to home has workforce implications. This will involve extending and enhancing the skills of existing staff, development of some new roles and changes in skill mix management for example investment in roles such as Emergency Care Practitioners in collaboration with the Ambulance service. A full and separate review of requirements for the workforce across the health economy will be required when the emergent model is clarified with stakeholders. The opportunity for rotation of staff across providers should be considered.

## **13.2 Patient, Public and Stakeholder Involvement**

The redesign and commissioning of all urgent care services will require patient, public and stakeholder engagement at all stages in the process and is of paramount importance. The Patient and Public Involvement strategy will be adhered to when commissioning services for Urgent Care. Stakeholder and partner organisation requirements will also be considered when redesigning services to meet the diverse needs of our population.

To plan appropriately for urgent care services, Population Health Manager will be used to identify the age, sex, ethnicity requirements of the population of NHS Birmingham East and North.

## **13.3 Practice Based Commissioning**

The involvement of GP practice based commissioners at Locality level and Clinical Leaders in the development of urgent care services is of paramount importance. The specific commissioning plans of PBC groups for urgent care will be entwined within the overall PCT strategy wherever possible.

### 13.4 Estates Strategy

The strategy for urgent care relies upon the PCT estates strategy to deliver new health centres and diagnostic facilities over the next 5 years. The recommendations of this strategy have been incorporated within the PCT estates plans and strategy. These plans are in place for urgent care centre facilities within the Washwood Heath new build. Further walk-in facilities will be available in the new PCT health centre in Erdington during 2009/10, and within the Sheldon Heath new build, scheduled for opening 2011/12.

### 13.5 Information Technology

Patients have highlighted their concerns about the lack of access to existing records. The improvements required within IT systems to facilitate the safe and timely transfer of patient records can not be under estimated and therefore this strategy relies upon the developments within the national Connecting for Health Programme.

### 13.6 Working Together for Health: Improving Care for older People

The project is analysing trends in the demand for and supply of services for older people. An important focus of the project is the increasing demand on acute hospitals in east and north Birmingham and Solihull from frail older people. Work has been commissioned to understand the nature of this demand and the availability of services to meet the needs of older people. The work will be used to formulate options for improving service in the future to ensure that care is provided in the right place at the right time.

## 14 Outcomes

The expected outcomes of the implementation of the Urgent Care Strategy are set out in the table below using the OSCAR Framework:

<b>Organisational</b>	<p><b>Improved, integrated urgent care system</b> - More coordinated and integrated urgent care services with more patients experiencing their entire urgent care pathway in primary care.</p> <p><b>Development of skills</b> around assessment, triage, treatment and referral</p> <p><b>Improved local access, and improved information</b> on urgent care facilities seven days a week</p>
<b>Satisfaction</b>	<p><b>Improved staff satisfaction</b> – consistent and rapid assessment, triage, treatment and referral, clear pathways, integrated services, improved partnership working, improved systems</p> <p><b>Improved Patient Satisfaction</b> - consistent and rapid assessment, triage, treatment and referral, clear pathways for</p>

	patients, integrated services therefore reduction in duplication, improved access to integrated services, improved access to information, clear access points
<b>Clinical</b>	<p><b>Improved clinical and health outcomes</b> – patient receiving consistent and rapid assessment, treatment, triage and referral.</p> <p><b>Improved quality of life</b> – conditions identified earlier, less need to access the system urgently, providing a more planned Urgent Care system</p> <p><b>High quality</b> integrated urgent care delivered across primary and secondary care</p>
<b>Activity</b>	<p><b>Reduction in the number of patients who don't need to visit A&amp;E</b> -Reduced reliance on A&amp;E and ambulance service for minor problems</p> <p><b>Increasing numbers of patients have the confidence and ability to self care.</b></p>
<b>Resources</b>	<p><b>Extending and enhancing</b> the skills of existing staff</p> <p><b>Development of new roles</b></p> <p><b>Changes in skill mix</b></p> <p><b>Facilities</b> – e.g. IT implications, including access to systems and patients records, Estates Strategy, ensure access to fit-for-purpose buildings, equipment, diagnostic facilities.</p> <p><b>Reduction of A&amp;E Attendances</b></p> <p><b>Reduction of Emergency Admissions</b></p>

## 15 Implementation

Following consultation, the programme of work to implement the Urgent Care strategy will be managed within the directorate of Strategy and Redesign with both senior Clinical and Managerial support. The work will be overseen by the Emergency Care Network.

## 15.1 Action Plan

Workstream	Actions	Time scales	Lead
<b>Develop consistent and coordinated clinical models of urgent care including clinically integrated pathways that will best meet the diverse needs of all BENPCT residents and simplify the patients journey through urgent care</b>	<p>Develop a work stream to scope current processes and agree priority pathways and conditions through the ECN.</p> <p>Continue planned developments and future priorities through the ECN.</p> <p>Ensure the management of urgent care episodes are included within service specifications of all providers.</p> <p>Raise awareness across all providers – integration, knowledge sharing and pressure planning event</p>	<p>July 2009</p> <p>Ongoing</p> <p>May 2010</p> <p>Annual event October 2009</p>	<p>Caroline Nolan/Louise Pritchard(Chair of ECN)</p> <p>Bhikhu Pattni</p> <p>Caroline Nolan</p> <p>Roxanna Modiri</p>
<b>Expand the provision of primary care urgent care services including urgent care centres with access to diagnostics in primary care and a primary care presence within accident and emergency departments.</b>	<p>Develop a service specification for primary care based Urgent Care Centres.</p> <p>UCC at Washwood Heath opening.</p> <p>Future provision at Erdington Health Centre and Sheldon Heath Primary Care Centre</p> <p>Pilot for one year of Primary Care Discharge Unit at Good Hope Hospital</p>	<p>March 2009</p> <p>Nov 2009</p> <p>2009/11</p> <p>May 2010</p>	<p>Caroline Nolan</p> <p>Roxanna Modiri</p>
<b>Enhance GP Access for Urgent Care across NHS BEN</b>	<p>Create a project group to include Primary Care Commissioning to agree a way forward for the programme of work surrounding GP Access.</p>	<p>June 2009</p>	<p>Caroline Nolan</p> <p>Roxanna Modiri</p> <p>Primary Care Commissioning – Donna McArthur</p>
<b>Provide patients with good information and education programmes that support self care and promote the use of alternative support services.</b>	<p>Develop a project group reporting to the ECN. Include information and communication plan.</p> <p>Links with Single point of access pilot.</p> <p>Reaching into providers such as pharmacy, NHS Direct, WMAS, A&amp;E.</p>	<p>April 2009-11</p> <p>April 2009-11.</p>	<p>Caroline Nolan / Anna Shaw - Head of Communications and the PRIME Project</p>
<b>Simplify the way high quality care is accessed by patients in the place most appropriate to their needs including implementation of a</b>	<p>Link to region wide Capacity Optimisation support service and the development of a single point of access and directory of services.</p> <p>NB Service Specification currently being developed at SHA level.</p>	<p>April 2009-11.</p>	<p>Caroline Nolan</p> <p>Roxanna Modiri</p>

<b>Single Point of Access (SPA).</b>			
<b>Develop Clinical Leadership Across providers</b>	Urgent Care Lead identified at all key providers and within the PCT  Ensure a clinical leader is involved in all key workstreams.  Ensure Clinical Leaders represented at the ECN monthly	April /May 2009	Caroline Nolan/Louise Pritchard  Bikku Pattni  Roxanna Modiri

## 16 Consultation and Next Steps

The views of stakeholders and patients are central to the development of the urgent care strategy. Expressed views have been incorporated to date and a full consultation will be undertaken both internally and with external stakeholders and patients using forums such as the Emergency Care Network. There is also a process underway within the urgent care project to continually consult with patients and stakeholders.

## 17 Conclusion

The Urgent Care Strategy for NHS BEN sets out how urgent care services will be developed so as patients get the right treatment in the right place without unnecessary delay. The vision and framework promotes integration of providers who are incentivised to deliver the best possible services and patient outcomes for the PCT population. This can only be achieved through high quality and rigorous commissioning processes that enable the PCT to understand the kind of urgent care services its patients and public want and need, and subsequently commission high quality urgent care services with and for its population.

This strategy has been written to clearly set urgent care commissioning in the context of the PCTs audacious goals, strategies and commissioning principles. It spends some time outlining the National and Local Drivers and suggests an approach to commissioning which is inclusive rather than exclusive and recognises the diverse needs of our population.

## Appendix 1 – Equality Impact Assessment

I am happy to confirm that the attached above Equality Impact Assessment of the urgent care strategy should now proceed to being approved or ratified.  
Please print this email and submit it with the equality impact assessment as evidence that this assessment has now been added to the PCT's EIA portfolio.  
Could you please add sections 9(a) & (b) to the comments part of Equality & diversity section of the report front sheet that you submit this strategy & EIA to for approval as indicated below.

### EQUALITY AND DIVERSITY IMPLICATIONS:

Has an initial Equality Impact Assessment been undertaken? Yes

*COMMENTS:* The evidence considered in section seven (7) above suggests that the overall actual impact of the urgent care strategy will be Positive. This is consistent with or effectively promoting equality, human rights or diversity requirements. The strategy explores the most appropriate settings for urgent care services, and where identified, supports the transfer of care from secondary care into primary care settings. There remains however clear areas where improvements are required and these are identified in the recommendations below.

### 9b. Recommendations

Rec1: monitoring will be undertaken to explore the impact and utilisation of services more when delivered in a local, community setting.

Kind Regards  
Equality & Diversity Adviser  
Kevin Nembhard  
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### EIA of Urgent Care Strategy (new)

#### 1. Function Assessors

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## 2. Function Nature

The definition of urgent care in the Direction of Travel for Urgent Care (DOH 2006) is applied throughout the strategy. Urgent care *“is 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 their carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need.”*

The range of urgent care providers considered within the strategy include the A&E departments at Heart of England Foundation Trust (HEFT), the Urgent Care Centre at Kingstanding, the Walk in Centre in the City Centre, GP practices in hours, Badger and Primecare GP out of hours providers, NHS Direct, West Midlands Ambulance Services, Mental Health teams, PCT provider services including Intermediate Care, Assertive Case Managers and District Nurses, Dentists, and Pharmacists.

The Urgent Care Strategy has been developed to set out a five year commissioning strategy for urgent care towards 2014. The strategy will be implemented by the Urgent Care commissioning team within the Strategy & Redesign directorate of NHS BEN, together with relationships and partnerships formed across the health economy to ensure the strategy is embedded.

## 3. Function Purpose

The strategy aims to provide patients with a choice of services that improve their experience of advice, assessment, diagnosis and treatment based on responsive, personal, seamless, convenient, safe and reliable clinical services.

The principle objective of the strategy is to create a system for commissioning that is designed around patient pathways and the needs of the wider population regardless of their race, religion and belief, age, sexuality, disability and gender. The strategic aims and objectives for urgent care reflect the PCT strategic aims which are:

- Tackling health inequalities
- Improving health
- Supporting self-care and wise choices
- No waiting for the care patients need
- Personalising care

The vision for future urgent care models acknowledges the need to be driven by patients' needs and preferences, providing care as close to home as is safe to do so, managing demand through appropriate care pathways and ensuring provision of services in primary care is complemented by secondary care provision when necessary. Demand for urgent care is relatively predictable and so it follows provision can be planned.

The strategy for urgent care is underpinned by the following aims:

- Developing and supporting self care - where appropriate
- Developing an integrated model across primary and secondary care providers and other partner organisations with consistent services and pathways
- Providing simple access including a Single Point of Access, choice and quality urgent care for patients as close to home as is safe as possible.

- Supporting clinical leadership across the urgent care system
- Developing capacity across the urgent care system to deliver new integrated models of care.
- Co-ordinated caseload management Out of Hours and eventually 24 hours a day and seven days a week

Commissioning of planned system for urgent care where incentive schemes are devised to support Providers in developing services which encourage patients to attend the most appropriate service for their needs.

The urgent care strategy is informed and influenced by the following key national and local health provisions:

- The Direction of Travel for Urgent Care (DOH 2006)
- The NHS Next Stage Review
- The vision and competency framework of World Class Commissioning (WCC) launched by the Department of Health (2007) - where the PCT as a commissioner of planned health services ensures these demonstrate better outcomes for patients; adding life to years and years to life.
- The Commission for Healthcare Audit and Inspection (September 2008) – Not just a matter of time
- PCT Strategic Direction including the Strategic Plan (BENPCT 2008a)
- Delivering care closer to home as set out in the White Paper *Our health, our care, our say* (January 2006b) & In *Delivering Care Closer to Home* (Department of Health 2008b)
- Right Test, Right Time, Right Place: a Framework for primary care access (RCR & RCGP 2006).
- Standards for better health quality care
- NICE evidenced based care
- Birmingham East & North PCT Strategic Plan (BEN PCT 2008a)
- Birmingham East & North PCT Commissioning Strategy (BEN PCT 2008b)
- Birmingham East & North PCT Operating Plan (BEN PCT 2008c)
- Working together for health - the SHA Investing for Health programme

#### **4. Function Activities**

The Urgent Care Strategy has been created by the PCT Urgent Care lead in consultation with the Urgent Care Project team, interviews with all stakeholders, eleven patient focus groups held across the locality, a local health economy wide visioning event which brought all stakeholders and patients together to create the vision of urgent care for Birmingham East and North PCT, as part of the urgent care project. Incorporated in the strategy are the following:

1. A vision and strategic framework for urgent care commissioning in BENPCT area
2. Information on local health needs, current services and planning for future needs
3. National and local commissioning drivers

4. Stakeholder and patient feedback.
5. Best Practice Review for Urgent Care
6. Objectives and strategic plan for urgent care.

The principle objective of the urgent care strategy is to set out how the PCT will commission urgent care services to meet the needs of present and future populations, providing the highest quality care in the most appropriate setting making best use of resources. It will do this through the following objectives:

- Develop consistent and coordinated clinical models of urgent care that will best meet the diverse needs of all BENPCT residents.
- Develop fully integrated urgent care pathways across all providers, delivered as close to patients homes as possible.
- Expand the provision of primary care urgent care services including urgent care centres with access to diagnostics in primary care and primary care presence within accident and emergency departments.
- Provide patients with good information and education programmes that support self care and promote the use of alternative support services.
- Simplify the way high quality care is accessed by patients in the place most appropriate to their needs including supporting a single point of access.
- Enhance Clinical Leadership across the PCT and providers to ensure the objectives of the urgent care strategy are realised.

## **5. Function Beneficiaries**

The Urgent Care Commissioning Strategy outlines a 5 year plan and vision for the development of Urgent Care services for the population of Birmingham East and North Primary Care Trust (BENPCT).

## **6. Function's planned impact**

The planned impact or benefits of the urgent care strategy are:

- more integrated urgent care system
- more consistency in urgent care pathways
- more local services for patients
- less waiting for services by patients
- Reduced reliance on A&E and ambulance service for minor problems
- Improved local access to and information on urgent care facilities seven days a week
- Increasing numbers of patients have the confidence and ability to self care
- More coordinated and integrated urgent care services with more patients experiencing their entire urgent care pathway in primary care
- High quality urgent care delivered across primary and secondary care

These benefits take into account:

- **Ethnicity** – the PCT will take into account, for example, that translation & interpretation services may be required for some patients to enable them to access services.
- **Disability** – all locations providing urgent care services will be Disability Discrimination Act compliant. For example, sign language interpretation will be used when required.
- **Gender** – the strategy will ensure that services are commissioned and will be provided for both male and female patients.
- **Belief** – the strategy will ensure that services will be commissioned and provided to take into account patient's beliefs and religious requirements.
- **Sexual orientation** – the strategy ensures that services will be commissioned regardless of sexual orientation.

## **7. Function's actual impact**

### **7a. Engagement**

Patient and public feedback remain high on the PCT agenda and patient consultation events were held to ensure the views of our patients are incorporated in Urgent Care. Eleven patient focus groups were held as part of the Urgent Care project and "The Big Conversation" event, where 16 focus groups were recruited from across the PCT area to give views on health services.

The most recent stakeholder event was a health economy event held as part of the Darzi NHS review in November 2007. Many of the themes put forward by local stakeholders are mirrored in the publication *Direction of Travel for Urgent Care* (DOH 2006) and there is fairly widespread agreement on key themes between patients and other stakeholders.

In addition, part of the Urgent Care Project included visiting stakeholder organisations, mapping the current services and patient flows.

Patient focus groups, patient forums and patient representatives on the programme board have enabled good engagement. All stakeholders were involved in creating the vision and options for improvement.

Best practice review to learn from local, national and international work undertaken.

This programme of work has and continues to require full stakeholder engagement on each of the workstreams, good programme management and two-way communication. A programme board with representation from Directors of each stakeholder organisation and patient representatives continue to oversee the integrated project.

In addition, the Urgent Care Strategy confirms that all of these plans require clinical leadership across all services. Much of this is already in place across existing networks – Emergency Care Network and through Working Together for Health. This will be enhanced further as the strategy is implemented further.

### **7b. Metrics / informatics**

Where possible data on patient use of urgent care services will be broken down by diversity.

### **7c. Research**

Lattimer et al (2006) conducted a literature review on out of hospital urgent care in order to inform the *Direction of Travel for Urgent Care* document (DOH 2006). The key messages from the evidence were grouped under workforce and skill mix, assessment and triage and treatment and referral.

### **Workforce and Skill Mix**

Nurses substituting for doctors in out-of-hours care, walk in centres, minor injuries units and general practice can deliver care that is safe and of equal quality in relation to a sub-set of clinical conditions. *Laurant et al (2004)*

Emergency Care Practitioners (paramedics and nurses) working in ambulance trusts, walk-in centres and general practice out-of-hours services are reducing hospital attendance and admission. *Mason et al (2007)*

Patients are uncertain about the variety of role titles and what they mean. *Barnes et al (2004)*, *Bunn et al (2006)*

### **Assessment and Triage**

Up to 50% of patients have their care managed over the telephone out-of-hours. Practice Nurses can manage over 40% of requests for same day appointments in general practice by telephone. *McKinstry et al (2002)*

Telephone assessment of Category C ambulance calls identifies patients less likely to require emergency department care and reduces ambulance dispatch rates. *Dale et al (2003)*

Patients managed by telephone either by GPs or nurses are more likely to re-consult about the same problem. Nurses are more likely than doctors to recommend follow-up, albeit appropriately. *Bunn et al (2006)*

### **Treatment and Referral**

Emergency Care Practitioners carried out fewer investigations, provided more treatments and were more likely to discharge patients home than the usual provider (an ambulance trust, a GP led out-of-hours service and a walk in centre). *Mason et al (2007)*

Appropriate transport of patients by ambulance crews to treatment centres rather than EDs may have positive effects on ambulance job-cycle times and improve patient satisfaction, but many schemes are at an early stage of development. *Mason et al (2007)*

Multidisciplinary models of intervention that include social care staff show promise in the care of older people including risk identification and admission prevention; in the care of people with mental health problems and in engaging frequent service users. *Macleod et al (2003)*

In summary, the review of the literature highlighted growing evidence of new roles, new ways of working, new ways of commissioning and delivering services in urgent care in the UK in response to a number of drivers for change. The drivers include policy requirements to improve local services for patients, the need to prepare for the future where GP resource may be more constrained and the need to make best use of resources. The evidence on the outcomes of many of these changes is limited both in the number of studies and the robustness of design. The pace of organisational change has ruled out the opportunity for before and after studies. However, it is becoming clearer from the international agenda Grol et al (2006) there is a need for service integration at local or regional levels and a move away from services working largely as separate components.

In addition, and part of the Urgent Care Project, the strategy incorporates a Best Practice Review that was undertaken by Warwick University to learn from local, national and international work undertaken.

## **8. Function's actual impact evidence gaps**

Details of any gaps, weaknesses or insufficiencies in evidencing impact and actions to remedy this.

## **8a. Engagement gaps**

A patient involvement strategy will be developed by the PCT setting out how patients will be engaged & their views sought in the implementation of the strategy & development of new services.

*The redesign and commissioning of all urgent care services will require patient, public and stakeholder engagement at all stages in the process and is of paramount importance. The Patient and Public Involvement strategy will be adhered to when commissioning services for Urgent Care. Stakeholder and partner organisation requirements will also be considered when redesigning services to meet the diverse needs of our population.*

Consultation with a range of stakeholders including patient will continue as services develop for this Urgent Care Strategy including:

- Patient and public focus groups
- Emergency Care Networks
- Localities
- Overview and scrutiny committee
- NHS providers
- Health care professionals
- Local strategic partnerships

## **8b. Metrics / informatic gaps**

To plan appropriately for urgent care services, Population Health Manager will be used to identify the age, sex, ethnicity and health needs/requirements of the population of NHS BEN and therefore this strategy is reliant on the accurate information to be provided about our population.

## **8c. Research gaps**

Throughout the life of the Urgent care strategy, information will be continuously gathered & fed into the commissioning of future services.

## **9. Function's findings & recommendations**

### **9a. Impact Findings**

The evidence considered in section seven (7) above suggests that the overall actual impact of the urgent care strategy will be Positive. This is consistent with or effectively promoting equality, human rights or diversity requirements. The strategy explores the most appropriate settings for urgent care services, and where identified, supports the transfer of care from secondary care into primary care settings. There remains however clear areas where improvements are required and these are identified in the recommendations below.

### **9b. Recommendations**

Rec1: monitoring will be undertaken to explore the impact and utilisation of services more when delivered in a local, community setting.

## **10. Function monitoring & Publication**

### **10a. Monitoring**

The senior management team of the strategy & redesign directorate in which this function belongs will ensure that its findings and recommendations will be integrated into its programme of work.

NHS BEN through its Emergency Care Network Group will ensure any recommendations identified in this equality impact assessment are implemented leading to an overall improvement in urgent care.

NHS BEN in its role as commissioner of will performance monitor all local urgent care provision & health care providers to ensure health care is delivered to best care standards including equality, diversity & human rights.

### **10b. Publication**

The action plans from all completed EIA's will be compiled into one document and:

1. Used to annually upgrade the action plan section of the single equality scheme that is made available to the public via the PCT website & on request.
2. Entitled EIA outcomes and published on the PCT website & intranet.
3. Mentioned in PCT annual report.

The implementation of the strategy will be monitored through the Planned Care Executive Group (PCEG). Each development will be evaluated and will include the views and experience of patients, clinicians and other interested parties.

Roxanna Modiri

12.02.09.

## Appendix 2 – Sustainable Development

The principles of sustainable development are:

- **Living within environmental limits.** Respecting the limits of the planet's environment, resources and biodiversity – to improve our environment and ensure that the natural resources needed for life are unimpaired and remain so for future generations; and
- **Ensuring a strong, healthy and just society.** Meeting the diverse needs of all people in existing and future communities, promoting personal well-being, social cohesion and inclusion, and creating equal opportunity for all.

An obvious implication of this definition is that the two goals are not – or, at least, should not be assumed to be – mutually exclusive but mutually reinforcing; that is, an environmentally sustainable community is also thought to be one that promotes personal well-being and strong social ties.

- **Achieving a Sustainable Economy:** Strong and sustainable economic growth, providing prosperity and opportunity for all, where environmental and social costs fall on those who impose them. Therefore moving away from the traditional method of measuring economic growth through GDP, to one that includes environmental and social indicators.
- **Promoting Good Governance** Actively promoting effective participative systems of governance in all levels of society - engaging people's creativity, energy, and diversity: The democratic accountability and legitimacy.
- **Using Sound Science Responsibly**  
Ensuring policy is developed and implemented on the basis of strong scientific evidence, whilst taking into account scientific uncertainty (through the precautionary principle) as well as public attitudes and values.

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