Welcome

To the

Thames Valley Urgent & Emergency Care Network
Out of Hospital Urgent Care Workshop

Dr Annet Gamell
Chair & Clinical Pathways Lead Thames Valley Urgent & Emergency Care Network
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Matthew Staples
Thames Valley Urgent & Emergency Care Network Manager and Thames Valley 111 Integrated Urgent Care Procurement Programme Manager
Matthew.staples@nhs.net
Purpose of today’s workshop

• To examine potential approaches to integrating the same day/urgent primary care offer with the community urgent care offer

• Together, to undertake more detailed work, planning and discussion

• Today is part of an evolutionary process in the development of ideas and options for new models of UEC (evolve at pace!)

• To update on UEC ‘reset’; delivery objectives 17-19
<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Lead</th>
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</thead>
<tbody>
<tr>
<td>1400 – 1405</td>
<td>Welcome and Introduction</td>
<td>Dr Annet Gamell Chair TVUECN</td>
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<tr>
<td>1405 – 1500</td>
<td>Session 1: Setting the scene</td>
<td>Dr Annet Gamell Matthew Staples Programme Manager TVUECN Locality Leads (Berks East, Berks West, Bucks, Oxon) TBC</td>
</tr>
<tr>
<td></td>
<td>Purpose of the event</td>
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<td></td>
<td>Background</td>
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<td></td>
<td>Key system Elements</td>
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<td>Mapping ‘as is’.</td>
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<td>Potential Future</td>
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<td>Points of clarity and discussion</td>
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<tr>
<td>1500 – 15.45</td>
<td>Session 2: New Models of UEC</td>
<td>Dr Steven Laitner GP, Senior Clinical Advisor, Primary Care Home, NAPC</td>
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<tr>
<td></td>
<td>Presentation – The Primary Care Home</td>
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<td>Presentation – Co-located UCC. GP Streaming at front door of ED</td>
<td>Tim Yorston Lead ENP Guys and St Thomas’ Hospitals</td>
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<td>Questions and Answers</td>
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<tr>
<td>15.45-15.55</td>
<td>Coffee Break</td>
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# Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session 3: How can we join the key system elements together?</th>
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<tbody>
<tr>
<td>15.55-16.50</td>
<td>Breakout session 1 – facilitated groups (15mins)</td>
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<tr>
<td></td>
<td>- Are there any more key system elements/options we haven’t considered?</td>
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<td>- Consider the answers to/implications from any discussions that arose earlier.</td>
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<td>Feedback</td>
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<td>Breakout session 2 - facilitated groups (20mins)</td>
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<td></td>
<td>Explore the relationship between UCCs and other elements of the system i.e. Primary Care Hubs, Out of Hours Primary Care, Community Hubs, GP at front door of ED.</td>
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<td>In the following scenarios:</td>
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<td>1) Consider no Hubs and current state same day urgent primary care is delivered in and out of hours</td>
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<td>2) Consider activity at Hubs is focussed around consolidating existing Practice-delivered (in hours activity)</td>
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<td>3) Consider activity in the Hubs includes consolidated existing Practice-delivered activity AND also includes most of/all of the patient activity (minor illness and minor injury) currently going to MIUs/WICs/UCCs.</td>
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<td>.... What would the role of UCCs be in these scenarios and what would be the implications for the system (including costs and workforce) and the patients?</td>
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<td>Feedback</td>
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<tr>
<th>Time</th>
<th>Next Steps and Closing Remarks</th>
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<tr>
<td>1650 – 1700</td>
<td>Dr Annet Gamell</td>
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<table>
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<tr>
<th>Time</th>
<th>Locality leads</th>
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<td>Thames Valley Urgent &amp; Emergency Care Network</td>
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TVUECN Workshop House Keeping
Session 1
Setting the Scene
Background

Keogh UEC Review proposed fundamental shift to improving out of hospital services

NHS England developed draft guidance around the designation of UEC services/sites

First draft guidance released early 2016. Introduced concept of an UEC system containing

- Urgent Care Centres (UCCs)
- Emergency Centres
- Emergency Centres with Specialist Services

Proposed the community urgent care offer is centred around the creation of UCCs ... aim of moving towards greater simplicity whilst moving away from the current confusing picture of MIUs, MIIUs, walk-in-centres, UCCs etc
Need to look at whole UEC system – cannot look at any element in isolation
Vital to base our thinking on key principles in defining the community urgent care offer:

Simplicity for patients in understanding where to go, when and why, and ...

Need a system that is:
- Safe
- Sustainable
- Affordable
- Consistent (e.g. opening times, diagnostics, staffing and common nomenclature)
Key System Elements

At a system level, key ‘givens’ proposed include:

• Within primary care, what is provided currently is a key given;
• The Royal College of Emergency Medicine is promoting the development of ‘comprehensive EDs’/”A&E Hubs”, now including GP streaming;
• Government drive to push the delivery of seven-day services;
• The 111 and 999 services, (will be developing into wider Integrated Urgent Care service);
• A need to work within the financial constraints across the UEC system;
• Maximising utilisation of existing sites (e.g. primary care premises, MIUs etc) and staff to support any proposed changes;
• Concentrating available workforce and services in a focused number of locations should lead to improved resilience and patient safety
A new urgent and emergency care system needs to shift more people from right to left, delivering as much care as close to home as possible.

- 438 million health-related visits to a pharmacy per annum
- 340 million GP consultations per annum
- 24 million calls to NHS urgent and emergency care telephone services per annum
- 21.7 million attendances at A&E, minor injury units and urgent care centres per annum
- 7 million Emergency ambulance journeys per annum
- 5.2 million emergency hospital admissions per annum

- 324 million visits to NHS Choices
- 20% of GP consultations relate to minor ailments which could largely be dealt with by self-care and support from community pharmacy
- Only 4% of emergency calls are currently resolved on the phone
- 40% of patients attending A&E require no treatment at all
- Up to 50% of patients dialling 999 could be managed at the scene
- Over 1 million emergency admissions in 2012/13 could have been avoided
Ill patient at home
Can they cope?
Are they safe?
Do they need treatment?

Voluntary sector friend
GP In & OoHs
Falls team

Community / mental health nursing
Rapid response care support

Slippery slope to hospital

When we can’t provide care or treatment in the community our NHS default is to a higher acuity, higher cost facility

Provide personalised care as close to, or in, the patients home as possible

Integrated urgent care clinical support hub ‘111’
Paramedic in the community ‘See and Treat’
Ambulatory Care / Frailty unit

20-30% of elderly patient admissions are avoidable and carry risk
<table>
<thead>
<tr>
<th><strong>NHS 111 Online</strong></th>
<th><strong>NHS 111 Calls</strong></th>
<th><strong>GP</strong></th>
<th><strong>Urgent Treatment Centres</strong></th>
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<tbody>
<tr>
<td><strong>The offer</strong></td>
<td><strong>The offer</strong></td>
<td><strong>The offer</strong></td>
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<tr>
<td>Online triage services that enable patients to enter their symptoms and receive tailored advice or a call back from a healthcare professional</td>
<td>Increase the percentage of calls transferred to a clinician when a patient calls the NHS111 service</td>
<td>By March 2019 the public will have enhanced access to evening &amp; weekend appointments with general practice</td>
<td>Urgent Treatment Centres across the country will be:</td>
</tr>
<tr>
<td>Services closely connected to NHS 111 calls (and other services including Primary Care over time)</td>
<td>The service will better support the number of patients who can be dealt with as ‘self-care’</td>
<td>In delivering this we will secure:</td>
<td>➢ Open 12 hours a day</td>
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<tr>
<td>Offer an increasingly personalised experience to patients</td>
<td>Where applicable patients will be referred on to an appropriate point of care</td>
<td>➢ Transformation in general practice,</td>
<td>➢ Will be staffed by doctors and nurses</td>
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<tr>
<td><strong>The plan</strong></td>
<td><strong>The plan</strong></td>
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<tr>
<td>Pilot the service in 4 areas from February 2017 onwards</td>
<td>30% of 111 calls transferred to a clinician by March 2017, rising to 50+% by March 2018</td>
<td>Coverage of enhanced access will reach:</td>
<td>These services will be in place as follows:</td>
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<tr>
<td>Complete evaluation by July 2017</td>
<td>Operational readiness for Care home Line by March 2017 with roll out from April 2017</td>
<td>➢ 50% of the population by March 2018</td>
<td>➢ 25% of facilities by March 2018</td>
</tr>
<tr>
<td>Roll out to 5 or 6 111 areas per month by December 2017</td>
<td></td>
<td>➢ 100% of the population by March 2019</td>
<td>➢ 50% of facilities by March 2019</td>
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<tr>
<td>Introduction of intelligent personalised triage by March 2019</td>
<td></td>
<td>➢ Invest £138M in 2017/18 and £258M in 2018/19</td>
<td>➢ 100% of facilities by December 2019</td>
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<tr>
<td>Ambulances</td>
<td>Hospitals</td>
<td>Hospital to Home</td>
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<tr>
<td><strong>The offer</strong></td>
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</table>
| * More clinically focused response for patients  
  * Quicker recognition of life threatening conditions  
  * Telephone advice, treatment on scene or conveyance to hospital  
  * End to long waits for an ambulance and handover delays at hospitals | * Highly skilled emergency department workforce to deliver life-saving care for our most sick patients  
  * Variation between hospitals will be reduced  
  * Patients streamed by a highly trained clinician to the most appropriate service  
  * Rapid, intensive support to those patients at highest risk of admission  
  * Use of a wide range of ambulatory care services  
  * Effective metrics used in oversight of hospitals | * Provide comprehensive packages of health and social care  
  * Fewer than 3 in 20 NHS Continuing Healthcare assessments (CHC) take place in an acute setting  
  * Patients only stay in hospital for as long as they have been clinically assessed as requiring treatment  
  * Coordinated and timely transfer of care from hospital to the most appropriate setting |
| **The plan** | **The plan** | **The plan** |
| * Planning for rollout of the Ambulance Response programme complete by end March 2017  
  * Implement enhanced Hear & Treat and See and Treat by March 2018  
  * STPs offer integrated model of urgent care, with clear referral pathways offering alternatives to conveyance to A&E by March 2018  
  * Development of ambulance workforce, to December 2018 | * Front-door ED streaming models in all UEC systems by September 2017  
  * Establish Frailty Assessment processes and Frailty Units  
  * 7-day ambulatory care  
  * Implementation of core best practice on medical wards to facilitate discharge | * Implement Discharge to Assess by March 2017  
  * Reduce national DToC rates 4.1% by September 2017  
  * Implement changes to CHC framework by April 2018  
  * Roll out Nursing Home Vanguard model by March 2019  
  * Deployment of 200 pharmacy professionals into care homes by March 2018 |
## 7 Pillars of Urgent & Emergency Care

<table>
<thead>
<tr>
<th>SELF CARE</th>
<th>MINOR ILLNESS /INJURY</th>
<th>ACUTE/LIFE THREATENING</th>
<th>REHAB &amp; MAINTENANCE</th>
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<tbody>
<tr>
<td><strong>111 Online</strong></td>
<td><strong>111 Calls/ Clinical Hub</strong></td>
<td><strong>GP</strong></td>
<td><strong>UTCs</strong></td>
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<tr>
<td>Online symptom checkers</td>
<td>TV IUC</td>
<td>Urgent Care Hubs</td>
<td>Minor injuries</td>
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<tr>
<td>Online triage</td>
<td>Call handler to clinician ratios/Warm transfer rates</td>
<td>Streaming in ED</td>
<td>Diagnostics</td>
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<tr>
<td></td>
<td>No decision in isolation</td>
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<td>See and Treat</td>
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<td></td>
<td>Telemedicine</td>
<td></td>
<td>Hear and Treat</td>
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<td>Review of green ambulance and ED dispositions</td>
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<td>Clinical triage</td>
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### Channel Shift

**High Intensity Users**

‘CARE SPACE’ Modelling
NHS England ‘Asks’

- A single delivery plan for UEC and A&E Improvement
- A UEC delivery plan for each STP agreed by the end of April
- A plan to deliver A&E streaming by October
- Working together to best effect
- System wide approach
- Reconsider local governance arrangement to maximise delivery
Thames Valley Urgent and Emergency Care Network

**Key**
- ● Type 1 Emergency Department
- ○ Type 1 Emergency Department (ED) with co-located UCC
- ▲ Standalone UCC
- ▲ Minor Injuries Unit (MIU)
- ★ Walk-in Centre
- ○ Large urban areas

**U&EC Network: total Urgent Care services**

<table>
<thead>
<tr>
<th>ED</th>
<th>WIC</th>
<th>MIU</th>
<th>Standalone UCC</th>
<th>Total</th>
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<tbody>
<tr>
<td>6</td>
<td>2</td>
<td>8</td>
<td>3</td>
<td>19</td>
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**Provider**

<table>
<thead>
<tr>
<th>Milton Keynes Hospital</th>
<th>ED</th>
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<tr>
<td>John Radcliffe Hospital</td>
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<tr>
<td>Horton General Hospital</td>
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<tr>
<td>Royal Berkshire Hospital</td>
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<tr>
<td>Wexham Park Hospital</td>
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<tr>
<td>Stoke Mandeville Hospital</td>
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<tr>
<td>Bracknell Urgent Care Centre</td>
<td>Standalone UCC</td>
</tr>
<tr>
<td>St Marks Hospital Primary Care Centre</td>
<td></td>
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<tr>
<td>Chipping Norton Memorial Hospital (FAU)</td>
<td></td>
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<tr>
<td>Reading Walk-in Health Centre</td>
<td></td>
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<tr>
<td>Slough Walk in Health Centre</td>
<td></td>
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<tr>
<td>Townsland Community Hospital</td>
<td></td>
</tr>
<tr>
<td>West Berkshire Community Hospital</td>
<td></td>
</tr>
<tr>
<td>Wycombe Hospital</td>
<td>MIU</td>
</tr>
<tr>
<td>Abingdon Community Hospital</td>
<td></td>
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<tr>
<td>Witney Community Hospital</td>
<td></td>
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<tr>
<td>Wallingford Community Hospital</td>
<td></td>
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<tr>
<td>Lawrence Home Nursing Team</td>
<td></td>
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<tr>
<td>Bicester Community Hospital</td>
<td></td>
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</table>
Berkshire East

48

1 WIC, 2 UCC

442,601

3

1
Berkshire West

52

1 MIUC, 1 WIC

528,000

3

HOSPITAL

H

A & E

1
Buckinghamshire

51

547,084

1 MIIU

5

1
Oxfordshire

72

3 MIU, 3 FAU

727,539

9

2
Thames Valley

- 223
- 1,517,685
- 12
- 20
- 5
<table>
<thead>
<tr>
<th>CCG</th>
<th>Population</th>
<th>GP practices</th>
<th>Community Hospitals</th>
<th>Urgent Treatment Centres</th>
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<tbody>
<tr>
<td>Buckinghamshire</td>
<td>547,084</td>
<td>51</td>
<td>2 (+3 redesignated sites)</td>
<td>1</td>
</tr>
<tr>
<td>Oxfordshire</td>
<td>727,539</td>
<td>72</td>
<td>9 (+1 closed)</td>
<td>3 MIUs, 3 FAUs</td>
</tr>
<tr>
<td>Berks West</td>
<td>528,000</td>
<td>52</td>
<td></td>
<td></td>
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<tr>
<td>South Reading</td>
<td>140,000</td>
<td>18</td>
<td></td>
<td>1 MIU (West Berkshire CH)</td>
</tr>
<tr>
<td>Newbury</td>
<td>118,000</td>
<td>11</td>
<td>3</td>
<td>1 WIC (Reading)</td>
</tr>
<tr>
<td>Wokingham</td>
<td>160,000</td>
<td>13</td>
<td></td>
<td></td>
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<tr>
<td>North &amp; West Reading</td>
<td>110,000</td>
<td>10</td>
<td></td>
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<tr>
<td>East Berkshire</td>
<td>442,601</td>
<td>48</td>
<td></td>
<td>1 WIC (Slough)</td>
</tr>
<tr>
<td>Bracknell &amp; Ascot</td>
<td>139,498</td>
<td>15</td>
<td>3</td>
<td>2 UCC - Bracknell (GP led)</td>
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<tr>
<td>WAM</td>
<td>151,899</td>
<td>17</td>
<td></td>
<td>St Marks UCC (Nurse led)</td>
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<tr>
<td>Slough</td>
<td>151,204</td>
<td>16</td>
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<tr>
<td><strong>Thames Valley</strong></td>
<td><strong>1,517,685</strong></td>
<td><strong>223</strong></td>
<td><strong>17</strong></td>
<td><strong>12</strong></td>
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Discussion – Setting the Scene
Session 2

New Models of Care
Primary Care Home
A unique model of care

Dr Steven Laitner
GP and Clinical Advisor, NAPC
March 2017
The next 15 minutes

1. An introduction to the Primary Care Home
2. The place of Urgent Care
3. Some Urgent Care examples
What is a Primary Care Home?

The ‘Home of Care’ for a population

The right size to scale and the right size to care
Our definition of Primary Care

- Patients’ **first point of contact** with the health and social care system
- Provides the **majority of our preventative and curative health needs**, health promotion and care monitoring requirements
- **Personalised** approach rather than disease focused
- **Comprehensive** services delivered by multi-professional teams focus on population health needs
- **Co-ordinates the integration of care** in partnership with patients and care providers.
The NAPC describes four core characteristics of a Primary Care Home

1. Focus on 30,000 to 50,000 people

2. Population health, personalisation, provision of care and outcomes

3. An integrated, multi-disciplinary workforce

4. Financial drivers aligned with the health needs of the whole population
Transforming Primary Care – the Primary Care Home

CURRENT STATE

1. Improved health and wellbeing

2. Improved quality of care for in local communities

3. Improved utilisation of local health and social care resources

TRANSFORMED STATE

- Allied Health Professionals
- Diagnostics
- Third Sector
- Speciality Care
- Social Care
- Mental Health Services
- Community Nursing
- High Tech Diagnostics
- Speciality Care

Lower referral rate

Working within a capitated contract

© 2016 National Association of Primary Care
One thing I have always found is that you have got to start with the customer experience and work backwards to the technology.

Steve Jobs 1955-2011
Typical journey ...........form follows function

Focus – on health and care needs of priority patient cohorts as well as the whole population

Functions – develop new models of caring – new models of service delivery

Form – what new organisations forms, if any, are required?

Funding – work with commissioners on funding, contracting, incentives
Population health management

Population health management is a proactive approach to managing the health and well-being of a population. It incorporates the total care needs, costs and outcomes of the population.

It involves segmenting the population into groups of people with similar needs to enable targeted interventions for both those population cohorts and the individual citizens within.
Segmenting the population

By people who share characteristics

Rather than just by disease group

e.g:

- Generally well
- Frail older people
- Adults with multiple, complex long term conditions
- Adults with drug & alcohol misuse, mental health and social problems
- Children with Learning Disability
<table>
<thead>
<tr>
<th></th>
<th>Generally well</th>
<th>Long term condition(s)</th>
<th>Complexity of LTC(s) and/or disability</th>
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</thead>
<tbody>
<tr>
<td>Children and young people</td>
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<td></td>
<td></td>
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<tr>
<td>Working age adults</td>
<td></td>
<td></td>
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<tr>
<td>Older people</td>
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Population health cube

Children and Young People
Working Age Adults
Older People

Ongoing Care Needs
Elective Care Needs
Urgent Care Needs

Complex Needs
Long Term Condition(s)
Generally Well
Possible 1’ Care Streaming

<table>
<thead>
<tr>
<th>REACTIVE CARE</th>
<th>PROACTIVE CARE</th>
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<tr>
<td><strong>Acute</strong></td>
<td><strong>Acute - more complex patients</strong></td>
</tr>
<tr>
<td><strong>Continuity not important</strong></td>
<td><strong>Continuity important</strong></td>
</tr>
<tr>
<td>Generally well or non-complex health problems</td>
<td>e.g. multi-LTC, complex, learning disability, nursing homes, residential homes</td>
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<thead>
<tr>
<th>Patient</th>
<th>Call Handler</th>
<th>Non-clinical</th>
<th>Any GP</th>
<th>Supported to self care</th>
<th>Managed on phone (eg Rx)</th>
<th>GP face to face</th>
<th>Nurse face to face</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>60%</td>
<td>40%</td>
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<tr>
<th>Patient</th>
<th>Call Handler</th>
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<td>60%</td>
<td>40%</td>
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<table>
<thead>
<tr>
<th>Patient</th>
<th>Single point of contact</th>
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<tr>
<td></td>
<td>Care plan</td>
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<td>Case manager</td>
</tr>
<tr>
<td></td>
<td>Care coordinator/ Navigator</td>
</tr>
<tr>
<td></td>
<td>Named nurse</td>
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<tr>
<td></td>
<td>Named GP/Geriatrician</td>
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<tr>
<td></td>
<td>Community health coaches</td>
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Source: Dr Steven Laitner May 2015
The rework routine:

- Reception takes call
- GP sees patient (10-min slot)
- Problem solved

"All gone, call back tomorrow"
How GP Access works as a system

- Reception takes call
  - 20% go to Admin completed
  - 60% go to GP phones patient
  - 20% go to Come and see nurse

- GP phones patient
  - 30% solved
  - 60% go to Come and see GP

- Come and see nurse
  - 10% return to Reception

- Come and see GP
  - 60% go to Problem solved
What if demand turns out to be stable, predictable and manageable?
Average wait time to see a GP falls off a cliff

Bourne Galletly MP, charts by PA Navigator
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ED Streaming & Urgent Care

Our Experience

Tim Yorston
Lead Emergency Nurse Practitioner

Guy’s and St Thomas’ NHS Foundation Trust
Urgent Care - Our Story

- ED Streaming
- St. Thomas’ Hospital UCC (Acute co-located)
- Guys Hospital UCC (Community)
- What works well (& lessons learned)
- The future
ED Streaming

• ‘Minute One Streaming’ – Get it right from minute one
• 24/7
• ED Nurse (Band 6 or above)

• Aims:
  • Identify sick patients early
  • Increase numbers streamed to UCC - ‘Overarching principle’ – all ambulatory patient’s considered for UCC unless excluded (exclusion criteria)
  • Redirect to right place, first time, every time.
Redirection options:
• GP appointments (Waterloo HC)
• Lambeth and Southwark Hubs’
• Self care
• Eye ED
• EPAGU
• Pharmacy
• Sexual Health
• Maternity Day Assessment
• Dental Emergency
• Harrision Wing (HIV)
Some Data

5th January 2017 (24 hours):

- 66 Pts redirected
- 6 refused

Picture overall:

- Approx. 12-20% of ‘Walk in’ Pts. redirected (less on weekend)
- Approx. 50% of adult Pts. seen in UCC
St. Thomas’ Hospital UCC

- **Co-located** with ED (24/7)

- **Staffing:**
  - **GPs** – (predominantly minor illness)
  - **ENPs/ED physiotherapist** (predominantly minor injuries/some minor illness)
  - **UCC assessment nurse:**
    - Assessment (Obs./Septic sieve/Bloods/Diagnostic image requests)
    - PGD – analgesia etc.
    - Flow & escalation
    - Admissions
    - Majors bounce back (approx 2-5%)
  - **ED VTS trainee and ED Drs**
What works well (& Lessons learned)

• **Streaming** and **proximity** to ED front door
• **Diverse** and **multi-skilled** workforce
• **Escalation** (+ flexing of staff)
• Uniform room setup (e.g. equipment etc)
• Keypad drug cabinet (£80)
• Blurred boundaries and expanding practice:
  • ENP/Physio. haematoma blocks/colles # reduction
  • Non-medial prescribers (ENPs 50% prescribers)
• Late opening pharmacy (+ OOH on call)
• UCC clinical governance meetings
Guys UCC (previously ED then MIU)

- **08:00 – 20:00** (last person booked in 19:00)
- Age profile: >1 year old
- **Staffing:**
  - GPs – (predominantly minor illness)
  - ENPs (predominantly minor injuries/acutely unwell)
  - Streamer (triage / S&T / redirection / escalation)
- **Run as a community UCC:**
  - High throughput rate
  - No bloods
  - Extremity X-ray only
  - Some redirection (Hubs’, dentist, sexual health clinic etc.)
What works well (& Lessons learned)

- Adastra (paper light) IT system & call forward
- Patient booking - self completion form (+ F&F)
- Receptionist - First Contact Protocol
- CBRN / MI / infection / IT & business continuity
- Accessible visible information on:
  - NICE Feverish Child ‘traffic light’ + escalation tool
  - qSOFA / NEWS
  - Normal paediatric observations
  - Safeguarding
  - Prescribing guides (Formulary, local antibiotic guide etc)
• **Pharmacy & X-ray** open during operating hours
• **Staff training** – ILS / PILS / Spotting the Sick Child etc
• ‘**Holding bay**’ (Resus facilities)
  • Rapid response and evacuation/transfer protocols (esp. paeds)
  • Basic emergency equipment and medicines:
    • Defibrillator, ECG, Monitoring (inc. 02 sats.)
    • Cardiac arrest drugs, steroids, nebulisers, adrenaline, IV fluids, Benzylpen.
  • Clear guideline wall posters (anaphylaxis, Paed and adult ALS algorithms, emergency telephone Nos.)
• Clear safeguarding SOPs
• ‘**Did Not Wait**’ SOP
• Robust results reviewing SOP
The Future

• Meet demand
  • Heat mapping (increased OOH demand)
  • Issues: Space during the day & decision makers at night

• Generic **Urgent Care Practitioner** (UCP):
  • RN, Physiotherapist, Paramedic, OT, Radiographer etc.
  • Core skills and practice parameters + specialist input to grow and develop service
  • Expand parameters of practice

• Develop specialist Urgent Care GPs/Drs
Cont.

- **Affordable, sustainable and tailored UCP training**
  - Accredited work based learning modules

- ‘**One team one queue**’ system (increase UCP autonomous practice)

- **Transforming care delivery:**
  - **IT** – paperless, call forward, electronic prescribing, easy spine access
  - **Referrals** – Glasgow Royal Infirmary fracture clinic transformation (e.g. discharging radial head # to self care)
  - **Splints** instead of plaster casts – quick! (walker boots now £15)

- **Live waiting time** information (waiting room)
Any Questions?
UCC EXCLUSION CRITERIA

General

These patients should be either directed to the appropriate area of ED or further assessed prior to a streaming decision.

• Appears unwell (Tachycardia 100+, Fever 38.5+ and/or NEWS score ≥3)
• Patients with suspected infection and SIRS ≥2
• In severe pain requiring IV analgesia
• Patient unable to communicate or speak English.
• They can’t walk (other than uncomplicated lower limb injury)
• Wearing a splint or bandage covering the injury
• Wounds with severe or arterial bleeding
• Fracture/dislocation requiring management in resus
• They appear intoxicated under the influence of drugs and/or alcohol
• Referrals from patient’s own GP to specialties or likely to require multiple or complex investigation
• Confused and/or unable to cooperate with their care
• Falls in patients over 65 with coexisting significant co-morbidities (e.g. head injury on warfarin or Hx. of LOC)
• Requiring PEP
• Likely to require PLN
• Epistaxis (active) in patients over 65 or in any age on anticoagulants.
NHS England IUC Video
Discussion – New Models of Care
Coffee and Comfort Break
Patients requiring same day urgent care would be seen at/cared for via a “Same Day Urgent Primary Care Hub”. This means that anyone requiring same day/urgent primary care would be seen in a central hub, which will draw patients from a number of local Practices, and be staffed by those Practices. They would care for people with a minor illness/minor injury that is typically seen in primary care. These Hubs are likely to cover a population of 30-50,000 people (aligning to place-based commissioning). All Hubs should operate to a common service specification.
Same Day Urgent Care Primary Care Hub (contd)

Issues for further consideration:

• Use of triaging/navigation/streaming
• Use of phone appointments as well as F2F
• Use of whole MDT, e.g. AHPs
• Does Hub provide booked access, walk-in or a combination?
• Managing patients with a LTC requiring same day care
• Maximising use of IT
• Which premises to use
• Staffing input from each Practice
• How to manage unregister patients/tourists?
• Minor injury management
• Links to out of hours primary care
• Funding and contracting models
• Relationships between the cluster Practices
Comprehensive ED

Would include:

A SDUPCH for minor injuries and illnesses;
An Ambulatory Care Unit (ACU) for those people who do not require admission to hospital for their assessment or management;
An Acute Frailty Unit (AFU) for those who need multidisciplinary assessment and management;
A mental health liaison service;
Assessment areas to see certain specialists: physicians (Medical Assessment Unit), surgeons (Surgical Assessment Unit) and paediatricians (Children’s Assessment Unit);
An Emergency Department (ED) with a Resuscitation Area for the more seriously ill and injured ....

Along with excellent navigation/triage/streaming processes
Urgent Care Centres

These are Centres focused on the assessment, diagnosis and treatment of a range of non-serious or non-life-threatening presentations, both injury and illness. UCCs would replace the existing range of community-based urgent care facilities/services delivered through centres known as UCCs/MIUs/MIIUs/Walk-in-Centres with one single offering.
It is assumed for all options (except option F) that planned primary care activity will remain ‘as is’, i.e. within Practices.
Breakout session 1 – facilitated groups (15mins)

- Are there any more key system elements/options we haven’t considered?
- Consider the answers to/implications from any discussions that arose earlier.
Feedback – Joining Key Elements
Breakout session 2 - facilitated groups (20mins)

Explore the relationship between UCCs and other elements of the system i.e. Primary Care Hubs, Out of Hours Primary Care, Community Hubs, GP at front door of ED.

In the following scenarios: (1 option per group)

1) Consider no Hubs and current state same day urgent primary care is delivered in and out of hours

2) Consider activity at Hubs is focussed around consolidating existing Practice-delivered (in hours activity)

3) Consider activity in the Hubs includes consolidated existing Practice-delivered activity AND also includes most of/all of the patient activity (minor illness and minor injury) currently going to MIUs/WICs/UCCs.

.... What would the role of UCCs be in these scenarios and what would be the implications for the system (including costs and workforce) and the patients?
Feedback – Joining Key Elements
Next Steps

- High-level ‘reality check’ for options under consideration – due diligence?
- Potential to usefully inform development of models – progress development?
- Not set in stone or yet fully comprehensive – what’s needed?

Need to fully understand where each local health and care system currently is in UEC planning 17-19, and what needs to be done to achieve the ambitions. Support, resources etc.

In light of today’s discussions, consider how best to share with our CCGs, A&E Delivery Boards and STPs ... part of UECN offer to help shape UEC strategy and delivery plan and support work going forward.
TVUECN Out of Hospital Care Workshop

THANK YOU

Feedback  Safe Journey

Room available until 1800 for further discussion