# London regional emergency care event

## Questions and answers



### The role of primary care

**1 - GPs aren't robots and can't work 7 days, every single day so there must be a way of actually shifting the resources to enable 7 day working.**
A - We do have 7 day working in primary care, we have out-of-hours services, as well as in-hour services.

**2 - What about 7 day working with a federate model, so patients don't go to A&E? But the younger group of people are going to A&E because they can't go to see their GPs during their working hours, so they go to A&E.**
A - I get the attraction and I can see the value of it, but it's probably not where I'd put my resources. I would put my resources on a) getting current general practice to work as well as it can, and b) to developing and improving the link with out-of-hours services and the rest of the system. It's great that we have an ambition to have genuine 24/7 care across the whole system, but I think the marginal benefit you'd get from 24/7 general practice, is probably not worth the investment.

**3 - Re-directing people, should we be doing it?**
A - It's an attractive thing to do, in that it fits in with "telling people-off" for using the system badly. But I think if we design the system properly, people will then use it in a more effective way. It comes back to the fact that people make logical, rational decisions based on the system that they're faced with. Some general practices are very complicated and incoherent – people will figure out a way to work around it, figure out how to get an appointment etc. But I think telling people to go elsewhere is smart, particularly because they have made a choice to go where they're going for better or worse.

## The role of CCGs

**1 - How do you manage nurse recruitment?**
A - In terms of recruitment for nursing, we have really struggled as have other community services, but what we have found is that working as part of GSTT has greatly enhanced our chances because we have been able to do something which we haven't done in previous years which is accept newly qualified acute nurses into the community, which wasn't an opportunity which was open to us before. So when we were recruiting two or three nurses last year, we got 10 this year. The other thing which we are doing is rotations between acute and community to give people that experience, so they understand what working as a community nurse is like and also to give them that confidence and whether or not this is a career option for them. Trying to grow a different breed of nurse, if you like – who is confident in working in either setting.

**2 - What do you do about I.T?**
A - In terms of IT, short answer is that we haven't solved it. We've found some work around it, we use NHS.net a lot, which has its own problems, but it's as close to a solution that enables us to communicate with a number of different parties.

We still have difficulties with that in our community services use RIO, our practices use EMS – one thing we all have in common is NHS.net, along with the rest of our Acute hospitals.

Sharing information is a really big issue on any aspects of integrated care with any of the partners. Within a specific service, and this applies to many of our specific pathways, we're still working on work-arounds. But we also understand there isn't one great big solution to this, so as an integrated care programme, looking across a range of different pathways, looking at more efficient and effective ways of linking systems as opposed to all moving onto one system – I think that's a pragmatic and sensible way of doing it. So if we could get all general practice at least onto one system, the opportunities to link all general practices into a community system, then if we could get all acute systems working in one way... It's working pragmatically – I think we've seen too many big bang approaches to IT which hasn't worked quickly enough or well enough for the NHS.

**3 - In terms of investment that you've had, was it purely NHS funded or did you get funding from local government as well? Have the outcomes you experienced (i.e. reduction in bed days /LOS) been replicated in the LA (with things like residential placements in their community care)? Is there a dual health and social care benefit?**
A - In terms of resourcing, we were originally funded by the NHS re-admissions money – the top-slicing that took place, was the pilot money that we used. We're now looking as we roll this out, exactly what the contributions are, and what should they be. Having said that, the funding is being managed by the integrated care pathways and that includes local authority funding and health funding, so there is joint funding more generally available with the admission schemes.

**4 - From a local authority perspective, are they seeing benefits effecting residential and nursing placements and community care budgets?**
A - It's a bit too early to show an absolute correlation, but we're planning on rolling out a much bigger and wider evaluation, rather than just focus on occupied bed days, so absolutely that's the sort of benefit we'd be looking at. We've had really positive feedback from our social work colleagues about the impact of having things like rehab workers and care workers actually based as part of the team. It's making their lives much easier, as well as the night owl service, which all takes the pressure off the day to day service.

**5 - What lessons are there for the rest of the system for CCGs, CSUs, other commissioners on how you share what you're doing with commissioners. How can we learn, particularly when we've built CSUs for a particular geography the river tends to be a barrier for all of us, how can we learn from that?**
A - We tend to look at geographies that they determine everything. My longest boarder in Lambeth is actually Wandsworth, and if I look at the changes in the population I know there will be huge changes across the river. I also know that if whatever happens in Westminster has a massive impact on St Thomas's, and we also mentioned before about transport hubs; all of those things contribute to a very complex population geography of the urgent care system, particularly for us in central London. We can't all be on each others' urgent care boards, nor can you have one urgent care board that covers everyone, because then there'd be too many people in the room.

So our approach has been to concentrate on the really local partnerships, where they make sense; and where the natural volumes of patient flows are and where the clinical relationships exist. Then, following the ways of engaging neighbouring areas in a way that makes sense; events like this are very important in aiding that process.

Alcohol – LAS run a different alcohol recovery centre on a Friday and Saturday night in Soho and we're starting to join up the work that we're doing in Lambeth with LAS, and we've started the meetings to see how we can make the same sort of approach across the patch.

**6 - How do you track the clinical effectiveness as well as cost effectiveness of the changes you're putting in to allow you to commission appropriately?**
A - This is a broad spectrum as many of the patients with regards to alcohol problems, come from across the whole country. So in part, we probably concentrate more of the evaluation on those bits of the service that are impacting the residents or registered patients because that's the bit that's recurring and going to keep coming back. The stuff on alcohol is really about how we can support getting a better flow into the system, and the extent to which it's value for money for the hospital.

## The role of local authorities

**1 - In terms of weekend discharge facilities, was it well publicised?**
We did a piece of work to understand if there was a requirement for it. It's important to engage clinicians not only support managers in conversations to provide support locally.

**2 - The model of long term care is difficult to apply in the system as a whole. Please describe how to approach it?**
We don't agree residential care for more than two weeks. We work with the individual and often put them in temporary placements. Beyond that, we maximise extra care and have a number of extra care facilities available. Social workers and parties need to come back round the table to swiftly create a robust assessment and make sure that opportunities of rehab are maximised and that equipment is delivered. Where possible, we put the individual in their home but in a small number of cases where people have to go into perm residential such as those with dementia.

**3 - Integrated care and infrastructure, how have you overcome working with different it systems?**
We have a programme working across Waltham Forest, Newham, Tower Hamlets looking at integrated care and one area is ICT. For health and social care we now have clear sharing of community health and social care that have access to all systems. With GP access, we won't have that but are looking at a platform or interface.

## What makes a good system redesign?

**1 - Talking about whole system approaches, and speaking on behalf of a local authority. So, thinking about this system which is pretty much within the context of the hospital, we're thinking of the next phase which is about the rehabilitation and re-ablement. The sequential steps of assessment that happen around the pull-back into the community, has some sort of dis-function in terms of how it contributes to the next phase of delay. If you really look at that critically, using a similar sort of system, you can actually really make it leaner and much more efficient.**
A - In Sheffield, we do it for Geriatrics, as Geriatrics is the same size as it is at Warwick Hospital, so they have real-time assessment for Geriatric patients coming into the system. We've got a secretary on the team who sends letters/emails to GPs straight away; and if a patient needs a home assessment, we dial a private ambulance who takes the patient home with an OT from the hospital. The OT goes back home and does the assessment. At that point they will call Social Services to advise what the patient will need (i.e. full time stay until the patient is fully sorted out), and then Social Services turn up.

**2 - Does this also contribute to reducing readmission?**
A - Yes, if you can keep it going. The whole secret to this is that you have to get every part of the health and social care system in sync. So we haven't got anybody doing twice weekly ward rounds, or monthly assessment panel – it's got to be everyday, doing the day's work, today.

Now because we have really super data, we've got CEOs having discussions about how to design the service, not to put people off, but to get everybody sorted out straightaway. Instead of if saying "well, we'll make this lot priority and we'll make those lot, not priority"; let's just get the whole lot sorted out today, and design the system to do just that. It's the same amount of work.

## Harnessing and supporting clinical leadership

**1 - We managed to get clinicians in a room to redesign pathways but their design was an expensive model. How do you get real financial sign off?**
We see this quite often because some systems have their own agreements. If you have a clinical pathway that is the right thing to do then you design a tariff that fits it.

**2 - Do you have examples of training grade doctors taking on leadership roles in urgent care? If so, how do you enable them to take on their leadership without making the consultants feeling less empowered?**
We should have service improvement work as routine with a bit of doctor training.

**3 - What about management training?**
Most management training for junior training is quite formal. What I ask my registrars to do is manage the junior staff, give them hands on experience, and attend board meetings etc. I never appreciated how the hospital ran until five years in a consultant post. It's the hands-on experience that is important.

## The nursing perspective

**1 - What is your retention of your nursing staff?**
I did some work at the Whittington where I introduced majors assessment nurses (ANPs) and found retention rates improved and we were attracting talent. If all departments are doing something similar, people won't hospital hop and as long as we look after them, they will stay.

**2 - Is there some comparisons around replacing doctors?**
We're not replacing training. It's about driving down locum middle grade use, to save money and fund more ST4s, more consultants, ANPs and ENPs.

**3 - Is there an advanced practitioner programme for nurses?**
Educational pathways are quite generic. The key is the education input, apply it to emergency care and expose them to patients.