NHS
North Tyneside
Clinical Commissioning Group

Report to: North Tyneside Urgent Care Working	
Date: 02/10/14	**Agenda item:**
Title of report: North Tyneside Urgent and Emergency Strategy Consultation-Council of Practices.	
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Purpose of the report and action required: The purpose of the report is to feedback views and ideas generated from the Council of Practices meeting and the consultation on one of the key strategic aims of the North Tyneside Urgent and Emergency Care Strategy. The information provided by member practices will help to inform the development of one of the strategic aims of the strategy and provide ideas for remodelling/transformation of services for patients in North Tyneside with urgent primary care problems and how they can be dealt with out of hospital	

Executive summary:

1.0 Introduction

The draft 'Urgent and Emergency Care Strategy' has been developed by North Tyneside's Urgent Care Working Group (UCWG) and has been guided by national policy and North Tyneside CCG's Strategic priorities.

The vision for North Tyneside is that people with urgent but non-life threatening needs should be met by highly responsive, effective personalised services out of hospital and care should be delivered in or as close to people's homes as possible.

At the Council of Practice (CoP) meeting on 17th September 2014, member practices were given the opportunity to contribute to and inform the development of one of the strategic aims of the North Tyneside strategy: '**Provide more responsive urgent care services out of hospital'**

Member practices were asked to consider 'what the future could look like for urgent care services out of hospital' and the consultation encouraged members to think of

new ways of working for urgent care services. Members were divided into four locality groups and 30 minutes was given to members to discuss one **question 'How could we remodel/transform services for patients in North Tyneside with urgent primary care problems to be dealt with out of hospital?'** Members were also asked to consider areas including: access, needs of different patient cohorts; helping people best to understand where to go; and best use of resources. A number of key issues emerged from the discussions and are outlined below.

2.0 Key Issues and Themes

A number of groups focused initially on what the current issues are for urgent care in North Tyneside and this allowed ideas to be generated on how to transform services to deal with urgent primary care problems outside of hospital.

CURRENT ISSUES

2.1 Fragmentation of services

- Currently the public are confused about how to access local services (111, GP, A&E) and so go to A&E.
- Need the same system in a wider area across the region to ensure clarity for patients. Currently we have different systems, different phone numbers.
- Too many routes in system for public.
- Access times at GP Practice not always convenient.
- In 2002/2003 urgent care was ran out of GP Practice's but this was not accepted by patients at this time, need to be clear what offering.
- Need for more improved pathway of care
- Significant variation in patient experience between GP practices.
- Overall fragmentation of the system means many people not able to access most appropriate urgent or emergency care service to suit their needs, leading to duplication and extra cost to the system.
- Huge differences in services available to a patient in a week day compared to weekend. The patient will be seen by different routes dependant on when they are ill, no consistency.

2.2 NHS 111

- Confusion by patients and professionals regarding 111, need clinical expertise in triage.
- 111 service, only option over weekend for patients – not always good patient experience.
- Over cautious restrictive system.
- 111 triage done by least qualified person.
- Too many ways into system-confusion needs to be algorithm –clinically experienced triage, medially trained for 111 systems to work.

2.3 Perceptions/Behaviour

- Two thirds of patients go to A&E and haven't attempted to contact their GP to get an appointment prior to going to A&E.
- There is duplication with patients booking GP appointment (as back up) in addition to attending A&E.
- Patients registered with GP Practices will opt for WIC on same site as Practice. Perceive seen earlier at WIC.
- We will not stop people attending A&E, people perceive A&E as a premium service.
- How do GP's define urgent and non urgent care, as it is so multi factorial? Default to urgent if a patient perceives it to be urgent. Are patients ever questioned why attended for appointment when it is non urgent? This would happen in WIC.
- GP's currently have good skills and a system in place to manage patient expectations and filter urgent and non urgent patients in the week, although we are aware that many non urgent patients still going to A&E.

2.4 Community Pharmacy

- If people go to community pharmacy- feedback really good for some minor ailments aspects- there is potential for pharmacies.
- Big issues with degree of clinical training in pharmacies (commercial expectations from larger pharmacy companies) and turn-over of staff is high and motivation quire low for some pharmacy staff.

3.0 Vision-What could the future look like?

A number of ideas were generated across the localities in relation to how services could be transformed for North Tyneside patients with urgent primary care problems dealt with out of hospital The main ideas generated are presented below.

3.1 Expand what we currently have in Practice

- Open appointments in general practice.
- Community nurse led service, e.g. a service to manage home visits, managed over a locality area. There are existing examples with nurse practitioners which would release GP capacity
- Desirability for patients-expand the offer for what GP Practice can offer.
- Consistency across in hours/out of hours-make message clear and simple and the same across the locality for GP Practice's.
- Patients want to go to a GP Practice, opportunity to introduce exciting new concepts into GP.
- Stratify primary care – recognising that there are elements that General Practice do very well, e.g. chronic disease management. Split acute from chronic increasing the capacity of GPs.
- More GP's and longer opening hours 8-10pm via rota system. Need to cater for working adults.
- What is British General Practice? Enable continuity and long term relationship with patients; help them to access correct services. Practices provide clear and consistent messages re: access to appropriate services.
- Book appointments across GP's and OOH and have multi access to appointments.

3.2 Expand Walk In Centre

- Primary care run WIC
- 8am-8pm access doctors at WIC, with access to IMT
- Funded and delivered by other staff (additional resources and staff).
- Make every GP Practice a WIC. Message to patients will be, if you come you will be seen.

- Path of least resistance make it an easy option for patients to attend.
- WIC inefficient but popular- 'Nurse Practitioner' there to see people but also having GP presence from locality-identity with sharing notes.
- Reduced urgent care workload in practice by sending people to WIC.
- Out of hours/weekend enhanced work.
- Rota for additional GP's.

3.3 Develop the base site NTDG as primary care with federation.

- Access easy and would cater for main patient cohort groups and access central and straight forward.
- A single of point access will help people to understand where and how to access.
- Education as part of service.
- Reduced urgent care workload in practice's by sending people to WIC.
- 8-8pm small practices.
- Exciting new concept for North Tyneside.

3.4 North Tyneside Primary Care Hubs in Primary Care

- 3 hubs across the locality, determined by geography, available buildings. GP practices have a critical mass to do urgent care across a patch.
- The concept could be a virtual hub - a telephone number to ring **h**ubs.
- Could be 3 hubs based upon existing 'estate': Battle Hill; Rake Lane; and Shiremoor Resource centre. GPs could work within this estate
- Hubs could be geographical, and therefore co-terminus with the Local Authority. *(Group considered the hub option to be achievable –scoring 3 out of 5).*
- Collection of practices makes sense for OOH work for economy of scale. This would allow and free up 1-2 GP's to deal with only urgent patients.
- Nurse triage in practices
- Does not have to be located in a 'centre' could be provided from GP practices
- GP's OOH- local GP knowledge for colleagues when practices come together (additional GP resource needed).
- Extending GP hours over a weekend will ensure work does not build up for GP surgeries on Monday (previously people just patched up over the

weekend).

- Practices come together to form a Co-op at the weekend to cater for peak 6-10pm with additional staff/resources.

3.5 A&E Department

- Place GP's/Primary Care teams actually in A&E seeing appropriate cases.
- Option to call the patient's GP practice for an appointment if the patient presents at A&E with a primary care problem
- 15% of A&E attendances are small children-engage with school nurses to refer back to practice.

3.6 Use of Technology

- 'Doctor on line' – using technology to be assessed and treated e.g. Skype
- App for patients that helps with self-care and how to access right service.
- Scope education and self-help with technology.
- Texts WIC and Primary care- make as easy as possible for patient- no excuse go to A&E.

3.7 NHS 111

- NHS 111 clinical triage
- Improve 111-approach to self diagnose and provide education and advice.
- Need clinicians as part of triage- GP's dentists etc.
- Need for simplicity with 111 services with effective advertising campaign.111 needs to be central part of triage.

4.0 Summary

It was acknowledged within the discussions that any ideas generated on the future remodelling or transformation of urgent care services needs to avoid further fragmentation and complexity of the current urgent care system. It was noted that there is no simple or easy solution to improving the delivery of urgent and emergency care. Many of the ideas generated built upon what is currently in existence, with added capacity, resources, improved access and consistency in the approach and messages required. The concept of' hubs' and 'collections of practices' was an idea presented with a number of delivery options based upon geography, virtual hub and coterminous options where appropriate.

There was a strong feeling from the discussions that there is the opportunity to work with patients and build upon the good relationships that many practices have established. Moving forward Primary care needs to clearly communicate how and what services will be delivered within the locality to ensure a clear identity for patients, e.g. same day, every day access and longer hours, community nurses to address urgent needs and harnessing the skills of community pharmacy. Currently this seems to contrast with the strong identity of A& E departments, which the general public can relate to.

Regarding self-care it was felt that people needed to be more supported and that there are current inconsistencies in the level to which health professionals are recommending and supporting self-care. In moving the urgent care agenda forward it was felt that technology could be utilised more effectively in the form of Skype, App's etc.