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North Tyneside Urgent Care Working Group

Primary Care Improvement Workshop

Summary Report

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Group distributions

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Primary Care Improvement Workshop Report

1 Introduction

This report provides an overview of the outcomes from the North Tyneside Primary Care improvement workshop which took place on the 22nd January 2015.

2 Background

North Tyneside's Urgent Care Working Group (UCWG), led by the Clinical Commissioning Group, has developed an urgent and emergency care strategy. The strategy sets out the strategic vision for the development of North Tyneside's urgent and emergency care system for the next five years.

North Tyneside's vision, endorsed by all partners of the UCWG, is aligned with the national vision. The aim is to develop a successful and long-lasting model of care which supports self-care; helps people with urgent care needs to get the right advice or treatment in the right place, first time; provides a highly responsive urgent care service outside of hospital so people no longer choose to queue in A&E; and ensures people are treated in specialty centres**.**
The strategy makes a clear distinction that for people with **urgent** but non-life threatening needs:

- we should provide highly responsive, effective, personalised services out of hospital,
- deliver care in or as close to people's homes as possible.

For people with **more serious or life threatening** emergency needs:

- we should ensure they are treated in centres with the very best expertise and facilities to reduce risk and maximise chances of survival and good recovery.

To realise the vision and move from the current to the future system of urgent and emergency care, the strategy outlines seven key changes that need to happen. The workshop focus was objective three:

Objective 1	Better support for people to self-care
Objective 2	Helping people get the right advice first time
Objective 3	More responsive urgent care services out of hospital
Objective 4	Serious and life threatening conditions are treated in the right facilities with the right expertise
Objective 5	Connecting urgent and emergency care services together
Objective 6	Integrating care along the pathway
Objective 7	High quality and affordable care within the resources available

- Connecting urgent and emergency care services together.
- Integrating care along the pathway
- Providing high quality and affordable care within the resources available.

The vision for North Tyneside is an urgent and emergency care system that is able to meet the needs of the people of North Tyneside; where all parts of the system are integrated with the wider health and social care economy; makes best use of, and are deliverable within, the resources available, to deliver improved quality and patient experience

3 Purpose of the Workshop

In order to tackle the challenges that North Tyneside CCG are currently facing around the urgent care system a workshop was held on the 22nd January 2015 with a range of stakeholders with the aim to generate ideas and a range of options for the future delivery model of care for perceived or actual urgent primary care problems to be dealt with outside of hospital. The workshop would fully consider the evidence base and best practice available locally, regionally and nationally.

4 Who attended?

Members of the UCWG were asked to identify representatives from their organisation to attend the workshop. A total number of 42 stakeholders were invited to ensure maximum input and development opportunities. The workshop was attended by 30 people from a range of organisations including:

- Freeman Clinics
- Healthwatch North Tyneside
- Local Pharmaceutical Committee
- Newcastle upon Tyne Hospitals, NHS Foundation Trust
- North East Ambulance Service, NHS Foundation Trust
- North of England Commissioning Support
- Northern Doctors
- Northumbria Healthcare NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- North Tyneside Clinical Commissioning Group
- North Tyneside Community and Health Care Forum
- North Tyneside Council
- Patient Forum members
- Priory Medical Group (Patient Representative)

A full list of those who attended can be found in Appendix 1.

5. Focus of the Workshop

There were 5 working groups at the workshop for the morning session and 3 groups for the afternoon session. The groups had mixed representation on each table. Each group was given the opportunity to consider:

- What currently works for dealing with urgent care outside of hospital and why does it work?
- What challenges do we need to resolve for dealing with urgent care outside of hospital and how do we do this?

- Consider and discuss models and examples of good practice from other areas.
- What will the future model look like for urgent care outside of hospital?
    - What will make it work?
    - What will stop it working?

5.1 What is?

What currently works for dealing with urgent care outside of hospital and why does it work?

An overview of the current situation regarding urgent care in North Tyneside was presented to the group, supported by data from relevant services. The information and data was provided to allow people to build up a picture of the current urgent care system and how this is operating in North Tyneside.

People were asked to identify and discuss in groups what is currently working regarding dealing with urgent care outside of hospital and to explain why. The discussions provided some key themes in relation to what is regarded by people as working well locally and how these areas could be harnessed and developed for the future.

What currently works well?	Why is it working well?
Battle Hill Walk in Centre	>Quick and efficient. >The WiC can do diagnostic tests and people can walk in and be seen quickly over extended hours without an appointment. >Ease of access/location and out of hours provision. >Patients feel safe and secure, as they are in the right place with professionals with the right expertise. >Not challenged by clinician currently if inappropriate person attending. Staff always pleasant and put people at ease. >Walk in centre is being used more and more, demand is there, especially from families and children. This was shown from the data presented in the session.
111 for minor illnesses	>Works through standard algorithms and works quite well. >Good new system for dealing with minor illnesses and signposting patient to most appropriate service. >Not sure if only available to certain sections of the population, should be expanded if it is. >Bookable appointments through 111 to WiC. This could be opened up in the future.
Patient forums	>Patient forums effective way of putting pressure on GP's/services to make changes and to put the patient at the heart of any changes/service improvements.
Community pharmacist	>Accessible, approachable, skilled workforce with lots of

	contacts in community. >All pharmacists in North Tyneside currently signed up to 'Think Pharmacy scheme' for minor ailments which is encouraging. >Pharmacists approachable and knowledgeable and quickly seen.
GP's	>Most people see GP as trusted professional and usually the first person they go to when they have a health problem. >Most patient experiences good. There are variations in Practices like most health professions. >Continuity of care in some GP practices e.g. GP seen patient for a number of years. Confidence in GP. >Good experience once accessed service.
Out of hours GP	>Convenient and timely service. >Good experience when used.
NEAS (Paramedics)	>See & Treat and Hear & Treat avoids the need to take patients to hospital. >Recognised as more than a transport system.
Community nursing/urgent care team	>Very responsive to need, alternative to GP.
Whole System	>System of health care best in world, committed staff, professionals, high standards. Can always improve but good starting point.

5.2 What challenges do we need to resolve for dealing with urgent care outside of hospital and how do we do this?

Groups were also asked to discuss and note down challenges that need to be resolved to deal effectively with urgent care outside of hospital and how this can be implemented.

What are the challenges?	How do we resolve these?
Service Challenges Identified by the groups	
1) NHS 111 Service Challenges >There is a reliance on each service to regularly update the DoS, to reflect the appropriate service provision available for the patient. This currently isn't being done in a systematic way.	>Need to make providers aware of their responsibility for updating the DoS on a regular basis. Need to build into contract agreements as a requirement.
>NHS 111 is working relatively well for a new system, further time is needed to help the service embed and see if it produces the relevant outcomes.	>The system needs to be left alone for a while to mature and grow as a service as more staff are recruited to fill staff vacancies.
> A long process when ringing 111. If people have a bad experience it will put them off using the service in the	>The service needs to ensure thorough training of all staff and that service has right staff with the right expertise.

future. Need to get right first time, every time. >Not enough clinical staff. Clinical staff and call operators are not in the same building-fragmented approach.	>Staff recruitment, most important the right staff with right skills. Call operator and clinical staff should be in same building to support each other in their roles.
>Algorithm needs more clinical input.	>Algorithm needs to be reviewed on a regular basis to make sure it works effectively. Is this nationally agreed?
2) A&E Service Challenges >Increasing number of people accessing urgent and emergency services who could have been seen and dealt with more appropriately outside of hospital.	A number of options are applicable: >Self-care needs to increase - recognised local campaign. >Education of the public on the role of community pharmacies to reduce inappropriate A&E attendances. >There could be an initial triage for people to ask for advice regarding urgent care needs that are not an emergency. This would be the first place to contact before attending or ringing another service.
>Specialist patients e.g. Oncology, Renal etc. there is complete information when attending A&E.	>Speciality advice / cover needs to be joined up.
>Fantastic service free at point of access and has excellent reputation (also downfall of the service.) Stable at minute regarding numbers but this can change quickly.	>Education of patient where to attend. >Turn away patients or redirect to more appropriate service. Initial triage at A&E and seen by GP at A&E or turned away and appointment made with GP next day if appropriate or self-care advice. Can't keep the current system going. >O.P Liaison Psychiatry to reduce length of stay & re-admissions –party of esteem.
>From A&E discharge back into community/home to avoid bed blocking.	>Need to make sure we are effective in doing this, in looking at the whole system across health and social care. >O.P Liaison Psychiatry role to reduce length of stay and readmissions.
3) NEAS Service Challenges >Need further investment in workforce.	>Workforce review to identify areas where need to recruit/invest.
>More Hear and Treat and See and Treat.	>Continue with this work, there has been a push of this area recently. Need to look at how effective it has been and learn from it.
4) GP Out of Hours Service Challenges >Currently limited to accessing information from other health professionals	>This can be resolved by more robust systems operating 24/7 that allows access to information across organisations and health systems.
>Underutilised GP OOH especially for people with complex needs.	No comments
>Lack of older persons services OOH	No comments

and weekends.	
5) Paediatric Service Challenges >Needs to be consistency in signposting to services, currently you can only suggest a patient attends and cannot refer directly.	>Signposting and referral mechanism is needed to change, across the whole system
6) Community Pharmacy Service Challenges. >Minor ailments scheme under used, could be much more effective.	>To promote 'Think Pharmacy Scheme' to the Public.
7) Walk in Centre Service Challenges **>**If further walk in centres are created there would be a challenge for GP's to provide the same level of care and expertise in all the WiC. Needs to be standardisation.	>Standards put in place to ensure same quality of care and standardised approach across all WiC.
>Need more walk in centres in localities to meet the needs of people and also walk in centres that are accessible by foot.	>Planning of where WiC sited to meet the needs of local people and accessible to all people.
>The data suggests people seem to use walk in centres more frequently if they live near to them, this convenience increases demand.	>Education for people regarding when to access WiC.
>Lack of consistency of triage – need to apply one triage model on phone and in person. Some patients need to be put through full triage process but others bypass and book appointment.	>Review of triage process so consistent.
Challenges for the Urgent Care System identified by the groups	
1) Navigation of the urgent care health system >Complexity of information to navigate the health system. Where to go for the correct advice, treatment or support at the right time.	>Information needs to be consistent to tell people which part of the health system they should go to for their ailment/illness. >Needs to use social marketing techniques to explain where people need to go for the right advice or treatment. >Consistent messages to the public.
2) Long term and multiple conditions >Care planning takes time to educate patients about their condition and management of this.	>Need staff to resource this area and support the patient self-manage their condition and avoid hospital admissions.
>In hours care for elderly patients with LTC poses a major challenge for the future re: the person staying in their own home and not needing to attend A&E.	>There needs to be greater use of specialist community teams e.g. respiratory (SPUDS) with flexible days and hours of cover. >Better use of appropriate teams such as district nurses, specialist community nurses.
>Pressure on urgent care system	>Need more self-help information and

from older people, how are we going to cope in the future?	prevention advice to stop people reaching this stage (secondary prevention). >Need to help people maintain their health and wellbeing and independence for as long as possible.

6 Models and examples of good practice

In preparation for exploring what urgent care outside of hospital *could* look like in the future, the group were provided with local, national (e.g. Prime Ministers Challenge Fund) and international examples of urgent care models that are being explored to tackle urgent care challenges (appendix report).

Presentations on the following areas were delivered to the group (appendix report).

1) South Tyneside's Vision for Urgent Care. The presentation's outlined 4 key urgent care areas of work:

- **The Urgent Care Hub Development (draft)-** The model showed a single front door with primary care triage to the appropriate services e.g. emergency, minor illness, ambulatory care, minor injuries and frail elderly assessment unit. The hub contained a range of services and expertise including pharmacy, emergency care medicine, dental, mental health, social care etc. with links to community outreach teams where appropriate.
- **GP working as part A&E team (2 projects)-** GP Federation working with FT to put GPs in the A&E team to achieve admissions avoidance. Secondly working with NDUC to run additional GP sessions at the Foundation Trust Site
- **Pharmacy-** Pharmacy in a box project staffed by South Tyneside CCG pharmacists, offering minor aliments in the A&E department. There is also to be a re-development and re launch of the Minor Aliments Scheme in South Tyneside open to non-South Tyneside residents.
- **Integrated Community Teams-** Three hubs positioned in the west, east and south of South Tyneside. Connected to the hubs are delivery community teams and linked into each community team is a number of GP practices.

2) Council of Practice Urgent Care Consultation. The presentation provided feedback on a listening event that took place with the Council of Practices (CoP) in North Tyneside. The CoP were asked 'How could North Tyneside remodel/transform services for patients in North Tyneside with urgent primary care problems to be dealt with out of hospital?'. 8 key themes emerged from the consultation: expand what we currently have in Practice; expand Walk in Centres; opportunities for A&E, develop the base site NTDG as primary care site with the Federation; North Tyneside Primary Care Hubs; Use of technology and NHS 111.

3) North Tyneside Operational Resilience in Primary Care. The presentation outlined the background to operation resilience funding for primary care and highlighted that the funds available were specifically for new approaches relating to primary care provision and admission avoidance over the winter months. The proposal was to stand up two pilot models:

- **Model A** (Locality GP Practice) - A locality based approach, utilising the 111 service with one practice from the locality opening on the 26th - 29th, 8am to 8pm, covering all patients within the locality, and;
- **Model B** (A&E Satellite Primary Care Clinic) - A primary care clinic on behalf of all GP Practices that consists of GP's working alongside A&E for the duration of 26th – 29th December, 8am – 8pm then rolled out at weekends for the remainder of the winter months (8 weekends)

The presentation outlined that Model A was delivered (Locality GP Practice) in three localities (North Shields, Wallsend and Whitley Bay) from 9am to 5pm, with a total of 560 patient appointments being made available. The findings showed that from the 560 patient appointments available across the three localities, 210 appointments were filled equating to a 37% uptake and patient feedback was very positive.

The workshop provided an opportunity to participants to discuss the information provided by three key presentations to move the focus to what potentially could be.

Themes have been outlined and placed under the relevant presentation area to provide an overview of the groups initial thoughts and reflections for the future.

1) South Tyneside's Vision for Urgent Care

- Multi-disciplinary teams (MDT) situated in a hub model, will this work for North Tyneside? Is this better than teams situated in the community? Good use of time/resources in a hub.
- Multi-disciplinary team key to future success of urgent care outside of hospital working in an integrated way.
- Idea of MDT in locality hubs with health and social care integrated.
- Local hubs are a good idea bringing different skilled professionals together and reducing barriers.
- Multi-disciplinary working is essential for future service provision. There will need to be a cultural shift and change across professional boundaries. We need to get better at integrated working.
- The capacity in social care needs to be increased in line with health services re: more demand for intermediate care beds to avoid hospital admission or reduce length of stay.
- Opportunities to improve referrals between practices and referral pathways as part of new hub model.
- Pharmacy should be called something different like 'walk in pharmacy' and clear protocols in place if patient can't be seen and refer to another service promptly. Need clear message regarding credibility for community pharmacies.
- Need to have social care input at the front end of urgent care, the needs of some patients may be better met by social care than health services but many referrers don't know how to access them.
- GP situated in A&E, is this an option?
- New model needs to have a single triage, standardised. Are patients currently being triaged correctly or is this driving demand for urgent care services?
- Central triage system needs to be in place for the whole urgent care system.

2) Council of Practice Urgent Care Consultation

- 7 day service in the future is this realistic with current workface pressure? Need investment and to look at other services such as community pharmacy, self-care takes pressure away from A&E and GP's.
- Employers can help staff to access services as appropriate and encourage healthier lifestyles and promoting self-care. Some larger employers are doing this e.g. local authority are doing this but more challenging for SME.
- Location is key; services need to be easy to get to so that people choose them over a trip to A&E.
- Community pharmacy could do more consultations; take pressure away from GP's.
- Need to invest in technology with new model e.g. skype works in rural areas.
- Need new system to communicate where to go for advice and information about conditions and illnesses.
- NHS 111, could book more appointments with appropriate services not just GP.
- Need to look at a range of models to meet local need e.g. telephone, walk in centre, bookable appointments. Need to look at whole system.
- Terminology for an 'urgent care centre' is confusing from a patient point of view, and makes it sound that people need to attend for anything the patient perceives as urgent. Clear guidance and messages for where people attend for what type of illness is needed.
- Future models need to think about mental health patients with urgent care needs.
- New model needs to have a single triage, standardised. Are patients currently being triaged correctly or is this driving demand for urgent care services?
- More time is needed to see the long term effects from other areas. Most of the urgent care models are in early stages, need to review evidence base and make sure the model is continually evolving to meet local needs.
- Model needs to look at the whole family and not just the individual patient, especially for frail and vulnerable groups.
- Need to look at the whole system for urgent care not focused on silo working in primary or secondary care.

3) North Tyneside Operational Resilience in Primary Care

- New models need to meet workforce requirements-capacity and demand.
- More open access GP appointments, will more appointment just mean more demand? Is there resource available? Can we afford it? It is sustainable?
- Primary care could do more but not enough workforce currently. Could we do things differently e.g. phone appointments etc?
- GP practices should be in primary care localities to deliver a range of services.
- Locality models-more affordable, open access doesn't mean that we need all practices to be involved just need a few to share resources where appropriate.
- Do GPs need to deal with urgent care or can they focus on long term co-morbidities in the future?

7 Patient Insight

As part of the workshop a presentation was provided to highlight North Tyneside patient perspective from a range of sources outlined below.

National GP Patient Survey.

- The results showed that North Tyneside patients were generally satisfied with the overall experience of appointment making, opening hours and ease of getting through on the phone.

Battle Hill Survey.

- It is interesting to note from the survey that 63% of patients surveyed at the walk-in service had not tried to contact their GP before attending. The main reason given was they believed that they would not get a convenient appointment. However of those surveyed only 25% said they would have waited to see their GP if the walk-in service had not been available
- 63% of patients surveyed at the walk-in service had not tried to contact their GP before attending.
- 44 out of the 62 patients (71%) travelled for less than 10 minutes to get to the walk in centre.
- 71% of patients stated that they would still have attended the walk in centre if they had been required to make an appointment with most of these patients commenting that this would be on the condition that an appointment was available that day.

A&E Survey

- 61% (n=42) of those surveyed at A&E believed their condition was urgent and requiring immediate attention. For almost a quarter (n=14), this was their first visit to North Tyneside General A&E.
- 45% of A&E attendances took place during the hours of 08.00 and 18.00 when GP practices and alternative services are available.
- Attendances at A&E were reported by patients to be for cuts, bruises or abrasions, eye/ear infection and stomach ache.
- Only 16% (n=11) had contacted their GP practice before attending A&E and of these less than half (n=4) were advised to attend A&E.

8. What could be?

What *could* the future model look like for urgent care outside of hospital?

All three groups was asked to consider a future model for urgent care outside of hospital for North Tyneside in 2020 and consider how the future model will work and what elements need to be included for out of hospital delivery to meet urgent care needs. Each group was provided with a sheet to outline their model and the only element completed on the sheet was an 'Urgent Care Centre' which is outlined in the strategy as a 'given' in line with the national strategy.

Group 1 Feedback
Model Outline >Single urgent care centre with a walk-in facility and single triage system – either phone, on-line or face to face. Appointments would also be built into the booking process.
UCC and 4 locality hub's >Localities based around the UCC. Other services include e.g. community paediatrics, diagnostic, x-ray, urgent mental health, elderly assessment.

>Each locality with a hub offering GP extended access including pharmacy and telecare facilities. Other services include e.g. community paediatrics, diagnostic, x-ray, urgent mental health, elderly assessment.
>Telecare facility between the UCC and emergency care/specialist emergency care hospitals– links to specialists.
>Elderly Assessment unit 7 days a week
>Robust triage and sign posting with health
>Integrated IT systems (primary & Secondary).
>Extend referral into community pharmacy (web based platform already available).
>Pre-bookable appointments via 111

Geography
>With the geography and proximity of the new hospital to the North West locality need some links with the specialist emergency hospital to discourage attendance at the new hospital – where should residents go?

Group 2 Feedback

Model Outline
>Single urgent care centre (for minor injuries) with diagnostics facilities.
>GP can refer directly to hub (UCC).
>Urgent care service in each locality run by the locality (spoke services in each locality).
>GP practice clusters would make up a spoke with at least 1 in each locality.
>Urgent care within the community linking to the hubs for chronic diseases – locality services/locality pharmacies.
>Urgent access to specialist opinion in hub and secondary care
>Signposting from 111 to hub and go for minor ailments

Paediatric Focus
>Paediatric specialist proving support to spoke services.
>Paediatric area specifically for observation as well as other facilities.
>In hub pharmacy on site and GP, pharmacy, nurse practitioners and social care (integration).
>Paediatric nurse practitioner in each cluster with links to the hub specialist support-possibly as paediatric clinic rotating around all the practices.

Shared Resources/Workforce
>Several GP practices working together to provide co-ordinated and consistent triage (GP and nurse practitioner).
>Shared work amongst GP practices-triage and home visits
>Home visits by GP and district nurses-rota for each practice to take the lead on home visits across the cluster
>GPs working together to bring greater flexibility (e.g. 1 GP do the home visits for all the practices/ 1GP doing the urgent triage.
>Nurse practitioner and nurse prescriber to have key roles in the cluster to release GP capacity. Prescribers to have key roles in the cluster.
>Community COPD and cardiac services to be more responsive and integrated in identifying patients at risk of admission in each practice.
>Need improved care planning and support for frail elderly including better access to consultants e.g. role for community geriatrician
>Better use of resources, pooled together.

Group 3 Feedback
Model Outline **>**4 hubs in the localities all do diagnostics as well, 7 days with MDT; not new estate, and existing services e.g. customer service centre. Not necessarily an Urgent Care centre. >Patient centred model/locality based model with one single standardised triage. > Integrated system – social and health care/mental health/diagnostics/paediatrics/ elderly assessment. > Standardised triage and standards working across all 4 hubs. >Option different hubs specialising in different areas as well as general urgent care work >An option could be to have a hub with greater diagnostic, paediatrics etc. with four smaller locality spokes linking in. >Community pharmacy in each of the 4 locality areas, integral part of model.
Shared Resources >Each hub will link with 3 or 4 GPs in the area. >Potential rotate staff/shared resource. >Integration social care and health teams within existing premises e.g. customer service centres.
Communications/Partnerships >Needs to develop a credible brand for the locality compere with A&E. >Key is 'buy in' of elected members. >Model use skype for care homes as an example. >IT investment needed for the future.

There were some clear themes that emerged from the 3 proposed models/concepts with a number of similarities and differences identified regarding the way forward by the groups. It is useful to note that the group's discussions reflected the expertise of professionals in that group. It was noted that one of the groups had particular expertise from a paediatric and clinical background that influenced how the group discussed potential model options.

It is also interesting to note that the 'Council of Practice' workshop held in September 2015, asked members to explore future delivery model of care for perceived urgent primary care problems to be dealt with outside of hospital. There were similar themes from the workshop including 3 locality hubs to be situated across North Tyneside, with practices coming together to share resources and provide extended hours. It was also thought that a future model should expand what we currently have in North Tyneside that is working well.

Similarities

- A clear consensus for robust standardised single triage across the urgent care system, which should be looked at as a whole.
- Integrated multi-disciplinary teams with a health and social care skilled workforce.
- Two of the groups suggested locality spokes (4) linking into one hub (urgent care centre).
- There was consensus amongst the groups that there could be a GP practice cluster, which would make up a spoke with at least 1 in each locality. This would be useful for shared resources and expertise.

- There was agreement about the need to move away from silo thinking to capitalise on the interdependencies between health, social care and self-care.
- All groups felt that services such as community paediatrics, diagnostic, x-ray, urgent mental health, elderly assessment were an essential part of the model, however there were differences in relation to where these services would be situated e.g. UCC hub or spokes.
- Community pharmacy was noted as a key element to support the models.
- It was felt that a credible strong brand needs to be established that the public can relate to for the new model.
- Several GP practices working together to provide co-ordinated and consistent triage, in a cluster.
- The model needs to be needs led and patient and public cantered from the start of the process.

Differences

- Two of the models outline an UCC with 4 locality hubs feeding into the UCC.
- Another model is to have four hubs, one in each of the localities.
- One of the groups identified a paediatric nurse practitioner in each cluster with links to the hub specialist.
- It was noted from one of the groups for urgent access to specialist opinion for the locality spokes from the hub and secondary care
- One group felt strongly that the existing Local Authority Customer Service Centre's in the localities could be utilised for the 4 locality hubs for the purpose of the model
- Not all of the groups felt that locality spoke elements needed to be able to deliver diagnostics, and that this could be delivered by the hub and the spokes could link into this when necessary.
- All groups generally felt that that GPs working together to bring greater flexibility, however once group detailed how this would work e.g. 1 GP do the home visits for all the practices/ 1 GP doing the urgent triage.
- Only one of the models mentions 'Telecare facilities' between the UCC and the emergency care/specialist emergency care hospitals.
- Only one of the models mentioned signposting from 111 to the hub for minor ailments.
- Technology including Skype was mentioned as an essential element of any future model by one of the group.

9. Enablers and Barriers

In relation to future models for urgent care outside of hospital, groups were asked to consider two factors:

- What will have to be developed to make models/future state work? (enablers)
- What might slow or impede progress? (barriers)

A number of key themes emerged from the group discussions, which outlined key enablers to support future models and also areas that may impede progress regarding a future model.

What will have to be developed to make it work?	Why might slow or impede progress?
1) Communications • Programme of patient education and publicity e.g. minor ailments, self-care. • Engagement of public and patients at the heart of any decisions • Co-ordinated communications campaign to inform the public • Social marketing campaign • Clear and credible vision that is communicated with staff and the public. • Use of technology e.g. Skype, FaceTime etc. **2) Partnership working/cultural change** • Model agreement and sign up by key partners locally- same vision. • Integration of health and social care teams • Shared code of conduct between partners. • Cultural shift e.g. MDT- need break down barriers • Handle and deal with patient expectations more effectively. • Get public on board, take them on the journey. • Commitment and buy in from senior managers • Political buy in from elected members • Need to incorporate links between health and social care, an integrated approach **3) Infrastructure Changes** • Information sharing protocols essential for future model and MDT working. • Diagnostics need to be available in most areas e.g. spokes and hub. • Triage standardised and	**1) IT/ Information Governance** • Access to patient records across services for MDT. **2) Cultural/Behavioural Change** • Competition amongst GPs other health professionals • Culture of A&E and WiC access (strong brand)-extend to rest of the system. It is going to take many years to shift people's behaviours? • Behavioural change- long term for patients and professionals. Different culture depending on health sector. • Longer working hours 24/7. There needs to be the right workforce in place with the right expertise. **3) Patient Perspective** • Need to find out further what the patients want. • Partnership working essential but might slow things down realistically. • Get the right partners involved; make sure people are involved from the start. **4) Policy changes /investment** • General election • Financial constraints will increase e.g. ageing population. • Tariffs and implications for the future. • Frequent policy changes in urgent care. • Are we just shifting resources/ from one part of the system to another. We need to make sure there is a clear rationale for this. • Will the model be left alone long enough to see if it is working? **5) Workforce capacity issues** • Need investment to have an integrated competent team. • Training requirements need to be addressed **6) Estates**

robust • Telehealth to support future model **4) Workforce** • Investment in the workforce required for future sustainability. • Educating the workforce – cultural shift and change how people will work together in an integrated way • More GP's needed to make things work. **5) Investment** • Invest resource where necessary into the system. • Locality Pharmacies need to be invested and expanded. • Integrated IT across all services, this needs further attention.	• Geographical sites important. • What is appropriate for each locality may differ? • Locality needs have to be taken into account.

10. Next Steps

A number of key areas were highlighted during the workshop which will be further explored to help develop a future model for dealing with urgent primary care problems outside of hospital.

The workshop provided a clear direction that due to the complex nature of patient flows across different services, urgent care services for dealing with people outside of hospital cannot be commissioned in isolation and the process requires a 'whole system' and multi-disciplinary approach across acute, primary and community based services and social care.

Recommendations

The Urgent Care Working Group is asked:

- to note and endorse this 'Primary Care Improvement Workshop' report.
- to note that future configuration of services has not been determined.
- to support the development of a consultation and engagement project plan to be shared with the UCWG outlining activities and timeline around the delivery of urgent care outside of hospital in the future.

Appendix 1 – List of Attendees

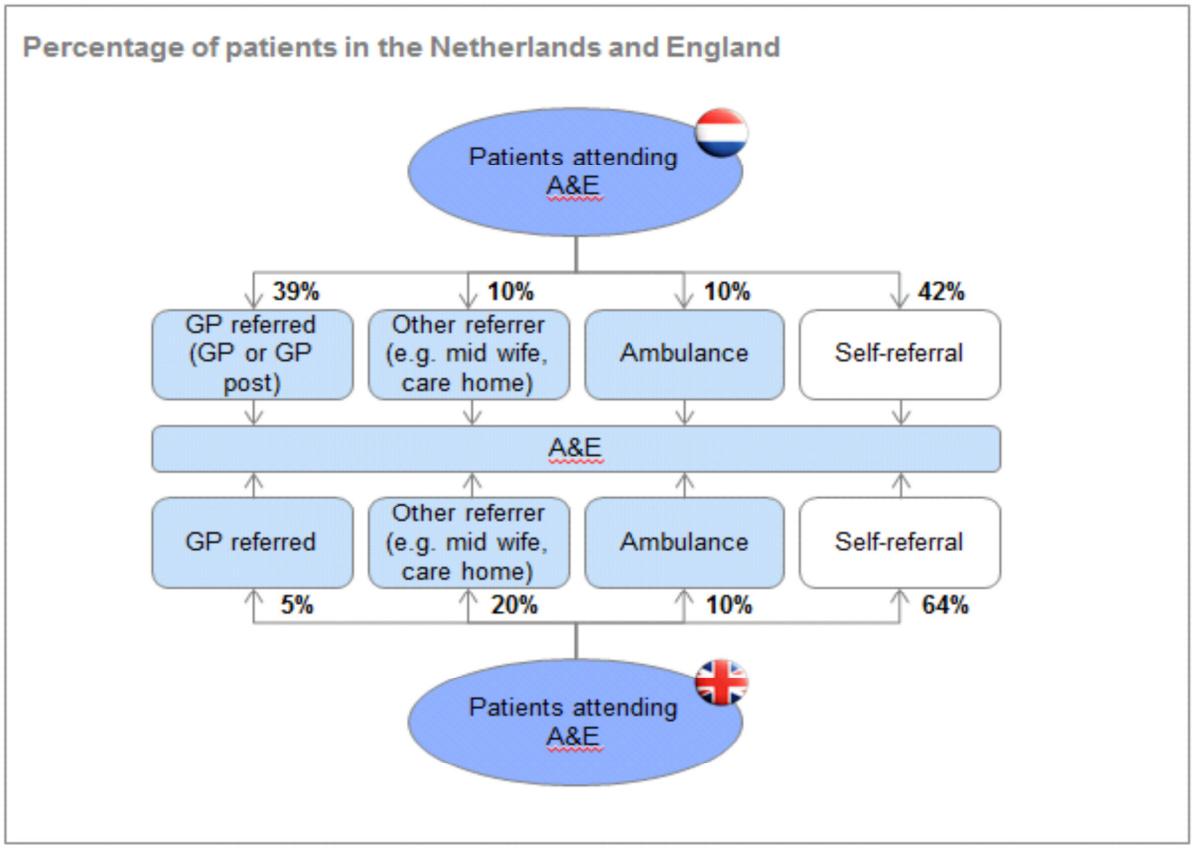
	Name	Organisation
1.	Anya Paradis	NTCCG
2.	Carol Proctor	NHCFT
3.	Dr Andy Jones	NHCFT
4.	Phil Clow	NTCCG
5.	Dr John Matthews	NTCCG
6.	Dr Jonathan Cardwell	NHCFT
7.	Dr Mathew Beattie	NTCCG
8.	Shaun Lackey	NTCCG
9.	Dr Nicole McLean	NTCCG
10.	Marc Rice	NTCCG
11.	Dr Susannah Thompson	Battle Hill Health Centre
12.	Gary Charlton	NTCCG
13.	Diane Wilcox	NTW FT
14.	Jean Banks	LPC
15.	Jennie Rasmussen	NHCFT
16.	Kevin Allan	North Tyneside Council/NTCCG
17.	Linda van Zwanenberg	Healthwatch
18.	Lindsay Perks	NT Healthwatch CCG Patient Forum
19.	Maureen Taylor	NDUC
20.	Michele Spencer	CHCF
21.	Helen Steadman	NTCCG Commissioning Manager
22.	Hannah Jeffrey	NECS
23.	Carole Wardrope	NECS
24.	Emma Gibson	NECS
25	Emma Roycroft	NECS
26	Adrian Dracup	NTCCG
27	Neil Frankland	NECS
28	Teresa Creighton	Newcastle Hospitals
29	Sue Wood	North Tyneside Council
30	Sandra Gillings	Priory Medical Group

Appendix 2 International Evidence Base- Netherlands

.A&E attendances in the Netherlands are about 120 a year per 1,000 people, compared with 278 in England. In the Netherlands 39% of patients attending A&E are referred by GPs, compared with 5% in England.

In the Netherlands, GPs are the gatekeepers of both urgent care as well as elective care, with 39% of A&E referrals coming through GPs in the Netherlands compared with just 5% in the NHS (see Figure 1).

Figure 1: A & E Referral Methods



Sources: Feb, 2012; *HSCIC: Focus on Accident and Emergency*, December, 2013

To some extent, these lower A&E attendance rates could be driven by the financial incentives that patients in the Dutch system face. Patients are required to pay a compulsory deductible (or excess) if they use any health service (including A&E) except for GP-provided care. However, as this is a fixed deductible, once it is incurred in the year, the incentive is removed for patients who access care most frequently.

This form of payment conflicts with the NHS principle that care should be provided free at the point of delivery to patients and is therefore not relevant to England. But other elements of the Dutch system could potentially help to reduce A&E attendances in the NHS. In particular, our research suggests that it might be possible to make greater use of GPs to deliver urgent out-of-hours care, a finding consistent with the NHS Five Year Forward View, which discusses the critical role of

out-of-hours access to GPs and nurses in supporting urgent and emergency care networks.

• Evidence of potential benefits in the Dutch system

In the Netherlands out-of-hours urgent care is delivered primarily through GP posts. These GP posts appear to offer benefits, including:

- Lower costs (with fewer A&E attendances). In the Netherlands, GP post attendances are cheaper than A&E attendances for low urgency/complexity cases - costing EUR92 compared with EUR267 for an A&E visit. Lower costs in the Netherlands are driven by lower overheads, lower rates of investigations and diagnostic tests, fewer referrals and fewer follow-up appointments. We would need to understand whether similar reductions could be expected within the NHS, dependent on case mix.
- Reduced A&E attendances could also benefit the NHS by reducing workload and capacity pressures at A&Es. In addition, where GP posts are co-located in hospital premises, there might be cost efficiencies resulting from shared use of resources and infrastructure, particularly X-ray availability, simple suturing, and so on.
- Good workforce outcomes. The Dutch system reports good GP job satisfaction and work–life balance improvement. Average time on call out-of-hours for a GP was reduced from around 19 hours per week to an average of 4 hours per week when GP posts were introduced.
- There is also evidence of good access to care in the Dutch system. The average waiting time is 30 minutes. Nearly 90% of all patients needing a home visit are visited within 1 hour. In case of life-threatening conditions, 70% of patients are reached by the GP post within the time target of 15 minutes.

• Important features of GP posts in the Dutch system

There are several elements to GP posts but some main features can be identified. GP posts typically:

- **operate from physical locations**. Around half of all patients get an appointment and visit the GP post at their purpose-built offices.
- **operate at large scale**. In the Netherlands since 2001 GPs have started forming larger consortia to cover out-of-hours care. An average GP now works out-of-hours for only 209 hours a year, but covers a larger population.
- **use telephone triage**. Patients need to call the GP post for a telephone triage, based on which they may get an appointment or a home visit.59 Of those that call the GP post, around 49% of patients go to the GP post, 10% receive a home visit and 41% are dealt with over the phone.
- **are often are co-located with the hospital (66%), with many co-located with A&E**.

There are four models of co-location:

- **separate from the A&E**. The GP post is in the hospital but the two are separate physical departments
- **before the A&E**. The GP post can function as a first contact, triaging all emergency patients and referring urgent cases to A&E
- **together with A&E**. Care is delivered as one department, staffed by A&E doctors and GPs
- **replacing A&E** - where a hospital does not have an A&E the GP post can fill in that function.

The co-location of GP services with A&E services could be more attractive to patients who do not need to change site should a referral on to A&E be required.

Each of these features of GP posts could provide useful insights for the NHS and may contribute to lower A&E attendance rates and costs as in the Netherlands. In particular co-location of GP services with A&E services could be even more important in the NHS given that, unlike in the Netherlands, patients will not have a financial incentive to report to GP posts first. More broadly, there might be scope for this principle of co-location and integration between GPs and A&E to extend from out-of-hours services to the whole week. Exploring

Source: 'Exploring International Acute Care Models' produced by Monitor: Making the Health sector work for patients.December2014

Appendix 3

Prime Minister's Challenge Fund 2013/14

Objective: to produce evidence for the NHS about successful approaches to improving access to general practices**.**

Background

In October 2013, the Prime Minister announced a new £50m Challenge Fund to help improve access to general practice and to stimulate innovative ways of providing primary care services.

Out of 250 expressions of interest, covering two thirds of the population of England, 20 pilot schemes were selected benefiting over 7.5 million patients across 1,110 practices.

The aims of these pilots is to enable NHS England to work more closely with GP practices to promote innovation, share learning and deliver the benefits of improving access and providing more flexible and extending access to services.

The 20 pilots explore a number of ways to achieve improved access including:

- Longer opening hours, such as 8.00 to 20.00 weekdays and opening on Saturday and Sundays
- Joining up urgent and out of hours care
- Greater flexibility about how people access general practice
- Greater use of technology to provide alternatives to face to face consultations, e.g via email, phone, webcam and instant messaging
- Greater use of patient on-line services
- Greater use of telecare and healthy living apps to help people to manage their health without having to visit their GP surgery as often.

	Area	No. of patients	No. of practices	Scheme
1	North East London	580,000	?	• 3 access hubs to see a GP evenings (6.30pm to 10pm) – Phase 1 bookable urgent appointments triaged through NHS 111 – Phase 2 (Oct) bookable appointments through other routes, e.g A&E and from 8am to 8pm weekend appointments • Care for 1000 patients with multiple LTCs – wrapping multi-disciplinary team around them to deliver integrated focused care. These patients will register with the Complex Care practice (start Nov) and receive care from the new team rather than their usual GP.
2	Greater Manchester	195,000	30	• Already have access to GP up to 8pm, Monday to Friday and 8am to 6pm weekends • Patients can book routine and emergency appointments at any number of locations across Bury (by end of 2014) • Patients able to use smartphone app to order prescriptions and book appointments without need to contact practice • Develop a comparison style website to help patients make better, informed choices about how they use GP services
3	Darlington, Durham and Tees	106,000	11	• Greater flexibility to access additional appointments during core opening times from selected practices • Greater opportunity to access primary care outside of core opening times including face to face appointments on Sat and Sunday from 8am to 2pm from a central site

				• A new multi-disciplinary specialist team of GPs, nursing and social care staff will provide additional support for frail, older patients to provide care closer to home.
4	Bristol, North Somerset, Somerset and South Gloucestershire	365,000	33	• Patient appointments to see a GP from 8am to 9pm Sat and 11am to 5pm Sun booked by GPs and hospital doctors as well as during the week • Focus on patients with the most need to improve quality and continuity of care achieved through shared common standards and new IT systems
5	Surrey and Sussex	111,846	14	• A new community navigator (CNs) scheme for patients who require health guidance rather than medical care • Working with voluntary care organisations, Age UK CNs provide support for patients with complex needs in community settings, particularly those living on their own. • Practices are working with pharmacies to create 4 'primary care' centre to give patients a flexible and responsive service including same day appointments from 8am to 8pm Mon to Fri and 8.00 to 20.00 weekends either at GP practice in a pharmacy or at home
6	South London	305,000	44	• Offering additional access to primary care health and advice, 8.00 – 20.00 7 days via new 'access clinics' delivered by neighbourhood groups of practices. • First pilot site operational from Nov 14 followed by the North in Jan 15.
7	Birmingham, Solihull and Black Country	60,000	7	• Offer extended access during the day including more ways to access e.g via Skype and telephone call handling and clinical call back and/or same day appointments. • Launched a clinical contact centre (Sept 14) providing

				remote and physical access – Online (via a new web portal, smartphone app and call centre) – Physical (via new consulting rooms) to patients requiring same day treatment and healthcare advice
8	Arden, Herefordshire and Worcestershire	185,000	24	Greater access – 8.00 to 20.00 7 days a week – in 3 new centres. • Offer appointments either by phone, video link or face to face • Offer new service for local hospital and care homes – A&E book appointments directly for those patients that need primary care support – Care home staff can access the primary care team weekends by video link New community initiatives • Training for carers, e.g spotting the early signs of illness, health advice clinics for teenagers at colleges • Health app giving patient health advice and information and book GP appointments
9	Devon, Cornwall and Isles of Scilly	1,670,000	230	• Trial a range of options to make services accessible: – Offering services in additional local venues – Establishing new urgent care centre offering extended hours – More ways to access GP services, e.g Sykpe – New case management for frail-elderly patients and those with complex needs where a lead GP co-ordinates a patient's care across primary, community and secondary care
10	Kent and Medway	109,746	17	• Patients can book appointments at any of 17 practices from 8am to 8pm, 7 days a week

				• Outside of core hours, patients can access urgent home visits, if required or short term residential facilities to avoid admission. • For patients with urgent mental health needs, the pilot introduces a new rapid assessment service delivered by a primary care mental health specialist at patient's home or GP
11	Lancashire	61,000	5	Offering 8am to 8pm, 7 days a week through a central hub including: – GP-led phone based triage system to guide patients to the right services for their health needs – Access to improved minor injury services, including treatment for fractures, sprains with an out of hours x-ray service
12	Thames Valley	148,000	?	• GPs offering extended hours (8am to 8pm) on weekdays (from July) and weekends (9am to 5pm) • Patients can subscribe to receive free texts to promote well being as well as routine health checks • Patients with complex needs or unstable conditions are offered a direct line to a clinician with whom they work closely.
13	The Care UK Superpractice	43,000	8	• Offer patients facility to access services by phone or on-line using a single point of contact from 7am to 10pm, 7 days rolled out to 24/7 (October 14) • Patients can call their practice and talk to a GP or nurse • Patients able to access health advice line and submit online consultations (to free up time for patients to see a GP)
14	Cheshire, Warrington and Wirral	208,000	29	To provide more integrated health and social care services, closer to patients' homes • Create 8 new virtual 'Primary Care Homes'

				– Each home covers 3-6 surgeries in the area providing an integrated service hub that includes primary health, community services, social care and psychological therapies – Each 'Home' will benefit from shared services across the practices including heart monitoring and blood testing and have dedicated care coordinators for patients with complex needs – Patients will have extended access 8am to 8pm, 7 days a week.
15	North Yorkshire and Humber	142,385	21	Extended opening hours, 8am to 8pm, 7 days for rural communities spread across 1,400 square miles • New focus on preventative care and care planning • Residents benefit from new community based teams bringing together GPs, community hospital, pharmacists and nurses and IT support • New services include, community IVs, pain management, management of stable prostate cancer and pre-operative assessments • Video technology will enable specialists to offer 'virtual' appointments at the patient's own GP surgery
16	Hertfordshire and South Midlands	111,000	15	Access GP appointments up to 8pm, 7 days a week – Patients can access appointments at own and at other practices within the pilot. – Patient records available to GPs working from hub sites Offer an enhanced multi-disciplinary team (GP, social worker, community nurse, physiotherapist and occupational therapist) to provide proactive care service with a linked 'telemedicine triage hub' supporting the team providing fast response primary care service for local care homes carrying out virtual home rounds to improve patient care

17	North West London	2million	396	• Extended access on weekends • Extended week day access for patients who urgently need to see a GP: walk in appointments or booked through NHS 111 • Improve access to telephone appointments and offering email and video conferencing appointments as well as electronic prescriptions and online records access for patients that want it. • Most practices are on the same IT allowing GPs to access patients records across the networks with consent.
18	Derbyshire and Nottinghamshire	1.2m	154	Testing different approaches: – Extending hours in centrally located hubs, 7 days a week – Access services at any practices in the pilot area – New ways to access consultations, by phone, email and Skype and telecare to better manage conditions at home – Access to GP appointments outside Mon to Fri traditional services – Increased same day urgent care – Access to GP triage – Access to video consultations
19	West Yorkshire	63,000	6	• Longer opening times 8am to 8pm, 7 days a week • Introduce a new online signposting service to give better access to GP and other community services including consultations by email, 'real time' web chats, phone with a care navigator • Book appointments to frontline physio for new problems without seeing a GP

				• Video consultations between GPs, patients, care homes and consultants will be available • A new pharmacy co-ordinator to work across practices to promote integration with community pharmacy and self-care for minor ailments
20	Cumbria, Northumberland Tyne and Wear	33,292	5	• 5 practices working as a single organisation – redesigned minor injury service into a Primary Care Centre offering same day appointments open 8-8, 7 days a week for minor ailments and injuries (end of Oct 14) – Redesigned the management of same day appointments releasing capacity within practices to focus on primary prevention and improve management and care of frail elderly with LTCs. – Implemented a specialist nurse practitioner post supported by GPs to support care homes provide one to one care, care planning and medicine reviews of those with complex long term conditions – Developed specialist diabetes and COPD clinic in primary care