SHIP

Unscheduled Care

Summary of the strategy for a remodelled system for Southampton, Hampshire, the Isle of Wight and Portsmouth

14 July 2010

Version 0.1

Southampton City NHS Primary Care Trust

NHS Hampshire

NHS Isle of Wight

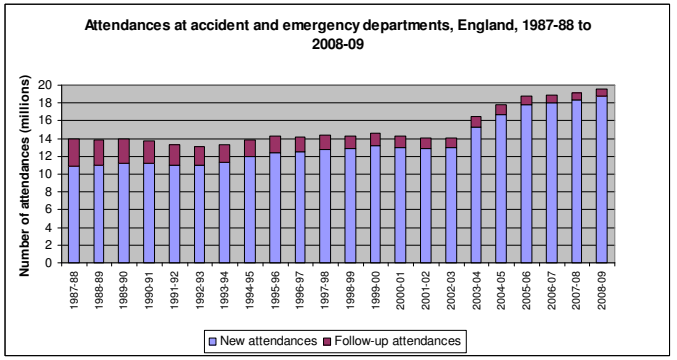
Portsmouth City NHS Teaching Primary Care Trust

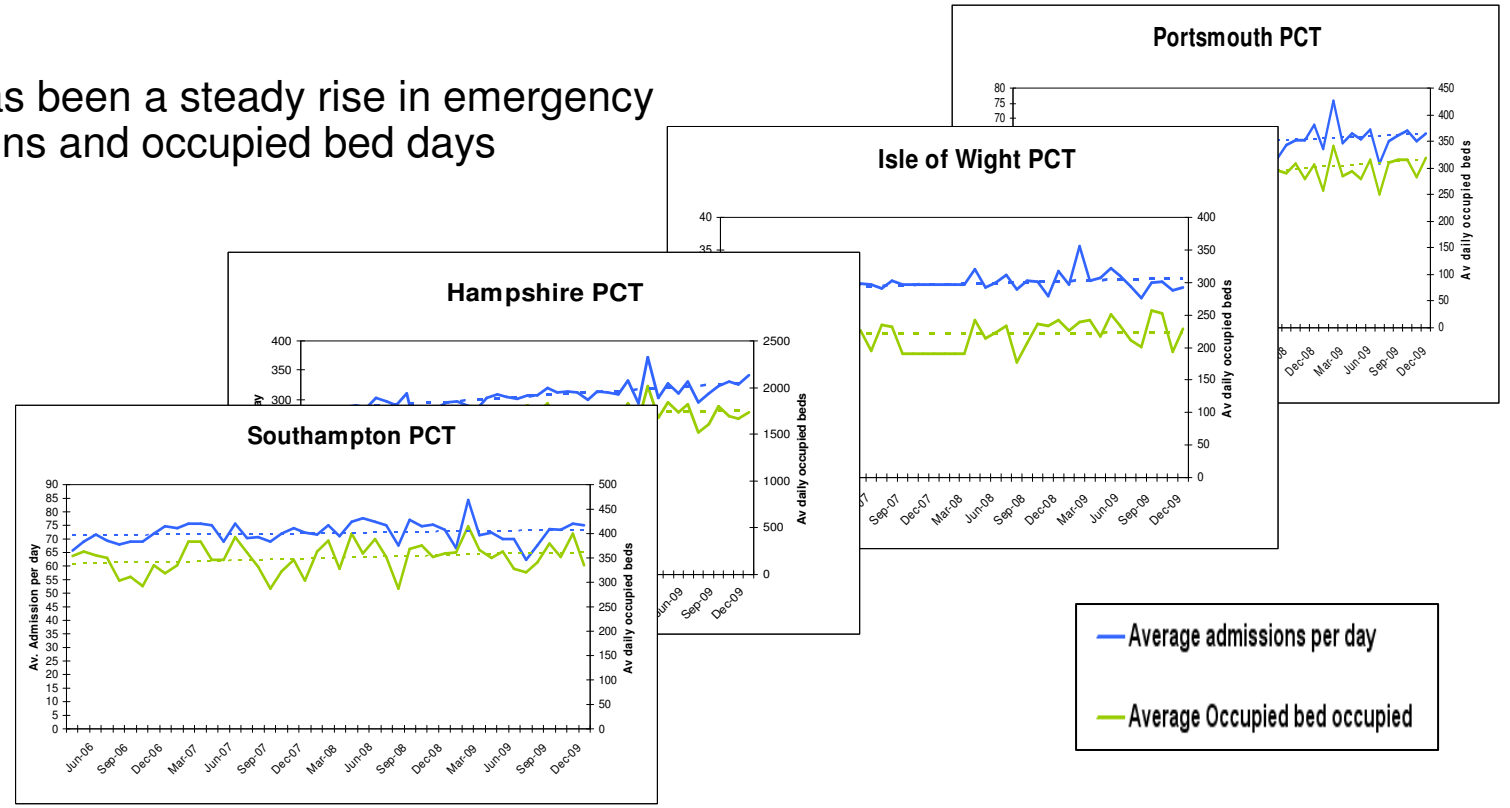
Introduction

- This document summarises the vision and direction for development of unscheduled care services over the next three years. It describes “what” we propose to see emerge, but is not prescriptive in determining “how” it should be managed.
- The document has been produced in collaboration by NHS Hampshire, NHS Southampton City, NHS Portsmouth City and NHS Isle of Wight (SHIP), working with NHS South Central SHA.
- The strategy segments unscheduled care by three categories of users:
  - Those with **chronic illness** such as mental health, elderly care, end of life and long-term conditions, especially with co-morbidity
  - Those who require **urgent care** such as minor trauma and illnesses needing an experienced primary care response for the initial assessment and treatment
  - Those who require **emergency care** such as major trauma, needing immediate access to fully staffed hospitals with senior clinical capability
- It articulates the underlying problems for each segment and proposes a strategic approach to resolve those problems. With the proposed centralisation of emergency care around major trauma networks, urgent care will become more accessible closer to home, with the responsibility for managing chronic illness based within primary care consortia
- The new models of care summarised here will, over the summer months, be costed and populated with detailed information drawn from initiatives that allow new ways of understanding how the unscheduled care systems work across SHIP. It is then for local communities, clinicians and commissioners to determine how best the model should be co-designed locally

Unscheduled Care – System not in balance

- Attendance at A&E has increased dramatically since 2002
- There is unacceptable variation in trauma care across England (NAO Report, 2010)
- There has been a steady rise in emergency admissions and occupied bed days





The Unscheduled Care Strategy begins by considering the public and patient perspective

Consider three very different perspectives of three typical user groups; 'the unwell', 'the at risk' and the 'critically ill'. Consider each prior to making contact with the health system:

- *What are their differing expectations?*
- *In what way does the current system let them down?*
  (even though in all cases they may not realise it)
- *How we might develop a better model for each?*
- *How in each case that model is better for the patient, whilst making significant productivity improvements.*

In what way do our current services not meet our ‘Unwell or Minor Accident’ patient needs?

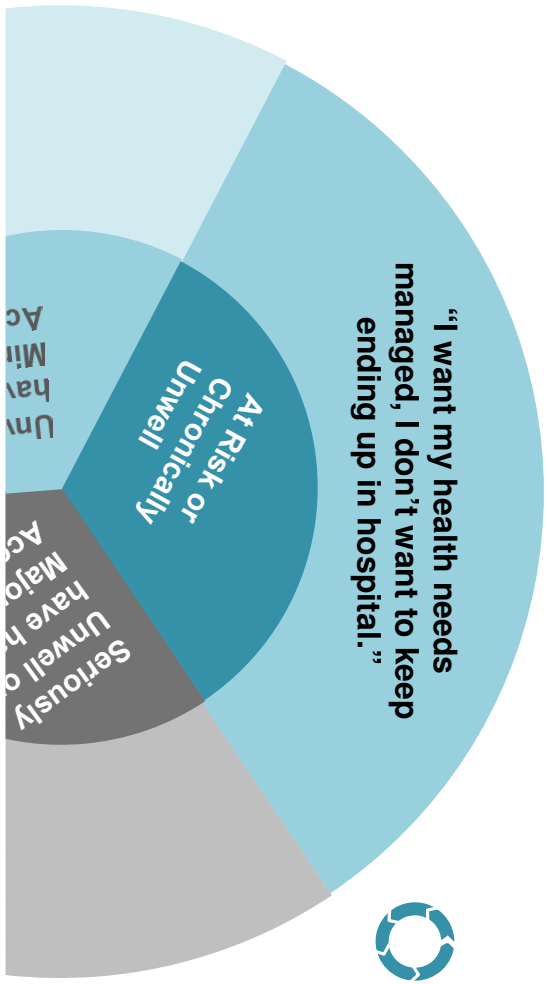
Unwell or minor accident

Our primary care, Out of Hours, A&E and Minor Injuries Units have developed over time in a rather uncoordinated and reactive way, responding more to political imperative than planning based on empirical evidence and patient needs.

The issues are:

- Postcode lottery provision in most primary care services (such as GP availability, accessibility, opening times)
- An inability to see your GP in a timely manner and at a time of your choosing. Primary care receptionists may sign post to A&E if no appointments available
- Variable OOH service which is not integrated with primary care (exacerbated with GP contract change)
- Public confusion as to which is the most appropriate service for what
- An A&E that has to provide a catch all for those areas that do not have adequate GP and OOH services
- High numbers of paediatric admissions without an overnight stay
- High proportion of worried parents/carers :1 in 4 people accessing NHS Direct relate to a sick child between 0-4 years of age
- A system that continues to put in place symptom solutions (GP front ends to A&E and MIUs that very few use) instead of dealing with the underlying issues
- Inefficient use of its resources and inability to embrace alternative approaches that benefit patients. (Surgery opening hours / telephone surgeries etc.)

In what way do our current services not meet our ‘At Risk or Chronically Ill’ patients’ needs?



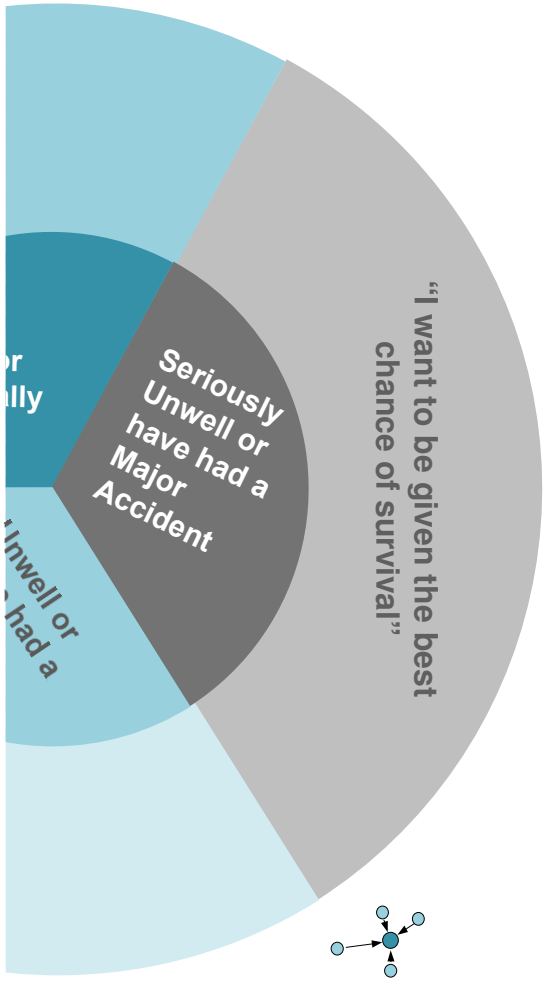
At Risk or Chronically Ill

Our Chronically Ill and At Risk patients are normally dealt with either when they turn up at the GP surgery or when they ‘crash’ in some way and end up in hospital. Unless they are being ‘case managed’ (very few, very high risk patients) the systems reacts

The issues are:

- Variable management of patients – need to be more consistently proactive
- The same amount of GP time allocated to a chronic patient as to someone with a minor complaint
- Most patients have co-morbidities, yet services are set up for specific diseases
- Lack of co-ordination of services (intra-health and between Health and Social Services)
- For vulnerable patients a feeling of lack of control
- Lack of skilled staff in primary care and intermediate services; breadth and depth (so hospital or nothing)
- Lack of expert advice in community (eg Community Gerontologist or Paediatrician)
- An endless succession of GP visits, repeat prescriptions, hospital visits with huge waits and emergency crashes in between

In what way do our current services not meet our ‘Seriously Unwell or Major Trauma’ patient needs?



Seriously Unwell or Major Trauma

In services such as Stroke/Cardiac/Trauma where:

- **The incidence rates are relatively low for a typical hospital catchment, and**
- **Where the skill and resource requirement are high**
  (Consultant, Nurse, and possibly equipment and diagnostics.)

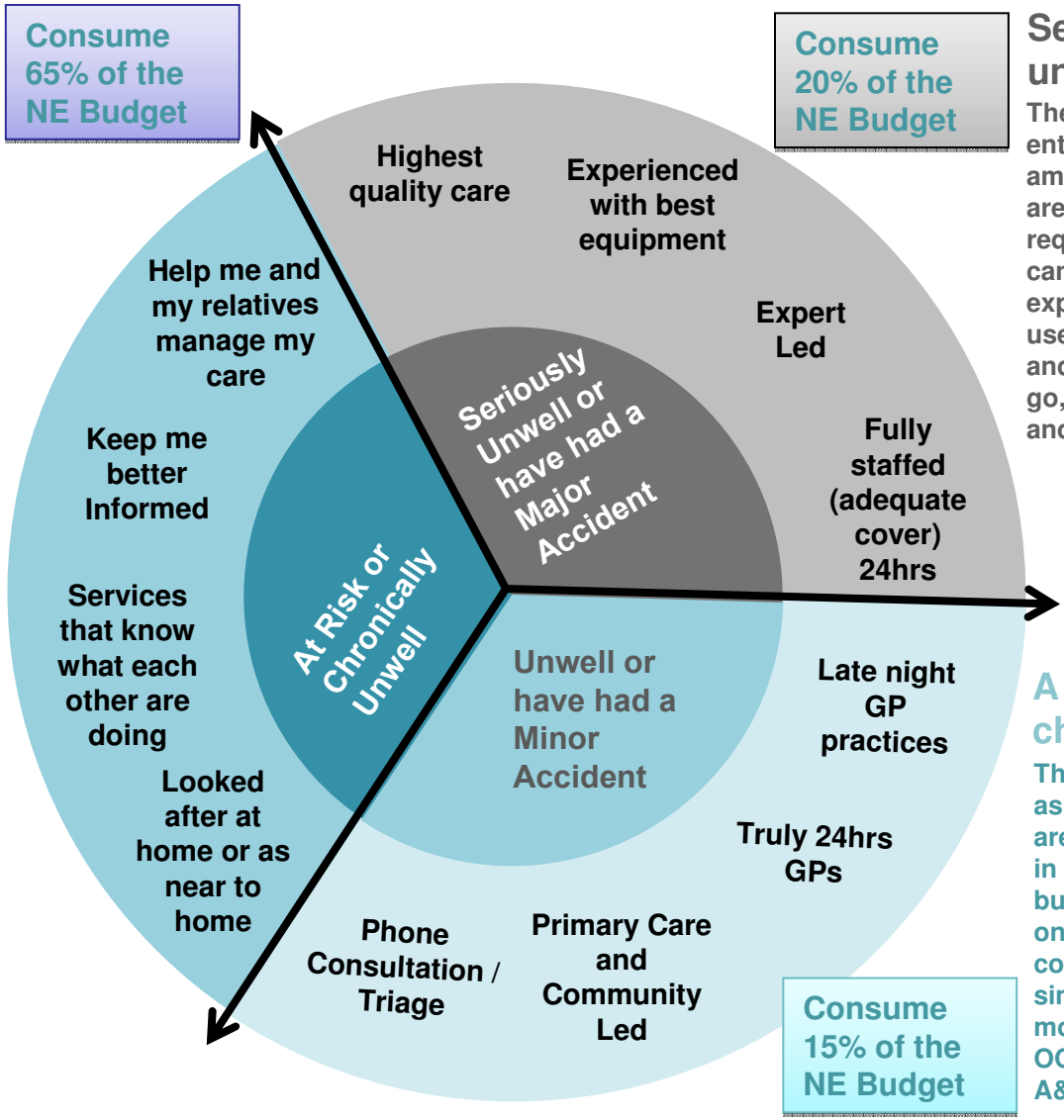
The issues are:

- Insufficient Consultant or nursing cover
  (With an inability to find new staff because of insufficient stock to draw from and because those available are attracted to hospitals with a ‘name’ in that particular field.)
- Inability within many hospitals to maintain skills (due to relatively low activity)
- Problem exacerbated for paediatrics (which represent a small proportion of this segment)
- Frequent inability to admit patients or inappropriate delay (sometimes necessitating long transfers)
- Outcomes falling or lower than in healthcare systems in equivalent western economies (National Audit Office Report, 2010)
- Inefficient use of clinical resources

This Unscheduled Care strategy addresses the public demand for the highest quality service where and when they need it.

A person with a chronic illness:

These are the patients who are at risk or chronically ill. They manifest in the system as 'frequent fliers'. They frequently use the system for minor things, such as repeat prescriptions and with the day to day issues of dealing with chronic illness, as well as having periods of acute exacerbation or 'falls' often due to poor management of their conditions. These patients currently turn up for treatment in the system as a minor or major incident. The significant difference for this group – is that they can identify themselves, and if we can too – can we better manage their problems to produce better patient outcomes and avoid downstream cost?



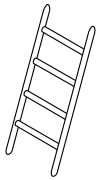
Serious injury or unexpected illness:

These are the patients who will be entering the system through an ambulance, and or via A&E. They are not making choices – they are requiring a responsive service that can ensure they receive the right expert clinical intervention, that are used to dealing with their problem, and that are primed and ready to go, with all the ancillary services and backup needed.

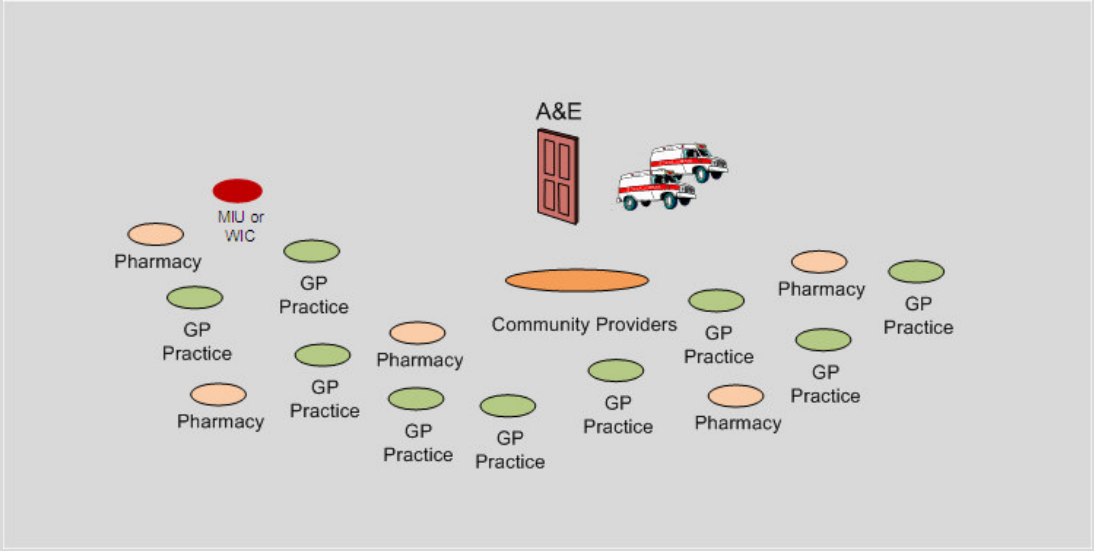
A working family with children:

These are the worried well, as well as the possibly seriously ill! They are a more demanding public than in the past, and just as work and business makes higher demands on them in terms of flexibility and communications, so they expect similar from their health service: a more flexible GP service, a real OOH alternative, an unclogged A&E.

The ‘Unwell or Minor Accident’ patient Segment



Minor Illness and Minor Accident – daytime model



Current Configuration

Predominantly planned GP appointments, typically 8 to 6.30, 5 days a week

A&E and Ambulance is the only unplanned alternative

Proposed Configuration

A 'Practice consortium' approach to Primary Care Provision 12 to 15 hrs a day 7 days a week

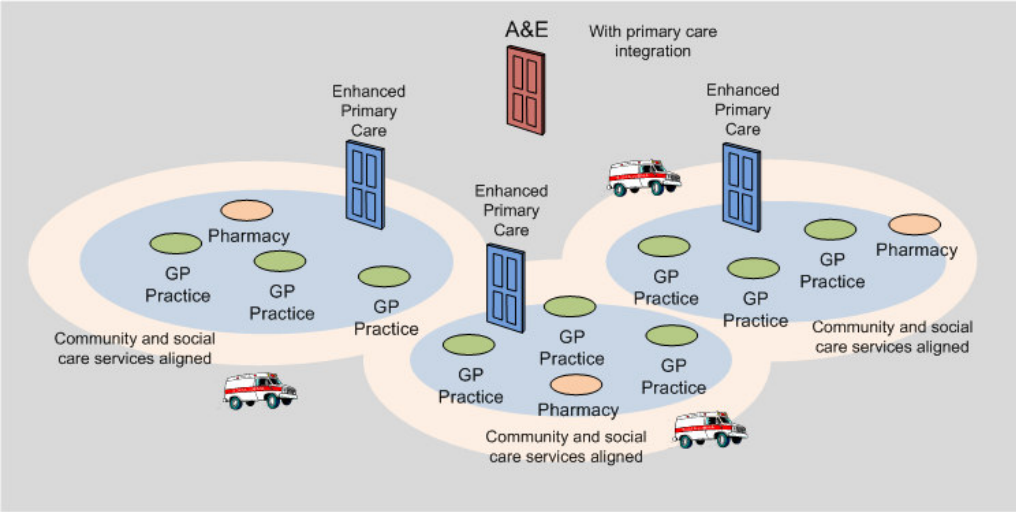
Where Practice consortia are charged with providing:

- **Unscheduled care services / drop in facility**
- **Some early morning & late evening GP surgeries**
- **Usual planned practice surgeries**
- **Smoothed patient flows (waiting times)**

Ambulance see, treat and if necessary refer

A&E still available to patients but consortia charged if used

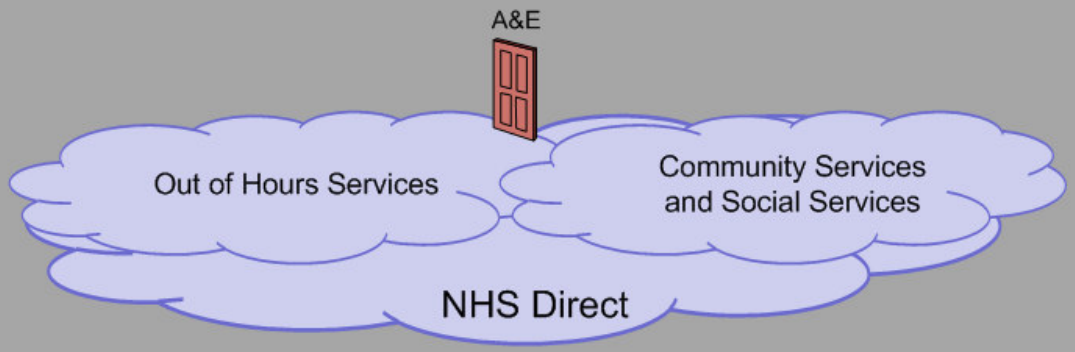
A&E to have integrated primary care team



Minor Illness and Minor Accident – night time model

Current Configuration

Variable OOH service supported by GPs mostly doing phone triage



Proposed Configuration

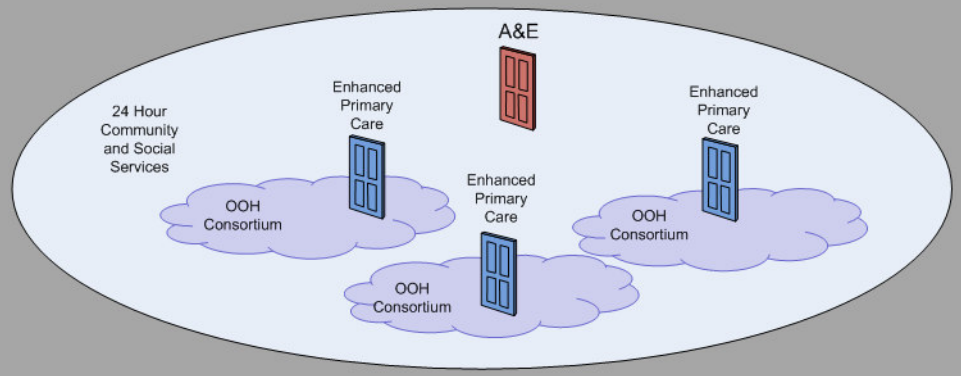
A more 'Practice consortium' approach to Primary Care Provision

Where Practice consortia are charged with providing:
- **Community A&E OOH**
- **Some evening Practice surgeries**

Ambulance see, treat and if necessary refer

A&E still available to patients but consortia charged if used

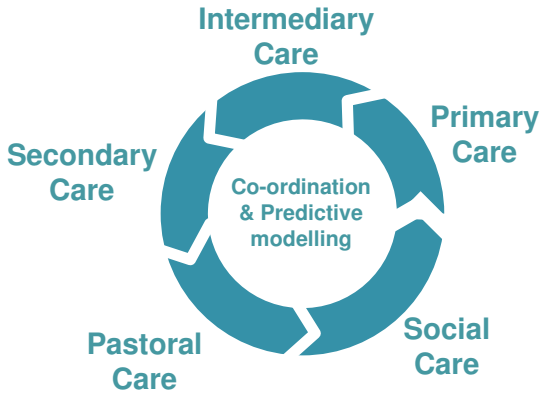
Automatic routing of GP telephone numbers to night time cover



The ‘At Risk or Chronically Ill’ patient’ Segment

A new model to meet our 'At Risk or Chronically Ill' patients' needs:

The broad approach: Pro-active Co-ordination



The premise:

- A relatively small but increasing proportion of patients (the chronically ill and the at risk) drive a significant proportion of the whole Non-elective Secondary care costs
- If we can manage more of these patients we can avoid them using secondary care, and keep their diseases from progressing (outcome and economic gains)
- A significant proportion of these patients that currently occupy secondary care beds actually only need either intermediary care or nurse led home help
- We can find these patients before their condition deteriorates (using GP and secondary care data and predictive modelling techniques) and therefore prioritise our resources around the care of these patients

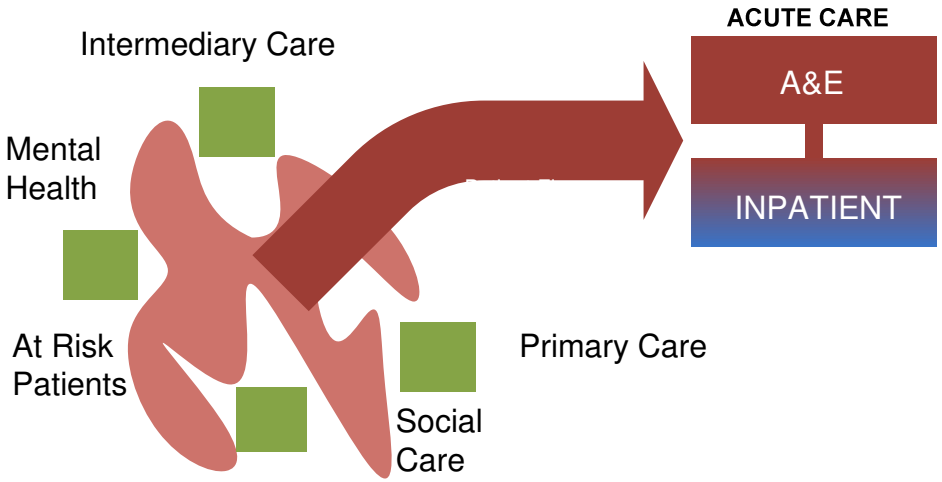
This approach will necessitate a new suite of supporting services. Such as:

- **Case Management (probably already exits)**
- **Virtual Wards**
- **Expert Patients**
- **Telephonic Health Coaching**

At Risk and Chronically Ill include all those within the public that are at high risk of needing secondary care:

- **those with co-morbidities**
- **those with chronic conditions**
  (such COPD, CHD, CHF, Diabetes, Asthma etc)
- **those with dementia or other mental health issues**
- **the frail elderly, or those at EOL**

At Risk or Chronically Ill Model

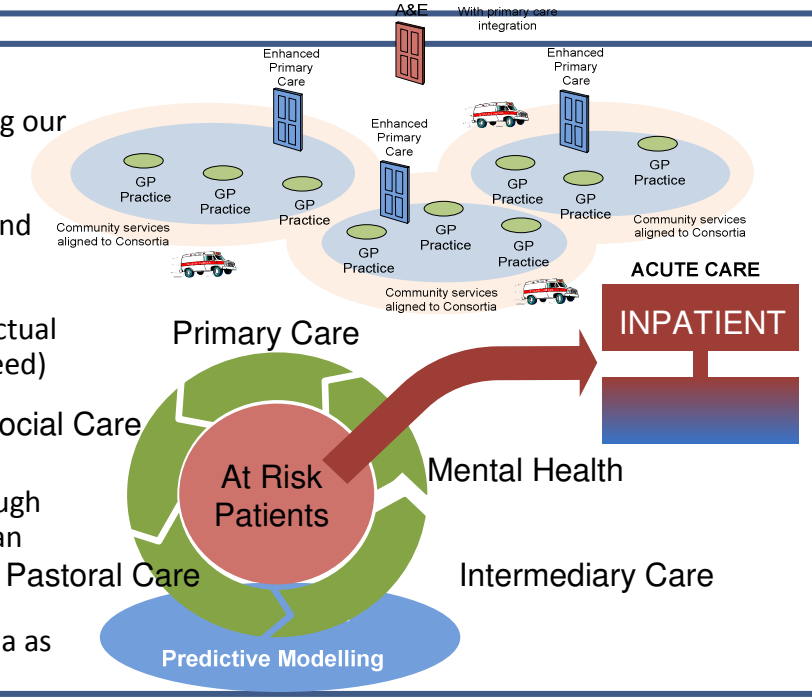


Current Configuration

- Re-active management of patients (A service characterised by an emphasis on secondary care)
- Lack of co-ordination of services (intra-health and between health and Social Services)
- Lack of skilled staff in primary care and intermediate services; breadth and depth (so hospital or nothing)
- Lack of expert advice in community (eg Community Geriatrician)

Proposed Configuration

- Pro-active management of patients (for our 'at risk population: changing our reactive culture to one with an emphasis on 'Planned Primary Care'.)
- Co-ordination of health services (inc. Mental Health) as well as Social, and Pastoral Care
- A better balance between Primary and Secondary provision based on actual need and an avoidance/prevention agenda (reducing secondary care need)
- Some mechanism for sharing budgets and/or aligning incentives
- New services especially telephonic and outreach related, targeted through predictive modelling to find and manage those patients on whom we can have the greatest impact.
- Urgent/emergency care in this segment care handled by same consortia as previously



A strategy that concentrates on initiatives around the high and moderate risk patients (likely to be mainly the chronically ill & elderly) offers the potential to achieve substantial health gains and more effective use of resources.

Characteristic / Approach

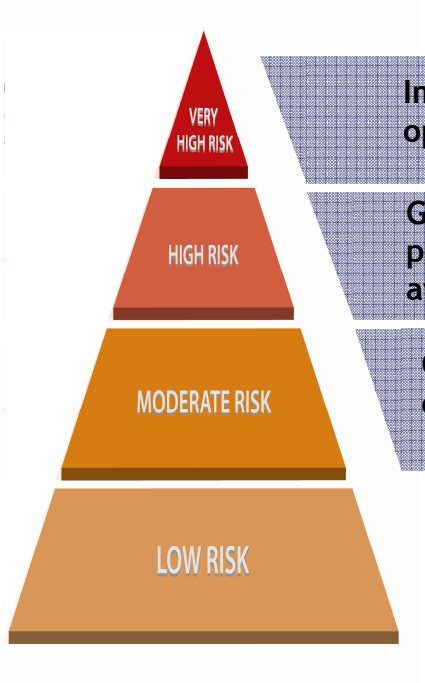
Complex Needs / Co morbidities: Complex Care Management

Established single illness: Disease and care management

Early Onset: Advice and monitoring

Well but at risk pop: Lifestyle change programmes

Well and low risk: Prevention, promotion, screening



Opportunity

Improve quality of care for patients / more limited opportunities for efficiency savings

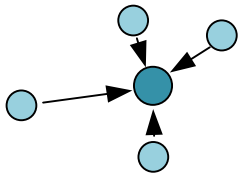
Greatest opportunities for short or medium term productivity efficiencies through alternative provision avoiding inappropriate admissions while improving care

Greatest opportunities for long term productivity efficiencies through preventative care

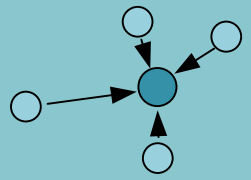
At Risk or Chronically Ill

Predictive modelling to specify high risk population concentrates our efforts where they are likely to have the greatest impact in terms of health improvement and productivity

The ‘Seriously Unwell or Major Trauma’ patient Segment



A different model for our ‘Seriously Unwell or Major Trauma’ patient needs;



The Case for a Network Approach (or Centralisation of service)

For low volume high resource services

Cons

Patient distance from designated network centre

Politically difficult

Public believe they are being exposed to a ‘transfer risk’

Other linked services destabilised

Clinical staff have to travel

Ambulance service requires additional patient transfer skills

Requires active approach to repatriation of patients

Pros

Better Outcomes

Availability (turn-away reduced)

More efficient use of resources
(Current distributed delivery often simply do not have sufficient skilled resources)

Controlled / managed transfer
(risks no greater, probably less, than a distributed service)

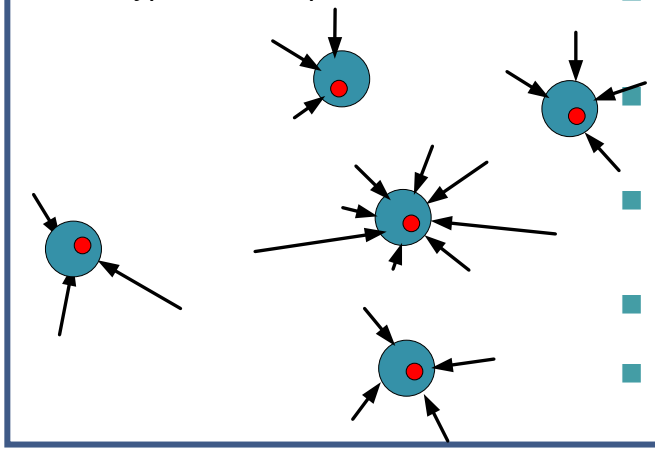
Easier for clinical staff to maintain their skills

Predictable work flow

Better clinical cover and more experienced clinical staff (reduced service risk)

‘Seriously Unwell or Major Trauma’ patient Model

Hospitals each with Major Trauma or other ‘hyper-acute’ provision

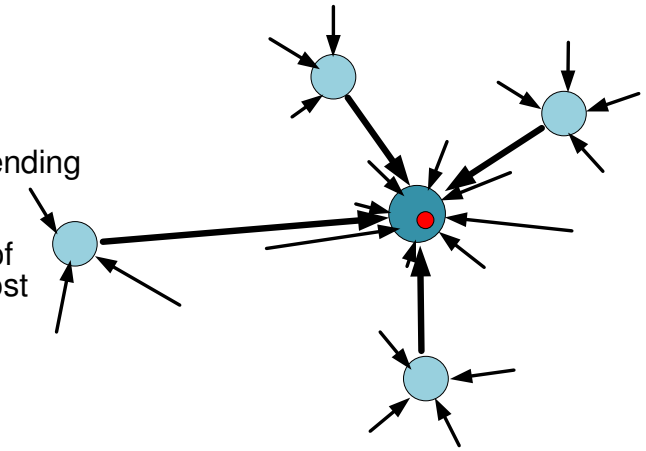


Current Configuration / Issues

- Every hospital in region attempting to provide almost all of the most complex care interventions to its local patients
- Outcomes falling or lower than in healthcare systems in equivalent western economies (National Audit Office Report, 2010)
- Insufficient clinical cover and activity levels that do not allow staff to maintain skill levels
- Frequent inability to admit patients necessitating transfer or inappropriate delay
- Inefficient use of resources

Proposed Configuration – South Central SHA led

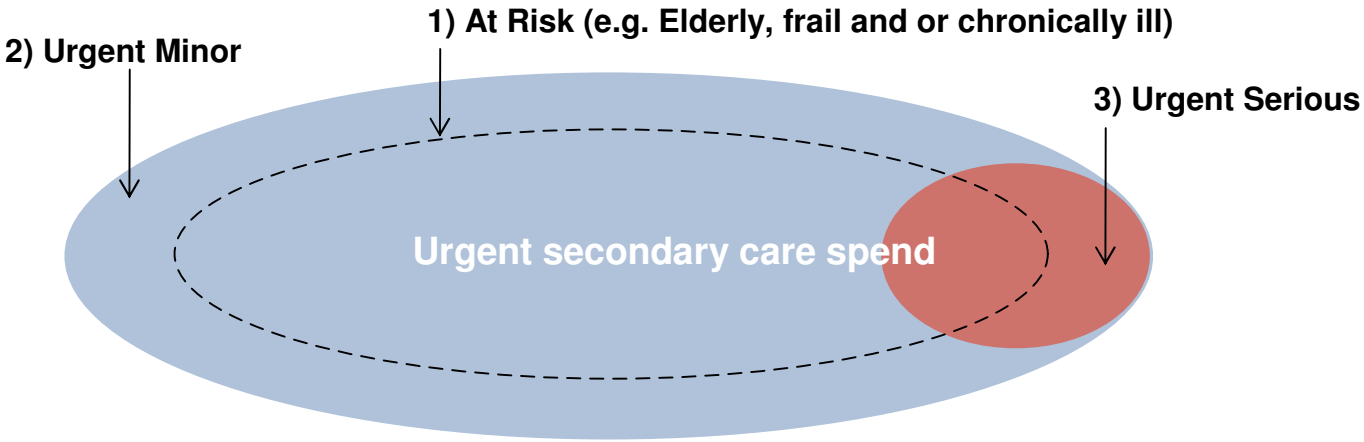
- Designate some hospitals as Network Centres concentrating highly skilled and experienced staff and facilities at those centres
- Designate other hospitals as Network Partners that are geared to stabilising/sending and receiving back local patients
- Ensure networks are optimised with an emphasis on reducing the probability of ‘turn-away’ to an acceptably low level – balanced with efficiency of resource/cost
- Ensure the transportation of patients is anticipated, funded and managed
- Clinical staff that are able to work across multiple sights
- The setting up of Network Boards (with Network Budgets)
- All open to consultation via SHA this year



Only designated Hospitals with ‘hyper-acute’ provision

A summary of the proposed model

Unscheduled Care: Our approach and underlying segmentation involves three groups



Segment	What's the underlying problem	What's our approach	Improving?
1) At Risk (e.g. Elderly, frail and or chronically ill)	These patients dominate unscheduled care (in terms of activity and cost) yet our emphasis to their care has historically been re-active – and secondary care based	Move Upstream: Systematic anticipatory / Care & Support Co-ordination / Close to Home Avoidance / Prevention	Outcomes / Quality of Care / Efficiency
2) Urgent Minor	Primary Care not meeting Patient Needs / Expectations & exacerbating A&E reliance	Greater decentralisation: improved availability of service through Primary Care led Consortia	Quality of Care
3) Urgent Serious	Falling Outcomes (relative to other similar economies)	Greater centralisation: Networking	Outcomes / Efficiency

Unscheduled Care: Strategy on a Page

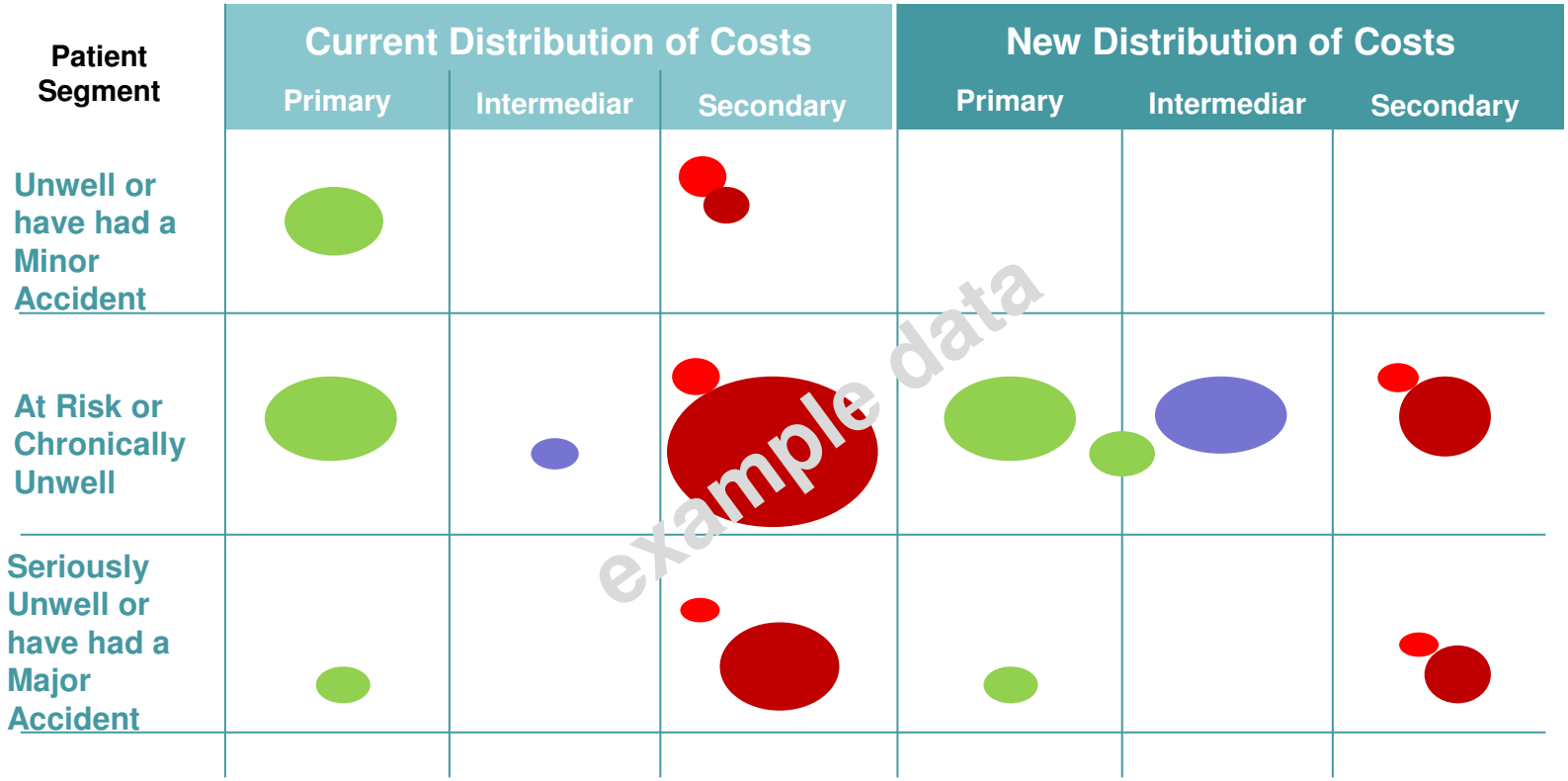
Patient need/ behaviour Segment	At Risk Patients	Urgent Minor Enquiry	Urgent Serious Need
Who	Elderly, Chronic, EOL, 'at risk' (that end up in Urgent Minor or Serious)	Anybody	Anybody
Dominant Driver	Outcome / Quality Care / Greater Efficiency	Quality Care	Outcome
What's the underlying problem	We need to stop waiting for patients to become ill (ending up in the two right hand segments) before we provide care for them, and we need to have more alternatives than just secondary care	Primary Care not meeting Patient Needs / Expectations & exacerbating A&E reliance	The numbers, and our resources do not allow us to be the best clinically at every acute site
Characterization of approach	Systematic anticipatory / Care & Support co-ordination / Close to Home	Primary Care co-ordination	Secondary Care Networking
Change in Approach Description	Whole new areas of service provision: 'pro-active management and co-ordination of services around predicted very high, high and medium risk public' – in the past picked up as a reactive minor or serious need – or in best case small numbers of 'very high risk managed by 'case management'	Much greater emphasis on unplanned Practice based and co-ordinated response (much less reliance on A&E)	Hospitals agreeing network centres and feeder hospitals / transport needs / repatriation policy / and how clinical staff would be shared / rotated
Supporting Technology	Predictive Modelling (ACGs) / Utilisation Management (InterQual). Single point of access for professionals for health and social care	New single point of access (111) GP Dashboard	Network Modelling to support tighter Network specific SLAs
Commissioning Approach	Until this area more mature, decide on range of complementary services (driven by predictive modelling), develop business cases and commission individually from best supplier.	Commission from Consortia of Practices to agree how they address a new minor urgent care SLA	Create Network specific SLA (based on expected clinical experience / transfers / turnaway / repatriation levels

Note: coloured areas provides relative scale of current secondary care cost for this segment (mutually exclusive)

Do the economics work?

System reform will necessitate a redistribution of costs. This is yet to be worked out in detail.

The schematic below reflects how we expect the economics to play out in the new unscheduled care model compared to the current model



- Overall costs will be lower
- There will be a significant shift in spend from secondary care to intermediate care
- Primary Care spend will be broadly constant

Conclusion

- The Unscheduled Care System needs to change:
  - patient experience demands it
  - there is a financial imperative to do things better and cheaper
  - the White Paper sets a direction which this strategy will implement

- The changes proposed in this Unscheduled Care Strategy will deliver:
  - the right care
  - in the right place
  - at the right cost

Next Steps

- We are conducting engagement over the next two months with key stakeholders before developing a final draft of the strategy
- The purpose of the engagement is to discuss the ideas included in the strategy about what services could look like in the future, not necessarily how it will be delivered in each area at this stage
- It is not a formal consultation to determine a specific reconfiguration
- Major trauma - one strand of the unscheduled care plans - is party to a separate consultation led by the SHA
- The focus is to ensure the best services are provided for patients within a sustainable system in line with future plans for the NHS
- Comments should be made to yourviewscount@hampshire.nhs.uk