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Interface between Primary, Secondary and Community Care.

Urgent – Unplanned - Unscheduled care

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Background

- UK leads the world in unscheduled care
  - Measurable change over the last decade

- Scope
  - 100M NHS calls or visits per annum
  - 1/3 of the activity of the NHS
  - Consumes about 50% of costs

- Complex system – needs to be joined up

Kings fund

Transforming our health care system

- Developing a more integrated approach to urgent care for patients who have an injury or illness that requires immediate attention but is not serious enough to warrant a visit to an accident and emergency department (A&E) through better co-ordination of the range of services available and sharing of clinical information across different agencies.
- Urgent care services are currently often highly fragmented and generate confusion among • patients about how and where to access care (Lattimer *et al 2010).*
- Poor sharing of information as patients move between different providers of care in an • emergency is a cause of many significant failures of care (Gandhi 2005).
- The quality of out-of-hours care is highly variable, particularly in terms of continuity of care, • leading to variable patient experiences (NAO 2006).
- The growth of new forms of urgent care has failed to reduce A&E attendances *Emergency attendances in England rose by 46 per cent between 2003/4 and 2009/10, (Department of Health 2011c).*
- Walk-in centres do not appear to have led to shorter waits in general practice or lower • admission rates at other health care providers (Salisbury 2003).
- Emergency admissions have also grown rapidly, rising in England between 2004/5 to 2008/9 • by 11.8 per cent – resulting in around 1.35 million extra admissions (Blunt *et al 2010).*

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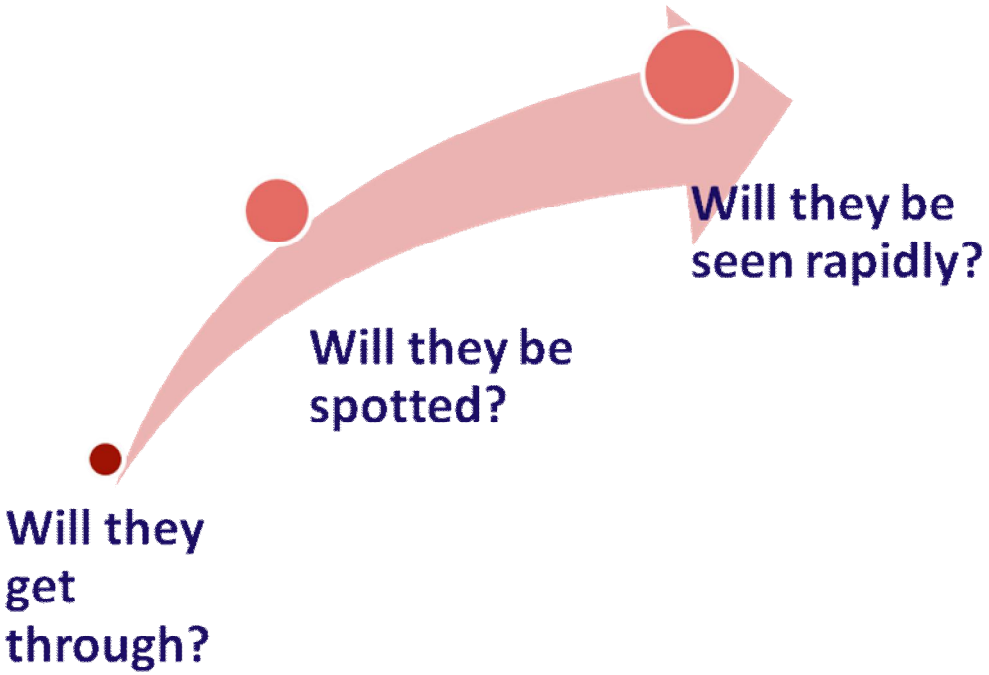

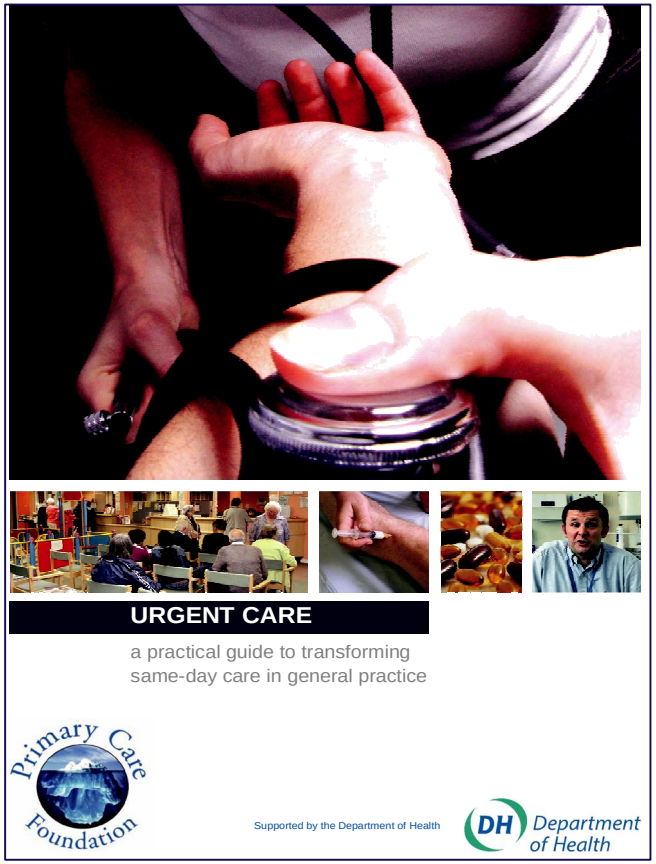

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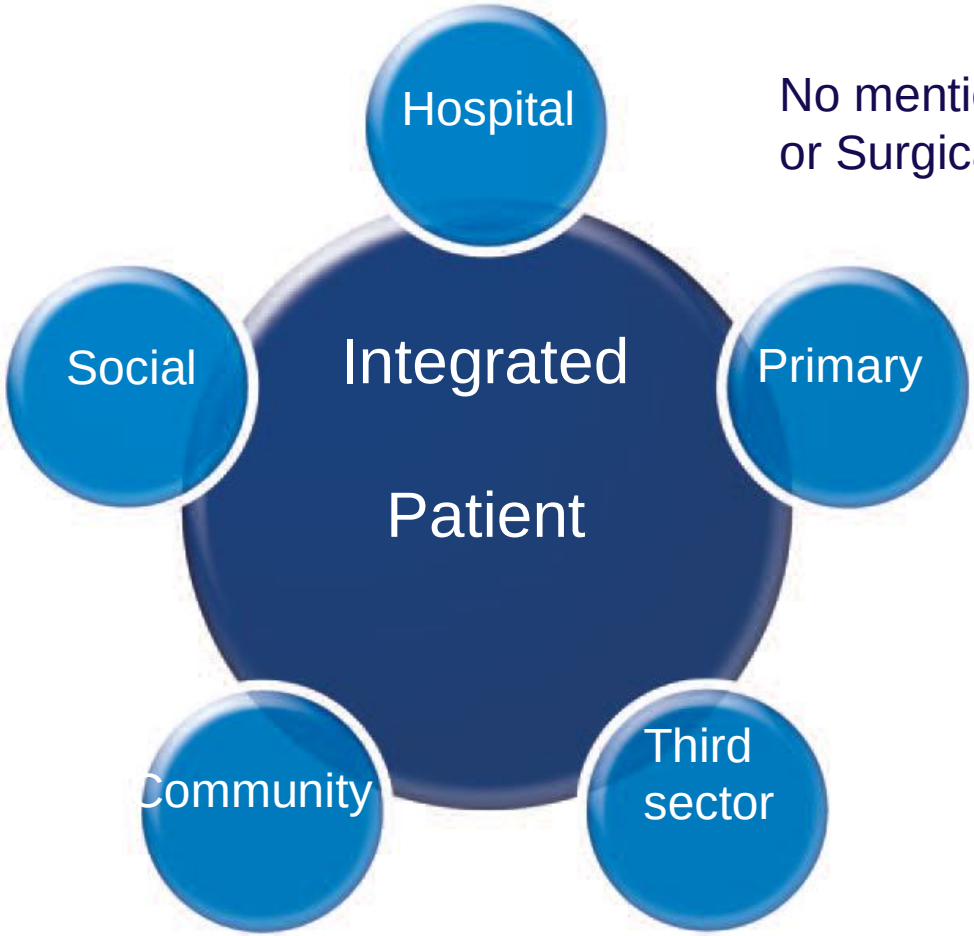
RCGP Commissioning



No mention of Acute Medical or Surgical services ?

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Size matters ?

- A&E 19m contacts per year
- Emergency admissions 13.5 M per year
- GP OOH around 9m contacts per year
- Ambulance 7.2 M 999 calls per year
- General Practice 300m per year !
- NHS Direct 12.5m
- Pharmacy 1.8M per day !
- Urgent social care

Multiple players
and interfaces
plus
the patient

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Patient Flows

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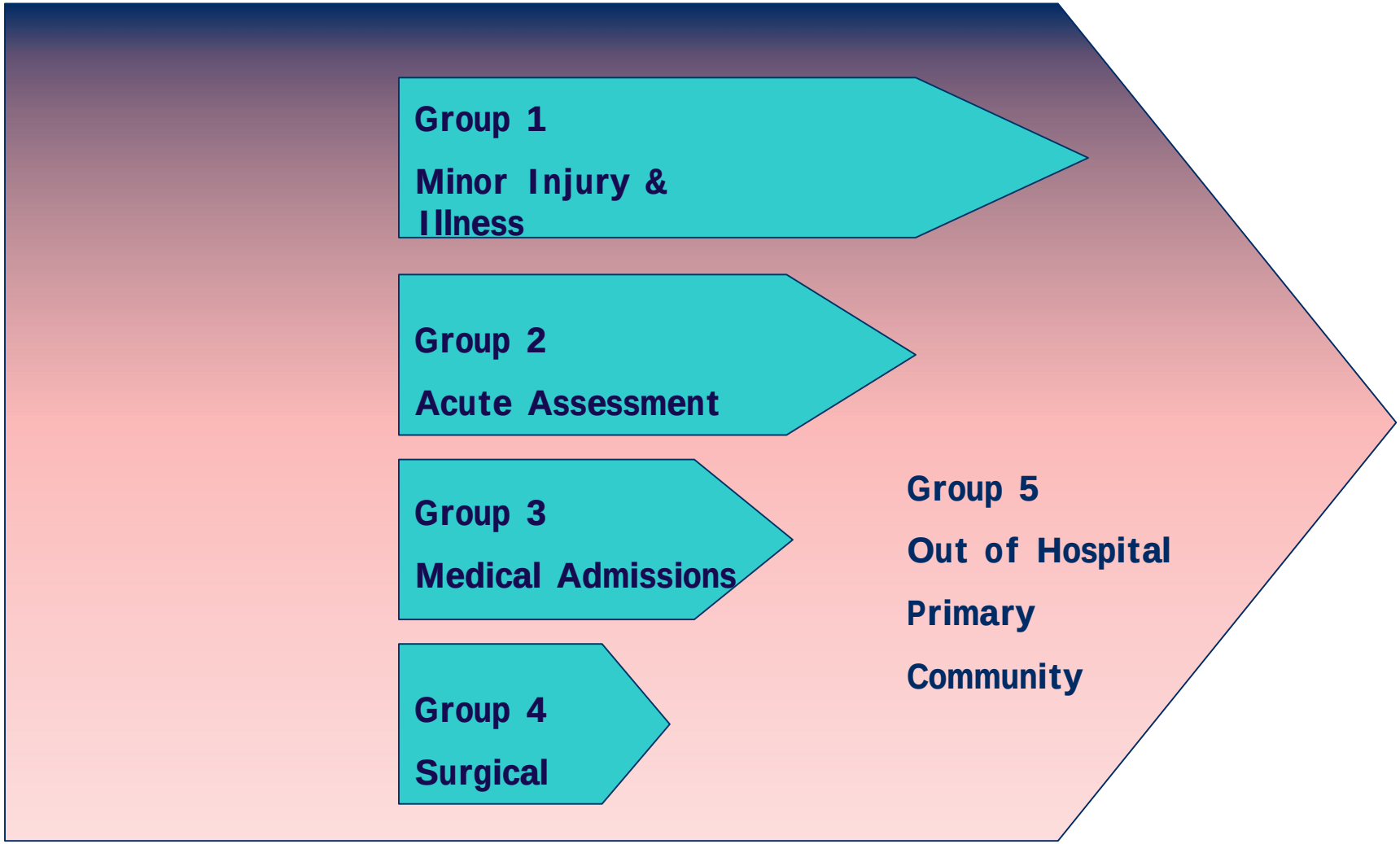

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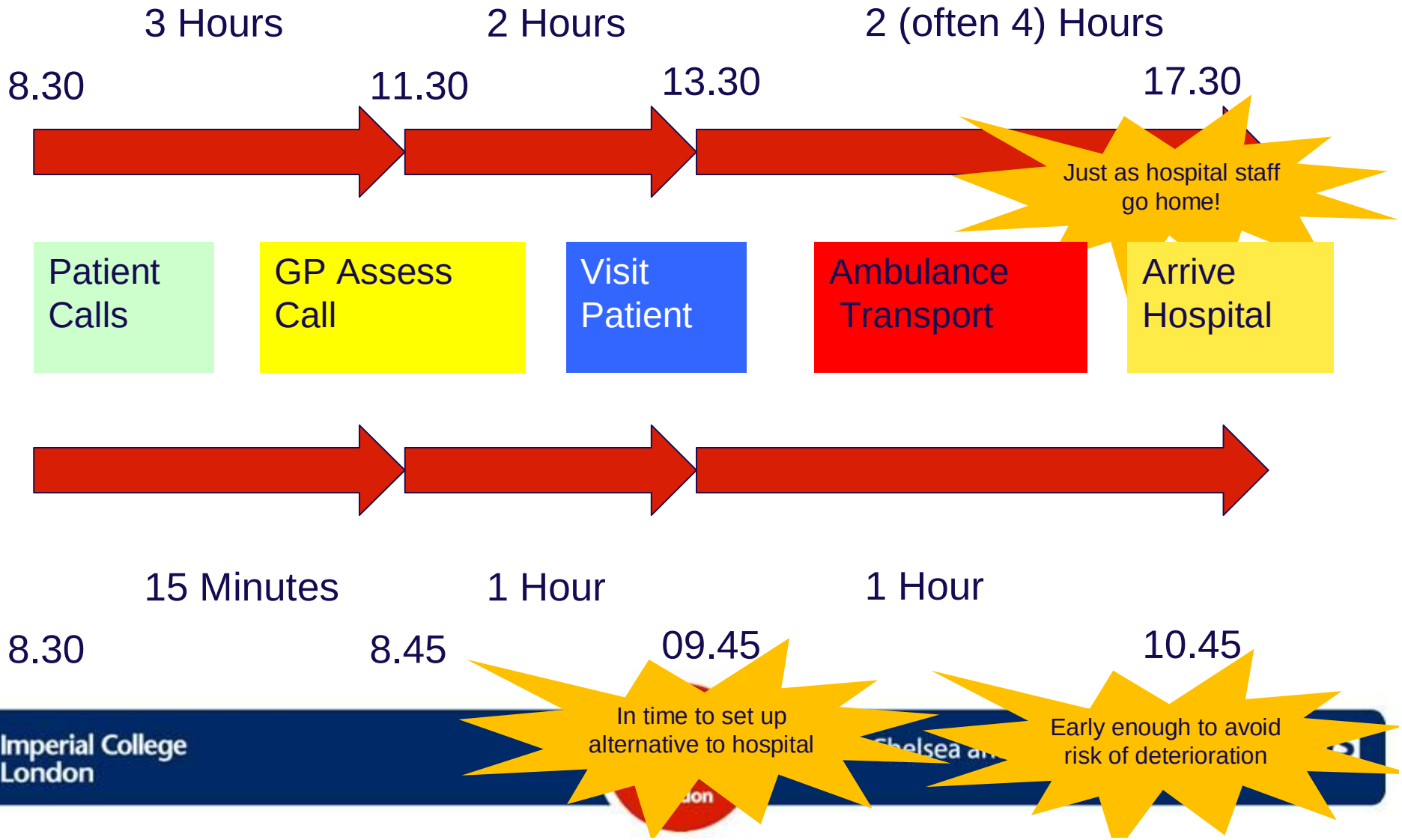
Acute Admission Timeline

Courtesy of David Carson



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Build care around the patient not the existing services

Simplify an often complicated and fragmented system

Ensure the urgent care system works together rather than pulling apart

Acknowledge prompt care is good care

Focus on all the stages for effective commissioning

Offer clear leadership across the system, while acknowledging its complexity

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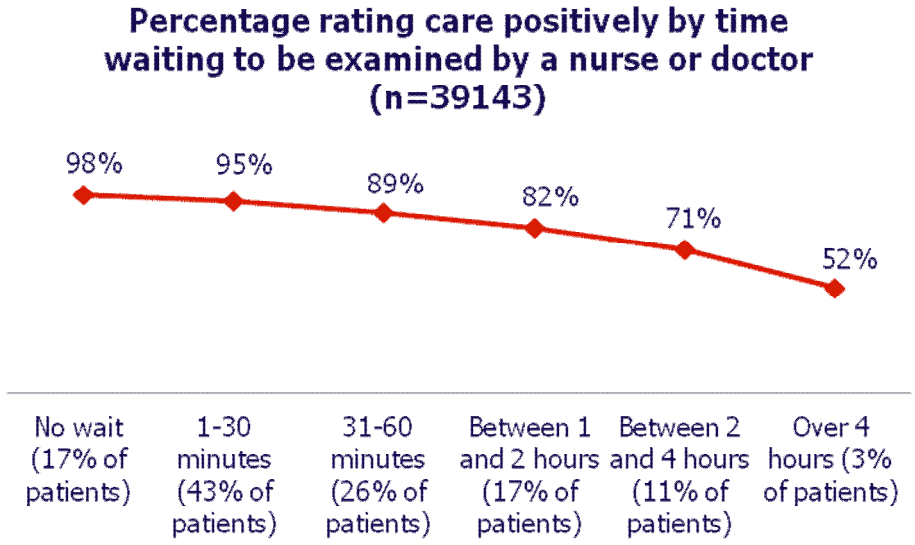
What do patients think about waiting
Patient Survey data



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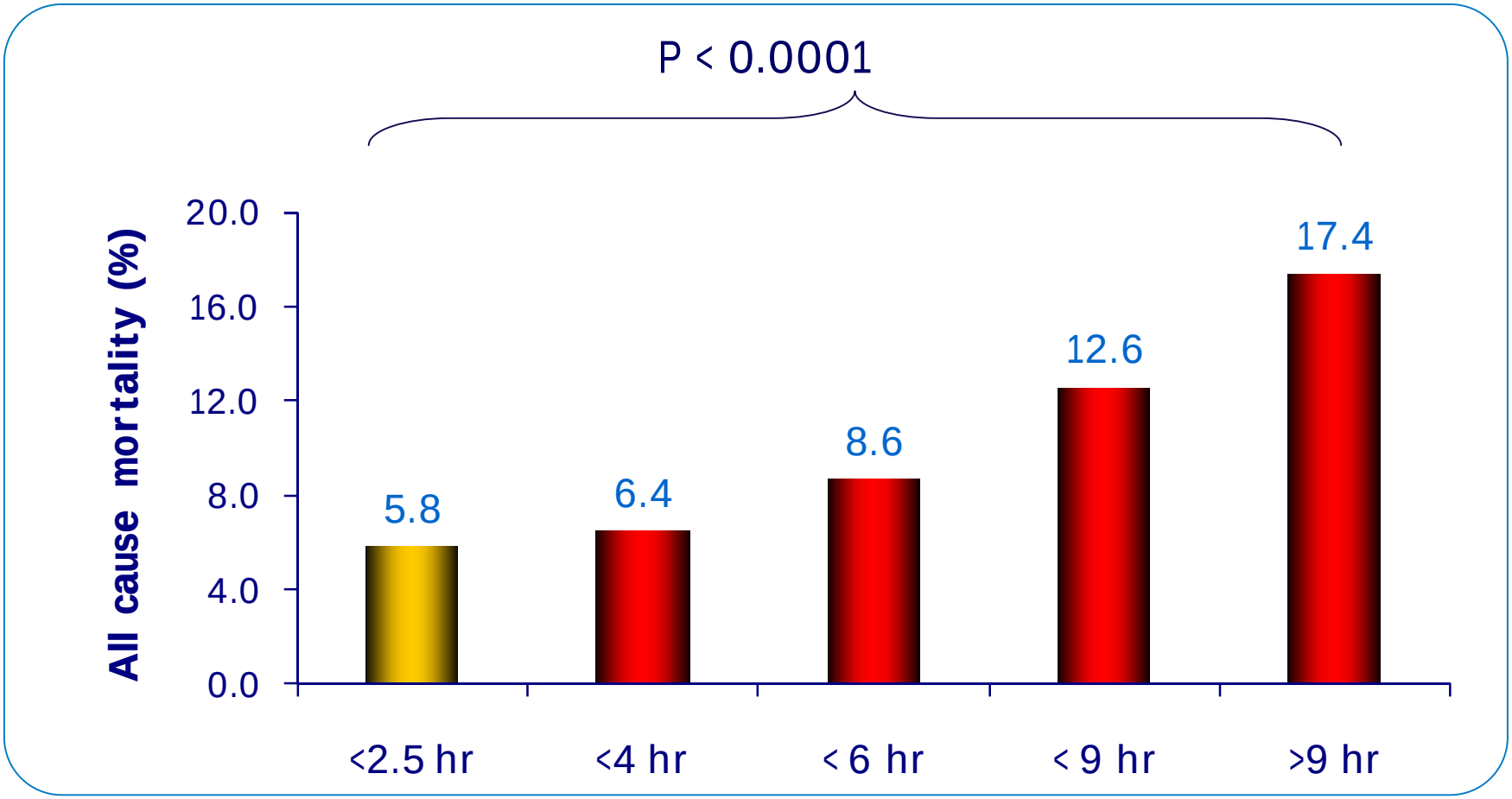
ED Door to medical team time
30-day adjusted mortality



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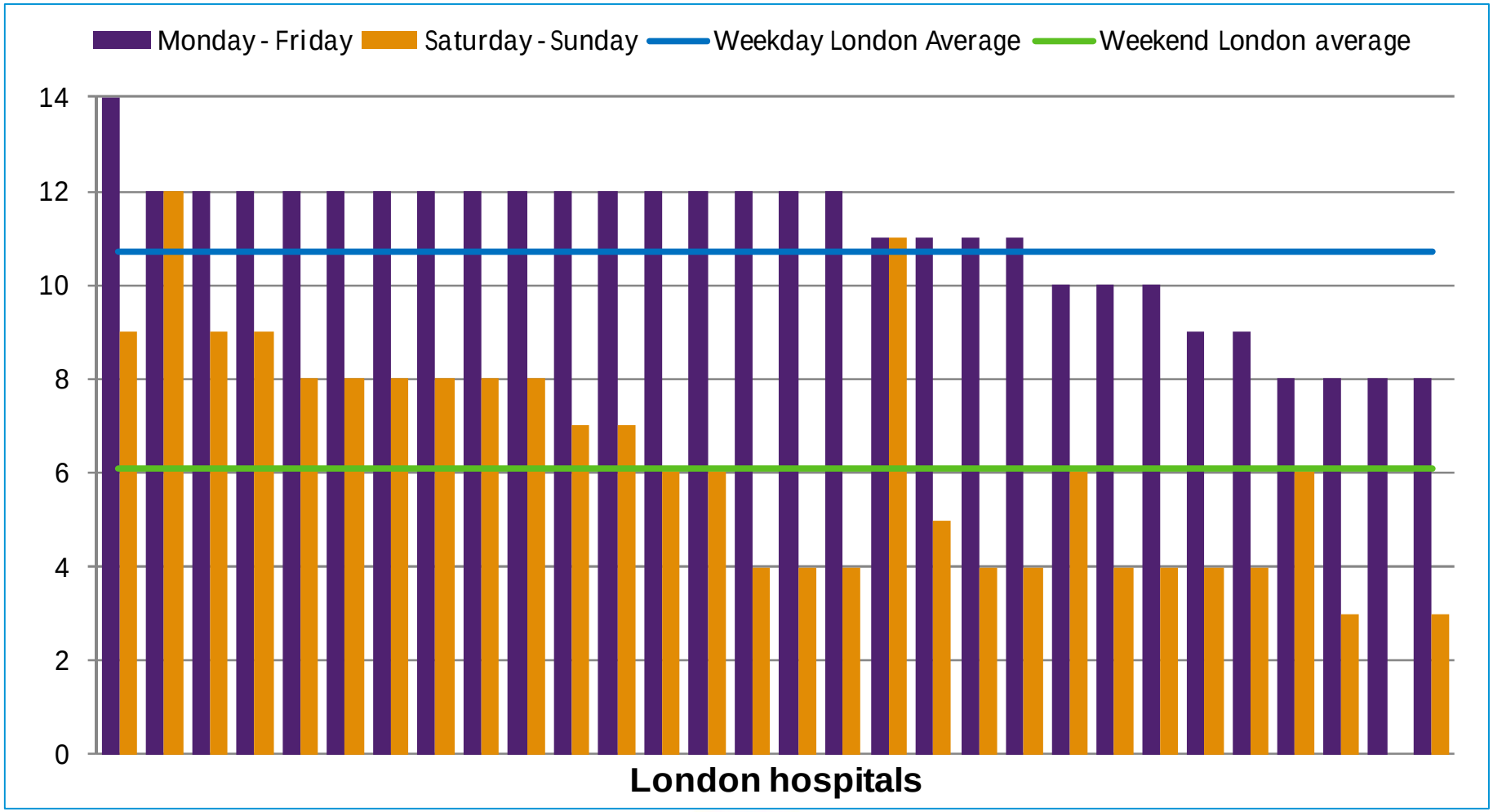
The number of on site Consultants hours varies



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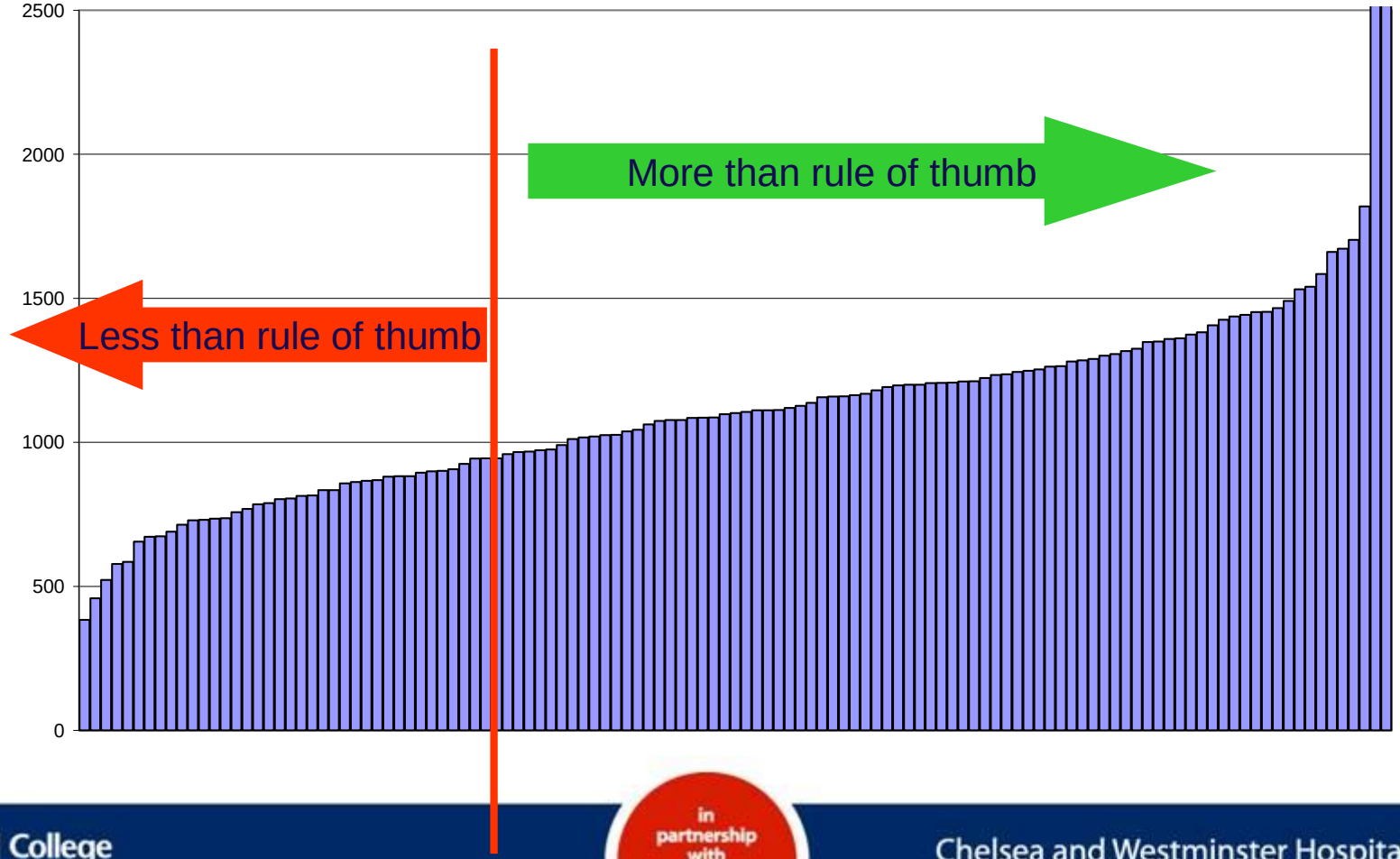
There is considerable variation in the number of appointments per 10000 patients

Total number of face to face appointments per 10000 patients for surveyed practices



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Capacity and demand

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Complex system

- Standards for
  - each organisation
  - each interface

- Underlying principles
  - Effective communication including sharing information
  - Simplify
  - Continuity of care
  - Timely care
  - Best quality
  - Value

- Needs to be coordinated at a regional / health and social economy level

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Commissioning: Core standards

- All emergency admissions to be seen and reviewed within 12 hours by a Consultant
- A clear multi-disciplinary assessment to be undertaken within 12 hours and a treatment plan to be in place within 24 hours
- All patients admitted acutely to be continually assessed using a standardised early warning system

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Commissioning: Core standards

- When on-take, a consultant and their team are to be completely freed from any other clinical duties/ elective commitments
- Consultant work patterns are to meet the demands for consultant delivered care with extended day working across the AMU/ ASU, seven days a week
- All patients on the AMU/ ASU to been seen and reviewed by a consultant during twice daily ward rounds
- All hospitals admitting emergency patients to have 24/7 access to key diagnostic services
- All hospitals admitting emergency patients to have 24/7 access to interventional radiology

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Care Pathways

Care Bundles

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Delivering and Sustaining Change

- **Information** – *needs to be real time*
- **Analysis –** *root cause*
- **Leadership** – *flows, sites, organisations*
- **Control –** *standard processes and practices*
- **Performance -** *clear roles and responsibilities at all levels*

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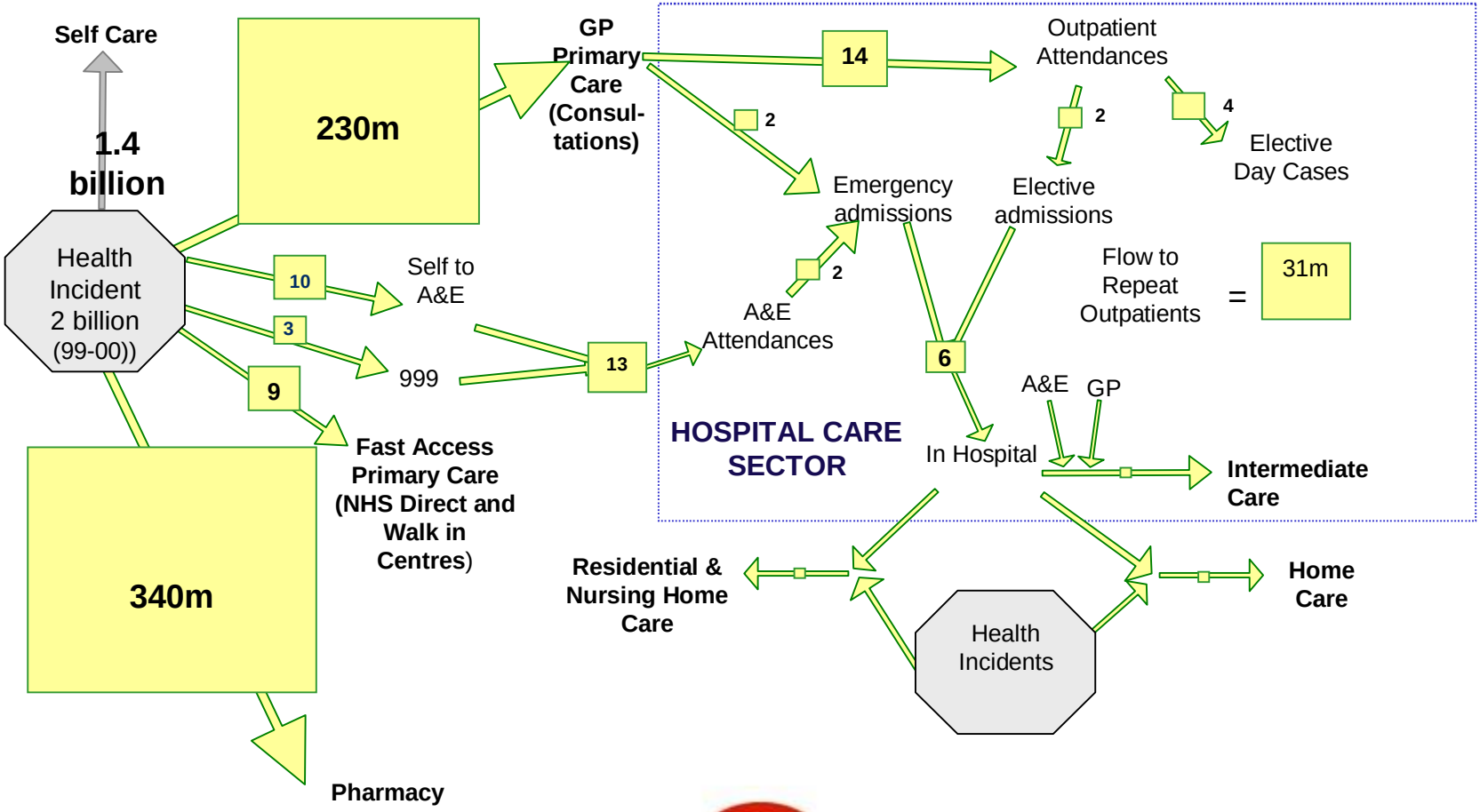
Health and Social Care Whole System: Overview of Patient Flows

(Figures in parentheses are patient flows, in millions of cases per year)



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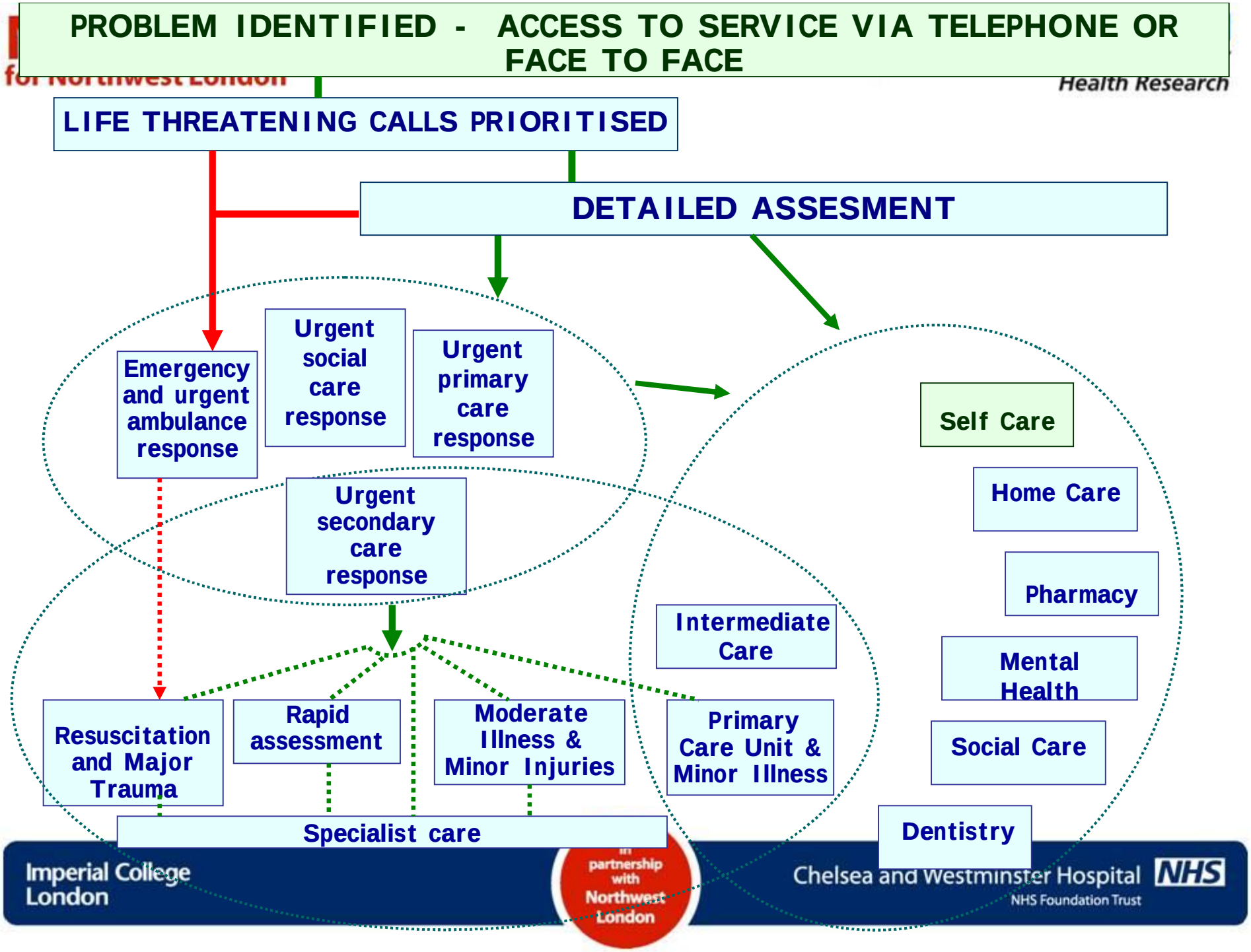
PROBLEM IDENTIFIED - ACCESS TO SERVICE VIA TELEPHONE OR FACE TO FACE
LIFE THREATENING CALLS PRIORITISED
DETAILED ASSESMENT
Emergency and urgent ambulance response
Urgent social care response
Urgent primary care response
Urgent secondary care response
Resuscitation and Major Trauma
Rapid assessment
Moderate Illness & Minor Injuries
Specialist care
Intermediate Care
Primary Care Unit & Minor Illness
Self Care
Home Care
Pharmacy
Mental Health
Social Care
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Whole systems approach

- Standards of care for all participants and for all interfaces of care with patients and carers
- Communication
- Continuity
- High quality of care
- Measurable outputs (real time) including patient experience

So is there a model ?

- NO
- Principles yes...
- Simplify where possibe
- So stop looking for a model – work on the principles of high quality cost effective care

Its also about process in the practice

- Identification of clinically urgent
- Can you get through on the phone
- Can you see the doctor you really want to see
- Is the practice set up to deliver a rapid response (when REQUIRED) all times of the day
- Does the process deliver continuity?