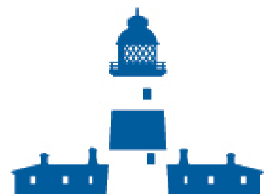
NHS

South Tyneside
Clinical Commissioning Group

South Tyneside

Urgent Care Workshop

4th October 2018



1. Introduction

Thank you for attending the workshop on 4th October, there was great representation across health and social care partners in South Tyneside.

The workshop group described how the below actions were essential as an initial steps to developing urgent care. The group asked that once the below actions have been implemented a further workshop is wanted to further develop urgent care and provide a forum to support each other.

2. Progress

The following document is the information, challenges, ideas and final actions generated from the workshop. There are updates on the progress for the key actions which were prioritised during the workshop. As the group developed an understanding around delivering the 6 key actions there were some key enablers that became apparent. The below information is the immediate work that is underway and are important steps to developing the 6 key actions.

- **Directory of Service and 111 utilisation**
  - Review of providers acuity levels and services provided
  - Re-align appropriate providers to appropriate algorithm outcomes

- **Urgent Care Hub:**
  - The Foundation Trust has updated there has been an improvement in staffing which enables the hub to delivery appropriate services
  - CCG and FT to understand commissioned contract as an enabler highlighted is around the Urgent Care Hub accessing diagnostics.
  - EMIS system discussions underway however this is complex due to multiple systems being utilised across providers.
  - Minor Injuries Unit to have a DoS profile created separately to A&E profile

- **General Practice:**
  - Collaboration and DoS to develop the extended access services profile to support General Practice in offering full availability to 111
  - Review timing trends of 111 General Practice appointments to ensure full utilisation
  - Pilot at a practice on new 111 timings to roll out across General Practice

- **North East Ambulance Service**:
  - NEAS Pathfinder now being rolled out in South Tyneside
  - General Practice, Pharmacy and Foundation Trust in support of the roll out and linking with pathfinder project to signpost patients to most appropriate services.

3. Top 6 Prioritised Actions:

Prioritised Actions
1. Develop clear comms plan, both across organisations and patients (define urgent care in simple terms). Technology to further support i.e. Instagram.
Progress
• Regional comms plan is active for winter 2018/2019 • On completion of the below work, a review of a comms plan will take place to dovetail into regional communication work.
2. IT/EMIS into hub. Availability of patient records and direct booking of appts into GP Practices
Progress
• Discussions to support implementation into the hub commenced however this is more complex than previously anticipated. • Further updates to be provided following discussion outcomes.
3. Streaming at ‘front door’, skills to redirect/see & treat at front door
Progress
• NEAS Pathfinder being implemented in South Tyneside in Winter 2018/2019 • Directory of Service (DoS) and 111 part of project group with following underway: • Review of DoS provider profiles to support patient streaming across South Tyneside • General Practice and DoS reviewing 111 slot times to support full utilisation
4. Consistent support of GP in the hub
Progress
• FT have updated on staffing improvement at the hub • FT understanding potential skill mix which is wider than GP only (i.e. Advanced Nurse Practitioners)
5. Extended access appointments to be open for others to book into
Progress
• GP2Pharmacy scheme is going live 27th November 2018 • Sub-group reviewing 111 slots with extended access to support full access to available appointments.
6. SW in A&E re: OOH
Progress
• Discussion at workshop indicated this had recently been tried and did not result in improved patient outcomes. No further progress required.

4. Group SWOT Analysis

Strengths	Weaknesses
• Social work teams working on '3 conversations' approach. 1 route, 1 person – social worker listens, enabling. • Extend this to health behaviour? Social worker + MDTs + link to practices • Learning benefit, 1 entry route per person – good relationships/trust • Workforce in place • Path links joined • Good working relationships, discharge plannins W2, W7 innovation sites, SW based there and sophisticated MDT working • Good at working together when structure allows	• Too many options for entry to urgent care. People need to be supported to self manage and stay safe • Jargon – perception of 'urgent' • Lack skilled people to triage/enable • Respond all of the time • Often tied by processes and procedures • Don't share computer systems – patient notes need to be linked to support action • Need to use safety nets • Pharmacies not linked in • Not good at telling people who they can see/most appropriate person/ saying no • Primary care doesn't have the option to dictate who is seen
Opportunities	**Threats**
• Extend the 3 conversation approach • Work with schools – self care • Improve communication with people • Use the workforce better • Put people with different disciplines together including social care • Integrated services need supporting IT systems – including pharmacy and social care • Social worker at hub/A&E • Extend the W2 W7 approach if successful • Need to do 'blue sky thinking' • What should it look like – then deal with it • Accommodate community support in practices	• Financial constraints • Lack of common sense • Structure doesn't always support joined up working • All 111 re-triaged • Lack clinical step down • Support for people/clinicians making decisions not undermined • Mixed messages – 'just do it' v's 'it doesn't work like that' • National directives, e.g. don't like 111 support networks diminished • Consider things not under our control • Funding 111 redirect • People can manipulate 111 • Some services back into community, e.g. community paediatrician.

Strengths

- Same day appointments (GP), same day OOH, extended access – good apt availability
- Willingness to change/trial processes
- Will to succeed – close knit community
- Everyone wants a good outcome
- ED – 4hr is 16th best in the country
- Patient focussed > money focussed
- Evidence of great teamworking

Weaknesses

- Lack of clinical staff at all levels across the system
- Mental health support issues – not supported in community, ED is the last resort
- Stakeholder/patient communication – ethnic minorities
- Understanding of stakeholder offering e.g. access times across the system
- Variation across primary care/practices
- How to access system/where
- Lack of integration

Opportunities

- Support from community teams
- Need to work differently across system
- Technology
- Patient user education – social media, how best to interact with system, demographics
- Health promotion long term < health problems manifested
- Use of pharmacies – link with urgent care, major opportunity
- Streaming at ED front door – senior decision maker, right place right time
- Senior clinician – ring for advice, consultant connect
- Support from senior leadership to plan, do, check, act – learn by doing, learn from failure
- Recovery at home – Sunderland? Learn from other areas

Threats

- Patient complexities/comorbidities/case mix
- Education is difficult
- Patient perceptions of pharmacists ‘will I get the same level of care’
- Frailty/aging population
- Social isolation/lack of support network – social issues fuel demand

Strengths	**Weaknesses**
• Good at directing to alternative services and signposting • Piloting joint posts and shared services/partnerships • Ambulatory care used well from A&E (not used well by primary care?) • Teams proactively finding and following up patients • Adaptable to change • Dedicated staff	• Similar organisations work in very different ways • Recruiting GPs – lack of GPs in the Hub • Performance management/monitoring • Winter trial of extended access was good but the new extended access lost the urgent appts and are routine only • Clinicians not using pathways/teams appropriately • Inappropriate referrals from 111/OOH • Assessment capacity resulting in a high rate of patients returning to GP • Do we listen to the patients? • Lack of resources/funding • System is too big/unwieldy
Opportunities	**Threats**
• Learning from other areas • Empowering front line staff to redirect/turn away • Direct booking of appointments at urgent care into primary care, pharmacies etc. • Care planning for chronic illnesses/ LTCs • Expanding skill mix and including other services e.g. podiatry/physio • Pathways aligned for all local hospital services	• Patient perceptions/complaints – conflicts and threats • Need to get it right first time for patients or they will look for alternatives • Pressures increase at closing times • Patients redirected inappropriately • Patients manipulating the system (different presentations to different services)

Strengths	**Weaknesses**
• Willingness to work together to improve system • Wide skill set	• Communication between ourselves and to patients
Opportunities	**Threats**
• IT systems, talk to each other, availability of health records • New ways of working, shared posts across primary and secondary care • Influence patient expectations	• Pilot schemes – introduce chance that is then withdrawn (e.g. walk in centres) • Confusion of different messages • Recruitment • Managing demand – can't cope with current expectations, more self care

Strengths

- People who genuinely need A&E are getting there
- This workshop
- Primary care data that Jackie L presented was brilliant, all practices should participate
- Committed workforce
- Hitting the A&E targets
- Being able to divert primary care patient attending at A&E to professional at the Hub
- Extended access – infrastructure to work collaboratively
- Practice manager cohort work well together
- LTC/Self Care/ Primary care strategies
- Home visiting pilot
- LADB proactively trying to make it work multi-agency/solution focussed

Weaknesses

- Lack of definition on what is the urgent care hub and who is it for
- Inability to tell patients they are wrong and send them away before treatment if it's the wrong place and safe to do so.
- So many routes to hospital
- Staffing in GP practices
- Staffing issues in Hub – who holds the hub provider to account
- Inability of GP practices to have consistent staffing models/rates of pay/gp offerings
- STFT need a nudge to get EMIS into the hub, there seem to be many delays, primary care doesn't understand why
- Perception by public that GPs have easy jobs

Opportunities

- Adverts on Instagram re health and how best to use the system, nothing currently on Instagram. This is how young people get key messages these days, they don't watch TV
- Appropriate media channels to target specific groups
- Leading from each one, particularly practices
- Triage at 111
- Technology is key. Sharing GP records with hospitals is key. Gives the hospitals ammunition to refuse antibiotics etc.
- Job planning/portfolio careers to include the urgent care rotations
- Need to change perception of the practices and the way they deal with patients. Some are friendly and helpful, some make patients feel bad for using the practice
- What has happened to patient charters – do we need to reinvigorate these? Agree a system wide one and publish to gazette/area forums etc.

Threats

- Language is important, if people who work in the system cant define a same set of terminology then what hoe have patients got. Consistent use of language is key
- Dispel walk in centre provision, these do not exist anymore
- Triage at 111, will this overburden 111

5. Group Ideas / Prioritised Actions

Target Area	Item	Action
Centre area	1	Develop clear Comms plan, both across organisations and patients (define urgent care in simple terms).
	2	IT/EMIS - Into hub/Patient Records/Appointments Across System
	3	Technology to support communication i.e. instagram
	4	Streaming at front door, skills to redirect, see & treat at front door
	5	Consistent Support of GP in Hub/Vocare held to account
	6	Extended access appointments to be open for others to book into
	7	Social Worker in A&E especially for OOH
4th Line	8	NHS 111 appointment slots shared across practices (same as extended hrs)
	9	Paramedic/Mental Health working together for community MH assessments
	10	Greater support from mental health services
	11	Reduce entry points into system
	12	Opportunity for hub to refer/make appts to primary care
	13	Benchmarking UCH attendance by practice / workshop
	14	Self Care promotion/Social Media push on self management
	15	Complete audit on urgent care reasons across primary care
	16	ED consultant advise for GPs
	17	Rotational posts across primary/ED/NEAS - Nursing/Paramedic roles
	18	Local regular face 2 face meetings between hosp/amb/neas/gps in times of winter pressure
	19	Closer working with community teams
	20	Letter/Ticket from ED to give to patient to advise need to see GP
5th Line	21	Learning from other organisations e.g. recovery@home sunderland / consultation commenced
	22	Be careful routine GP appts aren't used for urgent appts which has a knock on effect for GP waiting time (A&E attendance)
	23	How to cope with HV for all GPs 1) advanced paramedics 2) collaborative working between practices. Save GP time in the surgery
	24	Integration DOS to ensure all stakeholders offering s are communicated across whole system (web based - always
6th Line	25	Consider scaling up home visiting service pilot (post evaluation)
	26	Hibernate
	27	Sharing home visits - different skill mix
	28	Extend 3 conversation approach that's currently on wards in STDH
	29	Revisit a system wide patient charter
	30	Comms with GP practices from HV community teams (ACT/NEAS) re care planning. Interventions to prevent urgent need (tel call rather than written comms)
	31	Roll out community falls team/assessment to avoid hopsital admissions (paramedic/occ therapist or physiotherapists with immedicate access to equipment/services
Outer	32	Pray for good weather
	33	Help from on call services to front line
	34	Pharmacy & Community services OOH available
	35	Understand if all GP staff are offering extended hr appts (and utilising unused appts)
	36	Ensure patients are seen by appropriate role first
	37	Promote flu vaccinations
	38	Multi agency escalation calls during winter (problem solving approach/mutual aid)

6. General themes/comments

- Understanding across stakeholders, re: challenges
- Ideas to promote flow in ED
- Cohesion
- Community can support
- Understand a persons journey + blocks
- Understand approach – keeping UCH work in sight
- Carer/family journey
- Discuss/understanding of how best to manage at scale working
- UC influence ED / how to help / improve UC model
- Remove confusion from the system / simplify
- Be able to put in place decisions
- Clarity and support for primary care
- Understand system/operational side
- Promote patient flow at UC
- Understand everyones challenges and work through
- Involved in clear structure rather than 'onslaught'
- What is the plan and how will it impact primary care
- Manageable workload, especially primary care
- Strategic direction of ST
- How primary care can support urgent care/work together
- Something practical to change – both deliverable / improve patient care
- Do something different
- Practical changes – try them to see if they work / nothing 'off' the agenda, what works for you
- Patient education / confusion for patients
- Streamline entry points – use appointments, econsultation
- Not one solution
- Solution is streaming – UC no capacity to get to the right place
- ED working on how to stream better
- Right processes in place, stream at front door, change expectations
- Appropriate clinician + appointment
- Raise profile of other services, e.g. think pharmacy first
- All same day appointments urgent care center – GP/pharmacy/nursing/other
- Darlington employs primary care nurses to stream
- Technical issues with 111 accessing appointments
- System in Hub/ED to see appointments
- Self-presentation – right place
- Vocare contract
- Frailty
- Communication with acute care teams
- Comms / social media

- Access to patient records at hub
- IT & IG people in the room – EMIS into hub