Greater Manchester Health and Social Care
Strategic Partnership Board

Date: 13 October 2017
Subject: Greater Manchester Model for Urgent Primary Care
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SUMMARY OF REPORT:

The NHS Five Year Forward View (FYFV) states that over the next five years, the NHS will do far better at organising and simplifying the urgent care system. Following a review of urgent primary in Greater Manchester and in conjunction with urgent care and primary care leads, a draft model of 24/7 urgent primary care has been developed.

KEY MESSAGES:

The review of urgent primary recommended that any redesign of 24/7 urgent care should be provided at scale, be integrated with other services and have simplified and rationalised access routes.

The GM model has been designed to ensure that patients receive the right care, in the right place in a timely manner and reduce the burden on our highly pressurised A&E departments and core general practice. The model will contribute to a reduction in unnecessary hospital utilisation by avoiding A&E attendances and subsequent admissions and at the same time assist in community resilience.

PURPOSE OF REPORT:

The purpose of this report is to provide context regarding urgent and out of hours primary care reform in Greater Manchester. This paper provides an overview of progress to date and introduces the proposed future model for an integrated 24/7 urgent primary care offer.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:
• Note the progress to date including development of future model of 24/7 urgent primary care.

• Support the proposed 24/7 urgent primary care model.

• Note the risks to delivery and considerations which will be picked up as part of the work of the task and finish group.

• Agree the deliverables for 2017 and future ambition for GM.

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1.0 PURPOSE

1.1. The purpose of this paper is to provide context regarding urgent and out of hours primary care reform in Greater Manchester. This paper provides an overview of progress to date, the proposed future model of care and articulate the next steps.

2.0 INTRODUCTION

2.1. National Context

2.1.1. The NHS Five Year Forward View (FYFV) states that over the next five years, the NHS will do far better at organising and simplifying the urgent care system. This includes helping patient get the right care, at the right time, in the right place, by aligning general practice, community mental health teams, ambulance services, and wider primary care. Providing evening and weekend access to GPs, nurses and wider primary care from community bases equipped to provide a greater range of tests and treatments.

2.1.2. As referenced in ‘Next Steps on the Five Year Forward View’ there are a number of national directives for urgent primary care, including:

- Every hospital must have comprehensive front door clinical streaming by October 2017.
- Significant revisions to NHS 111 including NHS 111 online, improved clinical interfaces and booking of face to face appointments.
- Continued expansion of GP Additional Access services.
- Roll out of standardised new ‘Urgent Treatment Centres’ to act as urgent primary care integrated hubs in localities.

2.1.3. Following receipt of the national Integrated Urgent Care Service Specification and accompanying letter from the National Director of Operations and Information, GM has provided a collective response. Many of the elements contained within the covering letter are already in progress as part of the 24/7 review of urgent primary care e.g. agreement of collaborative provider arrangements, immediate gap analysis and consideration regarding procurement and re-procurement of services. We have an agreed way forward for the development of an integrated service, as articulated in Appendix 1. We will continue to work with localities to support the development of NHS 111 and the Clinical Advice Service.

2.1.4. In Greater Manchester, we will have:

- ‘GP Practice first - 24/7’ making it easier for patients to receive care when they need it.
- An Urgent Treatment Centre in each locality (e.g. CCG footprint) that will receive referrals from General Practice, A&E, NWAS, NHS 111 and ‘walk ins’ - it must be primary care led and open 12 hours a day

- Primary care lead streaming services in place that move people away from A&E and into more appropriate services

- Access to diagnostics including near patient testing, available in each urgent treatment centre

3.0 PROGRESS TO DATE

3.1. Review of urgent primary care

3.1.1. The review of 24/7 urgent primary care concluded on 30 June 2017. This culminated in a detailed baseline position of GM localities in terms of levels of integration and impact on A&E, provided best practice case studies from GM, the UK and the rest of the world and produced a set of core principles that would form the foundation of a reformed 24/7 urgent primary care system. The review recommended that any redesign of 24/7 urgent primary care should:

- Be provided at scale.
- Be integrated with other services.
- Have simplified and rationalised access routes.

3.1.2. To date there has been significant engagement with the system including co-production of the review and principles with urgent care leads, primary care leads, clinical leads and providers. There has also been input and discussions with the Association of CCGs, Primary Care Advisory Group and GM Directors of Commissioning.

4.0 THE PROPOSED GM MODEL

4.1. Summary

4.1.1. We have developed a model which articulates what a reformed, integrated 24/7 urgent primary care offer could look like (described in appendix 1).

4.1.2. The model outlines a series of key components that will enable patients to receive the right care, in the right place in a timely manner while reducing the burden on our highly pressurised A&E departments. This new model of urgent and out of hours primary care will contribute to a reduction in hospital utilisation by reducing avoidable A&E attendances and subsequent admissions and at the same time assist in community resilience.
4.2. **How will the GM model differ from national guidance?**

- Core general practice will be able to utilise the urgent treatment centre to help manage their same day demand

- The A&E streaming service will be able to stream directly into the urgent treatment centre

- The principle in GM will be ‘GP Practice First - 24/7’

4.3. **Rationale for a GM model**

- ‘GP Practice first - 24/7’ means that patients only need to remember their own practice number to be able to easily navigate services.

- Supporting additional same day access in general practice will help alleviate pressure on general practice as well as A&E.

- Creating more integrated services will ensure that the model is more affordable and sustainable.

- Streaming patients from A&E into the urgent treatment centre will ensure better utilisation of resources and mitigate risks regarding workforce.

- The GM model will reduce duplication and minimise handoffs.

4.4. **What will we achieve by December 2017?**

4.4.1. Work is ongoing to deliver the future ambition for 24/7 urgent primary care. However, by December 2017, we will have achieved the following:

- Primary care led streaming in place in all A&E departments.

- Urgent Treatment Centres in place in up to 4 localities.

- The location of proposed Urgent Treatment Centres identified in each locality (which can be done by adapting current streaming services).

- Access to diagnostics from local streaming services.

5.0 **RISKS**

5.1. A number of risks have been identified as follows.

5.2. **Roll out of A&E streaming to the national timescales**

5.2.1. Each locality with an A&E department has committed to delivering A&E streaming. However, the national timescales do not consider the time needed for building works, public consultation and procurement of services. Five acute trusts to date
were successful in securing capital funding for A&E streaming, with two trusts still awaiting the outcome.

5.2.2. **In GM the plans for 24/7 urgent primary care go beyond A&E streaming. A streaming service will be in place in each A&E department by October 2017, but not all will meet the national specification.**

5.3. **Supply induced demand**

5.3.1. There is a risk that co-location of urgent primary care services at the acute trust could generate supply induced demand, with patients using the service as a quicker way to access primary care.

5.3.2. **There will need to be clear communication with patients and staff to articulate what the service is and isn't, with continued patient messages about the right place to receive care.**

5.4. **Estates and infrastructure**

5.4.1. Localities may not have adequate or appropriate space to meet the estates requirements in the national guidance. UTCs will need to have the appropriate IT infrastructure in place to enable sharing of records and appointment booking.

5.4.2. **Consideration should be given about how to better utilise existing estate. For streaming purposes, consideration should be given to the distance between a community based urgent treatment centre and the A&E department.**

5.5. **Funding and investment**

5.5.1. Five GM acute trusts to date were successful in securing capital funding for A&E streaming. There may be significant capital and revenue costs attached to delivering reformed 24/7 urgent primary care.

5.5.2. **Localities will need to develop services to suite local needs and resources.**

5.6. **Workforce**

5.6.1. There is a shortage of key roles including GPs, ANPs and nurses to cover core general practice, A&E streaming, GP additional access, GP out of hours and urgent treatment centres.

5.6.2. **The new 24/7 urgent primary care system will be well integrated to ensure better use of resources. There are opportunities in GM to flex the staffing model to include wider use of ANPs, clinical pharmacists, mental health workers etc. Localities will also need to consider how they better make use of existing community pharmacy, dental and eye health services.**

5.7. **Digital technology/Information governance**

5.7.1. There is a risk that suitable digital solutions for online consultations, appointment booking, system interoperability, read/write electronic patient record access and
information governance will not meet the timescales of the newly reformed 24/7 urgent primary care system.

5.7.2. **Localities will need to consider interim solutions until a GM solution is found**

### 6.0 CONSIDERATIONS

#### 6.1. Provider relationships

6.1.1. The reformed 24/7 urgent primary care model will need to be developed with significant buy in from acute providers. Consideration is needed regarding the development of an effective triage process which is primary care led, but falls within the acute trusts quality and governance structure.

#### 6.2. NHS 111 and Single Point of Access

6.2.1. In GM, the single point of access will be the GP practice number. However, nationally there will be significant investment in NHS 111. This will include online triage, greater access to clinicians, care homes line and direct booking into services. The GM solution will need to fully interface with NHS 111.

#### 6.3. Timescales for adoption

6.3.1. Localities are already reviewing their urgent care systems and most areas have paused any re-procurement whilst awaiting the outcome of the urgent primary care review. Localities now need to consider how and when they will implement the national requirements and the GM principles, which have been consolidated into the proposed GM model (appendix 1).

### 7.0 OPPORTUNITIES

#### 7.1. There are a number of opportunities to do things once at a GM level where appropriate.

#### 7.2. Procurement

7.2.1. Localities are already reviewing their urgent care systems and most areas have paused any re-procurement whilst awaiting the outcome of the urgent primary care review. Localities now need to consider how and when they will implement the national requirements and the GM principles, which have been consolidated into the proposed GM model (appendix 2).

#### 7.3. Workforce development

7.3.1. A programme of continuous improvement should be embedded in the service to enable the service to have the correct skill mix and provide quality of care. There are also a number of training and development needs/opportunities that are referenced in the national guidance and review of urgent and out of hours primary care. These could be facilitated at a GM level and include:
• Primary care streaming is a relatively new role. This may require a different set of skills than traditional nursing.

• The principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues.

• Adult and paediatric resuscitation.

• Active signposting and care navigation.

8.0 NEXT STEPS

8.1. Engagement

• There will be continued engagement with commissioners and primary care and acute providers to ensure buy-in and an agreed approach.

• Engagement has commenced with NWAS (provided by NHS 111) and continue with CCG Urgent Care Leads regarding the new UTCs and future plans for 24/7 urgent primary care.

• Consideration will be given to standardisation of service models e.g. service dispositions.

• Engagement will commence with the GM communications and engagement team to support the development of appropriate patient messages.

8.2. Moving to implementation

• A ‘24/7 Urgent Primary Care’ working group has been established. The first meeting took place on 27 September 2017.

• The group will be chaired by the Association of CCGs Chief Officer Lead for Urgent Care. The group will work to mitigate the risks and develop the opportunities highlighted in sections 5-7, as well as support the operationalisation of the GM model.

• The membership of the working group will include representation from the GM Urgent Care and Primary Care Leads, the AGG and the Primary Care Advisory Group.

9.0 RECOMMENDATIONS

9.1. The Strategic Partnership Board is asked to:

• Note the progress to date including development of future model of 24/7 urgent primary care.
• Support the proposed 24/7 urgent primary care model.

• Note the risks to delivery and considerations which will be picked up as part of the work of the task and finish group.

• Agree the deliverables for 2017 and future ambition for GM.
GM Model for 24/7 Urgent Primary Care

1. Introduction
As referenced in ‘Next Steps on the Five Year Forward View’ there are a number of national directives for urgent primary care, including:

- Every hospital must have comprehensive front door clinical streaming by October 2017
- Significant revisions to NHS 111 including NHS 111 online, improved clinical interfaces and booking of face to face appointments
- Continued expansion of GP Additional Access services
- Roll out of standardised new ‘Urgent Treatment Centres’ to act as urgent primary care integrated hubs in localities

In Greater Manchester, we will have:

- A ‘Single Point of Access’ making it easier for patients to receive care when they need it
- One Urgent Treatment Centre in each locality (e.g. CCG footprint) that will receive referrals from General Practice, A&E, NWAS, NHS 111 and ‘walk ins’ - it must be primary care led and open 12 hours a day
- Primary care lead streaming services in place that move people away from A&E and into more appropriate services
- Access to diagnostics including near patient testing, available in each urgent treatment centre

2. Local context
Primary care is working to integrate and lead a wider public service community-based model, than currently exists. This will involve developing opportunities for new contractual models of care that build on the ‘place-based’ approach to delivery, and extend access to primary care, community and social care to elements of secondary care, mental health and third sector provision. More integrated models of care will mean people only need to tell their story once, and their assessment and treatment is less likely to be duplicated.

As noted in the Urgent and Emergency Care Reform paper in March 2017, there is significant variation between local offers in GM in terms of providing alternatives to A&E. This includes differences in access to primary care streaming, out of hours provision in communities, use of Walk in Centres and Urgent Treatment Centres.

As part of the GM Primary Care Reform Programme, a review of all urgent and out of hours primary care has been undertaken to understand the current baseline position across GM and local plans to meet the requirements of the FYFV. This was with the intention of developing a GM approach to urgent and out of hours primary care that reflects local needs, makes best use of resources, provides a level of consistency across GM and captures some of the national ‘must dos’ (detailed below in italics for ease of reference). Where possible we want to use the freedoms and flexibilities we have under a devolved system to create a 24/7 urgent primary care system that is suitable for the 2.8m residents of Greater Manchester.
Details of the locality baseline position and best practice examples can be found in the ‘review of urgent and out of hours primary care in GM’ document.

3. The GM approach

We want to design a service that will ensure that patients receive the right care, in the right place in a timely manner and reduce the burden on our highly pressurised A&E departments and core general practice. This new model of urgent and out of hours primary care will contribute to a reduction in unnecessary hospital utilisation by avoiding A&E attendances and subsequent admissions and at the same time assist in community resilience.

The outputs of the review of urgent and emergency primary care review recommended that any redesign of 24/7 urgent primary care should:

- Be provided at scale
- Be integrated with other local services
- Have simplified and rationalised access routes

3.1 Scope

GPs will continue to deliver core general practice 8.00-18.30, providing pre-bookable and same day urgent appointments to their registered list. They will also continue to provide the national Extended Access Directed Enhanced Service (DES).

‘24/7 urgent primary care’ is the collective term being used to describe a single primary care offer that covers A&E streaming, urgent treatment centres, GP out of hours and GP Additional Access and walk in centres. It primarily covers the hours of 18.30-08.00 on weekdays and 24/7 at weekends and bank holidays. However, the opening times of the urgent treatment centre and A&E streaming means that there will be capacity and service provision during core hours. The intention is to align various services or programmes to provide a cost effective, streamlined offer of primary care, 24 hours a day, 7 days a week. The proposed model will combine services, where appropriate to cover any gaps in provision and remove duplication.

For clarity, ‘Super hubs’ will be referred to as Urgent Treatment Centres (UTC) - in line with national documentation. The Urgent Treatment Centres’ will be integrated with the existing services, co-located in either the community or with an acute trust, open a minimum 12 hours a day, seven days a week, and offer patients who do not need to go to a main hospital A&E department treatment by clinicians with access to blood tests, ECGs and X-rays. The UTCs will offer booked appointments after being streamed from A&E, by calling NHS 111 or a GP practice. They will also have some capacity to see those who walk-in with problems that can’t wait. However, an Urgent Treatment Centre is not a traditional ‘Walk in Centre’.

3.2 Key Components in scope

3.2.1. Single Point of Access (SPA)

We will implement a robust Single Point of Access in Greater Manchester which will be available 24 hours a day, 7 days a week. Having one number to call will make it easier for patients and enable localities to develop simple message to patients. The technology that could sit behind the telephone number will enable phone lines to automatically divert to the most appropriate service outside of core hours e.g. GP Out of Hours, Urgent Treatment
Centre, GP Additional Access hubs etc. or beyond. This would be seamless and technology driven.

All types of urgent/OOH primary care appointments will eventually be directly bookable/referable to through the Single Point of Access. This includes telephone appointments (but will not replace clinical triage through out of hours services).

There must be the ability for other services (such as NHS 111) to electronically book appointments at the UTC, and relevant flags or crisis data should be made available for patients. All urgent treatment centres to ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), Looked After Child (LAC) or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child.

Nationally, significant investment will be made in NHS 111 over the next two years to develop online consultations, more clinical consultations and direct appointment booking.

3.2.2. Urgent Treatment Centres (UTCs)

UTCs will be clinically led by general practitioner, co-located on a hospital site or in the community, provide diagnostics and be open for a minimum of 12 hours a day.

a. Service offer

UTCs should provide both pre-booked same day, ‘walk-in’ and routine appointments; however patients should be encouraged to ring the practice number.

The urgent treatment centre should have capacity for appointments to be booked by NHS 111, A&E and General Practice.

All UTCs should have access to the full clinical record and should be connected to or have access to urgent mental health provision

Protocols should be in place to manage critically ill and injured adults and children who arrive at an UTC unexpectedly.

All UTCs should be able to issue prescriptions, including repeat prescriptions and e-prescriptions (when available) and be able to provide emergency contraception, where needed.

Patients attending urgent treatment centres will be counted in the 4 hour wait target.

b. Access to diagnostics

All UTCs should have access to investigations including pregnancy tests and urine dipstick cultures and ECG. Near patient blood testing should also be available e.g. troponin levels, simple x-ray facilities are recommended.

All 24/7 urgent primary care services should also have access to diagnostics, ideally co-located with services. In GM we should work towards this ambition over the next two years.
3.2.3. Streaming and warm transfers

Streaming will take place in front of A&E and be undertaken by a senior healthcare professional (e.g. senior nurse or GP) with primary care experience. It is a GM ambition that the streaming model will be delivered by a GP; however this is a future aspiration. Patients will be streamed to the most appropriate service e.g. A&E, UTCs, admissions avoidance community team, mental health response or ambulatory care.

Patients (that are streamed) need to be sent to the appropriate service according to explicit criteria based upon presenting complaint and basic physiology. Importantly, the criteria should not be based upon pathology, as this is only evident after clinical consultation. The basic premise is that if a patient is clinically stable enough to present on foot, and can continue to walk and talk unaided without deterioration, then they are suitable for initial clinical consultation with a GP.

Redirections to other sites e.g. an UTC located in the community, requires further safeguards to ensure redirection is both appropriate and safe, and that the off-site service has accepted the patient. Consideration should also be given to how patients are booked into services that are at another location and the distance a patient is being streamed to. This may incorporate booking or warm transfer.

Where possible, the streaming service should refer/book patients into other appropriate services including physiotherapists, pharmacists and dentists. Streaming services will need to be well integrated with community and social care, particularly rapid community response, reablement and discharge to access.

The streaming team should also be ‘mental health aware’; treating mental health issues with the same importance as physical issues. There is also an opportunity for a social assessment to be made - with pathways to appropriate services/packages clearly defined.

3.2.4. Treatment times

Streaming should be performed as soon as possible, and always within 15 minutes of the patients arrival. Patients who ‘walk in’ to the UTC should be clinically assessed within 15 minutes of arrival, but should only be prioritised for treatment over pre-booked appointments where this is clinically necessary. Following clinical assessment, patients will be given an appointment slot. Patients that attend the Urgent Treatment Centre must meet the national 4 hour wait target.

3.2.5. Service availability

The Urgent Treatment Centre and A&E streaming service should provide the same opening hours so that patients can be streamed directly from A&E into the Urgent Treatment Centre. This will provide a consistent offer to patients and ensure the best use of workforce and resources.

3.2.6. IT and interoperability

The patients registered GP should always be notified about a clinical outcome of a patient via a Post Event Message (PEM), accompanied by a real time update of the electronic patient record locally.
Systems interoperability should make use of nationally-defined interoperability and data standards; clinical information recorded within local patient records should make use of clinical terminology (SNOMED-CT) and nationally defined record structures.

3.2.7. Workforce

The national model for A&E streaming is prescriptive in terms of staffing stating that patients must be streamed upon arrival by a Band 7 nurse. The service should be delivered by a minimum of 1 GP (quiet periods), 1 clinical nurse and 1 Health Care Assistant. However, it is expected that an appropriately trained multidisciplinary clinical workforce will be deployed whenever the UTC is open.

In GM both the UTC and A&E streaming service will be clinically led by primary care. There needs to be flexibility to create a workforce that is suitable for local need and circumstances. Localities should consider how they make use of the wider primary care workforce and utilise existing services such as the GM Minor Eye Conditions Service provided by community opticians and GM Minor Ailments Service offered by community pharmacists. Services should also make use of late opening pharmacies, directing patients to them rather than urgent and out of hours services whenever appropriate. Local emergency and out of hours services should be integrated with or aligned to emergency dental services, providing pain relief for patient with dental problems during the out of hours period and direct booking into emergency dental appointments. This would be facilitated by detailed, up to date Directories of Services (DoS) in each locality.

There are also opportunities for a wider workforce within the urgent care provision e.g. ANPs, physios, mental health and clinical pharmacists.

The service should look to maximise the capacity of the workforce, particularly during lower peak times. There could be opportunistic use of ‘spare’ capacity focusing on frequent fliers, health checks for vulnerable cohorts, addressing the needs of the homeless, drug users, alcoholics etc. With increased integration of services, there may be further opportunities to utilise spare capacity/appointments within 7 day GP Additional Access hubs.

Where appropriate, Urgent Treatment Centres will provide additional capacity and support for core general practice, enabling them to utilise the service for same day appointments (enabled by access to patients’ records) that require less continuity of care. This would help to provide more capacity for general practice to focus on longer consultations to manage more complex patients.

3.2.8. Communications & engagement

A GM strategy for comms and engagement will be developed and tailored locally to ensure patients and staff understand how and where to access services. Providers should provide evidence of clear communications to patients as part of their service contract.

All services should actively signpost to the most appropriate access routes for urgent primary care, providing consistent messaging to patients. Contracts should allow for formal continual engagement with patients and should demonstrate how this engagement will be used to continually improve patient experience of access to and the quality of 24/7 urgent primary care services.
All services need to be accurately profiled in the NHS 111 Directory of Services and any local Directory of Services.

3.2.9 Advice and self-care

UTCs should provide the necessary range of services to enable people with communications challenges to access British Sign Language, interpretation and translation services.

Where appropriate, patients should be provided with health and wellbeing advice and sign posting to local community and social care services where they can self-refer e.g. stop smoking services or drugs & alcohol teams.

3.2.10 Measurement

All urgent treatment centres should collect contemporaneous quantitative and qualitative data, including patient experience and return the data items specified in the Emergency Care Data Set (ECDS). Locally collected data should be used in a process of continuous quality improvement and ongoing refinement of the service.

In GM we will collect information regarding the number of patients that have been streamed away from A&E and where the UTC is receiving patients from e.g. GP referral, self-referral/walk-in’, A&E streaming etc.

Patients that attend the Urgent Treatment Centre will be counted against the A&E 4 hour wait target
24/7 Urgent Primary Care System

- Standardised streaming protocol
- Streamed by senior primary care nurse
- Streaming before A&E triage
- Facility to receive patients from UTC
- Facility to warm transfer

- Co-located in hospital or community
- Access to diagnostics including X-ray & NPT
- GP led
- Minimum 12 hours per day
- Can book patients into routine access hubs

- Green light dispositions to UTCs

A&E Streaming

Urgent Treatment Centre

SPA - 469 GP practices

Additional Access hubs

Ambulance

- Single Point of Access
- Direct booking into routine access hubs and UTC
- Capacity to manage same day demand during core

GP OOH

- Receives patients via NHS 111
- Takes over after UTC closes

NHS 111

- Direct booking into UTC

- 6.30-8pm Weekdays
- Min 4hrs Sat and 4hrs Sun
- Routine/bookable