Strategy for consultation

NHS Islington

Urgent Care Strategy

2009 - 2014

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1. Introduction

1.1 This strategy focuses on the support local people require when they are in need of urgent care. Urgent care is a broad term and may include a range of conditions from suspected serious illness, to more minor conditions although still perceived by patients as urgent.

1.2 In this document we describe the current range of services available locally to provide support and care when needed. We also comment on how the system has performed over the past few years and identify priorities for improvement.

1.3 Set out in this document are proposals for the development of local services with a vision of a new mix of community and hospital based services – led from a community perspective – working with other parts of the health and social care system to provide the right treatment in the right place for people who live and work locally. The main proposals are:

- Tendering for an Urgent Care Centre located on the Whittington NHS Trust site to deal with all primary care related urgent attendances;
- Exploring the feasibility of establishing a 'hospital at home' and rapid response community service, and subject to a costed business cases go out to tender
- Establishing a new range of primary care led urgent care services including an improved response and coordination in-hours within general practice and extending the range of scope of community pharmacists to deal with urgent care;
- Implementing new models of highly specialised care as set out in the *Healthcare for London* work around stroke and major trauma, provided at a smaller number of sites; and
- Undertaking research and social marketing to understand patterns of attendance, to shape care around them and influence patterns of use.

1.4 This document is closely linked with the NHS Islington's draft Primary Care and Community Services Strategy, which will be going out to consultation early in 2009. Many of the proposals identified within the Urgent Care Strategy will be underpinned by the aims and initiatives resulting from the Primary Care and Community Services Strategy, which has amongst its aims to improve access to primary care.

1.5 This focus of this strategy is a model of urgent care for adults, although reference is made to some of the thinking that is going on around children's services within the *Healthcare for London* model. We recognise that there is much complexity more about how to deliver services for children and we are therefore proposing a phased approach with a roll out for adults services initially, allowing time for further discussion about how to implement the children's model. For this reason there is limited discussion about the children's model in this document.

2. What do we mean by Urgent Care?

2.1 The need for the public and patients to access medical care with a rapid response can arise in a variety of situations.

2.2 Situations requiring an urgent response can be vary, some of the range is set out below:

- When something is serious, not necessarily life threatening, but known by the individual or others to need immediate support (bad falls, initial chest pains)
- When something seems serious but you just don't know what to do (a child with worsening fever, a badly disorientated older person who has fallen, an individual who seems very depressed, an individual with tummy pains)
- When there is a minor injury which needs immediate attention (cuts, bruises)
- When you suspect a common illness or condition, but are not sure what to do about it (bad coughs, colds, flu, tummy upsets, toothache).

2.3 For members of the public the need for an urgent response is often driven by the need to understand their problem and then move quickly to specific diagnosis, treatment and care. The NHS often looks at requirements for urgent care in a different way, and organises' different responses depending on the level of need.

2.4 The response will need robust signposting to a range of service responses within primary, community and hospital care, and it is these responses which are the focus of this strategy.

2.5 For the purposes of this strategy we define urgent care as

> "Care, excluding planned care, which the patient seeks access to on the same day that the patient perceives it is needed."

2.6 There are times when an emergency rather than urgent response is needed when something critical or life threatening happens for example a major accident, a deep wound, heavy blood loss or a suspected heart attack. In these cases an immediate response is needed either an ambulance or attendance at Accident and Emergency. These kinds of cases are not included within the main focus of this strategy.

3. What Services Exist Locally?

3.1 Our definition of urgent care is broad and includes services provided by:

- GP Services and out of hours
- Pharmacists – Minor Ailments Scheme
- Dentistry – Urgent
- NHS Direct
- London Ambulance Service
- Local A&E
- Minor Injuries Unit
- Other urgent care services

GP Practices and Out of Hours

3.2 There are 39 GP practices in Islington, with more than 50% of practices providing extended hours. Local doctors' surgeries offer a wide range of services, including advice on health problems, physical examinations, diagnosis of symptoms and prescribing medication and other treatments. The doctor will usually be supported by a team of nurses, health visitors and midwives, as well as other specialists, including physiotherapists and occupational therapists. Local GPs also generally provide access to home visits for those unable to attend the practice.

3.3 All practices in Islington are covered by the GP Out of Hours (OOH) service commissioned by NHS Islington. The service operates every day, from 18.30 to 08.00 and all hours during weekends and bank holidays, which is available people including residents, workers, and visitors who happen to be in Islington at the time. Initial contact can be made by telephone and this may be followed by advice over the phone, a face-to-face consultation in local centres, or a home visit.

Pharmacists – general

3.4 Pharmacists are able to offer advice and treatment for many conditions, including ear infections, coughs, colds, diarrhoea and headaches. As health professionals on the high street, the public do not need an appointment to see them, nor is registration with an Islington GP required.

Pharmacists – minor ailments scheme

3.5 Since 2005/06, Islington residents have also been able to access through their GP practice the Minor Ailments Scheme provided by their chosen pharmacist. The scheme enables the community pharmacy to provide advice and support to people who have been given a voucher from the GP practice on the management of minor ailments, including where necessary, the supply of medicines for the treatment of the minor ailment, for those people who would have otherwise gone to their GP for a prescription.

Dentistry - Urgent

3.6 In-hours open access sessions are commissioned from a dental practice (based in Camden) for those patients who are directed for urgent treatment in-hours following a call to the OOH service via Camidoc. An out-of-hours telephone dental triage service is provided by Camidoc, as an add-on to the main GP OOH contract.

NHS Direct

3.7 NHS Direct is a phone service staffed by nurses and professional advisors, giving confidential healthcare advice and information 24 hours a day. The service covers what to do if an individual or a family member feels ill and needs information on particular health conditions

and local health services (such as GPs, dentists and out-of-hours pharmacies or self-help and support organisations). Over two million people access NHS Direct every month, which includes an average of 1,750 calls made by Islington residents (59 per day). Islington's peak calling period is during the hours of 9am-10am weekdays and weekends.

The London Ambulance Service

3.8 The London Ambulance Service (LAS) provides an accident and emergency service 24 hours a day across the capital. Ambulance staff attend emergencies and are trained to provide care at the scene of an incident and/or transport the patient to the most suitable service, such as Accident and Emergency Services. Category A calls are outside the scope of this strategy as they require an emergency response; the focus of this strategy is around categories B and C.

3.9 In 2006/07 the LAS responded to an average 72 calls a day in Islington, which included the following categories:

- Category A (immediate threat to life) = 9491 (26 average per day) in 2006/07
- Category B (serious but not life threatening) = 12,490 (34 average per day) in 2006/07
- Category C (neither serious nor life threatening) = 3,421 (9 average per day) in 2006/07
- Urgent (GP calls) = 1,082 (3 average per day) in 2006/07

Local A&E services

3.10 The local hospitals, Whittington NHS Trust in North Islington and UCLH NHS Foundation NHS Trust in Camden, provide the main points of access to Accident and Emergency services to Islington residents and those working locally.

3.11 The Whittington A&E department is open 24 hours a day; seven days a week providing treatment for anyone seeking attention for an urgent problem caused by an accident or illness. In 2007/08 80,000 people attended A&E, most of them from Islington or Haringey, along with those out of borough working in the vicinity. The Whittington Hospital has a separate paediatric A&E, around 25% of the total attendances at the Whittington A&E are children. Given the complexity of children's services, they are excluded from the scope of this initial strategy

3.12 At UCLH Accident & Emergency services comprise both the A&E Department and the Acute Admissions Unit (AAU). The A&E Department sees approximately 90,000 patients a year serving patients from Islington, Camden, Westminster and non-resident people from out of borough working nearby or visiting London. The A&E Department is subdivided into four areas: resuscitation; majors; minors; paediatrics. The Acute Admissions Unit (AAU) comprises a 56-bed unit and patients who are admitted remain on the Unit for up to 48 hours, during which time treatment will be supervised by the AAU clinical team.

Minor Injuries Unit

3.13 The Minor Injuries Unit located at St Bartholomew's Hospital in the City of London, is staffed by nurse practitioners. The service can treat injuries such as cuts and grazes, broken bones, minor burns and scalds, bites and stings, strains and sprains, minor head injuries, and minor eye or ear problems. It is a walk-in service, so no appointment is needed. Patients are seen in order of urgency. The Minor Injuries Unit is open Monday to Friday, 8am-8pm. It is closed at weekends and on bank holidays.

Other urgent care services

3.14 The Islington Social Services' Emergency Duty Team provides an 'out of hours' service for emergencies. An emergency is considered to be something that cannot wait until the next

working day when the full range of services will be available. The duty social worker will give advice and guidance over the phone on how to deal with the problem. You may be advised about other services which can help, or that it would be best to wait until the normal day services are available.

3.15 Adult Mental Health Crisis support is provided by Camden and Islington NHS Foundation Trust to provide a service to adults with serious mental illness who are being considered for hospital admission.

3.16 Young people with mental health needs who present as an emergency are offered a tailored service depending on whether they are already known to the CAMHS (Child and Adolescent Mental Health) team. If not currently known to the service they would be seen via their local A&E and if necessary would be admitted to the paediatric ward and a risk assessment is jointly carried out by paediatric and social work staff. If the child is already known to the service the clinician involved can seek advice from the psychiatrists within the Islington community team whho would assess the urgency of the case and ensure that they are seen by the service. If it is an emergency the young person may be advised to attend the Emergency Department as above.

3.17 A rapid response service is also available to patients requiring the establishment of social services care packages, which can be implemented within 2 hours.

4. How are local Services Used?

Access to Urgent Care Services

4.1 The Healthcare Commission published in September 2008 its review of urgent care services across the country, which rated Islington as a local health community as Fair Performing with an overall score of 2.88 on a scale of 1 to 5, placing it mid range amongst PCTs nationally.

4.2 The main areas from the review where Islington scored a mark of two or less were:

- the level of A&E attendances for conditions which could be avoided or treated in other settings;
- the public satisfaction with the opening hours of GP services;
- the percentage of patients who see a clinician within an hour of arrival at A&E/urgent care centre; and
- the score for facilities for people with disabilities.

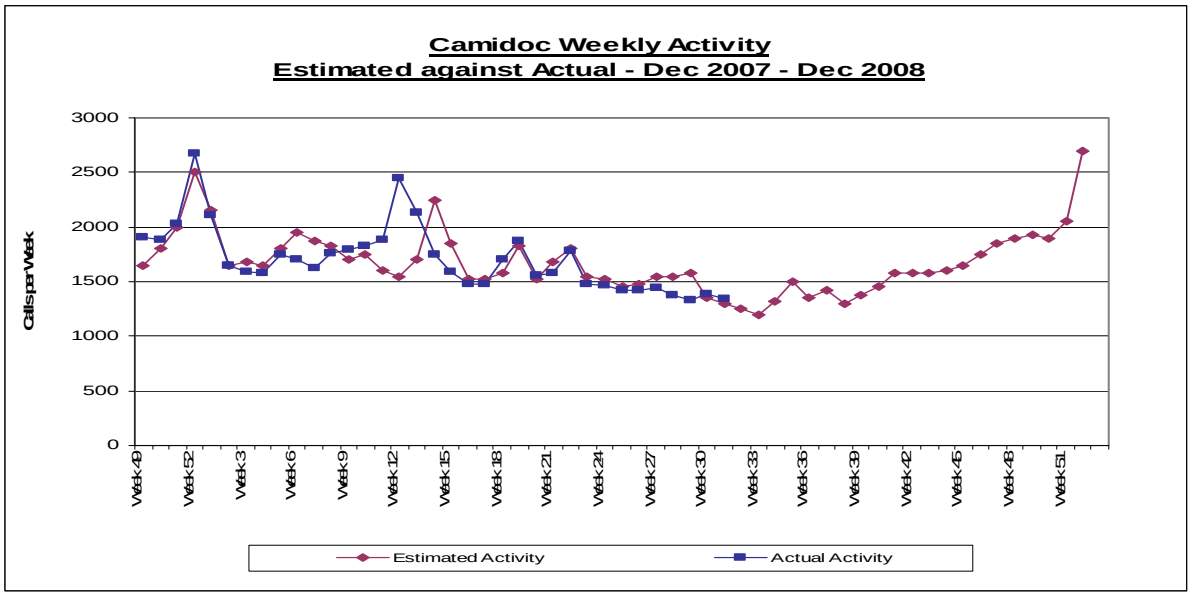
4.3 In addition to the Healthcare Commission report, research conducted within six London boroughs: Kingston, Hammersmith & Fulham, Camden, Barnet, Waltham Forest and Newham, provides a useful insight to the drivers for urgent care activity where a number of influences impacting on patient behaviour were identified. This research found that:

- Patients select their place of care on the basis of proximity and speed of access.
- People often attend A&E because they are confused about the number and range of ways to access urgent care services
- Patients' assessment of the urgency of their need appears to influence their choice of access point; patients attending A&E departments and WiCs (Walk in Centres) assessed their need as more urgent than those attending GP and pharmacy services for care/advice.
- Patients visit multiple access points for the same condition; more than 25% of A&E attendees with a minor illness/injury had visited either a GP or A&E department in the previous 3 days;
- One third of people attending A&E felt that their condition could have been treated by their GP and did try or consider accessing their GP as a first choice
- Whilst standards of care are important to patients, patients did not report a significant quality gap between care provided by GPs and care provided by A&E clinicians; only 12% of the patients interviewed at A&E stated quality of care influenced their decision to attend
- People understand and accept the process and rationale of triage
- People generally lack awareness of the skills of pharmacists
- Parents/carers of young children tend to use A&E more and are also more likely to use telephone access (GP out of hours and NHS Direct)
- There is a greater tendency for BME communities to access unscheduled care (need to define) than White British
- White British are more likely to use telephone services, BME communities are much less likely to use these services
- Older people appear to access GP services and A&E for their unscheduled care needs, with a lower propensity to use telephone access

4.4 The usage of services associated with urgent care can be depicted by the following information:

GP Out of Hours usage

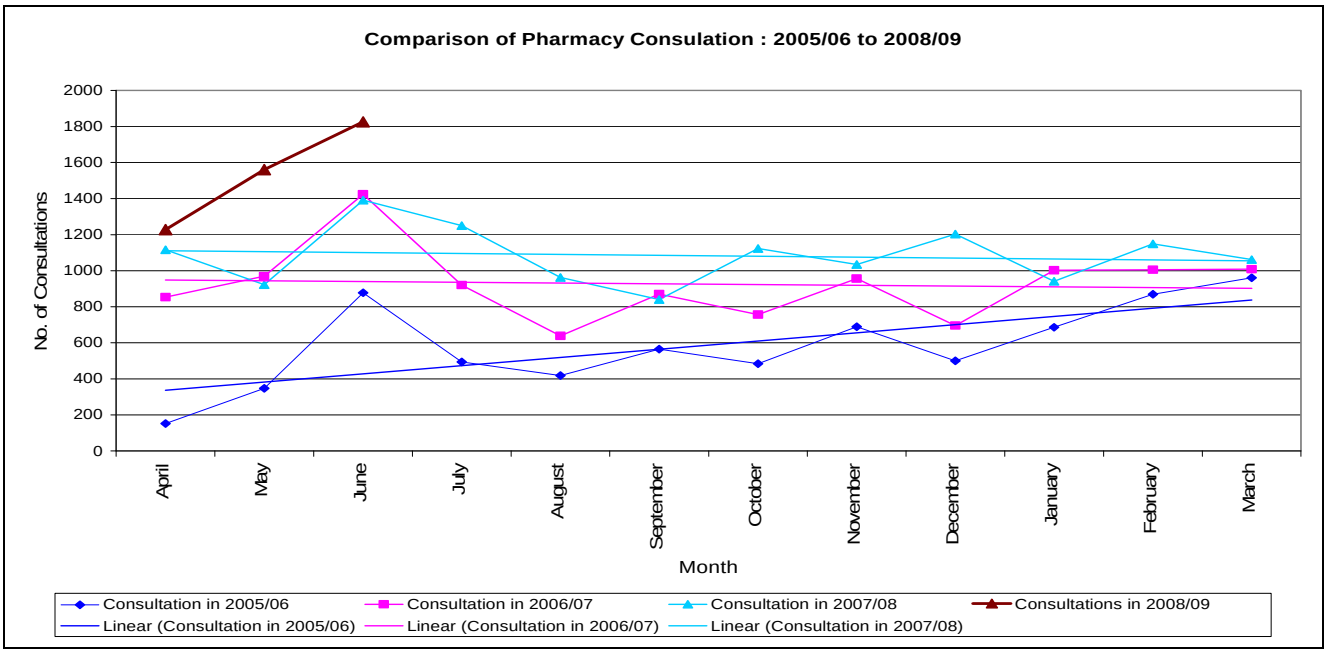
4.5 Between December 2007 and August 2008 there were an average 1,700 calls per month to the GP out of hours services.



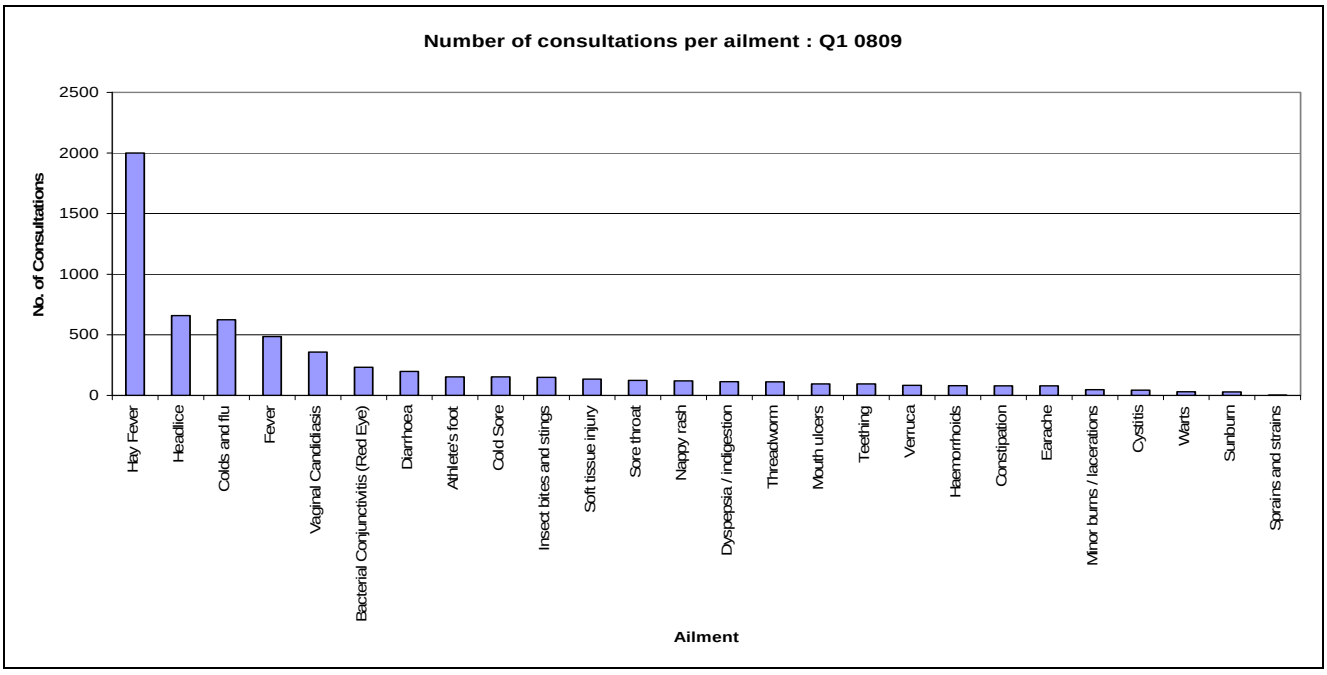
4.6 In terms of the response provided by the out of hours service the Healthcare Commission review identified that 84% of phone calls to the service were answered within 60 seconds of an introductory message. This placed Islington in the bottom 30% of PCTs nationally. Of calls received 47% of cases were provided with advice over the phone, 38% received a face-to-face consultation and 15% received a home visit.

Minor Ailments Scheme usage

4.7 Since its inception the minor ailments scheme's usage has gradually increased. The average number of consultation per month increased from 1143 in Quarter 1 2007/08 to 1538 in Quarter 1 2008/09. At present patients can be referred to the scheme from local GPs, everyone eligible who is referred to the scheme is seen.

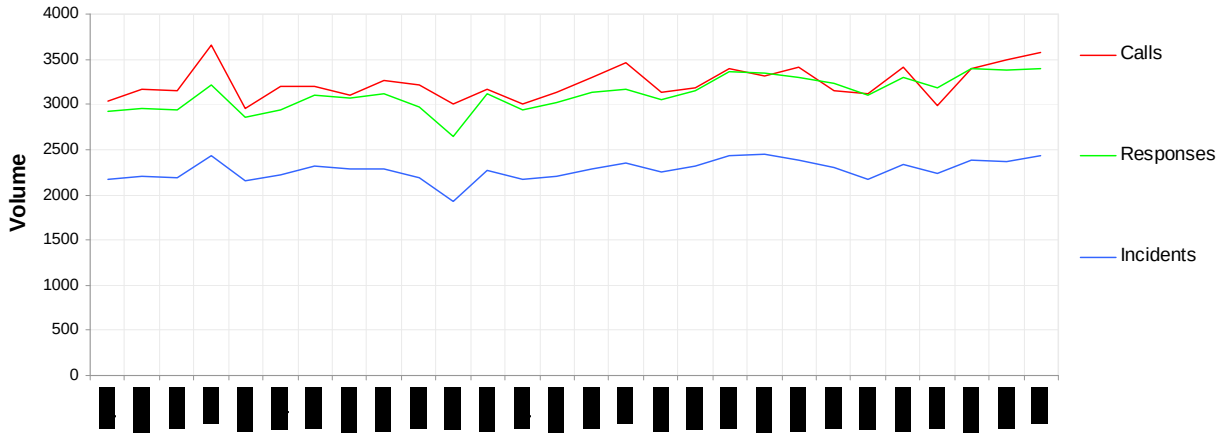


4.8 From April 2008 to June 2008 a total of 6,272 people were seen as part of the scheme. The graph below shows that the highest numbers of consultations are for cold and flu, hay fever and head lice, which is a similar pattern of conditions to previous years.



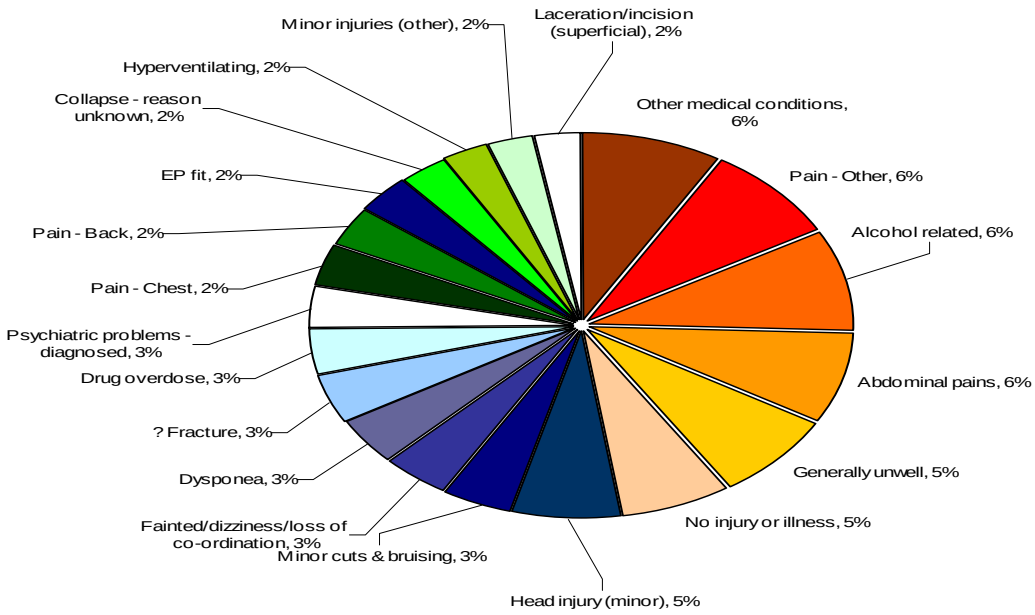
London Ambulance Service

4.9 Islington's activity in relation to the London Ambulance Service has broadly remained consistent over time; with between 3,000 to 3,500 calls received and responses made monthly.



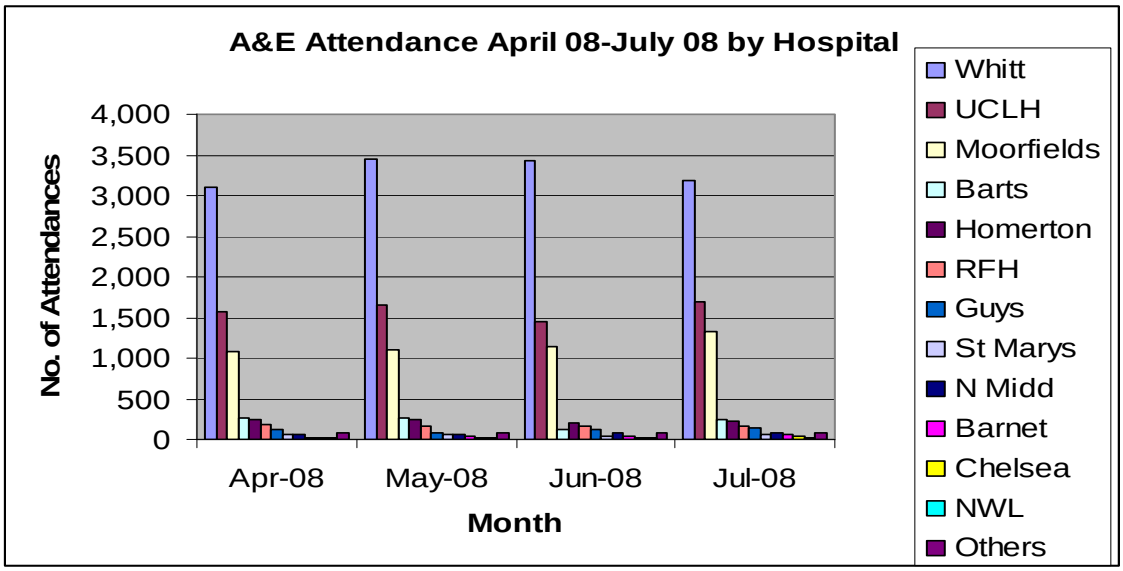
The number of incidents is lower than the number of calls and responses because incidents excludes calls abandoned for any reason, duplicate calls about the same incident or hoax calls. Calls are defined as the total number of emergency calls.

4.10 Of the calls made to the London Ambulance Service the top 20 illnesses reported are displayed below. Abdominal pain, alcohol related, and pain other each make up 6 percent of the activity reported.

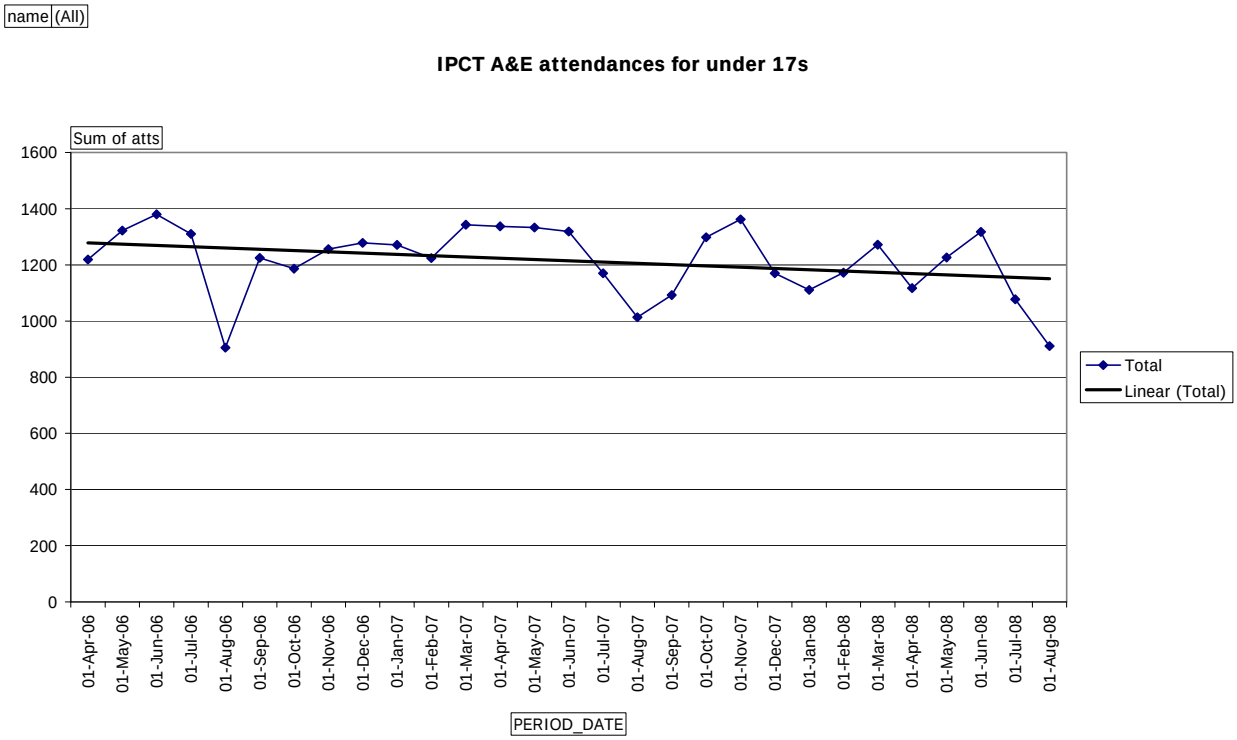


A&E attendance and Emergency Admissions

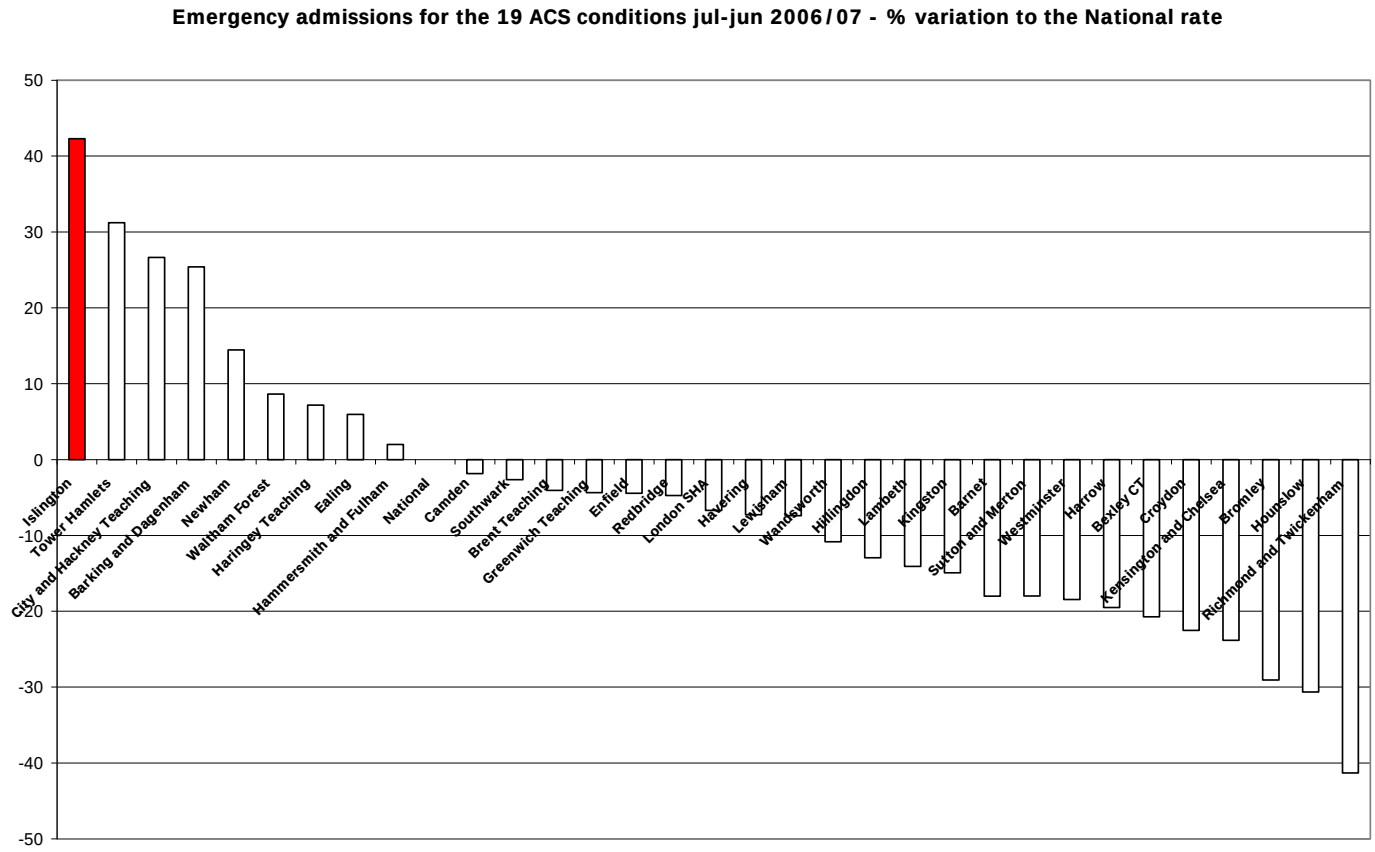
4.11 The majority of Islington's A&E attendances are provided at the Whittington NHS Trust (46%), with UCLH second (22%). Moorfields as a specialist eye hospital accounts for 16% of attendance to an A&E department, but this is exclusively for the treatment of eye conditions..



4.12 In relation to children to the number of A&E attendances has averaged about 1,200 per month between April 2006 to August 2008.

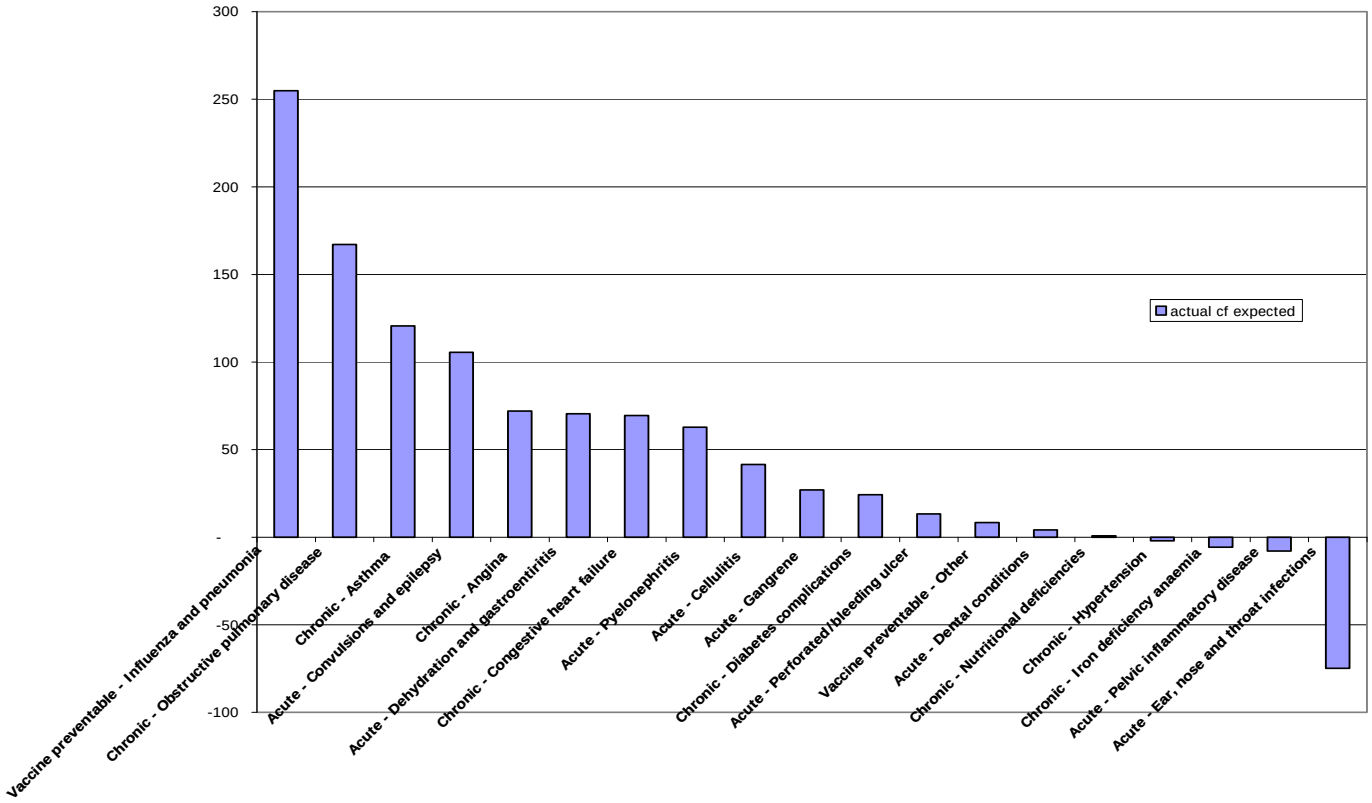


4.13 Islington has the highest rate of emergency admissions in London. It is 40% above the national average for admissions for the 19 ambulatory care sensitive (ACS) conditions. These are long-term health conditions that can often be managed with timely and effective treatment without hospitalisation, for instance COPD or influenza



4.14 The ambulatory care sensitive conditions that result in the highest number of emergency admissions are vaccine preventable admissions including influenza, and long term conditions such as COPD and Coronary Heart Disease.

IPCT - number of emergency admissions jul-jun 2006/07 above/below expected compared with National rate



5. So, why is further change required?

5.1 There are a number of factors that have pushed urgent care to the top of NHS Islington's agenda and prompted a look at how our local services are organised. Some are to do with work that is happening at a national and London level, and others are to do with the way that things work locally and our priorities for Islington.

5.2 There was a shared view amongst stakeholders that although there are real strengths in the current system, there are also areas where improvements need to be made.

Stakeholder views

5.3 As part of the preparatory work for this strategy a local group of stakeholders came together, including both the Whittington and UCLH, the London Ambulance Service and a patient representative, to look at how services work at the moment, the strengths that are there to build on and the areas where further work is needed. They identified the following:

5.4 *Strengths to build on:*

- The *Right Care: Right Place,* triage and redirection model that is in place at the Whittington has been a success*;*
- Admission avoidance; redirection; and, prevention work well locally;
- Improvements in hand-over between different parts of the NHS and social services and associated information exchange;
- Two strong local A&E departments;
- Improved working relationships between all providers;
- Move to towards reconfiguration of GP surgeries;
- That the London Ambulance Services is able to respond to patient choice when responding to calls; and
- Introduction of the pharmacy minor ailments scheme.

5.5 *Challenges to address:*

- Lack of a clear vision of 24/7 Urgent Care;
- Access to – and the role of – Primary Care as part of Urgent Care;
- Inconsistent sharing of information – between hospital and primary care and between primary care and hospital;
- Inadequate sign posting for patients of where they can go to receive care;
- Lack of coordination between providers;
- An understanding of the reasons why patients access care in the places and ways that they do; and
- There is limited monitoring and evaluation of changes once they happen.

National and London drivers for change

5.6 Over the last eighteen months there have been a number of pieces of London and national work that have changed the context within which urgent care services are being delivered, and pushed PCTs, as commissioners of services, to ask some searching questions about the organisation of local services and whether they are delivering the best quality services for local residents.

5.7 First came *A Framework for Action* written by Professor Lord Darzi about Healthcare in London that was published July 2007. This formed the basis of the *Healthcare for London* (HfL) public consultation that was led by 31 London PCTs (plus Surrey) and closed 7 March 2008. Lord Darzi concluded that community services are not providing a satisfactory alternative to

hospital and therefore many Londoners are accessing A&E departments for urgent care instead. He also concluded that very specialist areas, such as acute stroke and major trauma, need to be carried out in very specialist centres so that patients can get the very best, high quality, modern care. Lord Darzi's London work was followed up at a national level by the NHS Next Stage Review *High Quality Care for All*, which came out in June 2008.

5.8 The *Healthcare for London* team has taken the principles set out in Lord Darzi's work and come up with a model for urgent care that local PCTs have been asked to look at in the context of their own services. We have been involved in the development of this model at a London-level and have used this model as the starting point for this strategy; working with local stakeholders as part of our development process to see how the London-wide model could be adapted to fit our local needs and circumstances.

5.9 As a result of Lord Darzi's work the Government has made the connection between primary and community services and the way that patients access services for their urgent needs. He has also made a powerful case for an improvement in the quality of care in the NHS, with consistent clinical input from appropriately skilled doctors and nurses.

5.10 In order to improve access to urgent care for less severe problems, all PCTs are being asked to procure a GP led-health centre that is open for extended hours (8am to 8pm) all week long (including the weekends), which will see patients who are registered with a local GP and those that are not. We have also been asked to think about how NHS Islington will respond to the model of a polyclinic (a community based resource providing a wide variety of services which will include urgent care and GP services) that is set out in Lord Darzi's vision for the health service. These national requirements will need to be combined with Islington initiatives that are already up-and-running. These will include initiatives to encourage GPs to stay open for longer and to encourage the growth of larger practices in Islington to get the benefits that GPs working together can deliver.

5.11 In order to look at all of these initiatives as a whole, NHS Islington is developing a strategy and vision for Primary and Community Services for the next five years; which will go out to consultation in early 2009. Given the links between primary care services and when care becomes urgent, this document and the Primary and Community Services Strategy when it is completed will need to be seen as complementary, as well as standalone documents.

<u>Local impetus for change</u>

5.12 As a starting point for any strategy we need to go back to NHS Islington's long-term vision, this is:

> "In 2013 local people are healthier and live longer, living independently and participating in society. Local people know their voice is heard in how health services are provided. There are more services delivered closer to people's homes; the quality is higher and the standards more consistent; fewer practices provide a wider range of services; targeted and tailored services are provided to particular groups in the population and those with specific needs; and hospitals only do what they do best. All local people have easy access to services and make choices about their care."

5.13 This vision is translated into a number of objectives. These are:

- **Improve the health of local people**, especially targeting those with the worst health outcomes, through initiatives on CVD, mental health and obesity;

- **Improve the quality of the patient experience and health outcomes**, through benchmarking health needs and outcomes, and implementing the communications and engagement strategy, and aligning investment;

- **Ensure people and services work together to design and deliver the best care pathways**, focussed on end of life care, urgent care, mental health, and the Collaborative Commissioning Intentions of the North Central London sector PCTs;

- **Improve and expand services delivered closer to home and commission acute and specialist hospitals to provide only those services that they do best**, through implementation of the PCT's primary and community services strategy; and

- **Act as guardians of local NHS finances** through ensuring the best use of available resources to deliver improved health.

5.14 When tested against NHS Islington's strategic objectives the need to develop a new model for urgent care, implemented with a new vision for primary care, meets each one of these tests.

Improve the health of local people
5.15 We know that many of those residents accessing urgent care are those with the worst health, and that if the system was redesigned they would have a better experience. Islington has a very high number of patients with Long Term Conditions, like heart failure of COPD (Chronic Obstructive Pulmonary Disease, what used to be called emphysema). One way of measuring how well PCTs are doing at managing care in and out of hospital settings is to look at a cluster of nineteen conditions that have been termed Ambulatory Care Sensitive and to look at admission rates for all nineteen as a grouping as well as each of the individual indicators, these include preventable influenza and pneumonia, chronic asthma and acute dehydration following gastroenteritis. We know that NHS Islington has the highest rates of admission of any London PCT for these conditions when looked at as a whole, and is an outlier for lots of the individual conditions (see the detailed graphs in section 4.9) and it is an area highlighted by the recent Healthcare Commission review. We believe that if we improved the model for urgent care within Islington we could improve the quality of care for those with the worst health and provide high quality, responsive care for them within their own home.

Improve the quality of the patient experience and health outcomes
5.16 As part of the work developing their model of care *Healthcare for London* carried out patient surveys about why they access care in the way that they currently do. One was carried out in our neighbouring PCT, Camden. Although this evidence is by its nature subjective, these findings do mirror other evidence that suggests that people often default to A&E because they are confused about how to access care. The Healthcare for London survey showed that there is duplication and poor utilisation of the existing services; for example across London 20% of the patients surveyed visiting A&E had seen a GP in the previous three days for the same condition.

5.17 In the Camden-specific findings patients made the following suggestions about how they would like their needs to be met in the future: 69% wanted a generally quicker faster service with less waiting time; 51% wanted more readily available GP appointments; 34% wanted extended GP opening hours; 26% wanted to see an improved level of treatment; around 10% wanted better information about treatment options.

Ensure people and services work together to design and deliver the best care pathways
5.18 One of the reasons for the very fragmented experience of patients is that there is no clarity or simplicity about care pathways and where care is available. It is entirely understandable that because as healthcare professionals we have not make the system work for patients they default to accessing care at the only place that is open 24/7, is open to everyone and can guarantee to see patients within a four hour window. We have seen an increasing number of patients accessing hospital for relatively simply, or primary care, needs. Over a third of the attendances at the Whittington hospital fall into this category and over the years we have seen a huge increase in numbers of attendances at A&E.

5.19 The aim of this strategy is to design simple care pathways, and access points for care, that meet patients needs at the places they need them and that staffed appropriately for the complexity of their condition. These pathways also need to make sense to the care professionals who will be delivering them.

Improve and expand services delivered closer to home and commission acute and specialist hospitals to provide only those services that they do best
5.20 The Primary and Community Services Strategy will set out the NHS Islington's vision for extending the scope of services available through general practice, achieving responsive and integrated access to care, particularly with social services.

5.21 We know that lots of patients attending A&E have already seen their GP, or are attending because they perceive access to their GP surgery to be a barrier. We also know that a very large proportion of patients attending A&E are presenting with a problem that could be dealt with by their GP or someone else in a community setting like a pharmacist. In order to make this shift there will need to be extended access to primary care and community care services, particularly changes to operating hours and a remodelling of the way that urgent cases are dealt within the day in primary care.

5.22 At the other end of the spectrum, the Darzi report and *Healthcare for London* have made clear that some services are much better provided in very specialist settings, for instance the immediate care for people who have had a stroke, and those that have experienced major trauma, for example a serious car accident. These services will be provided in smaller specialist centres and the London Ambulance Service will take patients there direct. This model already works very well for patients who have had a heart attack, who are taken directly to UCLH.

Act as guardians of local NHS finances
5.23 In order to make this model work the financial flows in the system will need to be changed, with different models of care funded in community and primary care settings. At the other end of the spectrum there will also need to be different models of costing for the much more complex care, like stroke and trauma. We believe that new funding flows will help to cement a new model of care by freeing up resources. This is not about reducing the amount of money spent, and at least initially we may need to invest some additional funding to get the step change in the quality of care that we want to see. Before proceeding to implementation, and after consultation, detailed financial modelling will need to be undertaken for each aspect of the model.

6 What will urgent care services look like in the future?

6.1 This section of the strategy sets out at a high-level the changes that would happen to local services and the differences that resident and the public would be able to see, compared to current services. The model is based on the one that has been developed by *Healthcare for London*, and puts it into an Islington setting. There has been extensive input from local stakeholders, including primary care the two local hospitals, as well as patient representation.

6.2 This group, plus a number of other stakeholders, spent a day together in June and identified a vision for urgent care in Islington in 2013. In looking at the Healthcare for London model this was the vision that we were seeking to implement.

Our vision for urgent care in 2013:

- Patients are better informed;
- Patients feel safe and satisfied;
- Patients have 24/7 access to professionals within a Primary Care and Community Care setting to support both diagnostics and treatment;
- There is consistency in the management of risk across different urgent care pathways;
- Urgent care is planned, designed and delivered in response to current and future needs;
- Urgent care services are affordable and value for money;
- Urgent care services in Islington dovetail with those in neighbouring boroughs, especially Camden and Haringey;
- Better coordination overall with a single patient record shared across the health system with links as appropriate to Social Care;
- Professionals have a greater knowledge about the range of services and associated access points and are therefore better placed to sign post patients; and
- The whole system is staffed appropriately with trained professionals.

6.3 Over the next few sections we will explain in summary the models of care, describe the main changes that will need to occur to make the new system work and then set out the model in diagrammatic form.

A summary of the *Healthcare for London* models of care

Care in hospital

6.4 *Healthcare for London* has put forward two model of care: one for adults and one for children. Both are based on some fundamental changes to the way that patients currently access urgent care in hospital. This strategy focuses mainly on the model for adults, although the model for children is also set out. We recognise that there is much more complexity about how to deliver services for children and we are therefore proposing a phased approach with a roll out for adults services initially, allowing time for further discussion about how to implement the children's model. For this reason there is limited discussion about the children's model in this document.

6.5 First all hospitals that currently have an A&E will host an Urgent Care Centre (UCC) on the hospital site; this might be right next door to the current A&E but would be physically separated from it. The UCC will see both adults and children and will be staffed by people with primary care skills, primarily GPs and nurses working with adult social care. This will be

the place where patients will be able to self-refer at any time of the day or night, 24/7. Patients will be able to receive care, as quickly, if not more quickly than in A&E. The care provided in Urgent Care Centres is not intended to be a replacement for patients accessing care through their GP, particularly for patients with complex Long Term Conditions. However, some patients may choose to make UCCs their main access point for care and the system needs to be able to respond and accommodate this too, although those doing so regularly will be encouraged to register with a local GP.

6.6 A&E will become more specialised and patients will not be able to have direct access to A&E, which will now only be for those with more serious or life threatening and complex cases. It will take patients who are very unwell and come in by ambulance or those that have been fast tracked by the Urgent Care Centre, or referred by their GP. Severely ill patients arriving at the Urgent Care Centre will be fast tracked to the A&E. The need for doctors and nurses in both the Urgent Care Centre and A&E to be very skilled at triage and assessment, and to make fast and accurate judgements, is one of the underpinning principles of the new model. This strategy will need to be accompanied by a sophisticated approach to the management of the workforce and training to ensure that this is delivered and very robust clinical governance arrangements particularly around the time of implementation and transition between different services.

6.7 Next door to A&E will be an Acute Assessment Unit and Paediatric Assessment Unit where patients seen in the A&E who need to stay for a short time for observation or tests will be admitted. These short stay wards already exist and allow patients – for instance someone needing intravenous antibiotics – to be kept for a short period of time while their condition stabilises and the medication begins to work.

6.8 Some A&Es will take on additional specialised responsibilities for their area to deal with even more complex conditions like the very first stages of stroke and major trauma, such as car accidents. The London Ambulance Service will take patients direct to these centres; this already happens and works well for heart attacks, and increasingly also for acute stroke. Work is underway through *Healthcare for London* to decide where these specialised centres will be located.

6.9 These changes will mean that everyone attending hospital with an urgent care need will be seen by the kind of health professionals with the most appropriate clinical skills to help resolve their problem, in the faster and most cost-effective way.

Summary of Healthcare for London model for urgent care and acute assessment (adults)

1. Patients conveyed by ambulance would be delivered straight to the Urgent Care Centre (UCC) or to the A&E; more complex patients could be delivered directly to the Acute Assessment Unit (AAU)
2. Patients can self refer ONLY to the UCC; there would be no direct access to A&E and patients assessed to require A&E treatment would be referred via the UCC
3. Patients referred by GPs would be referred directly to the AAU (although could be referred to the UCC in some cases)

Summary of Healthcare for London model for paediatric assessment

1. Children conveyed by ambulance would be delivered straight to the Paediatric Assessment Unit (PAU)

2. Patients can self refer ONLY to the UCC; there would be no direct access to the PAU and patients assessed to require paediatric assessment would be referred via the UCC
3. Children referred by GPs would be referred directly to the PAU

Diagrams setting out the *Healthcare for London* model for when services should be available and indicative models for both adults and children are set out at appendix 1

Care in a community setting

6.10 Alongside different ways of care working in a hospital setting there will be some changes to the way that care works in a community setting. The *Healthcare for London* model is based on patients having greater access to urgent care within a community setting alongside Urgent Care Centres. This will come in part through the GP led-heath centres, which will see registered and unregistered patients, and also from existing GP services increasing access to their services by extending their opening hours.

6.11 Coupled with increased access to primary care is a presumption that community services, including social services, need to be able to offer a much more immediate response to enable packages of care to be put in place very quickly to help patients stay at home, rather than being admitted to hospital, including outside normal office hours. For this to work GPs will need to look at how quickly they are able to manage day-time emergencies.

6.12 There is also a place in the new model of working for other health professionals, particularly pharmacists, to take on a much more extended role and provide treatment advice to patients with primary care needs earlier and helping them to avoid needing to see a GP either at their own practice, a GP led-health centre, or the UCC.

6.13 These changes will mean that over time, the default option for patients who assess their needs as urgent will not necessarily be a hospital setting, although this will still be an option. The access offered at an UCC will be complemented by a network of more community based options that will be able to offer the same standards of access, nearer to patients' homes. For vulnerable patients, many with long term conditions (the Ambulatory Care Sensitive Conditions that we talked about earlier) there will be a different kind of response within a community setting which will be able to rapidly assess their needs and if they are well enough, care for them at home, rather that being admitted to a hospital bed.

The main changes that will need to happen to make this work

6.14 The next few sections go through the changes highlighted in the *Healthcare for London* document and what they would mean in an Islington context. Underpinning all of the changes is a fundamental shift from the delivery of urgent care being managed and led by hospitals, to urgent care being led and shaped by PCTs from a community perspective.

Change 1, Healthcare for London:
Community provision needs to expand to increase delivery of pre-emptive care (especially for older people, people with long-term conditions and home support), through integrated multi-disciplinary (health and social) care teams working across organisational boundaries.

Recommendations 1: Community Provision

This change accords with the findings from the Islington stakeholder day in June, where increased responsive community care was cited as a big gap for Islington. Specifically we will:

We know that in Islington many people are admitted to hospital for conditions that could be cared for in a community setting, if services were organised differently (see the ambulatory care sensitive conditions). We think that this is because services are not organised in a way that enables GPs and other community clinicians a rapid response to assess a person's needs and organise an appropriate package of care, either at home or perhaps in a short-term bed in a care home.

First, we want to explore the feasibility of establishing a rapid response community team to operate outside working hours, this will be integrated with social services with a particular focus on vulnerable groups like the elderly. This will enable GPs and other community health professionals to get a quick response – in and out of hours – to make a decision about how to best care for a patient's needs and to quickly organise care for those needs through one professional who will coordinate with all of the other care agencies, including social services. Subject to a costed business case we will go out to tender for the service.

Second, community care needs to be organised and managed differently to enable patients who might have been admitted to hospital a level of support and nursing care for them to be able to be cared for at home with some conditions. We will explore the feasibility of establishing a 'hospital at home' model of care in Islington to provide intensive packages of support for patient to be cared for safely at home rather than being admitted to hospital if that is clinically appropriate. Subject to a costed business case we will go out to tender for the service.

We will also:

- Look at business process redesign work within Primary Care to establish new models of dealing with in-hours urgent cases within practices; a second phase may be to establish a bespoke home visiting team;
- Ensure rapid and appropriate primary care referrals to intermediate care beds;
- Review current arrangements and secure alternative models as required for specialist medical input within a community setting; and
- Work with the Whittington and UCLH, to give GPs rapid on-the-day access to outpatient appointments, including diagnostics and imaging.

For patients this will mean improved access to community support. Enabling patients to be

rapidly assessed and cared for in their own home, or community setting, rather than being admitted to a hospital bed.

Change 2, Healthcare for London
Acute assessment services should be developed to ensure prompt access to enhanced assessment and decision-making skills and to prevent admission or facilitate early discharge wherever possible. This needs to be supported by 24/7 access to diagnostics. The needs of older people and children require a particular focus.

Recommendation 2: Enhanced assessment and decision-making skills

The Islington stakeholder group agreed that the implementation of the new model was dependent on the quality of clinical decision-making skills. Specifically we will:

- Be very specific about the levels of seniority and skill-set of clinicians dealing with cases through the UCC and any other tendered component of the service;
- Ensure service specifications make clear the need for service providers to work together and share education and training expertise. This will need to link with work that is already underway developing skills within primary care;
- Encourage providers to work together to provide integrated care pathways.

For patients this will mean that they should have confidence about the skill set of clinicians managing their care, and be accessing care at a place which is appropriate to their level of need and the complexity of their case. There are skills shortages and developing different skill sets, particularly within a primary care setting, will take time and we need to be realistic as well as ambitious.

Change 3, Healthcare for London
M*ore capacity is required in primary care services and there needs to be greater support for people to self care.*

Recommendation 3: Primary Care Services

The group of Islington stakeholders agreed with this assessment. This does not mean that we need additional numbers of GP surgeries but that we need to increase the expertise and provision within a primary and community setting. This is mainly cover through Recommendation 1. We would also look to:

- Commission additional analysis to look at the reasons behind repeat attendances at GPs and A&E. Use this analysis to plan and rollout a social marketing campaign – by which we mean a focus on health prevention messages, early detection, encouraging knowledge and understanding of signs and symptoms, plus a focus on GP registration – to change patterns of use and help to embed knowledge about how to access services when the need is perceived as urgent; and
- Link the social marketing campaign with NHS Islington's self-care agenda, particularly around Long Term Conditions, through the Expert Patient Programme to understand patient behaviour and ensure that services are designed around patients' needs. This will help patients to feel confident and reassured when seeking care.

For patients this will mean two things: first at the points where they access services, particularly

the UCC, those services will be designed to be appropriate to their levels of need. Second, NHS Islington will work with patients to make sure that they understand where and how to access the services that are appropriate to their needs, to reduce duplication and confusion.

Change 4, Healthcare for London
Primary care led Urgent Care Centres (UCCs) should be established to deal with urgent undifferentiated caseload; An UCC should be co-located with every A&E to meet need in the place of choice. UCCs in community settings are more likely to meet un-met demand (and increase costs) consequently development should be limited and based on an evaluation of need across the system; demand management protocols should be put in place.

Recommendation 4: Establishing Urgent Care Centres

The UCC is the pivot point of the Healthcare for London model, with the assumption that there will be an UCC on every hospital site that currently has a general A&E. These will be run by clinicians with primary care skills with clinical leadership from GPs. Islington is responsible for commissioning (or buying) care for its residents for all their healthcare needs. This means that we are responsible for making this change in Islington.

This strategy is recommending that NHS Islington should tender for an UCC on the Whittington hospital site, working with Haringey PCT to make sure that it meets the needs of its patients in West Haringey. The Whittington Hospital have been involved in the development of the strategy and have been very explicit that whilst they support the direct of travel in the urgent care strategy they do not agree with the principle of tendering for the UCC on the Whittington site.

NHS Islington will be mindful to ensure equity of access to Urgent Care Centres for all its residents and will work with other PCTs to ensure that UCCs are being commissioned at hospitals accessed by Islington residents, specifically UCLH, Barts and The London, Royal Free and Homerton hospitals.

It is anticipated that Camden as lead for UCLH will be responsible for a similar exercise with UCLH. NHS Islington will aspire to align timescales for the implantation of an UCC on the Whittington site with the rollout of similar initiatives at other local providers led by neighbouring PCTs in order to make the system as clear as possible and to minimise any confusion for patients.

We already know that a large number of patients go to A&E for their primary care needs. This change will mean that whichever hospital they attend they will be able to clinician with exactly the right skills appropriate to their needs 24/7

Change 5, Healthcare for London
Evaluation of newly commissioned capacity is required for unscheduled and scheduled care in primary care services and within routine weekday hours and extended hours. New ways of delivering care are needed and an increase in access points; this is recognised in developments already underway e.g. polyclinic proposals and GP led health centres - these should be supported and further expansion, or acceleration, may be needed.

Recommendation 5: Expanding capacity in primary care

Islington part way through a process of procuring a GP led health centre which will open by March 2010. Our approach for polyclinics will be included within the Primary and Community Services Strategy that is being developed; it is not expected to see a polyclinic open in Islington for another two to three years. This strategy and the Primary and Community Services strategy should be read as complementary documents. In particular the Primary and Community Services Strategy will set out:

- Exploring whether the UCC at the Whittington can form the centre of a different kind of network primary care in North Islington linked to the polyclinic model;
- Working with colleagues in Haringey PCT, to ensure that the models of care set up in north Islington meet the needs of the West Haringey GP population and their patients;
- Working with colleagues in Camden PCT, to input into their models of care around UCLH, to ensure that the models of care meet the needs of South Islington GPs and their patients; and
- Keeping under review whether additional GP led-health centres or alternative models of care need to be commissioned to meet patient needs in other parts of the borough to ensure equity of access to primary care led urgent care services.

For patients this will mean that the way there should be a greater alignment between the way that they access care for their urgent and more routine needs. All care should be able to take place closer to a patient's home and we will see an increased range of services available within the community, as well as further integration with social services to join up care.

Change 6, Healthcare for London
There needs to be faster and extended access to diagnostic tests and prompt (within 4 hours) return of results in and out of hospital settings and which are easily accessible to a wide range of primary care services. Access to diagnostics needs to be matched to related services; the aim should be to ensure access 24/7.

Recommendation 6: Expanding access to diagnostics

Access to diagnostics – like ultrasound, x-ray, pathology and echo, rather than CT or MRI scans – was seen by Islington stakeholders as being of vital importance in ensuring that the new model of care is able to work. To enable this to happen:

- Carry out an assessment of the diagnostics needed a within primary care setting, taking into account the need for diagnostic capacity as part of the development of any polyclinic model within the borough;
- NHS Islington will be working with local acute providers to offer rapid access (4-hour) direct access diagnostics and will invest in the infrastructure to enable this to happen;
- Rapid access direct access diagnostics will be extended to a range of other health professionals in a community setting, for example Community Matrons and Specialist Nurses; and
- NHS Islington will invest in further direct access diagnostic capacity in community and primary care settings and work with NHS London to improve the turn around times for the independent sector diagnostics service.

For patients this will mean that their GP, and other community based clinicians, will be able to make a rapid assessment of their care needs and put in place appropriate arrangements for their care either in their home, community setting or a hospital depending on the level of complexity.

Change 7, Healthcare for London
Pharmacies need to be firmly integrated into unscheduled care systems. Enhanced availability of dispensing facilities (potentially 24/7) is needed to improve access to prescription medicines. There should be wide roll out of the Minor Ailments Scheme, medicines management linked to admission prevention/discharge, plus self-care advice.

Recommendation 7: Minor Ailments Scheme

NHS Islington already has a Minor Ailments Scheme; however this is only available to patients who have already presented at their GP practice. As part of the Primary and Community Services Strategy NHS Islington will:

- Extend the scope and open up the access to the current Minor Ailments Scheme, this will involve additional investment;
- Ensure that pharmacists receive extra training and support in assessment skills to take on new and extended roles;
- Explore increasing the role of community pharmacists in the management of urgent presentations, building on the current CVD (Cardio Vascular Disease) case finding and ensuring extended opening times and access; and
- Through the Primary and Community Services Strategy look at the availability of medicines 24/7 and whether different access arrangements are needed.

By using community pharmacies in this extended way, patients will have an additional access point for treatment advice and support for needs that they identify as urgent.

Change 8, Healthcare for London
Primary care access/GP registration function (or direct access to it) is required at every access point to steer the non-registered population to universal primary care services.

Recommendation 8: GP registration

A GP registration officer is already in place at the Whittington and this model works well. As well as providing easily accessible care to all patients wherever they present NHS Islington also needs to make it easier for patients to register with a GP. In order to take this forward, NHS Islington will:

- Work with neighbouring PCTs, like Camden for UCLH, around the establishment of their UCCs – to ensure that GP registration is embedded in the model of care; and
- As part of the Primary & Community Care Strategy look at whether it is possible to simplify the GP registration process and link with national work that is being undertaken in this area.

For patients this will mean that it should be easier to register for a GP, in addition to being able to access care at other points in the system.

Change 9, Healthcare for London
Greater integration and consistency is needed to bring primary, secondary and social care processes and working arrangements closer together; challenges that will need to be addressed include working across boundaries, effectiveness and compatibility of IT systems and funding mechanisms; there should be an integrated approach to training and education, including staff rotations between access points.

Recommendation 9: Integration

Islington already has a high level of integration between health and social care. The steps set out in this strategy should further enhance this integration. The need for joint-working will need to be a key component of any tender specifications for new services, as will expectations around joint-approaches to training and education. Adult social care already plays a part in urgent care through the rapid response teams that are situated within A&E, this will continue in the new model with rapid response available in both the UCC and A&E and a focus on integrated pathways of care.

Change 10, Healthcare for London
A whole system and extended service model must include mental health, substance misuse and maternity care and be more responsive to the needs of vulnerable people e.g. with disabilities and complex needs.

Recommendation 10: A whole system approach

The specific needs to vulnerable groups will need to be specified within any tender documentation for new services. In addition the Islington stakeholder group felt that two specific issues that would need to be addressed are:

- Care pathways for adolescents particularly those presenting who self-harm and people with drugs and alcohol dependencies; and
- Working with Camden around pathways for mental health service users at UCLH.

The Steering Group set up to contribute to the development of this strategy added two important recommendations in addition to those taken directly from the *Healthcare for London* model.

Recommendation 11: Financial modelling.

Following consultation and before implementation further detailed work is required to ensure that the model is underpinned by a robust financial assessment. This will involve:

- Developing a detailed business case for an Urgent Care Centre, this would need to model changes to financial flows within the system as highly specialised work around major trauma or stroke moves to specialist centres funded outside of the tariff; and
- Carrying out a feasibility studies for both a hospital at home and rapid response community team and subject to a costed business case go out to tender. This will need to model how funding might over time move from a hospital to a community setting in order to support patients' being cared for at home but also the step-change in the quality of care set expected from the new model of care set out in the strategy.

Recommendation 12: Monitoring, information and implementation.

The changes proposed at a high-level in this document will make a fundamental shift in the way that patients who need to see a doctor or nurse immediately, or perceive their need to be urgent, are treated. In order to make these changes the Islington stakeholder group recommended that:

- Work is undertaken to ensure that the new models of care are underpinned by very strong information and management support, and if initiatives to integrate and ensure compatibility of systems across NHS providers, health and social care;
- Pilots are going to take place across London of a single telephone number to access urgent care services, so that 999 is reserved for emergencies. Work is also going on locally in Islington by the council to look at a single point of telephone access for social services. Both of these initiatives will need to be evaluated with a view to extending over time to the new model of care in Islington set out in this document;
- Working with colleagues in public health, the models of care set out in this document will need to be evaluated over time, to ensure that they are meeting their objectives, and as part of adding to the national evidence and literature base about models of urgent care.

7 What is change dependent upon?

7.1 This section sets out the significant factors on which change is dependent, and which will determine the success of this strategy.

7.2 NHS Islington has agreed a market management and procurement strategy in line with the Department of Health's new guidance on competition and co-operation in the NHS, which requires commissioning organizations to hold an open tender when developing new services. The development of an Urgent Care Centre and many of the other developments envisaged within this strategy, are of sufficient value to trigger this requirement and NHS Islington is of the view that an open tender is the best way to secure a quality service that is value for money. NHS Islington will need to follow the Department of Health procurement rules when procuring these services. It will also be looking to ensure that the new services it procures are of a high quality, cost effective and build on the care pathways that already exist and work that has already been undertaken.

7.3 Delivering this strategy is built upon the need to understand why patients make the choices that they currently do and to design services that will over time impact on their behaviour. The models described need to be realistic about the degree of change that is possible – supported through social marketing and patient education – and creating a model that works around patient behaviour rather than trying to change it completely. As the money will follow the patient the new models need to be flexible enough to shift with actual as well as envisaged patterns of use.

7.4 A big determinant of this strategy is the successful rollout of the *Healthcare for London* strategy including successful implementation of big changes for more complex conditions, particularly stroke and major trauma work. The five PCTs in North Central London (Barnet, Enfield, Haringey, Camden and Islington) are in the process of establishing an acute agency to manage all acute commissioning and deliver on these big areas of service redesign. The successful implementation of this agency will be crucial.

7.5 Two other dependencies which will affect the strategy are first the successful implementation of the Primary and Community Services Strategy which will be completed in early 2009 and go out for consultation. The two strategies are complementary documents and integral to each other's success. Second, is the need for other neighbouring PCTs to pick up the Healthcare for London model and run with it in their local area, as this will be one of the determinants in establishing equity of access for Islington residents. The rollout of the Primary and Community Services Strategy will need to be flexible enough to compensate for any differential rollout by neighbouring PCTs, and by over time compensating by looking at where to site additional capacity within Islington, for example additional GP led health centres.

7.6 The Islington stakeholder group identified as one of their strategic aims 'better coordination overall with a single patient record shared across the health system with links as appropriate to social care'. It is undoubtedly true that improving information management and connectivity between providers would vastly improve the ability of organisations to work together and improve integration. The key dependency here is the successful implantation of Connecting for Health, a series of IT systems and a single spine that enables information sharing in a structured and secure manner between acute services, primary care, NHS Direct and social services. It is acknowledged that slippage has occurred, although it is currently envisaged that Connecting for Health should be implemented within in the lifetime of this strategy.

7.7 This strategy is dependant on changes to the financial flows within the system. In order to implement the Healthcare for London models of care, there will need to be new tariff structures for care in Urgent Care Centres at one end of the spectrum and the specialised trauma and stroke work at the other.

7.8 Finally, NHS Islington will over the next few years be looking at the future configuration of GP out-of-hours services. This is subject to a separate process and as part of this NHS Islington will want to look at the longer term alignment of out-of-hours services and how this would fit with the model of care described in this strategy.

8 What will happen when?

8.1 If Islington is to implement the model of care described in this strategy a number of changes will be required to current local services.

8.2 The strategic proposals for change outlined below will be implemented in a phased way between now and 2012/13.

Proposals for Change	**Timetable for Implementation**				
	2008 - 2009	**2009 - 2010**	**2010 - 2011**	**2011 - 2012**	**2012 -2013**
Governance					
Establish an Urgent Care Steering Group to manage and co-ordinate care across Islington					
Recommendation 1:					
1. Explore the feasibility of establishing a rapid response community team to operate outside working hours, this will be integrated with social services with a particular focus on vulnerable groups and subject to a costed business case go out to tender;					
2. Explore the feasibility of establishing a 'hospital at home' model of care in Islington, and subject to a costed business case go out to tender;					
3. Looking at business process redesign work within Primary Care to establish new models of dealing with in-hours urgent cases within practices; a second phase may be to establish a bespoke home visiting team					
4. Ensure rapid primary care access to intermediate care beds					
5. Review current arrangements and secure alternative models as required for specialist medical input within a community setting					
6. Work with the Whittington and UCLH, to give GPs rapid on-the-day access to outpatient appointments, including diagnostics and imaging					
Recommendation 2:					
7. Be very specific about the levels of seniority and skill-set of clinicians dealing with cases through the UCC and any other tendered component of the service					
8. Ensure service specifications make clear the need for service providers to work together and share education and training expertise. This will need to link with work that is already underway looking underway developing skills within primary care					
9. Encourage providers to work together to provide integrated care pathways.					

Recommendation 3:					
10. Commission additional analysis to look at the reasons behind repeat attendances at GPs and A&E. Use this analysis to plan and rollout a social marketing campaign – by which we mean a focus on health prevention messages, early detection, encouraging knowledge and understanding of signs and symptoms, plus a focus on GP registration – to change patterns of use and help to embed knowledge about how to access services when the need is perceived as urgent					
11. Link the social marketing campaign with NHS Islington's self-care agenda, particularly around Long Term Conditions, through the Expert Patient Programme to understand patient behaviour and ensure that services are designed around patients' needs. This will help patients to feel confident and reassured when seeking care.					
Recommendation 4:					
12. NHS Islington will tender for an UCC on the Whittington hospital site, working with Haringey PCT to make sure that it meets the needs of its patients in West Haringey					
13. NHS Islington will be mindful to ensure equity of access to Urgent Care Centres for all its residents and will work with other PCTs to ensure that UCCs are being commissioned at hospitals accessed by Islington residents, specifically UCLH Barts and The London, Royal Free and Homerton hospitals					
14. The unit cost for care provided at Urgent Care Centres will be less than the lowest band tariff for A&E attendances and neighbouring PCTs will be cross-charged for activity relating to their patients and residents					
Recommendation 5					
15. Exploring whether the UCC at the Whittington can form the centre of a different kind of network primary care in North Islington linked to the polyclinic model					
16. Working with colleagues in Haringey PCT, to ensure that the models of care set up in north Islington meet the needs of the West Haringey GP population and their patients					
17. Working with colleagues in Camden PCT, to input into their models of care around UCLH, to ensure that the models of care meet the needs of South Islington GPs and their patients					
18. Keep under review whether additional GP led-health centres or alternative models of care need to be commissioned to meet patient needs in other parts of the borough to ensure equity of access to primary					

care led urgent care services					
Recommendation 6:					
19. Carry out an assessment of the diagnostics needed a within primary care setting, taking into account the need for diagnostic capacity as part of the development of any polyclinic model within the borough					
20. NHS Islington will work with local acute providers to offer rapid access (4-hour) direct access diagnostics and it will invest in the infrastructure to enable this to happen					
21. Rapid access direct access diagnostics will be extended to a range of other health professionals in a community setting, for example Community Matrons and Specialist Nurses					
22. NHS Islington will invest in further direct access diagnostic capacity in community and primary care settings through the existing Independent Sector providers and work with NHS London to improve the turn around times for this service					
Recommendation 7:					
23. Extend the scope and open up the access to the current Minor Ailments Scheme, this will involve additional investment					
24. Ensure that pharmacists receive extra training and support in assessment skills to take on new and extended roles					
25. Explore increasing the role of community pharmacists in the management of urgent presentations, building on the current CVD case finding and ensuring extended opening times and access					
26. Through the Primary and Community Services Strategy look at the availability of medicines 24/7 and whether different access arrangements are needed					
Recommendation 8:					
27. Work with neighbouring PCTs, like Camden for UCLH, around the establishment of their UCCs – to ensure that GP registration is embedded in the model of care					
28. As part of the Primary & Community Care Strategy look at whether it is possible to simplify the GP registration process and link with national work that is being undertaken in this area					
Recommendation 9:					
29. The need for joint-working will need to be a key component of any tender specifications for new services, as will expectations around joint-approaches to training and education					

Recommendation 10:					
30. Care pathways for adolescents particularly those presenting who self-harm and people with drugs and alcohol dependencies					
31. Working with Camden around pathways for mental health service users at UCLH					
Recommendation 11:					
32. Developing a detailed business case for an Urgent Care Centre, this would need to model changes to financial flows within the system as highly specialised work around major trauma or stroke moves to specialist centres funded outside of the tariff and the impact of activity remaining at A&E funded at tariff					
33. Carrying out a feasibility studies for both a hospital at home and rapid response community team and subject to a costed business case go out to tender. This will need to model how funding might over time move from a hospital to a community setting in order to support patients' being cared for at home but also the step-change in the quality of care set expected from the new model of care set out in the strategy.					
Recommendation 12:					
34. Work is undertaken to ensure that the new models of care are underpinned by very strong information and management support, and if initiatives to integrate and ensure compatibility of systems across NHS providers, health and social care					
35. Pilots are going to take place across London of a single telephone number to access urgent care services, so that 999 is reserved for emergencies. Work is also going on locally in Islington by the council to look at a single point of telephone access for social services. Both of these initiatives will need to be evaluated with a view to extending over time to the new model of care in Islington set out in this document;					
36. Working with colleagues in public health, the models of care set out in this document will need to be evaluated over time, to ensure that they are meeting their objectives, and as part of adding to the national evidence and literature base about models of urgent care.					

9 How will these changes be managed?

9.1 NHS Islington will establish a small steering group that will meet, under the leadership of the Director of Strategy & Commissioning, to ensure that there is stakeholder engagement in the process going forward. Care will need to be taken to manage any potential conflicts of interest during the tendering process.

9.2 Delivery of the strategy will be managed through Strategy & Commissioning; some additional project management resource will be required to support the tendering process and this will come out of the additional investment that has been secured.

10 Resource implications

10.1 NHS Islington currently spends an estimated £11.30 million on services commonly associated with urgent care covering: A&E, the London Ambulance Service, GP out of hours, urgent care dentistry and the minor ailments scheme.

10.2 Additionally, it spends a further £26 million annually on emergency admissions to hospitals; some of which could be avoided if supported by the improved organisation and delivery of primary and community care. This cost excludes that for district and community nursing teams who provide a range of responses in the management of patient with a long term condition who are at risk of an exacerbation, and potentially could avoid admission to hospital.

10.3 It is recognised by NHS Islington that improvements in care will require not only efficiencies and the reorganisation of resources within current services, including district and community nursing, but additional investment that the Board is committed to providing. As part of NHS Islington's investment plans it has been recognised that additional funding will be required to support these changes in 2008/09 and 2009/10. The exact requirements will be presented within financial modelling to be calculated alongside the finalisation of the Strategy, which will incorporate any modifications required following consultation.

10.3 As well as investing additional money into the service NHS Islington, as part of the financial modelling there will be a review all current urgent care spend in its widest sense against the objectives set out in this strategy to make sure that they fit and will reprioritise spending where it is not felt to meet our strategic aims.

Urgent Care Service	Provider	Cost of service 2007/08
Minor Ailment Scheme	Local Pharmacists	£91,000
Primary Care Out of Hours	CAMIDOC	£1,100,000
Urgent Care Dentistry	CAMIDOC & Local Dentistry	£21,500
Ambulance Services	London Ambulance Service	£5,799,682
Accident and Emergency	The Whittington Hospital NHS Trust	£2,880,000*
	University College London Hospitals NHS Foundation Trust	£1,407,000*
	Sub-Total	**£11,299,182**
Emergency Admissions	The Whittington Hospital NHS Trust	£12,739,676
	University College London Hospitals NHS Foundation Trust	£8,449,149
	Royal Free Hampstead NHS Trust	£1,655,829
	Barts And The London NHS Trust	£1,102,926
	Homerton University Hospital NHS Foundation Trust	£1,020,677
	Other Trusts	£1,952,711
	Total	£38,220,150

* Accident and Emergency costs are based on the 2008/09 plan, because of changes in the de-hosting of A&E in London.

11 Next Steps

11.1 The Strategy went to the Finance and Commissioning Sub-Committee of the Board on 16 September and the Board meeting on 25 September and was approved to go forward for public consultation, subject to comments and input from the Urgent Care Steering Group at the end of September.

11.2 The consultation will start on Monday 5 January 2009 and stakeholders and the public are invited to comment on the standards, model and outcomes proposed, with a closing date for comment of Monday 30 March 2009.

11.3 The final strategy with any modifications following consultation will be recommended to the NHS Islington Board for approval.

11.4 If you have any comments or suggestions to make regard this strategy please contact the following:

Anna Stewart
Deputy Director Strategy & Commissioning
Urgent Care Consultation
NHS Islington
338-346 Goswell Road
London EC1V 7LQ

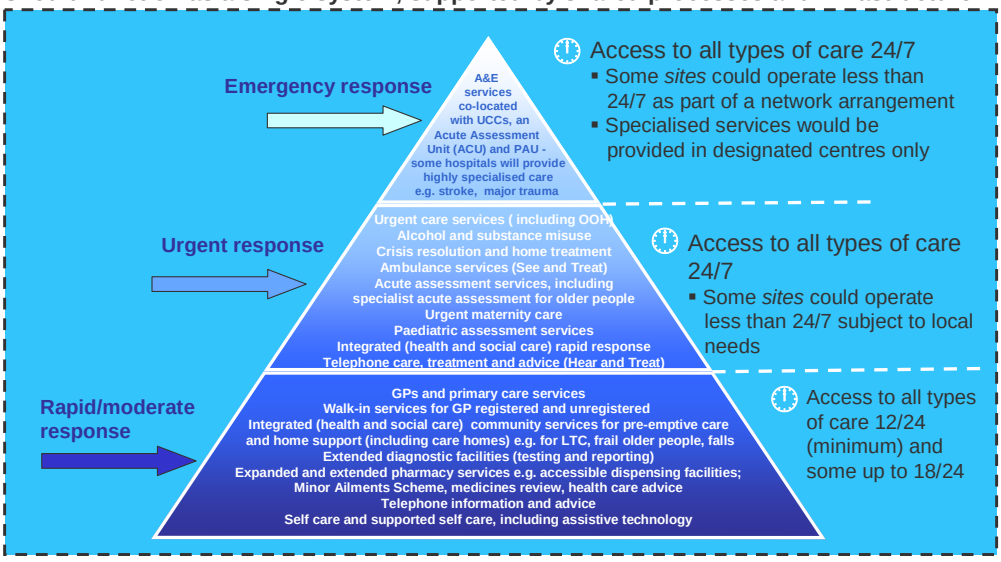
Email: nikki.bozdogan@islingtonpct.nhs.uk

Or comment via the PCT website
www.islington.nhs.uk

Appendix1: Healthcare for London models of care

When services should be available

Most services, as now, would be community based. Regardless of location, they should function as a single system, supported by shared processes and infrastructure

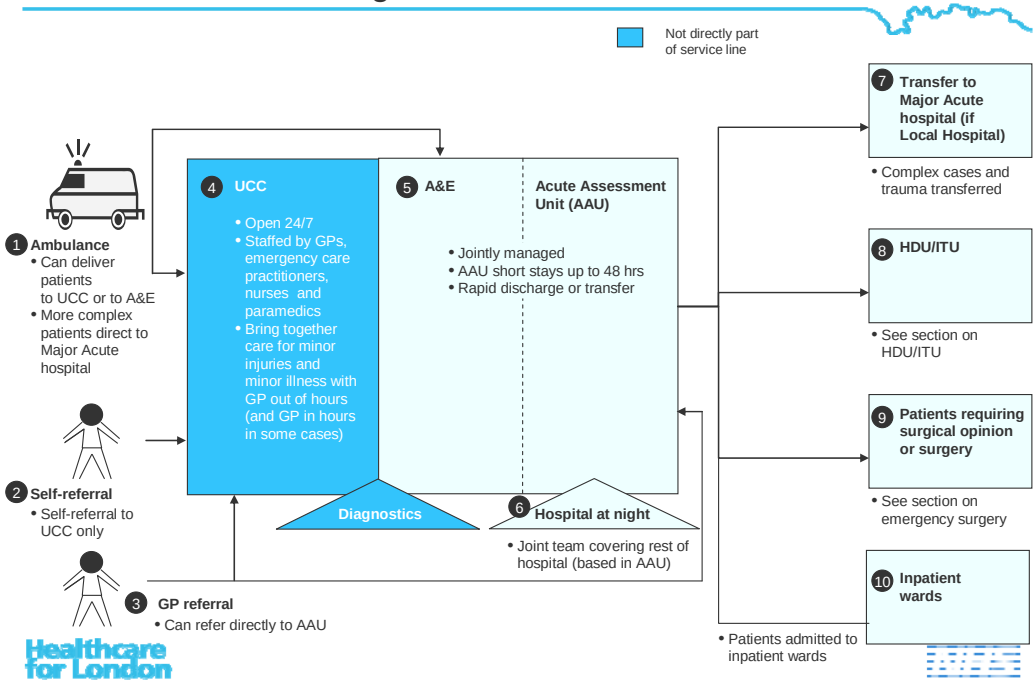


Healthcare for London

15

A&E, UCC, AAU

Indicative Model for Urgent Care and Acute Assessment



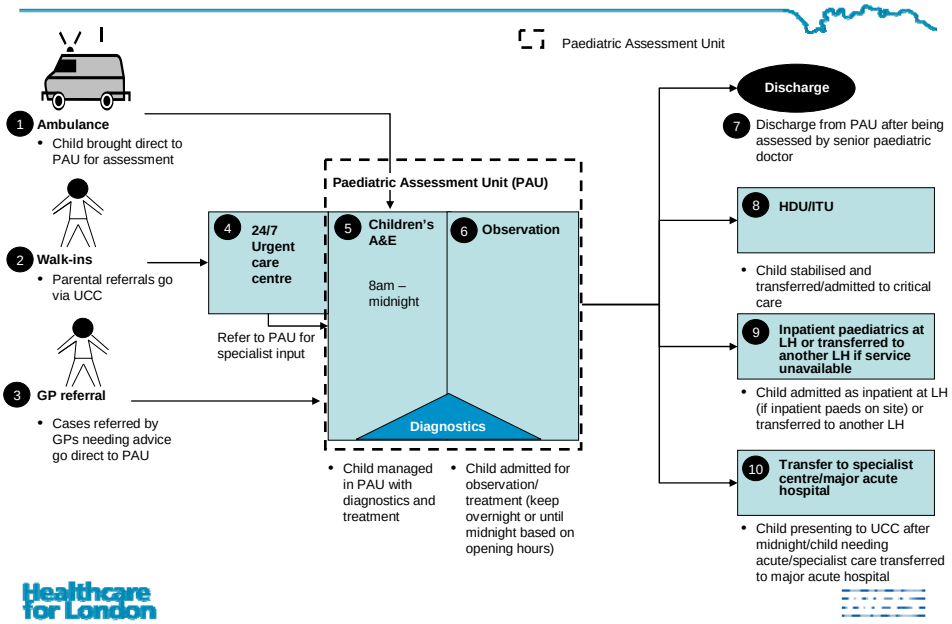
Healthcare for London

Source: Indicative model developed for discussion as part of the Local Hospital Feasibility Project

20

UCC, PAU

Indicative model for Paediatric Assessment



Source: Indicative model developed for discussion as part of the Local Hospital Feasibility Project

Appendix 2: Glossary

Acute Assessment Unit	Short stay ward adjacent to the A&E where patients seen in the A&E who need to stay for a short time for observation or tests can be admitted
Acute Stroke	The first stages of stroke care where patients need hospital treatment rather than rehabilitation
A&E	Accident and Emergency (department of a hospital), used to be called casualty
Ambulatory care sensitive (ACS) conditions	Are long-term health conditions that can often be managed with timely and effective treatment without hospitalisation, for instance COPD or influenza
BME	Black and Minority Ethnic communities
Commissioning	Buying, purchasing or contracting for healthcare services
Community provision	Care outside a hospital setting, normally provided in Islington by the NHS Islington provider-arm e.g. district nursing or specialist nursing services
COPD	Chronic Obstructive Pulmonary Disease, what used to be called emphysema
CVD	Cardio Vascular Disease
Expert Patient Programme	Scheme to help patients feel confident to manage their own conditions and symptoms more proactively
Healthcare Commission	Government body that inspects and regulates healthcare services
Healthcare for London (HfL)	Programme of work looking at making significant changes to the way that healthcare is organised in the capital, based on the recommendations from Prof Lord Ara Darzi
Hospital at home	Service in the community to provide intensive packages of support for patient to be cared for safely at home rather than being admitted to hospital if that is clinically appropriate.
In-hours / out-of-hours	Care taking place during the normal working day or out-side of office hours (for GP out of hours this is normally after 6pm and before 8am)
Major trauma	Serious or life threatening injures e.g. those sustained in a major road traffic accident
Minor Ailments Scheme	Schemes for pharmacists to see and give advice and medication to patients with minor illnesses without them needing to see a doctor
NHS Islington	The operating name of Islington Primary Care Trust
PCT	Primary Care Trust
Polyclinic	Model of primary care set out in Healthcare for London, the Islington approach will be set out in the Primary and Community Services Strategy
Right Care: Right Place	Service set up by the Whittington and NHS Islington to redirect patients to alternative provision in the community and to ensure that patients with primary care needs attending A&E are registered with a local doctor
Social Services / Social Care	Services provided by local authorities, generally meeting the social care rather than health care needs of the local population
Social marketing	Focus on health prevention messages, early detection, encouraging knowledge and understanding of signs and

	symptoms, plus a focus on GP registration
Tender	Process by which organisations interested in providing a service, set out their proposals and NHS Islington as a commissioner (purchaser) of services considers all the proposals against published criteria and chooses one that will carry out the service for a contracted period of time.
Urgent Care Centre	Facility right next door to the A&E but physically separated from it. The UCC will see both adults and children and will be staffed by people with primary care skills, primarily GPs and nurses working with adult social care. This will be the place where patients will be able to self-refer at any time of the day or night, 24/7. Patients will be able to receive care, as quickly, if not more quickly than in A&E.
Urgent care	Care, excluding planned care, which the patient seeks access to on the same day that the patient perceives it is needed.
Walk in Centre / Minor Injuries Units	Services that offer walk-in services (ie no appointment is needed) for minor or primary care type illness and injuries. They are unable to care for patients with serious illnesses who would need to go to an A&E.

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NHS Islington is the operating name of Islington Primary Care Trust (PCT)