

Urgent Care in General Practice



How can PBC and PCT commissioners support change in general practice?

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Primary Care Commissioning



URGENT CARE

Supporting Change in General Practice

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About Luton

- 187,000 population
- Relatively young population
- BUT . . . older population growing
- Very high birth rate
- Large numbers of low birth weight babies
- Low life expectancy compared with rest of region
- Very high demand for services



Luton continued

- Population relatively unhealthy
- High premature death rates from stroke, heart disease and smoking
- Significant deprivation
- Childhood poverty is an issue
- Childhood obesity is an issue
- Ethnic mix : 72% white, 18.3% asian, 6.3% black/African Caribbean, 0.9% chinese



Practice Based Commissioning in Luton

- Two PBC groups
- Luton Healthcare Collaborative the smallest group
- 12 practices covering 68,000 population
- Varying degree of commitment
- 4 single handed practices
- More than 90% of care delivered at one local hospital
- 100% fair shares PBC budgets
- Both PBC groups work together
- Just moving to consider providing services as well as commissioning



Snapshot of Urgent Care last winter

- Serious emergency care pressures at local hospital
- 4 hour A & E wait target breaches
- Large & sustained increase in emergency admissions (highest levels in region)
- Above average admissions for ambulatory care sensitive conditions (Luton an outlier)
- Large overspends in emergency admissions budgets
- Large (unexplained) variations between practices for emergency admissions



Snapshot continued

- Serious concerns in local health community
- Review undertaken in 2008 identified 35% of admissions did not justify acute admission
- Also showed that peak for admissions was around 12 noon and from 5pm to 8pm
- At the same time, the current OOH contract was up for renewal



Local Decision

- Agreed we needed to sort this out . . and fast!
- Weekly operational urgent care meetings with all relevant organisations
- Work to be undertaken at all levels
- System-wide contingency planning needed
- Luton & South Beds PBC actively involved



Secondary Care Response

- Director appointed (joint appointment)
- Identified weaknesses in discharge planning and in whole system contingency planning
- Several changes made :
 - Active discharge management
 - Use of MFD date
 - Senior medical reviews daily
 - Speeding up diagnostics and drugs to take out
 - Developing 'hot' outpatient clinics



Primary Care Response

- PBC and PCT worked together building on work done in South Beds
- Primary Care Foundation engaged to undertake individual practice visits asking the basic questions :
 - Can patients get through on the phone?
 - Is there capacity to see them?
 - Will the small number of potentially urgent cases be spotted?
 - Will they be seen with the necessary urgency?



What was Found

- About 66% of practices had insufficient telephone capacity
- Around 55% of practices did not have enough appointments relative to list size
- About 60% of practices out of balance for same day and advance appointments
- Only about 20% of practices offer formal booked telephone consultations
- Only about 10% of practices assess the need for a home visit within 20 minutes



What We Did

- Held a Luton-wide workshop to discuss
- Good engagement from practices
- Outcome :
 - Practices wanted PBC groups to set local standards
 - Practices wanted detailed practice level information
 - Solutions need to be tailor-made (one size does not fit all)
 - Smaller practices may need support to deliver



What We Did Next

- Negotiated with the PCT to incentivise practices to focus on urgent care via the PBC LES :
 - Practice level action planning and reporting on outcome of PCF report
 - Review their A & E attendances
 - Reduce their ACS emergency admissions
 - Focus on ‘frequent flyers’
- Programme of individual practice visits



What We Did Next continued

- Developed local standards based on the PCF national report
- 9 Recommendations :
 - Calls should be answered within 30 seconds
 - Review number of appointments available based on own consultation rate (?)
 - Offer a balance of 66% advance and 34% same day
 - Consider telephone consultations
 - Plan for peaks in demand
 - Develop a script and train staff and review every 6 months
 - Clinical assessment within 30 minutes
 - Home visit to be carried out within one hour
 - Support for smaller practices around home visits (?)



Procurement

- Working with PCT to support urgent care review
- Tender for new OOH/urgent care service from October (to start in April 2010)
- Early days – but general agreement that we need a new model of care
- Existing model has not worked well
- PBC considering a social enterprise model to offer aGP-led integrated primary care front end (Hertfordshire model)



What we haven't cracked

- A & E demand – still very high, particularly on Mondays
- High levels of emergency admissions, particularly at weekends
- Practices have no idea of their own consultation rates but believe they are higher than the national average
- Balance of demand to capacity at ward level
- What practices can do to support winter planning
- The issue of home visits in smaller practices
- How to keep this high profile at practice level



Where we are now

- Our highest ACS costs are for COPD & ENT
- Plans to commission local services for the above
- Midway through practice visits
- Practices reviewing A & E attendances & ACS conditions at patient level – early days
- One practice has developed patient letter when A & E is being used inappropriately
- Emergency admissions overperformance at Month 1!
- Hospital looking to appoint a GP to work in A & E from 2pm to 8pm in the short term



Over to You

- Questions?
- Table Discussion :
 - What do you think about our local standards?
 - How could we improve what we're doing?
 - Any ideas about the areas we haven't managed to crack?
 - What happens in your area?



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