MIDDLESBROUGH COUNCIL

AGENDA ITEM 7

SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

10 JUNE 2015

DEVELOPING LOCAL URGENT CARE SERVICES
Making Health Simple
Purpose of Meeting

PURPOSE OF THE REPORT

1. To present the committee with an outline of the meeting, present additional information as requested by the committee and introduce a number of representatives who will be in attendance to provide information for the committee's questions.

BACKGROUND

2. As members of the Committee will recall the South Tees Clinical Commissioning Group's (CCG) consultation on the development of urgent care services took place between 11 January and 1 April.

3. This meeting has been arranged to give Members the opportunity to ask any final questions with regard to the review and in the next agenda item, receive information from the South Tees CCG on the results of the public consultation.

Next Steps

4. The Committee can then make comments/recommendations on the proposals and respond in writing to the CCG. Should there be any disagreement on the recommendations, both the CCG and the Committee should take steps are as reasonably practicable to try and reach agreement. Local authorities can refer proposals for substantial developments or variations to the Secretary of State in certain circumstances.

5. When responding, the Committee has the power to make comments on the proposals. The Committee can make recommendations and, in certain circumstances, may refer proposals to the Secretary of State in certain circumstances

   - If it is not satisfied with the adequacy of the content of the consultation.

- If it is not satisfied that sufficient time has been allowed for consultation: or if it considers that the proposals would not be in the interests of the health service in its area.
- If it has not been consulted and it is not satisfied that the reasons given for not carrying out consultation are adequate.

6. A response from the committee to the South Tees Clinical Commissioning Group is required by **24 June**. The proposals will be submitted to the CCG's Governing Body on 1 July for formal approval.

7. Further to my email to the panel on 11 April, I have attached the questions which were prepared for the CCG to ensure that the information the committee required would be presented to this meeting .The questions can be found at **Appendix 1, a response to the questions form the CCG can be found at Appendix 2.**

8. At the last meeting on 7 March, Members sought further information on examples of GPs located within A&E departments. Whilst there is a limited overview of evidence around the success of GPs being located in A&E departments, attached at **Appendix 3** is information taken from the CCG and additional information found through a desk top review.

9. The Committee were interested in finding out more information about A&E attendances over time, including from the introduction of the walk in centres. This information has been provided by the CCG and is attached at **Appendix 4.**

10. The CCG have also commissioned a separate travel plan to help them understand more about the access to the potential buildings. The CCG have also provided a list of criteria for determining appropriate estates from which to deliver the GP extended hours centres (which is attached at **Appendix 5** for information.

IN ATTENDANCE

11. The following representatives will be in attendance at the meeting.
    - Julie Stevens, Commissioning and Delivery Manager, South Tees Clinical Commissioning Group
    - Craig Blair, Associate Director of Commissioning, Delivery and Operations, South Tees Clinical Commissioning Group
    - Simon Clayton, NHS North of England Commissioning Support
    - Andrew Robinson, NHS North of England Commissioning Support

RECOMMENDATIONS

12. That the Committee responds to the consultation.

BACKGROUND PAPERS

No background papers were used in the preparation of this report

Contact Officer:
Elise Pout **-** Scrutiny Support Officer
Telephone: 01642 728302 (direct line)

Appendix 1

Urgent Care Services

Location	Does the location of the services, especially the GP extended hours, ensure equitable access across South Tees?
Accessibility	How accessible will the GP centres be in terms of location, car parking, and public transport?
	What work has been carried out to ensure that public transport will be accessible to the GP centres, especially in the early evening?
	If the option of a GP being located within James Cook Hospital's A&E Department is chosen, how accessible will that be for people across the South Tees area, where will people who arrive in cars park and will they be expected to pay?
Resources – Personnel	We know that there is a shortage of GPs both nationally and in the South Tees area. In the Tees area there are high levels of expected retirement and there are recruitment difficulties. The proposals are heavily reliant on there being enough GPs to meet the demand and to cover the proposed extended opening hours, what work has been carried out to ensure that there will be enough doctors and health care professionals (both now and in the future) to ensure that cover is provided as stated in the consultation documents?
	There is an expectation that as a result of the proposals more patients will attend A&E, can the committee be assured that clearly planned and alternative provision will be put in place to deal with the demand before the current walk in centres are closed?
	Given the recent breakdown of the management of Marske Medical Centre which resulted in emergency action by a group of GPs to maintain service at the Centre, how will this affect the ability of GPs to provide the additional services proposed?
	Given the pressures on a diminishing number of GPs to maintain their present service to patients and also move to provide the STAR system, how will the GPs be able to provide additional resources to man the front of A & E Dept. at James Cook Hospital?
Resources – Finance	There is no additional funding to accompany these proposals. Is there a danger that with some GP surgeries that are currently running at full capacity they will not be able to 'soak up' any further work?
	GP practices are free to run their own appointment systems, will all GP practices required to take part in the booking system proposed as part of the improvements to the 111 system?
	What plans are going to be put in place to ensure fully collaborative working between commissioners to ensure an integrated urgent care system, notably pharmacy provision, dental care and primary care?
	What plans are being put in place to promote self-management, sale care and empowering people to take responsibility for their health?

Appendix 3

Evidence regarding GPs located in A&E

1. The Royal College of Emergency Medicine alongside Urgent Health UK (a federation of Social Enterprise unscheduled Primary and Community Care) made the case for the immediate co-location of out-of-hours urgent and emergency primary care services with Accident and Emergency departments.

2. Recent research by the Royal College of Emergency Medicine has confirmed that around 15 to 20% of patients attending A&E departments could be more effectively treated by other healthcare professionals such as out-of-hours primary care practitioners, community pharmacists and mental health teams. They believed that those primary care skills should be brought in to A&E departments. They argued that after many years of trying to discourage people from attending A&E departments with less serious conditions have proved that 'diversion' schemes to be both costly and completely ineffective. Patients continue to come to a place that they know and trust. Therefore, they argued, that there should be provision of a service within A&E departments that matched the need of the patients who attended rather than constantly and unsuccessfully trying to change patients' behaviour at a time of personal crisis.

3. In a joint statement from the Royal College of Emergency Medicine and the Royal College of General Practitioners they stated that the colleges understood that the most cost-effective form of care was general practice and that investing in general practice services – in and out of hours – and making those services more integrated would alleviate pressures across the health services, including Emergency Departments.

4. In the NHS's 5 Year Forward View (5YFV) it outlined the benefits of having co-located urgent care/primary care services within emergency departments for the following reasons:

- They have a useful role in managing people with minor illnesses to avoid emergency department crowding and that it may only be appropriate to focus on treating less serious injuries
- Where there is a single co-located model of urgent/primary care models within an emergency department there should be shared governance and a single 'front-door'.

5. There are a number of models which in a Guide to Good Practice developed by the Emergency Care Intensive Support Team have been developed four models of how co-locating primary care into an emergency department could work, along with the associated advantages and disadvantages.

6. In 2015, over a four week period, a GP led triage service was put in place at the A&E department of St George's Hospital in South London. The hospital's A&E department is 'among the busiest in the world'. The aim was to re-direct 15 or more patients per day and often they ended up doing 25-30. This resulted in freeing up potentially 2-3 A&E doctors per day. Of those patients who were re-directed, 56% went to see their usual GP and 44% to out of hours GP services/other GP services/Dentist. All were

given a same day appointment, co-ordinated by an administrator with many booked in to see a GP within a few hours which is often sooner than they would have been seen by and A&E doctor.

7. The skillset of GPs is regarded as unique, they are able to see patients, take histories, understand their narratives and unify all of that to make a diagnosis within a very short space of time. Following the South London experience it was argued that if this service was rolled out across all A&Es it would fulfil a very important role. It would ease waiting times and provide patients with better care.

8. In the Netherlands, all patients have to see a GP before going to A&E and Monitor, the organisation that regulates health services in England, were carrying out reviews of acute service line models in other countries to help inform thinking. In the Netherlands, GPs are often the gatekeepers for emergency care. A&E attendances are about 120 a year per 1,000 people, compared with 278 in England. (Although to some extent the lower attendances could be driven by the financial incentives that patients face in the Dutch system).

9. A policy paper by the Royal College of Emergency Medicine in 2015 sets out thirteen recommendations to address profound pressures in urgent and emergency care services. There are two recommendations relating to having a GP at the front of house in A&E.

    - Every emergency department should have a co-located primary care out-of-hours facility. It is not appropriate for accident and emergency to be regarded as ‘anything and everything’ or for the emergency department to be ‘everyone’s default’. It is unreasonable to expect patients to determine whether their symptoms reflect serious illness or more minor conditions. Co-location enables patients to be streamed following a triage assessment.
    - Having senior decision-makers at the front door of the hospital should be normal practice. It is the most reliable way to deliver safe, effective and efficient care.

10. In March 2010 the Department of Health commissioned a Primary Care Foundation to carry out a study across England of the different models of primary care operating within or alongside emergency departments. Analysis found that

    - A GP working in the emergency department may result in lower admissions and less tests being undertaken.
    - Re-direct away from the emergency department has led to variable results regarding future attendances and the assessments of the safety of this intervention have also revealed variable results.
    - Educational interventions have not been shown to change attendance patterns.

11. The conclusion of the report is that there may be benefits of systems of joint working between primary and emergency care but at that moment in time there was no evidence base.

12. Haverstock Healthcare GP Federation, **Camden**, London have provided a GP surgery at the front door of the Royal Free hospital's A&E Department since 2009. An initial pilot revealed that walk-in patients did not need to be there, nor did they need to see a doctor. Following the pilot, a contract was negotiated by the federation to staff a two GP surgery within A&E from 10am-10pm, 7 days a week. The service is specifically designed to mirror a GP surgery and this has a powerful psychological effect as once seen in this environment, patients have the knowledge not to use A&E casually again.

13. In a report by the **Sheffield** Teaching Hospitals NHS Foundation Trust and the Sheffield General Practitioner Collaborative, it documented a triage pilot programme in March 2010. Unfortunately the scheme was not as successful as had been hoped. It had been anticipated that 80 patients per week could be triaged from the Emergency Department (ED) to general practice, but in reality the average sent per week was closer to 36. A number of factors contributed to this: the physical distance between the ED and the GP; the variance in the practice of triage nurses, the workload of the GP which led to the closure of the service at busy times and the perceived differences in the acceptance criteria between the ED and the GP for patients to be treated.

14. The initial pilot ran for 4 weeks. However there were difficulties in securing GPs to fill all of the shifts, particularly during the half term school holiday period which coincided with the last week of the pilot.

15. GP feedback noted that there were a proportion of the sessions where GPs felt under-utilised. The consistency of GP availability throughout the pilot was a concern and feedback regarding individual sessions was very subjective and dependent on the GP carrying out the role. The GP collaborative (GPC) feedback highlighted their concern for the availability of GPs from the outset.

16. The overall evaluation of the pilot gave the opportunity to evaluate the pool of patients flowing though the ED. Actual 'primary care' cases amounted to 19%. Communications between the GPC and the ED were improved. However it was difficult to correlate 4 hour target achievement with the presence of a GP in triage. However anecdotally, staff in the ED felt that patient flow was easier at weekends, when a GP was present.

17. From the Trust's perspective, it had been beneficial to have primary care input In the ED. The closer the provision the more effective it has been, and to that end any future plans would be best incorporating such a stream in or adjacent to the ED. The future success of any model of integration would be dependent on the availability of suitable primary care clinical staff.