

**MANCHESTER CITY COUNCIL
REPORT FOR INFORMATION**

Committee: Health and Well-Being Overview and Scrutiny Committee
Date: 8th January 2009
Subject: Urgent Care – Central Manchester
Report of: Commissioning Directorate – NHS Manchester

Purpose of report:

To inform the Committee of proposed developments to urgent care services in Central Manchester over the next three years.

Recommendations:

The Committee is asked to note the report.

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1. Background

NHS Manchester, in partnership with Manchester City Council and Central Manchester Practice Based Commissioning (PBC) Group, have undertaken a programme of work to draw up a system design and implementation plan for commissioning urgent care services in Central Manchester. KPMG has provided consultancy support to this programme. This was in response to a brief for external support issued by the PCT in June 2008.

Urgent care has been identified as one of the 10 priorities within the Commissioning Strategic Plan (CSP) and therefore this work forms an important context for both Central Manchester and the development of urgent care services across the city.

2. Introduction

Manchester was rated amongst the best performing areas for urgent care services in the recent Healthcare Commission Report 2008. However, there are still issues which challenge the urgent care system in Central Manchester which include rising demand, over reliance upon hospital based models of care and fragmentation of clinical pathways.

NHS Manchester, with its partners, was therefore keen to set out the requirements of a world class urgent care system and this is contained within the Urgent Care System Design document.

A robust methodology was developed which drew upon the following:-

- Empirical evidence drawn from best practice sites
- Engagement and consensus with key clinical stakeholder groups across primary and secondary care
- Social marketing with key user groups
- Intelligence gathering including activity, finance and performance information
- A Prior Information Notice was issued to engage external bodies to share examples of best practice and innovation

3. Key features of the new service model

The new system will be designed around patients and pathways rather than organisational and physical boundaries. This will give people a more patient centred and responsive service with less duplication, breakdown in pathways and will give more opportunities for care to be delivered closer to home.

The system will forge stronger links between urgent care and other health and social care services e.g. planned care and prevention services to ensure that patients' outcomes are optimised and future urgent care episodes are avoided.

This model is designed to reduce inequalities by bringing more integration and coordination to pathways. These pathways will be designed to ensure that they meet the needs of all people who require urgent care services. Specific social marketing approaches have focussed upon older people, hard to reach communities, people with mental health problems and students.

The programme will move urgent care provision from a collection of services into a system. This will be built around the development of a Single Point of Access (SPA) which will coordinate the delivery of common pathways for both clinicians and patients to access. It will manage both step up access to services e.g. GP referral to intermediate care or step down services e.g. early discharge from an acute medical bed into intermediate care.

The front end function of A&E will be able to utilise a wider range of referral options in the community as an alternative to management in acute care.

Services supporting long term conditions will be able to offer planned, urgent and preventative pathways in one patient centred service. This will target conditions which present frequently to urgent care services such as Chronic Obstructive Pulmonary Disease (COPD) and heart failure.

The programme will engage with providers to develop a Mutual System Partnership (MSP). This will enable services to work closer together in terms of delivering pathways. The MSP will consist of a core set of principles, aims and objectives signed up to by all providers of urgent care services with regard to managing demand and service delivery.

A summary of the key commissioning initiatives, which will deliver the required outcomes in Central Manchester, are described at Appendix 1. An assessment is being undertaken at the moment as to which should be developed as citywide projects and which reflect the specific needs of Central Manchester locality.

4. Outcomes

The urgent care programme will be considered a success if it can:-

- Improve patient experience and clinical outcomes.
- Offer urgent and emergency care which is responsive, accessible and appropriate to need with a reduction of both investigation and treatment by integrating pathways within and between organisations.
- Reduce the demand on acute urgent care services through improved access and scope of community services.
- Contribute to the ongoing management of long term conditions which present to services e.g. Chronic Obstructive Pulmonary Disease (COPD) and support the introduction of preventative measures.
- Achieve urgent care targets and performance indicators on a sustainable basis e.g. 4 hour emergency access target.
- Achieve financial savings for investment in planned and preventative care.

5. Engagement

Stakeholder engagement has been instrumental in the development of the system design and for the programme to be a success this must continue. Due to the breadth and complexity of the programme an engagement exercise will be undertaken with regard to urgent care on a citywide basis. In addition to this each initiative has been evaluated to determine what level of engagement is required at a service specific level.

Urgent Care has been an integral part of the Talking Health debate launched by NHS Manchester in May 2008. It will continue to be central to this engagement programme and the membership scheme which was developed as part of this.

6. Next Steps

The next steps for this programme of work are as follows:-

- The detailed programme plan will be consistent with the CSP and further developed as part of the PCT's Operational Plan. Assurance will be provided by the Commissioning Committee and the Board of NHS Manchester.

- Ongoing engagement with key commissioning partners, including PBC and the Local Authority, will be central to the programme and necessary to deliver the required outcomes.
- Mobilisation of the initiatives will commence in early 2009.

7. Summary

This will be a challenging programme of work over the next three years but will have a notable affect upon the services received by the resident and registered population of Central Manchester and City wide.

A copy of the urgent care System Design document can be found on the NHS Manchester website

<http://www.manchester.nhs.uk/pct/commissioning/urgentcareprogramme/>

Appendix 1 – Key commissioning initiatives

Workstream	Description	Key initiative(s)	Outcomes	Delivery
Access and navigation	<p>Because of the nature of urgent care services it is difficult to determine patient flows along commissioned pathways. Patients' should expect their problems to be addressed where they present with an urgent care need but this is not always the optimal service for the patient.</p> <p>This workstream will ensure that patients can be navigated around the system to the best service for their need. This will enable both step up e.g. referral from GP to intermediate care or step down e.g. discharge from hospital to home with homecare rehabilitation support.</p>	<p>The Manchester Access Point (MAP) will act as a Single Point of Access to patients and clinicians which will manage urgent care patient pathways and transitions of patient from service to service. This service will integrate urgent care services to enable them to work as a system.</p> <p>Front end of A&E services will be able to refer to a wider range of referral options in the community as an alternative to acute care. The Single Point of Access will act as a key enabler for this.</p>	<p>A reduction in emergency medical admissions, A&E attendances and acute bed days. The service will increase the options for referral/presentation which will enable more services to be delivered in the community. The management of pathways and transitions will make for a better experience for patients due to reduced duplication of work, shorter waits and care closer to home and earlier discharge to home.</p> <p>An increase in urgent care delivered in the community and increased capacity for emergency care in the acute setting.</p>	<p>The service is proposed to undertake a phased start from April 2010.</p>
Treat and Stabilise	<p>The early part of the urgent/emergency pathway is to treat and stabilise the patient. This involves development of a working diagnosis, stabilising the patient where necessary and developing a management plan for onward treatment.</p> <p>This part of the pathway needs to be rapid and provide timely access. Once this stage is completed a more considered appraisal of the future pathway can be made.</p>	<p>The introduction of consultant led outpatient clinics which can be accessed by GP or Medical Assessment Unit (MAU) referral. Often patients are admitted to hospital because a consultant opinion and diagnostics are required to eliminate certain elements of risk e.g. respiratory problems. This service will enable an assessment to be made in the very short term so that an emergency admission is not required.</p> <p>New community services which can respond to exacerbations of certain conditions and prompt management of them due to knowledge of patient and their management plans. This will commence with COPD and development of other long term conditions e.g. diabetes and heart failure.</p>	<p>The consultant clinics will give earlier senior input to a patient's management. This will improve patient care and experience and reduce pressures on acute beds.</p> <p>The service will reduce emergency medical admissions.</p> <p>These services will support the achievement of the CSP commitment to increase capacity and effectiveness in the community. It will reduce emergency admissions and improve patient care by combining ongoing planned care management with a community response to exacerbation.</p>	<p>This initiative will be piloted from December 2008 for a six month period.</p> <p>The COPD service is expected to become operational by June 2009</p>
	Once the patient is stable, a fuller picture of	Further development of community health and	These initiatives will promote earlier	Service

Urgent Planned	their medical history is gained and a management plan is in place more options can be developed about the best pathway to follow. Urgent planned service can deliver services to patients who no longer require high intensity care.	social services such as community beds or homecare services will increase the numbers of patients who can be discharged earlier from hospital.	discharge from hospital which will offer care closer to home and promote independence, particularly of elderly/frail patients. It will support CSP objectives and ease capacity issues in hospitals.	developments outside of the CSP are planned to be introduced from April 2010
Prevention and early intervention	Whilst not part of the urgent care episode of care much can be achieved in terms of reduction of urgent care demand through preventative measures. Prevention will focus on managing long term conditions so that urgent care needs do not arise, ensuring that patients can respond and be responded to early in an exacerbation and secondary prevention following and urgent care episode to reduce the risk of future need.	The CSP initiative to deliver personal care plans (PCPs) will contribute to this reduction in demand. PCPs are to be focussed initially on those areas which cause demand upon acute services. Improved advice and support services to vulnerable people will be expanded so that people are supported to manage their health and social care needs. It will support the transition from emergency care into long term planned care and condition management.	PCPs will improve people's ability to manage their condition which will improve their health and quality of life. They will also cause a reduction in emergency admissions and acute length of stay Advocacy will improve the care that vulnerable patients such as elderly people without a regular carer to ensure that they are able to access services which meet their needs.	COPD and Diabetes – April 2010 April 2010
Mental Health	There is a strong correlation between mental health and urgent care. This ranges from high levels of presentation due to minor issues relating to anxiety and depression, issues resulting from alcohol and drug abuse and the response to acute psychotic episodes. This section addresses urgent care responses to mental health needs. Urgent medical care to people with mental health problems will be delivered through generic urgent care pathways where possible.	Personal Care Plans will be introduced for people with mental health problems and support services linked to them. Interventions for anxiety and depression will be developed to support frequent A&E attendees. Interventions for alcohol will be incorporated as part of the CSP. Further work will be developed with regard to urgent care pathways for mental health patients.	Similarly to other PCPs mental health patients will be able to manage their condition better improving quality of life and reduce the need for health care at a point of crisis.	April 2010
	System management will perform two interlinking functions. Firstly it will bring operational integration through increasing shared pathways and flows of information.	Engagement with providers to develop a Mutual System Partnership which will ensure that providers collectively work towards achieving a system approach. It will develop a core set of	The MSP will support development of pathways which will reduce duplication and improve patient experience. It will allow the system to flex its capacity in line with	April 2010

System Management	Secondly it will build a commissioning environment which encourages the system to work.	<p>principles, aims and objectives with regard to managing demand and service delivery.</p> <p>The workstream will develop a new financial model which will build in incentives for commissioning of new and/or existing services which will promote commissioned pathways e.g. the potential for introducing a PbR tariff to community service such as intermediate care.</p>	<p>demand and for providers to support each other when demand peaks.</p> <p>PbR, QOF and other quality payments have been proven to change service delivery in a relatively short period of time. Applying such a mechanism to services previously block funded would support increased utilisation and growth in such services.</p>	April 2010
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