primary care FOUNDATION

Henry Clay – 07775 696360
Henry.clay@primarycarefoundation.co.uk

NHS England

primary care FOUNDATION

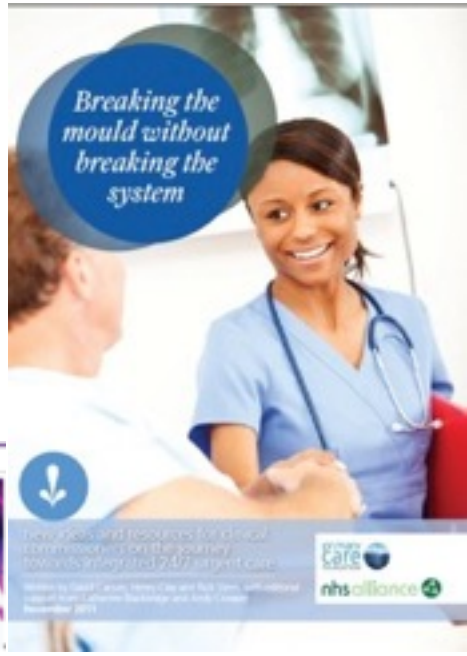
Integrated Urgent Care
The Financial and Capacity Model

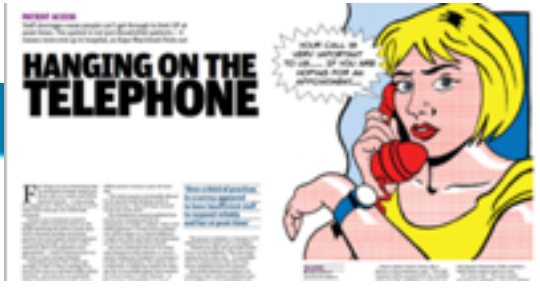
Henry Clay

henry.clay@primarycarefoundation.co.uk

PCF have looked at urgent and primary care from a number

- Reviews of urgent care system, 111, OOH etc.
- Reports for Department of Health, NHS England and others
  - Primary Care in A&E
  - Urgent Care in general practice
  - Urgent Care Centres
  - Urgent Care Commissioning guide (with NHS Alliance)
  - Potentially avoidable appointments for GPs
  - Reducing bureaucracy in general practice
- Benchmark of out of hours services
- Projects for
  - Commissioners, particularly CCGs
  - Providers, practices, OOH providers etc.
  - NHS, commercial and mutual organisations





primary care FOUNDATION

The Brief …

primary care FOUNDATION

Develop a model that allows local health systems to test out different assumptions

What are the financial implications of implementing new standards in urgent care?

How many clinicians and staff are needed to meet this level of demand?

What is the benefit to the system from improved dispositions?

What is the model?

primary care FOUNDATION

- The model is a spreadsheet
- Local commissioners enter current data and assumptions about the potential future models of care
- It makes people think hard about key questions that underpin their vision
- Changes in design are reflected in changes to the cost of the service

To set up the model the user needs:

- Populations served by the 111 and OOH services
- The volume of calls
- Dispositions from NHS 111 (note cautions where OOH calls do not come through 111)
- Call lengths (call handlers and clinicians)
- To reflect the operational model for each OOH service:
  - Direct booking by 111 or further phone assessment (clinical management)
  - Length of phone and face to face consultations (base and home visit)
  - The OOH bases and their opening times
  - Proportion of home visits

primary care FOUNDATION

The model requires data on the NHS 111 dispositions (based on MDS)

Patient

100%

Call-handler

22% of cases go via a clinician

Largely nurses and paramedics – small % of GPs

22%

Clinician

14.0%
Not triaged

8.0%
Non-clinical

9.2%
Ambulance

6.7%
A&E

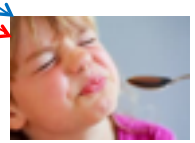
37.2%
'Contact'

11.3%
'Speak to'

5.0%
Dental/phar

NHS

3.1%
Other



5.5%
Homecare

primary care FOUNDATION

and it takes account of and allows for

- Calculation of demand and staffing by hour of day
- Whether the next day is a working day
- The proportion of cases going to the clinical hub & mix of staff
- The Erlang formula to calculate call-handler numbers
- Realistic assumptions about utilisation of clinical staff based on the level of demand
- Staff pay, anti-social hours payment, pension and on-costs
- Cost per case for referrals (eg to A&E, Ambulance etc.)
- The availability of UCC, WIC or MIUs or the use of extended hours primary care hubs (there is a mini-DoS)
- Up to five OOH services under the 111 operation, with up to ten bases in each
- Non-Labour on-costs

primary care FOUNDATION

But the group will have to develop their vision of the model – answering ...

- Will clinicians use NHS Pathways?
- Who will be in the hub? Is it 'virtual'?
- Can GPs contribute from the OOH Base?
- How will they access the DoS?
- How much 'local knowledge' is needed?
- What is the right mix of skills in the hub?
- Are there enough?
- How will we direct cases to the right person?
- Is demand sufficient to justify specialist practitioners?
- Can they contribute 'when required'?
- How will cases be drawn to their attention?

…and many more questions

primary care FOUNDATION

We ran two scenarios in addition to the current service … this is what it looked like

	Base case	'must achieve'	'transformational'
% to clinical hub	*20.7%*	*41%*	*62%*
% to A&E and 999	*5.4% and 10.3%*	*5% and 9.2%*	*3.5% and 7%*
'Speak to primary care'	*18.6%*	*Almost none (phone assessment and advice from hub)*	
Homecare/NFA	*13.6%*	*25%*	*33%*
'Contact GP'	*40.4%*	*49%*	*44.7%*
C/H to Floor-walkers	*20:1*	*10:1*	
ECP/GP/Other clinicians in hub	*95:5:0*	*45:45:10*	
Can call handlers book slots for OOH?	*No – re-triage of all cases*	*Yes, Direct booking*	
GPs with capacity at base contribute	*OOH phone triage*	*Clinical Hub*	

primary care FOUNDATION

Three line summary from the first indicative run of the model …

	'base'	'must achieve'	'transformational'	Comment
111 & OOH cost	*14.93M*	*14.30M*	*14.15M*	*The cost of the hub rises but not as fast as the reduction in OOH costs so the total is still 'within the*
No. referred to A&E and	*19,612 and 39,448*	*18,159 and 35,235*	*12,711 and 26,809*	*This is a significant reduction in the pressure on A&E and the ambulance service*
Nominal cost of A&E/999 referrals (on cost per case)	*£2.59M and £9.19M*	*£2.40M and £8.21M*	*£1.68M and £6.25M*	*Of course, these costs are much more difficult to release from such 'always on' services. But it does give some idea of how costs might be contained if the change offsets continuing growth in numbers*
And there are also benefits in lower UCC cases (fewer A&E dispositions)				

Projected overall impact on the Urgent & EC system:
In option 1 'must achieve': £1.18M saving
In option 2 'transformational': £4.63M saving
… but note:
1. ***Most of this saving is likely to be in activity rather than cash***
2. ***To achieve this, it will require excellent implementation across the U&EC system***

Next step might be to change call lengths at the Clinical Hub (which should reduce with clinical support and early exit), the view was that homecare might be higher than initially assumed and we had not even started to look at the opportunity to refer to other centres (% to UCC, for example, was not changed)

primary care FOUNDATION

primary care FOUNDATION

Might funding be available for the workshop?

Yes it might well be. NHS England have been supporting this for a number of areas as they recognise that the thinking involved is helpful in defining the right model for each locality – but they are prioritising Vanguards, transformation areas and those going to procurement earliest