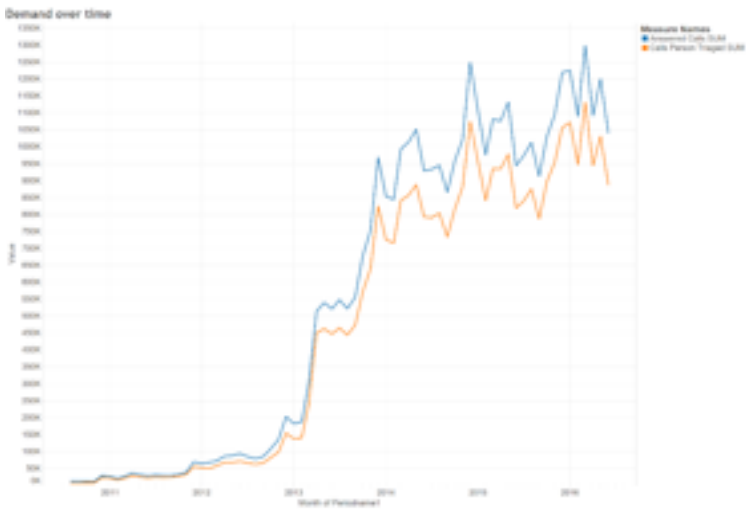
Integrated Urgent Care – how to make NHS 111 work

There has been a considerable focus on Integrated Urgent Care[1] (IUC) and on how NHS 111 (***just a number'***)[2] might act as the front end of the urgent care system. A crucial part is an increase in telephone advice provided by a mix of clinicians through the Integrated Urgent Care clinical assessment service (IUC CAS). It can be argued that, at least in the out of hours period when the large majority of 111 calls are received, the pendulum is simply swinging part way back. It shifted from the old model, in which a caller was effectively guaranteed a telephone assessment with a clinician to an algorithm driven solution delivered by non-clinical call-handlers using NHS Pathways. The new emphasis on the IUC CAS, where perhaps 50% of cases will be referred to a clinician, is only a move back to the middle ground.

The commissioning standards for Integrated Urgent Care[3] have provided an opportunity for commissioners and providers to look at how the service operates. It empowers then to make changes so that each group of patients receive the best care (including advice and reassurance over the phone) and, crucially, are directed towards the right service and skill group. Having worked with 111 and out of hours services, benchmarking and analysing their data, NHS England asked us to develop a financial and capacity model of how such a service might operate[4]. It has been a privilege to work with a dozen areas applying the model, exploring potential benefits and pitfalls of introducing a CAS. This article is informed by those and other discussions. It focuses on the detail of the operational processes without which the CAS cannot work and I hope that it captures the richness of the debate.



First some facts about NHS 111. Although it looks as if calls to 111 since national roll-out in 2013 have been growing (graph 1), much of this is because callers to out of hours services have only been gradually directed through 111. Even today there are some places where GP out of hours callers do not dial 111. Demand has stabilised or is rising only slowly in places where the arrangements are consistent.

Second, most demand is during the out of hours period. Graph 2 shows the profile of demand for a population of a million with the blue line being an average 24-hour period at the weekend and the orange that for a weekday. The demand during the in-hours period is only just over twice that at 3 in the morning, less than a quarter of all demand is during the in-hours period and, for primary care dispositions to

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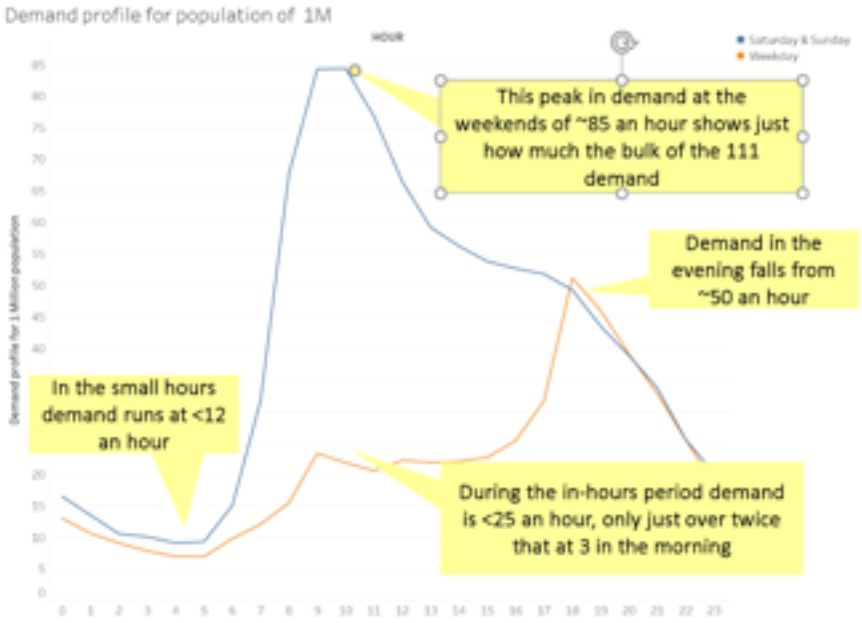
[1] Add detail of Integrated Urgent Care review

[2] As frequently repeated by the Integrated Urgent Care Team in describing the new ways of working outlined in the commissioning standards

[3] Detail of commissioning standards

[4] Link to the financial and capacity model

'Contact GP' (NHS Pathways terminology for needs a face to face consultation) or 'Speak to GP' only one in six occurs in-hours. This is not surprising, bearing in mind the availability of local services during the working day – but it is also a clear indication that 111 needs to be well integrated with face to face services during the traditional out of hours period.



Finally, in looking at the features of a CAS there is a worry that the additional clinical input into the assessment service will increase cost with, potentially, uncertain downstream benefits. This is unfounded. In many areas, all of the calls passed to primary care during the out of hours period are assessed on the phone by a clinician with many completed at that stage so reducing the numbers seen face to face. In these areas the clinical resource for the IUC CAS is already in place, albeit that there may be good reasons for adjusting the mix of skills to meet the need at different times. The existing resource is sufficient to allow 50-60% of cases to be assessed in an IUC CAS. In areas where there is direct booking of 'Contact GP' dispositions the resource is in place too – but it is deployed seeing more patients face to face.

Given this understanding how does the IUC CAS need to operate? There are a number of tricks that providers will need to pull off if the service is to reduce the pressure on both the urgent and primary care systems through satisfactorily completing many of the cases on the phone:

Minimising the occasions on which a caller speaks to more than one clinician

Clearly if a call is passed from a call-handler to a nurse to a GP and only then to a mental health specialist much more resource is used than is desirable and it is frustrating for the caller. There are a number of approaches that will help here:

- Using rules to categorise patients (based on a combinations of age bands, symptom group, disposition and the use of flags to identify frailty or palliative care patients) is one approach. Those with a symptom group of 'Unwell, under 1 year old' are, for example, highly likely to be seen face to face whilst, for those with a symptom group of 'pain/frequency passing urine' it may be possible that the less elderly who are more likely to be suffering from uncomplicated lower UTI can be assessed by

phone with a good chance of a prescription being provided without seeing them face to face

- The use of interactive voice response systems allows patients, say with toothache or those seeking advice about medication, to identify their need so that they can be directed preferentially to a dental nurse or pharmacist within the IUC CAS
- Using clinical navigators to manage the queue of cases waiting for phone assessment to direct cases to particular skill-groups and/or encouraging clinicians, within limits, to pick those cases that they feel they are competent to deal with so that (say) the nurse leaves the obviously complex case to the GP
- Making more use of call-handlers, training them to recognise complexity and so which type of clinician can best deal with the case flagging it accordingly
- Arranging for a senior clinician to provide support to other clinicians, perhaps through 'floor-walking' (as used for call-handlers), through the clinical navigator or through arranging clinicians in groups
- And, finally, clinicians need to be clear that their objective is to complete the case on the phone themselves if that seems reasonably possible or, if this looks as though it will be difficult, to recognise the need for the patient to be seen face to face early and direct them to the right place. To support this, we should measure and feed back to clinicians comparative information about cases completed with homecare advice, cases passed on for further phone assessment, cases referred to ambulance and, perhaps when we can join the data, information about the proportions of patients that followed the agreed plan

Call-handlers can maximise the value added by clinicians

There is little value in a clinician assessing a patient on the phone to reach the same disposition as the call-handler (except when reassurance is needed) - the extra step just introduces delay. Yet we know that often clinicians can successfully and satisfactorily provide reassurance, advice and/or a prescription to patients by phone thereby saving the face to face assessment, need to travel etc. How do we maximise the value that a clinician might add? There are two suggestions here.

- The first, which requires a change to the thinking and way the NHS Pathways is deployed, is to ask the patient 'Do you think this is something that might be dealt with over the phone – in which case I can get a clinician to ring you shortly? But if you think it will be necessary to be seen face to face then I can book you an appointment in … hours at…' The wording will need to be refined, but this approach might offer real advantages. Certainly what we know at present is that NHS Pathways is poor at identifying which cases might be completed over the phone, with more than half of <u>both</u> 'Speak to' and 'Contact GP' dispositions being completed by phone when assessed by a clinician from the OOH service.
- The second is to build on the comprehensive suite of information held within NHS Pathways that supports call-handlers in giving advice on the management of symptoms and which call-handlers are already trained and experienced in providing. Although NHS Pathways was designed for self-care advice to be provided by the call-handler, when NHS 111 started a decision was taken that a clinician should always follow up with patients given self-care advice. If call-handlers provided the advice and then asked 'Would you like me to arrange for a clinician to ring you to explain more, or are you happy that the advice I have given you is sufficient?' we might reduce the instances when clinicians add little or no value.

Manage the call so that the patient follows the plan

Call-handlers and clinicians using NHS Pathways get extensive training. But there is inconsistency in how they manage the call. Some, early in the process, ask an open question along the lines of 'How can I help you?'. By referring back to the answer that the patient gives ('I know that you wish to speak to the doctor about Thomas, but first I need to ask some questions for safety') they are better able to manage the conversation. There is, I believe a lesson here that needs spreading.

But there is something else too. When they reach the end of the assessment by a call-handler, over 5% of cases are identified as 'disposition refused'. But, as commissioners and providers join data from A&E to that from 111 they are beginning to realise that this is only the tip of an iceberg. Significant numbers of patients use a different service than the one that we expected from the disposition and service chosen in NHS 111. Training call handlers and clinicians to agree the plan with the patient is important. If the recommendation is ignored then, as far as the patient is concerned, there was little value in the process.

Don't use 111 for everything

111 should be the default number. But it should not be the only number. There are great advantages if those with a palliative care need have been given a different number to ring, if there is a separate number for those suffering a mental health crisis etc. The reason is that it is then possible to differentiate calls before they are answered, allowing the call to be routed directly to the right group and allowing the call-handler to answer it differently.

Conclusion

The ideas described are mainly untried and untested – so the first step is to experiment and develop them (with appropriate clinical oversight and risk management). But they are things that can and should be tested. Providers and commissioners should work closely together on this as it will be an important part of delivering a clinical assessment service that works.

Meanwhile commissioners will also be well advised to consider the likely impact on demand of some of the other changes that are in the offing. Have they, for example, assessed the impact on demand of extended hours working (will it reduce the demand at weekends near to that of the weekday?), the introduction of an online clinical decision support tool (Will this head off demand or fuel its growth?) and the role of the IUC CAS in providing support to clinicians across the system (How much will this be used by General Practice, by Hospitals looking to discharge patients as well as by Community services, Paramedics etc.).

There is much to be done – and there will still be a need for contracts to recognise the levels of uncertainty building flexibility into the arrangements. But smart commissioners and providers are working hard to answer these questions.