NHS
Wirral
Clinical Commissioning Group

Urgent and Emergency Care Review

'The case for change'

August 2018

Contents

1. Introduction

NHS Wirral Clinical Commissioning Group is responsible for the planning and commissioning of health care services in Wirral. We continually look at what we commission to ensure it delivers a high standard of care whilst recognising that increasingly services need to represent value for money and are sustainable. As part of this on-going work, we have been talking to local people, health and care staff and other stakeholders for a number of years about how we can improve urgent and emergency care. We now plan to go out to public consultation, based on what we have heard, on a new proposed model of care for urgent and emergency services for Wirral.

It has been widely reported that the NHS is under increasing pressure and is struggling to cope with the demands being placed on it for a number of reasons, these include:

- People are living longer which is a good thing but means that they are living with more medical conditions that may require urgent treatment at times.
- An increase in the number of people needing to be admitted from Accident and Emergency Departments to a hospital bed.
- An increase in the number of patients who are medically optimised and could be discharged from hospital as they may be waiting for additional support in the community or their home.
- An increase in the number of people who are living with conditions that can be caused by unhealthy lifestyle choices including alcohol consumption and diet.
- Confusion about what option is best when people need help or a lack of awareness of what services are available in their local area.

Accident and Emergency departments, located on hospital sites have seen a significant increase in people using them over recent years and this is continuing to rise. We believe we can make improvements to urgent and emergency care by considering different ways to deliver urgent and emergency care these services. Our proposals have been developed in partnership with local clinicians and are based on national guidance, clinical evidence about best practice and our conversations with local people

A great deal of work has been done across the NHS as a whole, and locally, to understand how people make their individual choices when they need to use Urgent Care services, these include the following:

- People do not clearly understand the choices available to them and how to access or use them.
- When people are ill or scared, they will tend to use the option that is most familiar and 'safe' to them
- When people choose an Accident and Emergency department they do so based on ease of access even though this is the most costly for the NHS to provide

It is evident that the NHS needs to deliver urgent and emergency care in a different way which not only covers A & E departments but also incorporates other services provided in community locations. The following publications set out NHS England's guidance to enable this transformation:

- **General Practice Forward View (April 2016):** describes requirements to ensure improvements in both 'in hours' and 'out of hours' access to Primary Care as part of a broader Integrated Urgent Care (IUC) offer.

- **Next Steps on the NHS five year forward view (March 2017):** set out the mandate to standardise existing Walk in Centres (WiC) and Minor Injuries units (MIU) through the implementation of Urgent Treatment Centres (UTCs), open 12 hours a day, seven days a week and integrated with local urgent care services by December 2019.

- **Integrated Urgent Care Service Specification (August 2017):** which describes the requirement for CCGs to ensure delivery of an IUC offer which includes a 24/7 clinical advice service (CAS) fully integrated with NHS 111 and direct booking to both in hours and out of hours primary care appointments by March 2019.

Wirral is not immune to the pressures highlighted above and it is within this context that we are intending to transform how Urgent and Emergency Care is delivered in Wirral, based on what we have heard from local people. This proposal is about improving care for Wirral residents, making it easier for people to access a consistent offer, providing safe and effective urgent and emergency services when they need them that are appropriate to their clinical need.

Across Wirral a number of urgent and emergency services are commissioned for local people, including:

- Category 1 (major) A&E department in Arrowe Park Hospital (Wirral University Teaching Hospital Trust)
- 3 Walk-in Centres (WICs) at Victoria Central Hospital, Arrowe Park Hospital and the Eastham Clinic
- 3 Minor Injuries Units - Moreton Health Clinic, Miriam Medical Centre and Oates & Partners Group Practice (Parkfield Medical Centre).
- NHS 111 acts as the triage for the GP out of hours service in Wirral.
- Ambulance services

This document sets out the case for change and includes information that we feel is relevant for people to consider. It describes NHS Wirral CCG's position with regard to the national requirement to ensure the standardisation of Urgent Treatment Centres (UTCs) across the country as part of an integrated urgent care offer, aligning NHS 111, out of hours and GP access with face to face urgent care. It also demonstrates how implementation will be aligned with plans for improving local primary care services. Primary Care is healthcare provided in the community for people making an initial approach to the care system. It is the first point of contact for people who need to access clinical advice, guidance or treatment. Chapter 9 describes a draft model of care and three options in which this model could be delivered, based on the insight described in this document and the NHS England guidance as referenced above. We are being supported by NHS England to develop an urgent care system that is genuinely integrated and one that that will guide the patient to the correct level of care and treatment.

Quality and Equality Impact assessments (QIA/EIAs) have been undertaken for each of the options described in Chapter 9, they have been developed with quality, equality and clinical leads within the CCG. This paper describes the benefits and considerations of each option and

highlights the key issues identified when conducting the quality and equality impact assessments.

This review is being conducted in partnership with the Public Health and Health and Social Care departments at Wirral Council.

2. Understanding Urgent and Emergency Care Services

In this section we describe what Urgent and Emergency Care Services are and how they are provided in Wirral. In England, Urgent and Emergency Care (UEC) is delivered by:

- Accident & Emergency departments (A&E),
- General Practitioners (GPs),
- GP Out of Hours services (GPOOH),
- Minor Injuries Units (MIUs), and Walk-In Centres (WICs)
- There is also the NHS 111 service which provides telephone advice, signposting and triage for patients. In 2018, NHS 111 will become an online service, allowing people to enter specific symptoms and receive tailored advice on clinical management.

The term Urgent Care is used to describe the care you require when it is not an emergency but you still need medical attention on the same day. Emergency Care is when you need immediate medical attention for an accident or injury that cannot wait. This is a situation where you would only attend A&E.

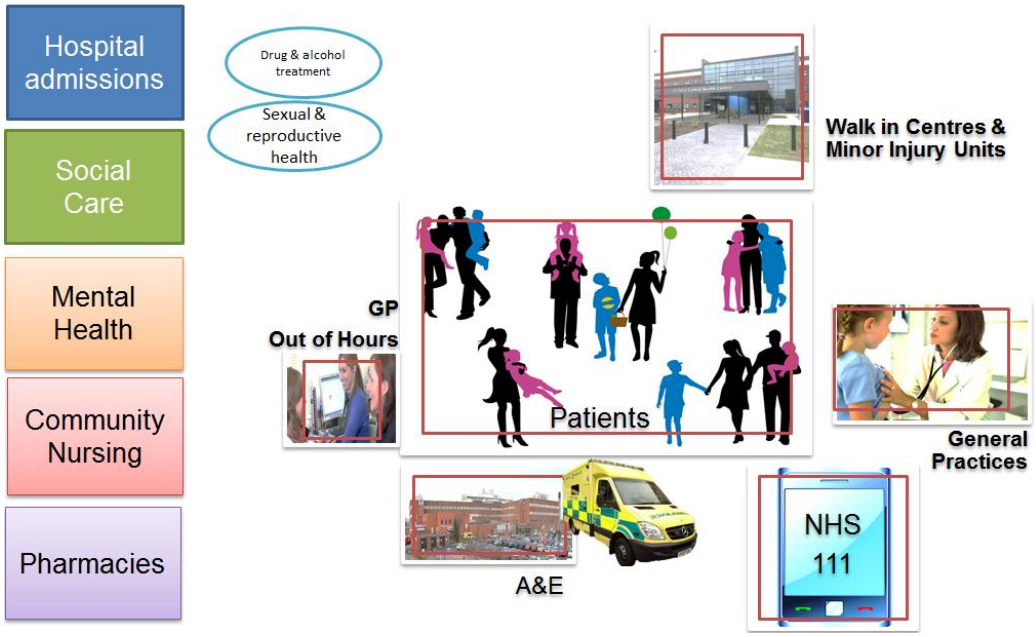
NHS England has announced Urgent and Emergency Care (UEC) as one of the NHS' main priorities for service improvement, with focus on improving national A&E performance whilst making access to services clearer for patients. [1] One element of the UEC improvement is the roll-out of standardised new 'Urgent Treatment Centres' in England. These will be open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics and be integrated with local urgent care services.[2] Therefore, this review is influenced by how the standards for these new Urgent Treatment Centres will be applied in Wirral given the defined specification detailed above.

Wirral currently has

- Category 1 (major) A&E department in Arrowe Park Hospital (Wirral University Teaching Hospital Trust)
- Three WICs at Victoria Central Hospital, Arrowe Park Hospital and the Eastham Clinic
- Minor Injuries Units at the Moreton Health Clinic, Miriam Medical Centre and Oates & Partners Group Practice (Parkfield Medical Centre).
- NHS 111 acts as the triage for the GP out of hours service in Wirral

[1] https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/urgent-and-emergency-care/
[2] NHS England: Urgent Treatment Centres – Principles and Standards

Figure 1: The Urgent Care System



3. Summary

In this section we give a summary of the evidence base that we believe is the driver for the need to change how we delivery urgent care services and outline our proposals.

3.1 Evidence base

This section summarises what we know about urgent and emergency care services in Wirral and the NHS in England. Further detail is given later in the report. We recognise that there are some gaps in our knowledge and these will be explored further during the engagement activity as part of this review, these gaps are summarised in Chapter 4 of this document.

- Evidence (local and national; cited further on in this case for change) does point to some confusion amongst the public about the range of urgent care services available (other than A&E). It may be that people's lack of knowledge about other options (versus the ease and familiarity of accessing A&E), combined with the fear and stress of being ill results in people resorting to the 'default' of A&E - a choice which they perceive to be the easiest, safest and most reassuring option.
- There is evidence (cited further on in this case for change) that Walk-In Centres and other urgent care interventions may increase rather than reduce total demand on the system and some areas are closing their WICs (e.g. Bury).
- Deprivation is a significant factor in driving A&E attendances. Data suggests that people from the most deprived areas are more than twice as likely to have emergency admissions for conditions which could have been managed in outpatient clinics/services.
- Mental health issues are also a factor in A&E attendances. Mental health problems account for around 5% of A&E attendances, 30% of acute inpatient bed occupancy and 30 % of acute readmissions. Well-resourced liaison mental health services provided seven days a week and

24-hour a day will help to prevent people with mental ill health reaching a crisis point and then having to be admitted.

- Performance is deteriorating in many areas across operational, financial and clinical measures.
- There is ongoing and consistent failure to achieve the A&E standard (95% of patients being seen and admitted or discharged within 4 hours. For A&E performance see pg 78)
- There are delayed ambulance response times and handovers at Arrowe Park Hospital
- The rates of A&E attendances have risen in both England and Wirral over the last 7 years. The steepest rate of increase in attendances in Wirral is seen amongst the older age groups, in particular the 90+ age group who are likely to have a large number of co-morbidities.
- The number of A&E attendances in Wirral averaged of 85,000 per annum (average of last 3 years 2014/15, 2015/16 and 2016/17)
- In 2016/17, almost 50% of A&E patients presented at Arrowe Park with minor symptoms such as skin rash, cough, back pain and abdominal pain
- Sundays and Mondays are the peak days of the week for A&E attendances in Wirral
- Attendances at A & E departments peak between 10am and 2pm and between 5pm and 8pm. The first peak is when GP services are open although the second peak is when most GP practices are likely to be closed.
- The age groups in which the number of A&E attendances peak is the 0-4 yrs., 20-24 yrs. and the 80+yrs age bands.
- Attendance rates peak very sharply in the very oldest age group, i.e. 90+ years (due to fewer older people surviving to this age, but they account for a relatively high number of attendances)
- Attendance rates in the 90+ age group are more than double those of the 0-4 yrs.
- Older people have longest A&E waits. Only around one in 10 patients in their 20s wait for more than 4 hours, whereas more than 4 in 10 of patients aged over 90 wait longer than 4 hours (likely to be due to the complexity of their pre-existing medical conditions).
- A&E attendances presenting with a Mental Health problem have increased in Wirral in 2016/17, compared to 2015/16
- In 2016/17, A&E attendances recorded as Self Harm/Suicide increased by 45%, compared to 2015/16
- A&E Liaison Psychiatry referrals peaks in the months between April to July
- In the period 2014/15 to 2016/17 over half (55%) of total emergency admissions to WUTH were via the A&E department
- Over half (57%) of emergency admissions via A&E in WUTH are admitted and discharged between 0-2 days
- VCH is the most commonly used WIC in Wirral, followed by the WIC located at Arrowe Park Hospital and then the Eastham Clinic. WICs appear popular amongst younger people and families, but usage is low in the older population, who appear at A&E and GPOOH in much greater numbers. It is difficult to understand the reasons why this is the case due to the lack of detail available within the data sets.
- Trend data shows a fluctuation in WIC attendances in Wirral, with a rise in 2015/16, followed by a drop in 2016/17. Longer term data is required if more definitive trends are to be determined
- The current rate of Walk-In Centres per head of the Wirral population (based on 3 sites), is 9 per million residents. This is higher than the national average of 5.4 per million people

- Miriam was the busiest Minor Injuries Unit in Wirral in 2016/17 (17,513 attendances)
- We do not have good quality data on diagnosis for people using urgent care in Wirral. The data is focussed mainly around what kind of treatment individuals received, so whether they had diagnostic tests, wound care, etc. For Walk in Centres and Minor Injury Units, a high proportion of patients had infections or wound care needs which could potentially be dealt with in primary care.
- NHS 111 calls triaged and ambulance despatches peak in the month of December (for further detail, refer to pg 60 & 61 of this case for change)
- There appears to be a relationship between the introduction of the NHS 111 service (October 2015) and the reduction in referrals to GP out of hours services year on year
- Much of the evidence around primary care GP services and their impact on A&E attendances are conflicting. On the one hand, some evidence indicates difficulty accessing primary care increases A&E usage (e.g. evidence from the Prime Ministers Challenge Fund pilots that increasing access to primary care can reduce A&E attendances), but other evidence appears to contradict this theory.
- For instance, A&E usage is highest (in Wirral) when most general practices are open, many people will attend A&E despite being offered a same day appointment with their GP, a large proportion of people are actually sent to A&E by primary care, for example NHS 111 out of hours triage service, and local data shows no relationship between satisfaction with general practice opening hours or ability to get a same day appointment and A&E attendances by general practice patients.
- There is a very clear relationship between deprivation at general practice level and the rate of A&E attendances (higher deprivation = higher rate of A&E attendances) for detail please refer to pages 20 and 26, 62 & 63 of this case for change).
- In 2016/17, 79% of calls assessed by the NWAS Respond and Refer service were for residents aged over 65 years, more than half of the calls related to a fall

Key points within Evidence base summary

- Evidence (both local and national) points to confusion amongst the public about the range of urgent care services available (other than Accident and Emergency (A&E)).
- Deprivation is a significant factor in driving A&E attendances. Data suggests that people from the most deprived areas are more than twice as likely to have emergency admissions for conditions which could have been managed in outpatient clinics/services.
- In 2016/17, almost 50% of A&E patients presented at Arrowe Park with a minor case such as skin rash, cough, back pain and abdominal pain
- Over half (57%) of emergency admissions via A&E in WUTH are admitted and discharged between 0-2 days
- The age groups in which the number of A&E attendances peak is the 0-4 yrs, 20-24 yrs and the 80+yrs age bands. Attendance rates in the 90+ age group are more than double those of the 0-4 yrs.
- For Walk in Centres and Minor Injury Units, a high proportion of patients had infections or wound care needs which could potentially be dealt with in primary care.

3.2 Proposal

A new national model of care for urgent and emergency services will be implemented across Wirral by December 2019, as mandated by NHS England. This primarily involves the

introduction of Urgent Treatment Centres across England, integrated with Accident and Emergency Departments, Integrated Urgent Care Clinical Assessment Service (IUC CAS) and the roll out of additional GP appointment provision in Primary Care.

In summary, the proposed model includes certain aspects which are mandated as 'Got to haves' and other elements of urgent care provision in the community that are for local determination. It has been developed with involvement from local clinicians and with input from members of the public. The public consultation aims to inform the public about the mandated elements along with asking for their views on the options we have proposed for the community offer.

Our local clinicians believe there is a more effective way to provide urgent care services, which is better for patients. The proposed model of care includes the following mandated provision;

- The existing A&E department and an Urgent Treatment Centre (UTC) based at Arrowe Park, with the UTC as the single front door for all urgent but non-life-threatening illnesses or conditions. An Urgent Treatment Centre has an enhanced model of care provision when compared with any of the existing Walk in Centres and therefore will require additional resources to introduce.
- This will be supported by an Integrated Urgent Care Clinical Assessment Service, to ensure that people who need urgent treatment or advice are directed to the right service. The service will integrate NHS 111 and GP out of hours services. This will provide a complete episode of care concluding with either: signposting, advice, self-care support, a prescription, or an appointment for further assessment or treatment.
- This will be further enhanced through a new primary care core offer and extended access provision, which will be in addition to existing local GP services, as follows:
    - This is likely to be provided in a cluster/hub basis across nine localities within Wirral and means that patients will be able to make an appointment to see a GP in the evenings and at weekends, but this may be at a site other than their own general practice.
    - Local services will be delivered across Wirral and will also offer a variety of other services accessible in the community, closer to your home, such as a children's urgent care service offering walk-in facilities as well as bookable appointments and a dressing and wound care service offering bookable appointments.
    - The primary care offer will include same day appointments booked via NHS 111 for urgent need and will manage urgent home visits at a time of day appropriate for patients to help to avoid unnecessary admissions to hospital and improve patient experience.

The implementation of a revised model of care will result in changes to existing service delivery, potentially re-locating services and staff and changing the focus of the community offer to a more comprehensive, consistent offer. All possible considerations and impact, positive and negative for the public and stakeholders are considered in this paper. The overriding factor is that a new model of care will improve the patient experience; the local population told us that people do not clearly understand the choices available to them and how to access or use them, and therefore the aim of a new model is to offer consistent, standardised care for patients. It will also ensure that patients are seen in the most appropriate place for their need.

Our clinical leads believe the revised model has the potential to enhance patient safety and improve patient outcomes through delivery of a clearer, consistent model to urgent care in Wirral with closer integrated working between organisations delivering urgent care.

4. Gaps in Knowledge

- **GP appointments:** We do not know Wirral's current capacity in terms of GP appointments, attendances, or how things may have changed over time (e.g. whether there are more or less GP appointments available in Wirral now, compared to 5 or 10 years ago)
- **GP appointments:** We do not know the reasons people have booked a GP appointment - and particularly pertinently to this report - how many appointments are for urgent issues or long-term conditions. Ethics approval needs to be sought via Local Medical Council to access this information (if available) in line with Information Governance rules and Data Protection Act.
- **Ambulance Service:** We do not have the reasons for conveyances to A&E. This is currently being explored with the North West Regional Ambulance Service analytics team.
- **Reasons for A&E attendance:** Many A&E attendances in Wirral are not comprehensively coded unless they are subsequently admitted when a diagnosis code is then usually available. It would be extremely useful to analyse information about those patients who were not admitted for differences and trends.

5. Evidence Base

In this section we present the evidence base that is the driver for the need to change how we provide urgent care services. We cover the national policy context; national insight on urgent care; national evidence on A&E use; Wirral specific A&E insight;

5.1 National Policy Context

Each year the NHS provides around 110 million urgent same-day patient contacts. Around 85 million of these are urgent GP appointments, and the rest are A&E or minor injuries-type visits.[3] Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have been seen in other parts of the urgent care system, but attend A&E because they think it is their best or only option.

The rising pressure on A&E departments prompted a review of urgent and emergency care (UEC) which was carried out in 2015 by Sir Bruce Keogh, the medical director for NHS England. This review suggested that each area should establish urgent and emergency care networks (UECNs) if they do not already exist, and produced a report, 'Safer, Faster, Better: good practice in delivering urgent and emergency care.[4] There is a route map with timescales for changes to be made.[5] The review outlined a vision of people in need of urgent care having highly responsive services close to home; alongside more specialist services in fewer centres for those with more serious or life-threatening emergency care needs. A further recommendation was that general practices cluster together to support populations of around 30-50,000 patients in order to jointly deliver a range of primary care services such as Dressings, Vaccinations, Diagnostics and other services such as Minor Illness and Injury support.

The review proposed five key changes to meet this vision;

1. Providing better support for people and their families to self-care or care for dependants
2. Helping people who need urgent care to get the right advice in the right place, first time
3. Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments
4. Ensuring that adults and children with more serious or life-threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery
5. Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts

The review outlined some top-level, evidence based principles;

- Preventing crowding in emergency departments improves patient outcomes and experience and reduces inpatient length of stay
- Getting patients into the right ward first time reduces mortality, harm and length of stay

[3] NHS England: Urgent and emergency care
[4] http://www.nhs.uk/NHSEngland/keogh-review/Documents/safer-faster-better.pdf
[5] http://www.nhs.uk/NHSEngland/keogh-review/Documents/1600505%20UEC%20Routemap%20updated%20FV.pdf

- Patients on the urgent and emergency care pathway should be seen by a senior clinical decision maker[3] as soon as possible, whether this is in primary or secondary care. This improves outcomes and reduces length of stay, hospitalisation rates and cost
- Daily senior review of every patient, in every bed, every day, reduces length of stay and costs of care
- Frail and vulnerable patients, including those with disabilities and mental health problems of all ages, should be managed holistically (to cover medical, psychological, social and functional domains) and their care transferred back into the community as soon as they are medically fit, to avoid deterioration in the ability to self-care. Ambulatory emergency care is a streamlined way of managing patients who present to hospital who would traditionally be admitted:

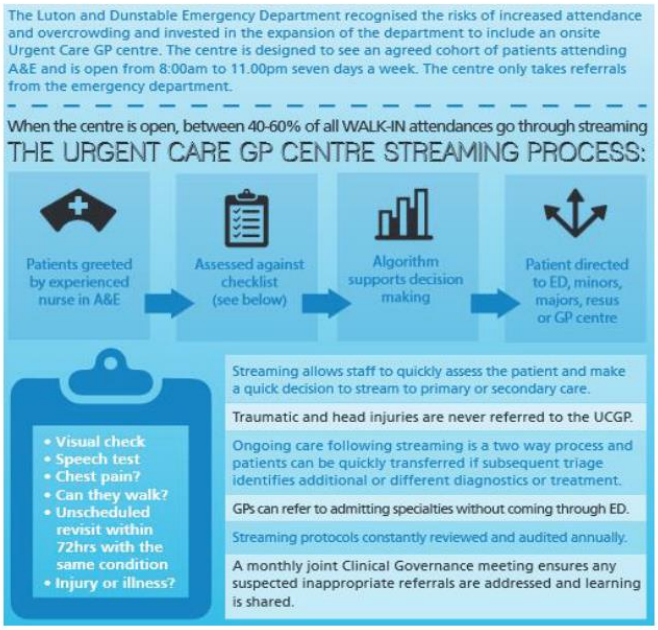
  "Ambulatory care is clinical care which may include diagnosis, observation, treatment and rehabilitation, not provided within the traditional hospital bed base or within the traditional outpatient services and that can be provided across the primary/secondary care interface."

Royal College of Physicians (RCP) Acute Medical Task Force, and endorsed by the College of Emergency Medicine, 2012.

- This approach is clinically safe, reduces unnecessary overnight hospital stays and hospital inpatient bed days
- Acute assessment units enhance patient safety, improve outcomes and reduce length of stay
- Mental health problems account for around five per cent of A&E attendances, 25% of primary care attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions. Mortality and morbidity ratios amongst people with mental illness are much higher than amongst the general population.[6] Well-resourced liaison mental health services provided seven days a week and 24-hour a day are cost effective and an essential part of any urgent and emergency care system.
- Continuity of care is a fundamental principle of safe and effective practice within, and between, all settings. The sharing of and access to key patient information is essential to this
- Getting patients to definitive, specialist hospital care can be more important to outcomes than getting them to the nearest hospital for certain conditions, such as stroke or major trauma.
- Properly resourced intermediate care, linked to general practice and hospital consultants, can prevent admissions, reduce length of stay and enable home based care and assessment, including supporting 'discharge to assess' models
- In March 2017 NHS England mandated the front door clinical streaming in every A&E department.[7] This is based on the Luton & Dunstable model. See Figure 3.

[6] http://www.bjmp.org/content/physical-morbidity-and-mortality-people-mental-illness
[7] http://www.gponline.com/every-a-e-will-gps-front-door-christmas-says-simon-stevens/article/1426992

Figure 2: Luton & Dunstable model of urgent care front door clinical streaming



The below should be considered when doing a baseline/gap analysis to support implementation of a streaming service:

Minimum service requirements

- Service operational from 8am to 11pm (365 days per year)
- ED streaming – 1x band 7 nurse
- GP clinic
- 2 GPs available (for quiet periods this can be 1 GP, and flexed up if required)
- 1 clinical nurse
- 1 HCS

Space requirements

- 2 consulting rooms
- A clinic room (which can also be used as a 3rd consulting room)
- Small waiting area
- No diagnostics

Another development which will impact on future A&E usage is the General Practice Forward View (GPFV)[8]. Clinical Commissioning Groups (CCGs) in England were asked by NHS England to pull together plans by December 2017 to detail how they will translate the aims and key local elements of the GPFV into more detailed local operational plans[9], including as a minimum:

- How access to general practice will be improved
- How funds for practice transformational support will be created and deployed to support general practice
- How ring-fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed
- How requirements to ensure improvements in both 'in hours' and 'out of hours' access to Primary Care as part of a broader Integrated Urgent Care (IUC) offer.

The 'Next Steps on the NHS five year forward view' (March 2017) [10]sets out the mandate to standardise existing Walk in Centres (WiC) and Minor Injuries units (MIU) through the implementation of Urgent Treatment Centres (UTCs), open 12 hours a day, seven days a week and integrated with local urgent care services.

Urgent Treatment Centres need to comply with the 27 standards set out by NHS England within 'Urgent Treatment Centre's Principles and Standards' July 2017 The guidance details key components of what an urgent treatment centre must include such as:

- GP led service with other multidisciplinary clinical workforce as locally determined (including prescribing ability)
- Planned and Unplanned (walk in) appointments
- Opening hours - for at least 12 hours a day seven days a week 365 days a year

[8] General Practice Forward View (April 2016) https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
[9] BMA General Practice Forward View information: https://www.bma.org.uk/advice/employment/gp-practices/gps-and-staff/focus-on-general-practice-forward-view
[10] Next Steps on the NHS five year forward view (March 2017) https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

- Direct booking from NHS 111 and other services, with access to a Directory of Services (DoS)
- Access to simple diagnostics such as swabs, pregnancy tests, urine dipstick and culture, near patient blood testing and electrocardiograms (ECG)
- Access to x-ray facilities, with clear access protocols if not available on site
- Access to ED consultant

Urgent Treatment Centres will deliver a clearer service offer for patients, with directly booked appointments via NHS 111, general practice and ambulance services, in addition to being able to walk-in. Urgent treatment centres will also be required to operate as part of a networked model of care, with referral pathways into emergency departments and specialist services as needed.

All UTC services will be considered Type 3 / 4 A&E and will contribute to a 95% emergency access target locally. It is expected that the standardisation of UTCs will also offer:

a) An improvement in patient and staff experience of a consistent urgent and emergency care service with:
- Reduction in minor attendances at A&E
- Reduction in long waits for treatment (improved performance against 95% target)
- Improvement in patient and staff experience of urgent and emergency care
- Opportunity for co-location and collaboration between services – UTC, Clinical Assessment Services, GP OOH, GP access hubs - and offers patient convenience and professional variety experience, and the opportunity for signposting patients to the appropriate service on initial presentation.
- Offers alternative to conveyance to accident and emergency departments for ambulance services

b) Enhanced clinical quality by offering:
- Access on site or via explicit referral pathways to diagnostics including x-ray
- Electronic access to patient records, diagnostic information and prescribing
- Access to specialised advice through a) clinical assessment service and b) networked approach to UEC
- Increase in patient safety and satisfaction

c) An improvement in the way people access urgent and emergency care with:
- A clear access route – directly booked appointments through NHS 111, general practice, ambulance services and walk-in
- Care delivered in a more convenient setting / closer to home

d) Financial savings by:
- Contributing to modelled savings as part of networked model of care. Once the model is implemented it is likely that connected services such as streaming, GP OOH, extended access to primary care and a reduction in assessment ward usage will be impacted and lead to an efficiency across the system.

The guidance describes an opportunity for commissioning a genuine integrated urgent care service, aligning NHS 111, Urgent Treatment Centres, GP Out of Hours and routine and urgent GP appointments with face to face urgent care.

Urgent Treatment Centres that are co-located with primary care facilities, including GP extended hours/ GP Access Hubs or Integrated Urgent Care Clinical Assessment Services are seen as key to the above with even greater benefits available if they are also located alongside the hospital A&E department and other urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector. A central site that enables access to multiple services will ensure that people quickly get to the service that best serves their need.

The guidance also explains that the Urgent Treatment Centre could be commissioned as an integral part of a service delivery model which contributes towards the GP access commitment which is set in the NHS England Planning Guidance (2018). This requires CCGs to provide extended access to GP services, including at evenings and weekends, including pre-bookable and same day appointments. This can be provided through a hub and spoke model so CCGs could plan a hybrid model where some of the routine access appointments could be delivered in Urgent Treatment Centres to maximise resources and estates.

Following this an Integrated Urgent Care Service Specification (August 2017)[11] was published which describes the requirement for CCGs to ensure delivery of an IUC offer which includes a 24/7 clinical advice service (CAS) fully integrated with NHS 111 and direct booking to both in hours and out of hours primary care appointments by March 2019.

Summary of National Evidence and Policy Context

- The 2015 Keogh review outlined a vision where people in need of urgent care have highly responsive services close to home; alongside more specialist services in fewer centres for those with more serious or life-threatening emergency care needs
- Since September 2017, hospitals are mandated by NHS England to have primary care streaming in A&Es
- The NHS are also implementing a national programme of new 'Urgent Treatment Centres' in England which will open 12 hours a day, seven days a week, integrated with local urgent care services
- A recommendation was that general practices cluster together to support populations of around 30-50,000 patients` in order to jointly deliver a range of primary care Services such as Dressings, Vaccinations, Diagnostics and other services such as Minor Illness and Injury support[12]
- CCGs must (by December 2017) show how they will support the training of care navigators, medical assistants and promote online consultations in primary care
- A new national model of care for urgent and emergency services will be implemented by December 2019, as mandated by NHS England. This primarily involves the introduction of Urgent Treatment Centres across England, along with current Accident and Emergency Departments, Integrated Urgent Care Clinical Assessment Service (IUC CAS).
- Urgent Treatment Centres need to comply with the 27 standards set out by NHS England and will deliver a clearer service offer for patients, with directly booked appointments via NHS 111, general practice and ambulance services, in addition to being able to walk-in.
- Commissioners should align thinking for Urgent Treatment Centres with the core requirements for Extended Access, as well as opportunities with the clinical assessment

[11] Integrated Urgent Care Service Specification (August 2017) https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
[12] Next Steps on the NHS Five Year Forward View. NHS England, March 2017: https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

service that supports NHS 111. There are many opportunities to integrate wider primary care with urgent care, to rationalise the service offer, reduce duplication and flex the workforce to provide urgent and primary care services which meet the needs of the local population

5.2 National Insight on Urgent Care

Behavioural insight is about using evidence from behavioural science to understand human behaviour, make public services more cost effective and enable citizens to make better choices. Behavioural economics is the study of cognitive, social and emotional influences on people's observable economic behaviour. It moves beyond the traditional idea of individuals behaving like rational consumers.[13]

Behavioural insights and behavioural economics are interested in how people make different decisions depending on how choices are presented to them, or the *choice architecture*. In supermarkets for instance, branded products which are more expensive are often placed at eye level because people are more likely to buy them. Behavioural science or 'nudge' theory has been used to attempt to make 'better' choices the default choices, for instance by compelling people opt out of occupational pensions instead of opting in, or in Wales asking people to opt out of organ donation. People are prone to *inertia*, where they stick with the default because deviating involves effort and do not want to be seen to disagree with the norm.[14] 'Nudging people' means positive reinforcement and indirect suggestions to try to achieve non-forced compliance; it is a form of 'liberal paternalism'.

Urgent care is a good example of where behavioural insights can be useful, as people have a range of options, so will choose the option that they believe is easiest to access, quickest, that will give them the best outcome. People who are using urgent care may often be afraid and ill which drives their decision making, as people may be more likely to use options they have used before or that are familiar to them, like A&E, in these circumstances.

A rapid evidence review was carried out for London's A&E Behavioural Insight Project into the use of urgent and emergency services which aimed to change the behaviour of the public to attend primary care instead of A&E. It may be that insights from London are less applicable to areas like Wirral as London has a high proportion of the population who were born in other countries which is one driver of A&E use.[15] This review identified some case studies where there had been a quantifiable reduction in A&E use. There was a large-scale programme through the Prime Minister's Challenge Fund that produced some reductions in A&E use. These schemes were around the country in areas including Warrington, Birmingham and Wakefield and were concerned with increasing access to GPs, through hub and spoke services, and increasing access to telephone appointments. Some of the services were targeted around reducing health inequalities. Up to May 2015 there was a reduction of 29,000 minor self-presenting A&E attendances which represents a 15% reduction. Nationally, there was a 7% reduction in these minor A&E attendances, so this reduction was 8% faster.

In behavioural insight work carried out in London, one A&E consultant said;[16]

[13] http://www.behavioraleconomics.com/BEGuide2015.pdf
[14] Voyer, Benjamin G. (2015) *'Nudging' behaviours in healthcare: insights from behavioural economics.* British Journal of Healthcare Management, 21 (3). pp. 130-135. ISSN 1358-0574
[15] https://www.myhealth.london.nhs.uk/sites/default/files/Rapid%20review%20-%20Behavioural%20insights.pdf
[16] https://www.myhealth.london.nhs.uk/system/files/Nov%202015%20Event%20-%203%20The%20Patient%20Perspective_0.pdf
https://www.myhealth.london.nhs.uk/sites/default/files/Rapid%20review%20-%20Behavioural%20insights.pdf

'A&E is a trusted brand. Open 24/7 with instant access to blood tests and radiology and a doctor with specialty support. Why would people go elsewhere when there are no other one stop shops like A&E?'

This work suggested that for patients who were worried and unwell, going to A&E was a logical decision for them. Many had tried to get GP appointments first, but were unable to. The sum total of logical decisions at an individual level however, can create problems at a population level. The research suggested that to change behaviour, 'an exchange' needs to be provided for the current behaviour. The UK Government's Behavioural Insights Team (BIT) use the acronym EAST; that if we want to encourage a behaviour, make it Easy, Attractive, Social and Timely.[17] The BIT ran an experiment where they sent a letter to people who had an unnecessary attendance at A&E recently, giving them alternative options for care, but found that the letter made no difference to subsequent rates of using A&E unnecessarily. The BIT is currently running a study based on Boston University's Re-engineering Discharge (RED) project which aims to reduce unnecessary re-presentations to hospital for children with fever. In the US pilot, this intervention reduced readmissions from 19% to 10%.[18] There is evidence from the same programme that adults with a self-care plan following hospital discharge reduced readmissions by 30%.[19]

In Kent[20] and North Wales[21] piloting of a smartphone app showing real time waiting times for different services to motivate people to choose different options to A&E have been implemented (awaiting results). In Bury, there has been a decrease year on year in Walk-In Centre activity, resulting in proposals to close Walk-In Centres, replacing them with specific wound care clinics and greater availability of GPs.[22]

Summary of National Urgent Care Insight

- There are several different options for urgent care, which are not easily understood or navigated by patients
- People will choose the option that they *believe to be* the easiest, quickest option that will give them a good outcome
- When people are ill and scared, they tend to use 'default' services that feel familiar and 'safe' to them
- What seem like logical decisions at an individual level however, can create problems at a population level. A&E is the 'easiest' service for the public to access, but the most costly for the NHS to provide
- Prime Minister's Challenge Fund pilots produced reductions in A&E use of around 15%. These schemes were involved increasing access to GPs, often via greater access to telephone appointments, with some services targeted at reducing health inequalities

[17] http://catalyst.nejm.org/applying-behavioral-insights-improve-health-care/
[18] https://www.ncbi.nlm.nih.gov/pubmed/23608528
[19] Jack, B. W., Chetty, V. K., Anthony, D., Greenwald, J. L., Sanchez, G. M., Johnson, A. E., … & Culpepper, L. (2009). A reengineered hospital discharge program to decrease rehospitalisation: A randomized trial.
[20] https://www.kentcht.nhs.uk/2016/12/19/new-app-aims-cut-waiting-times-ae/
[21] http://www.deeside.com/live-ae-wait-time-smartphone-app-launched-north-wales/
[22] http://www.buryccg.nhs.uk/Library/Board_Papers/CCG/2017/18_jan_17/03a_-_Appendix_1.pdf

5.3 National Evidence on Accident & Emergency usage

Nationally, there has been a 26% increase in A&E attendances over the last ten years and new forms of urgent care services, such as Walk-In Centres and urgent care centres have failed to reduce A&E attendances.[23] Many people still find it more convenient to use A&E or use it because they are not registered with a GP. People may use A&E or other urgent care when they are away from home, for instance, working away, at university or on holiday. A&E departments have targets of four hours to either, treat patients and discharge them, or to admit patients to hospital.

In a Healthwatch England survey in 2014, over 20% of people admitted to going to an A&E department with a condition that they knew was not urgent.[24] In a report by the Patients Association / RCEM in May 2015, almost a quarter (23%) of patients attending A&E had already contacted their GP surgery to request an appointment and 45% had been offered an appointment on the same day.

The people who wait longest in A&E are typically older people with complex needs.[25] The main causes of A&E crowding include surges in demand and lack of access to beds in the hospital system due to poor patient flow and high hospital occupancy rates. Where there is a lack of hospital beds, patients may have 'trolley waits'.

Approaches to managing demand in A&E include matching surges in demand (e.g. on a Monday) with appropriate staffing levels, trying to change patient behaviour and/or diverting people to other services and trying to free up beds elsewhere in the hospital. Nationally, A&E attendance rates peak in the summer, but rates of admission through A&E peak in the winter. Many hospitals make a net financial loss on their A&E departments.[26] Hospitals struggle to attract senior medical staff to work in A&E and A&E is not an attractive career choice for many doctors.[27]

It has been suggested that demand for urgent care is partly related to the resilience and availability of community-based services, so if people can access their GP or community nursing then they may be less likely to use A&E. A&E use is also driven by deprivation, with national data suggesting that people from the most deprived areas are more than twice as likely to have emergency admissions for ambulatory care sensitive conditions (conditions where people could have been seen as an outpatient).[28]

If, as research suggests, a proportion of urgent care use is related to mental health crisis, then ease of access to specialist mental health services will inevitably impact on use of urgent care. The 'Crisis Care Concordat' is focussed on improving access for people in mental health crisis, reducing ambulance conveyances and reducing the number of people being detained under Section 136 of the Mental Health Act. Some urgent care use may be down to drug and alcohol problems so having accessible drug and alcohol treatment may reduce demand. Urgent care use may also be related to whether people are confident using, and able to access pharmacy

[23] https://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/urgent-care
[24] http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/final_report_healthwatch_special_inquiry_2015_1.pdf
[25] https://www.kingsfund.org.uk/sites/files/kf/media/alternative-guide-urgent-and-emergency-care-system-apr2014.pdf
[26] https://portal.rcem.ac.uk/LIVE/docs/Policy/RCEM_Essential%20Facts%20for%20England.pdf
[27] https://www.kingsfund.org.uk/sites/files/kf/media/alternative-guide-urgent-and-emergency-care-system-apr2014.pdf
[28] http://www.health.org.uk/publication/qualitywatch-focus-preventable-admissions

services, whether people who need them can access sexual and reproductive health services and whether people can access social care services.

A series of systematic reviews[29] of interventions to reduce unplanned hospital admissions from 2012 found that specialist clinics for heart failure patients (but not asthma or older people) reduced hospital admissions. Evidence was limited for the impact of providing home visits to infants, older people and heart disease patients. Providing patient education in adults with asthma (but not children with asthma) and COPD appeared to reduce unplanned admissions. Exercise-based cardiac rehabilitation for coronary heart disease was effective in reducing unplanned admissions in shorter term studies, while therapy-based rehabilitation targeted towards stroke patients living at home, and falls prevention programmes did not reduce unplanned admissions. Telemedicine reduced unplanned admissions in individuals with heart disease, diabetes, and hypertension and in older people.

An evidence review carried out by Sheffield University in 2014[30] found that attempts to make access easier via services such as Walk-In Centres, NHS Direct and NHS 111 increased expectations and consequently, increased demand. This review suggested that the following elements also need to be understood and considered in relation to their impact on the whole system: access and navigation, direct access to services, media campaigns, workforce and capacity, ambulance services and primary care.

Summary of National Evidence on A&E usage

- Nationally, there has been a 26% in A&E usage in the last 8 years in England (the corresponding increase in Wirral was 4% over the same period)
- A national survey in 2014 found that 20% of patients had attended A&E with a condition that they knew was not urgent, and 23% had previously tried to contact their GP and 45% had been offered a GP appointment on the same day
- Deprivation is a significant factor in driving A&E attendances. Data suggests that people from the most deprived areas are more than twice as likely to have emergency admissions for conditions which could have been managed in outpatient clinics/services
- Mental health issues are also a factor in A&E attendances. Mental health problems account for around 5% of A&E attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions. Well-resourced liaison mental health services provided seven days a week and 24-hour a day are cost effective
- Other interlinked drivers of A&E usage are; older age; long term conditions (mainly related to older age); being unregistered with a GP; young adults starting to navigate the healthcare system independently; drug and alcohol issues and levels of knowledge about other options and/or the perceived complexity of the system
- There is evidence that Walk-In Centres and other urgent care interventions may increase rather than reduce total demand on the system
- Acute assessment units enhance patient safety, improve outcomes and reduce length of stay

5.4 Wirral-specific Urgent Care Insight

Introduction

[29] http://www.apcrc.nhs.uk/library/research_reports/documents/9.pdf
[30] https://www.sheffield.ac.uk/polopoly_fs/1.366353!/file/Whole_System_Solutions_for_Emergency_and_Urgent_Care.pdf

There have been a number of surveys, focus groups, reviews, research and public workshops carried out in Wirral between 2009 and 2016 on the topic of urgent care. This document summarises the insights gained from these events and surveys, from which there were many common themes. A summary of all the insight, with a focus on the recurring themes is presented in the box below.

Summary of insight of use Urgent Care Services in Wirral

- Around one in three of all visits (in those aged 0-16) to any urgent care venue in Wirral are for an infant aged 2 or under
- Parents of children said they would be more likely to use WICs in the future if they knew what services were available (e.g. paediatric skills, required medication was available, nurse or doctor led services, X-ray etc…) and were clear on practicalities such as opening times
- Improved advertising and marketing of what services are available in which settings is seen as key by both parents and frontline urgent care staff, as was having advice or people they can contact to help them discuss the symptoms prior to making a decision about which service to attend
- A recurring theme across multiple Wirral surveys and reviews was patients reporting attending A&E because they could not get an urgent GP appointment. Again, this is not particular to Wirral and is also a national finding
- A large proportion of people attending with conditions which could have been seen elsewhere, reported having been referred directly from primary care. This was echoed by further local research in which Wirral A&E clinicians reported frustration at what they saw as inappropriate referrals from primary care
- Data indicates that high rates of attendance at Victoria Central Hospital WIC in children aged 0-16 appears to divert attendances from A&E, as attendances are low from those wards which surround this WIC (Seacombe, Liscard) despite these wards being fairly deprived, which usually results in high levels of A&E usage
- Walk in Centres and Minor Injury Units were valued in the communities they serve. Over 90% of respondents agreed that they would recommend the service to friends and family
- Patients wanted access to an urgent care facility that would provide an accurate diagnosis and appropriate treatment quickly (within 2 hours of attending) and would prefer extended hours (9am -9pm) or 24 hours a day; most people indicated a preference for 7 day access.

Workshops for public and professionals on Urgent Care: 2016

In 2016, Wirral CCG conducted three Urgent Care Value Stream Analysis[31] events. The events included representatives from local NHS organisations and members of local patient groups. The events looked at the challenges faced locally, as well as information on service usage. The main insights collected from these workshops were as follows:

- People were confused about what is offered and therefore will choose to go to A&E, because they know they will be seen
- There should be a greater use of technology to enable people to make the right choice when they need to access urgent care services
- There should be more coordination in how urgent care is delivered.

[31] Value Stream Analysis is a technique used to document, analyse and improve the steps in a patient's journey and flow of information or material required to produce or improve a service

- There should be a greater emphasis on 'Self Care', meaning that people make every effort to care for themselves before using urgent care services
- Related to the above, there should be an increased focus on promoting health and wellbeing
- There should be consistent availability of urgent access to general practice
- Services should be redesigned to deal with non-urgent issues like wound dressings

Workshops for the public: January 2016

In January 2016, the Healthy Wirral partnership held a series of public workshops[32] on urgent care which asked the question, "What matters to Wirral". A large proportion of responses indicated a preference for A&E over other services (including people's own GP) for various reasons, including:

- Having access to support/treatment the same day (unlike GPs, where urgent appointments or appointments at weekends were unavailable)
- Greater trust in the service provided
- Preferring to take a cautious approach

People also expressed a desire for more joined up services and specifically mentioned concerns such as not to have to tell their story repeatedly, and for services to provide more holistic care, rather than being seen as a set of diseases.

Survey of Walk-In Centre (WIC) and A&E users: 2015

Using the questionnaire used by Wirral CCG (see below 'Survey of Wirral residents 2015), Healthwatch completed face-to-face surveys with patients at WICs and A&E; findings included:

- When asked why they had chosen to use a WIC or A&E, the most common response was that patients could not get a GP appointment, or that patients thought that the service they had chosen was the most appropriate for their condition.
- Almost 2 in 3 patients (65%) said that they would consider using an alternative service if they were aware of an appropriate service available
- The three most highly rated services that patients would recommend to family and friends were Pharmacies (98%), Walk in Centres/Minor Injuries (93.59%) and A&E (81.94%) The lowest rated service was NHS 111 at 38.89%, but it should be noted that this service had the most 'unsure' responses, due to the fact that many of the patients surveyed had not used the service or were unaware of it.

Survey of Wirral residents: 2015

In September 2015, Wirral CCG conducted a survey (as part of the Healthy Wirral programme) to ask at an early stage, the views of residents on urgent care and gauge how residents thought these services could be changed to ensure that urgent care services meet need. There were 443 respondents, key findings included:

- People were unclear about the different urgent care services offered

[32] 'What Matters to Wirral' presentation, Healthy Wirral, 07-03-2016

- People were most likely to feel knowledgeable about A&E (43%), General practice (38%) and pharmacies (36%) compared to other services such as WICs and Minor Ailments/Injuries units
- The most common reason for choosing to attend a WIC or Minor Ailments/Injuries unit was because they were unable to get a GP appointment (46.3%)
- The majority (73.6%) of respondents felt that a reasonable time to wait for an assessment at an urgent care facility was less than 1 hour
- The majority (64.4%) of respondents felt that a reasonable time to wait for treatment at an urgent care facility was less than 2 hours
- A high proportion of respondent felt that urgent care facilities should be open 24hrs a day, 7 days a week; some respondents felt that extended hours for GP appointments would be suitable.
- When asked, 'What matters most to you', in relation to urgent care facilities 'Accuracy of diagnosis' and 'Quality of treatment' were identified as most important by respondents

Surveys of Urgent Care service users: 2015

The findings from reviews carried out by Healthwatch in 2015 with Urgent Care service users[33] found that although in most cases, quality of care was good, there were some recurring themes, see below:

- Waiting times from registration of attendance to treatment was very long
- Patients were on trolleys in corridors often for a considerable time
- Frequent attendees did not receive appropriate referrals to other services which could help them
- Patients with mental health conditions were discharged and referred to services that they had been signposted to many times before, but ended up back at A&E regardless
- Patients did not know what different services (e.g. GP Out of Hours, A&E, WIC) provided, resulting in inappropriate attendances at A&E
- There should be clear, consistent communication about opening times, possibly to include generic opening times to remove confusion
- Clear communication of what each urgent care service offers patients (e.g. whether it is Nurse or Doctor led service, X-ray available)

Surveys of Minor Ailments service users: 2014

Healthwatch undertook several, 'Enter and View' quality reviews of the Minor Injuries services at Miriam and Parkfield medical centres[34] in 2014. Findings included:

- The main reason for choosing to attend the clinic was because respondents were unable to get an appointment with their GP
- If there had been a choice of additional locations, 78% of respondents would attend another minor injuries unit
- Patients were pleased with the care they received and the short waiting time, with the majority of patients rating the experience as 'good' or 'excellent'. All patients surveyed were either 'extremely likely' or 'likely' to recommend the service to family and friends

[33] Healthwatch Wirral: Urgent Care Survey results (2015)

[34] Healthwatch Wirral (2014) Miriam Minor Injuries/Illness Service Survey results

Qualitative research with patients and professionals: 2014

In 2014, in-depth qualitative research was undertaken by Wirral CCG. A total of 25 interviews were undertaken with parents and frontline staff (GPs, receptionists, Nurses, Managers) 12 of the interviews were conducted with parents of children who had visited A&E, the remaining 13 interviews were conducted with front line staff from several healthcare settings; Children's A&E Service, general practices, GP Out of Hours (GPOOH) and Walk In Centres. The key findings from the analysis where:

- General practices were identified as the most appropriate place for parents to take children for non-emergency care. However, there was a perception from both parents and frontline staff that GP access is a problem when parents want to see someone urgently.
- In the majority of cases that have led to an A&E attendance, there was a reported feeling of panic and anxiety from parents about the health of their children. Parents needed re-assurance and felt that A&E staff fulfilled this need. Re-assurance was also seen as key by frontline staff when dealing with worried parents and children
- Whilst Wirral Children's A&E was considered excellent by parents, it was indicated that improved communication around waiting times and discharge procedures could reduce stress and frustration of parents
- It was felt that WICs would be used more often if they had more paediatric skills and required medication available. There was a perception by parents that they might as well go direct to A&E, as they would ultimately have to go there anyway
- It was believed that there is a lack of awareness amongst parents about other health care alternatives available in the health community and what these services can provide
- Advertising and marketing were seen as key by both parents and frontline staff as to the services available and that social media could help facilitate this
- It is important for parents to have advice or people they can contact to help them discuss the symptoms prior to making a decision on which service to use. This can be family, friends, NHS Direct, GP or dedicated websites with advice
- There was a clear belief amongst staff and service users that education and experience combine to help parents self-manage conditions and potentially prevent A&E attendances
- There was a perception among staff that a 24 hour Children's A&E Service would improve the service and care for parents and children
- It was believed that some parents will always choose to go to A&E purely based on location because it is the most convenient place for them

Review of data on children's urgent care usage: 2013

A review of urgent care usage data among children aged 0-16-year olds in Wirral in 2013 found that;

- Children most likely to visit any urgent care venue were those aged under 2 years old. One in three of all visits (33.6%) to any urgent care venue in Wirral in 2012/13 were for a child aged 2 or under
- The peak age for children to attend any urgent care service was age 1
- Boys had a consistently higher number of attendances at A&E (at all ages 0-16)
- In the very youngest children (those aged <2), the GP OOH was more commonly used than A&E (A&E was the second most popular option for the under 2s)

- For all other ages, A&E was the urgent care service most likely to be attended
- There was a second, much shallower peak in attendances to A&E at ages 11 and 12, the age at which children become more independent and go to secondary school
- Deprivation appears to have a marked effect on attendances. High levels of deprivation equalled high rates of attendance (at A&E, GP OOH and Victoria Central Hospital WIC). Eastham WIC appeared unaffected by deprivation
- The wards with the highest rate of both attendances and admissions were the most deprived (e.g. Birkenhead and Tranmere)
- The highest rates of attendance at any venue were seen for children from Seacombe, Wallasey, Liscard and New Brighton using Victoria Central Hospital WIC. These four wards also had correspondingly low rates of usage of other urgent care services
- Proximity appears to have an effect on attendances (at both A&E and WICs), but not admissions (e.g. Upton ward has high rate of attendance, but not admissions).
- The GP OOH service did not seem to be affected by either deprivation or proximity

Focus groups and literature review: 2009

An evidence review of the literature on reasons for urgent attendances, followed by focus groups with parents who had used A&E on behalf of their children, were both carried out by NHS Wirral in 2009[35]. Findings were:

- Self-referrers to A&E were no more likely to be 'inappropriate' than those referred by primary care. A large number of non-urgent A&E cases had been referred by other health services or professionals. This was echoed by more recent research[36] in which A&E clinicians reported frustration at what they felt were inappropriate referrals from primary care (solely to reassure anxious parents)
- Estimates of 'inappropriate' A&E use vary widely. Definitions used, and different population groups affect estimates, making them virtually impossible to quantify
- There are certain population groups more likely to use A&E for non-urgent conditions (e.g. mental health patients, younger people, people living in deprivation)
- Targeting frequent attendees has the potential to reduce a significant proportion of A&E workload, investigation of underlying (medical, psychological or social) conditions may yield positive results
- Alternative services such as WICs and Minor Ailments/Injuries services will have an effect on A&E usage, but it is likely to be small and significantly less than the 55% cited in some studies. In addition, the facilities available at such sites need to be widely publicised (e.g. availability of X-ray)
- The most commonly cited reason for people (classed retrospectively as 'inappropriate') to go to A&E was belief that they need an X-ray
- Use (of A&E) promotes future use, as although waits can be considerable, because A&E was seen as providing safety, reassurance and familiarity at a time of anxiety and crisis

[35] Wirral Public Health Intelligence Team (2009) Evidence briefing on avoidable or non-urgent attendances at A&E.
[36] Experience Led Commissioning: Urgent Care findings (2014)

6. Why Change is required

The focus for all urgent and emergency care services should be on providing high quality, safe, responsive care using a whole system approach. We need to ensure that there are effective and efficient systems in place to meet the urgent care needs of patients with significant illness or injury. In this section we cover insight gained from a series of Healthy Wirral value stream analysis events; urgent and emergency care performance across Cheshire and Merseyside; and performance at a Wirral level.

6.1 Healthy Wirral

Healthy Wirral is the partnership between the organisations that deliver health and social care in Wirral with the aim of transforming the way health and wellbeing services are designed and delivered in Wirral, by putting the people at the centre of everything.

Key benefits:

- Improving health and wellbeing outcomes
- Improving patients' and service users' experience
- Providing efficient, well organised and value for money health and social care service

The value stream analysis events referenced in section 5 identified a range of factors causing an increase in the pressure/demand on services supporting the case for change, overall it was concluded that;

- Urgent care is a complex system with multiple entry points means the default is often the easiest point of access i.e. A&E or 999
- Multiple access points offering subtly different services can lead to duplication
  - patients can often access more than one service during a single episode
  - poor journey across the pathway of care for the patient and costs more
- Increasing demand, rising costs and the challenges to make efficiencies across the health and social care economy. Services need to transform to meet the needs of a changing demographic

Drivers for change:

- Offering better care, better health and better value for residents in Wirral
- Feedback from the public and patients demonstrates confusion about which services to access, when in need of urgent care
- Ongoing and consistent failure to achieve the A&E standard (95% of patients being seen and admitted or discharge within 4 hours)
- Delayed ambulance response times and handovers at Arrowe Park Hospital site
- Direction of travel as set out in the Five Year Forward View and the vision for new care models
- Emergency Care Improvement Programme (ECIP) identifies improvements required in:
  - hospital patient flow
  - assessment prior to admission

- effective assessment outside of the hospital setting at discharge

The final event concluded with all stakeholders in agreement that transformation and redesign was required to deliver a sustainable future for urgent care on Wirral, that the urgent and unplanned care system needed to be;

- **Responsive:** Quick access to the very best advice and care, delivered as close to home as possible
- **Reliable:** Right care, first time with consistent delivery across service providers
- **Efficient:** Improved quality and effectiveness whilst reducing cost

Additional outputs from the events were draft models of care that would enable the delivery of care to meet the above outcomes. These models have been fed into the development of the proposals that are described in Chapter 9.

6.2 Cheshire and Merseyside Performance

Table 1 below compares the performance of the urgent care system across Cheshire and Merseyside as at March 2016/17. The indicators identify pressures in the urgent care system, such as:

- Longer ambulance (NWAS) response times and turnaround times which are typically indicative of bottlenecks in the emergency department
- Low 4hr A&E performance suggests pressures within emergency department process; whether in seeing patients in a timely manner or delays in processes or capacity in moving patients to assessment areas and wards
- The 4-12hr wait from decision to admit (DTA) indicator may suggest how the emergency department interfaces with the hospital. A high percentage of emergency admissions waiting over 4hrs from a DTA suggest process issues and/or bed availability/capacity issues.
- Bed occupancy suggests internal and back-door pressures on urgent care. High bed occupancy can be a pressure as bed availability is reduced. It is indicative of longer length of stay (LoS)
- Delayed transfers of care highlight bottlenecks in discharge processes from hospital either due to NHS, Social Care or both.

6.3 Wirral Performance

There are national operational standards that Wirral CCG is measured against as a direct result of the Urgent and Emergency Care Review (2013) and its proposal for a radical shift in care to a 24/7 functionally integrated access, assessment, advice and treatment service.

Wirral Urgent Care Performance measures set out in Table 2 identify pressures in the urgent care system on Wirral for the financial year 2016/17, such as:

- 18.13% reduction in ambulance service response to Red Calls 1 – March 2017 (% of patients responded to for life-threatening and serious conditions within 8 minutes)

- 13.19% reduction in ambulance service response to Red Calls 2 – March 2017 (% of patients responded to for life-threatening and serious conditions within 8 minutes)
- 15.80% increase in ambulance average notify to handover time – March 2017 (<15mins)
- 5.43% reduction in walk in centre attendance – April to March 2017
- 85.10% of patients seen within 4 hours against a national target of 95% in the last 12 months
- 0.90% increase in A&E attendances in the last 12 months
- 2.05% increase in emergency admissions in the last 12 months
- 20% reduction on average for Bed occupancy of Intermediate Care/Transitional/Carer Respite Beds – March 2017

Table 1: Cheshire and Merseyside: Urgent Care Summary 2016/17 March

Pressure Indicators	Aintree	Chester	East Cheshire	Mid Cheshire	Royal Liverpool	Southport & Ormskirk	St Helens	Warrington	Wirral	Cheshire and Mersey
NWAS Avg Overall Arrival to Clear Time all Attends	34:06	34:29	28:17	24:53	33:40	34:14	34:23	33:52	37:43	33:52
4hr T1	79.84%	84.68%	82.39%	96.41%	73.56%	78.84%	80.05%	86.17%	75.64%	81.33%
4hr Overall	89.93%	85.99%	83.47%	97.21%	89.65%	88.12%	87.44%	90.74%	81.26%	88.97%
4-12hr waits from DTA % of emergency admissions	17.70%	24.79%	10.33%	0.05%	0.04%	13.60%	6.63%	15.62%	29.62%	13.11%
No of patients over 12hrs - Total	0	0	0	0	1	0	0	0	0	1
%attendances admitted T1	37.82%	25.60%	23.96%	32.24%	30.38%	29.12%	39.70%	38.20%	31.56%	32.79%
Bed Occupancy	93.35%	97.59%	82.94%	85.86%	96.13%	91.03%	91.67%	86.73%	86.04%	90.47%
Mean (avg) Length of stay (includes same day discharges)	4.67	4.28	5.18	3.88	5.07	4.51	3.73	3.53	4.17	4.23
DTOC Days total as % of Occupied bed	3.28%	6.35%	11.91%	6.67%	1.41%	1.65%	3.05%	4.74%	5.74%	5.98%

Source: North West Utilisation Management Unit

Table 2: Wirral Urgent Care Performance Measures 2016/17 March

Measure	Coverage/Area	Reporting Period	Previous Year Activity	Current Performance	Target	% Total Variance
Arrival (Ambulance and NHS 111)						
Ambulance Red 1 - Category A calls within 8 minutes	Wirral	Mar-17	61.90%	61.40%	75%	-18.13%
Ambulance Red 2 - Category A calls within 8 minutes	Wirral	Mar-17	63.20%	65.11%	75%	-13.19%
Ambulance All Reds - Category A calls within 19 minutes	Wirral	Mar-17	87.80%	92.44%	95%	-2.69%
Ambulance Handovers (Minutes)	Wirral	Mar-17	56.00	37.43	33.00	13.42%
Average Notify to Handover Time (<15 mins)	Wirral	Mar-17	30.10	17.37	15.00	15.80%
NHS 111 - Calls Triaged	Wirral	Mar-17		4,756		
NHS 111 - Ambulance Dispatches	Wirral	Mar-17		659		
GP Out of Hours and Walk-in Centres						
GP Out of Hours Attendances YTD	Wirral	Apr-Mar 17	54,241	47,847	54,241	-11.79%
ADHC WIC Attendances YTD	Wirral	Apr-Mar 17	34,426	30,829	34,426	-10.45%
Eastham WIC Attendance YTD	Wirral	Apr-Mar 17	14,005	13,075	14,005	-6.64%
VCH WIC Attendances YTD	Wirral	Apr-Mar 17	39,306	39,066	39,306	-0.61%
Total WIC Attendances	**Wirral**	**Apr-Mar 17**	**87,737**	82,970	**87,737**	**-5.43%**
Accident & Emergency						
A&E Attendances (Type 1)	All Providers	Apr-Mar 17	92,834	93,674	92,834	0.90%
A&E % 4 Hour Target YTD (Type 1)	WUTH	Apr-Mar 17	87.44%	85.10%	95.00%	-10.42%
A&E 12 Hour Target YTD (Type 1)	WUTH	Apr-Mar 17	6	0	0	0.00%
Emergency Admissions						
Emergency Admissions	All Providers	Apr-Mar 17	46,429	46,590	45,656	2.05%
Emergency Admissions via GP	WUTH	Apr-Mar 17	14,683	14,431	14,683	-1.72%
Emergency Admissions via A&E Type 1	WUTH	Apr-Mar 17	27,821	27,789	27,821	-0.12%
% of A&E Type 1 attendances admitted (attendance conversion)	WUTH	Apr-Mar 17	29.97%	29.67%	29.97%	-1.01%
Hospital Bed Occupancy & Discharge						
Average bed days lost due to Delayed Transfer of Care (DTOC) per 100,000 population (18+)	Wirral	Mar-17	133	*421.1	118.9	
% of care packages able to commence within 24 hours of initial contact	Wirral	Mar-17	56.00%	64.90%	95.00%	-31.68%
Admissions to residential and nursing care homes per 100,000 population (65+)	Wirral	Mar-17	40	911.3	661.1	37.85%
Average length of stay in weeks (Intermediate Care)	Wirral	Mar-17		4.40	5.00	-12.00%
% Bed Occupancy of Intermediate Care/Transitional Beds	Wirral	Mar-17	82.24%	75.90%	95.00%	-20.11%
% Bed Occupancy of Carer Respite Beds	Wirral	Mar-17		74.80%	95.00%	-21.26%

Source: Wirral Urgent Care Dashboard

***Variance not applied as calculation changed part year in 2016/17 therefore is not comparable year on year

Wirral performance is consistent with the regional picture in that Wirral consistently underperforms across the emergency front-door system and process key performance measures. This suggests that there is pressure on the ambulance service and the emergency department with delays in handing patients over to the emergency department, delays in initial

assessments and decisions due to increased demand or lack of capacity in the emergency department to assess patients. In terms of the 'back-door' (patients leaving hospital) pressures i.e. bed occupancy, average length of stay and delayed transfers of care, Wirral performs average across the region. This suggests that once patients are assessed beds are made available when the decision has been made to admit the patient, although Wirral does experience pressure or delays in discharge processes from hospital either due to NHS, Social Care or both.

Summary of why change is required

- Performance is deteriorating in many areas across operational, financial and clinical measures
- There is variability in performance and clinical outcomes and the opportunity to improve standard and services
- Ongoing and consistent failure to achieve the A&E standard (95% of patients being seen and admitted or discharged within 4 hours)
- Delayed ambulance response times and handovers at Arrowe Park Hospital

7. How Local Services are used

N.B. to ensure data in this section was comparable to previous years and across datasets the data has been updated up to and including the end of the financial year 31st March 2017. Any significant changes to this data have been acknowledged and supplementary data referenced in the appendix.

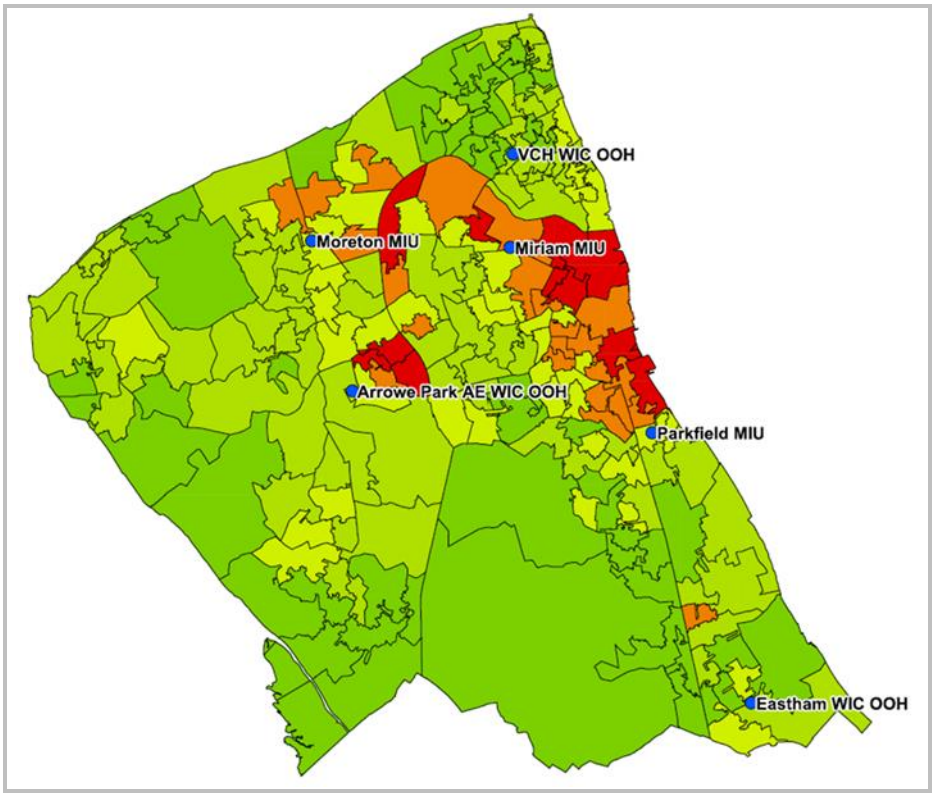
In this section we provide information on how the existing local services are used.

7.1 Analysis of A&E (Emergency Department) data for Wirral

A&E data in Wirral has been analysed by:

- Patient home residence (LSOA)
- Number of attendances
- Trend in rate of attendances by age band (current and trend)
- Attendances by gender, age and month
- Time of arrival, length of wait and 4 hour target

Map 1: A&E activity rate by patient residence (LSOA) 2015/16



The map shows the location of all urgent care venues in Wirral, but only attendances at Arrowe Park A&E have been included in the data. It shows that there is a clear effect of both deprivation and proximity which is driving attendances at Arrowe Park A&E.

Number of A&E attendances

The total numbers of A&E attendances appear to have increased in Wirral over the last 3 financial years. As Table 3 shows, there have been just over a quarter of a million A&E attendances by Wirral patients in the last 3 financial years.

When the 19,992 attendances at A&Es other than Arrowe Park by Wirral residents are included (e.g. people who have visited the Royal Liverpool when visiting Liverpool), the total number of attendances between 2014 and 2017 by Wirral patients is 274,954.

Table 3a: Number of attendances at Arrowe Park A&E, by month, 2014/15 to 2016/17

Month (financial year)	2014/15	2015/16	2016/17	All years
1 (Apr)	7,183	6,767	6,598	20,548
2 (May)	7,427	6,908	7,697	22,032
3 (Jun)	7,181	7,184	7,436	21,801
4 (Jul)	7,420	7,264	7,563	22,247
5 (Aug)	6,666	7,023	7,196	20,885
6 (Sep)	6,996	7,136	7,186	21,318
7 (Oct)	6,867	7,356	7,355	21,578
8 (Nov)	6,584	7,284	7,249	21,117
9 (Dec)	6,722	7,114	7,435	21,271
10 (Jan)	6,307	7,457	7,104	20,868

11 (Feb)	6,009	6,974	6,521	19,504
12 (March	6,692	7,618	7,483	21,793
Total	**82,054**	**86,085**	**86,823**	**254,962**

Table 3b: Average number of attendances at Arrowe Park A&E **per day**, by month, 2014/15 to 2016/17

Month (financial year)	**2014/15**	**2015/16**	**2016/17**	**All years**
1 (Apr)	239	226	220	228
2 (May)	240	223	248	237
3 (Jun)	239	239	248	242
4 (Jul)	239	234	244	239
5 (Aug)	215	227	232	225
6 (Sep)	233	238	240	237
7 (Oct)	222	237	237	232
8 (Nov)	219	243	242	235
9 (Dec)	217	229	240	229
10 (Jan)	203	241	229	224
11 (Feb)	207	249	225	227
12 (March	216	246	241	234
Average for year	**224**	**236**	**237**	**232**

*averaging number of days in month takes into account varying number of days in each month, leap years etc.

The average number of attendances **per month** for 2016/17 was 7,235, compared to 7,174 in 2015/16 and 6,838 in 2014/15. This gives an average number of attendances **per day** of 224 in 2014/15, 236 in 2015/16 and 237 in 2016/17.

There does not appear to be a clear pattern on why some months are busier than others. For instance, December and January might be assumed to be the busiest months for A&E attendances, but in fact, the Summer months of May, June and particularly July appear most busy (excepting 2015/16 when February and March had the highest average number of attendances per day).

When patients present at A&E they are assigned a classification. This is a system whereby patients are allocated to different flows according to their needs.

Classification examples:

- Minor cases – where patients who require emergency care but are not seriously ill are treated.
- Major cases – where seriously ill patients go to be treated
- Resuscitation (patients with serious illness or injury that need emergency assessment and care)

Table 4 shows almost 50% of Arrowe Park A&E attendances in 2016/17 were classified as minor cases. When you apply this to 2016/17 Arrowe Park attendances this equates to a total of 42,960 attendances classified as Minor cases, averaging 3,580 **per month** or 117 **per day.**

Table 4: A&E attendances at Arrowe Park by patient flow, 2016/17

Stream (Patient Flow)	2016/17 (%)
Minors - Including Staff Nurse Triage	49.48%
Major - Including Initial Major Assessment	27.19%
Children Emergency Department	16.93%
Resuscitation	6.30%
NULL (not coded)	0.09%
Awaiting Stream	0.01%
TOTAL	**100%**

Phase 1 of Clinical Streaming was introduced 4 September 2017 whereby an ED Nurse will stream a patient to one of the following flows:

- Minors:
  - Primary Care GP
  - Primary Care Nurse (ANP)
  - remain in ED if additional diagnostics/ treatment required
- Majors – remain in ED
- Resuscitation - remain in ED

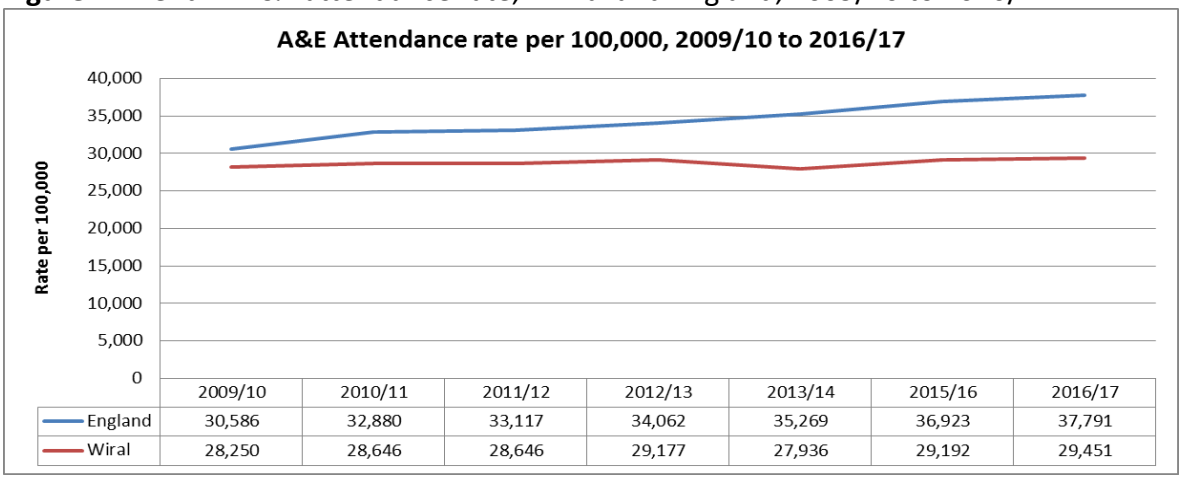
Streaming data for October 2017 demonstrates an average of 30 patients streamed to a primary care clinician each day. As this is a new service, it is anticipated that this may further increase as the service becomes embedded.

Phase 2 is currently in the process of development and will build on the lessons learned during phase 1. It will also look to expand the streaming outcome to include more off site options including patients' own GP, pharmacy, ICCTs, community rapid response service.

Trend in rate of A&E attendances

Longer term trend data from both Wirral and England shows that the rate of A&E attendances is increasing over time, both nationally and locally. Figure 4 below, compares England and Wirral from 2009/10 to 2016/17.

Figure 4: Trend in A&E attendance rate, Wirral and England, 2009/10 to 2016/17

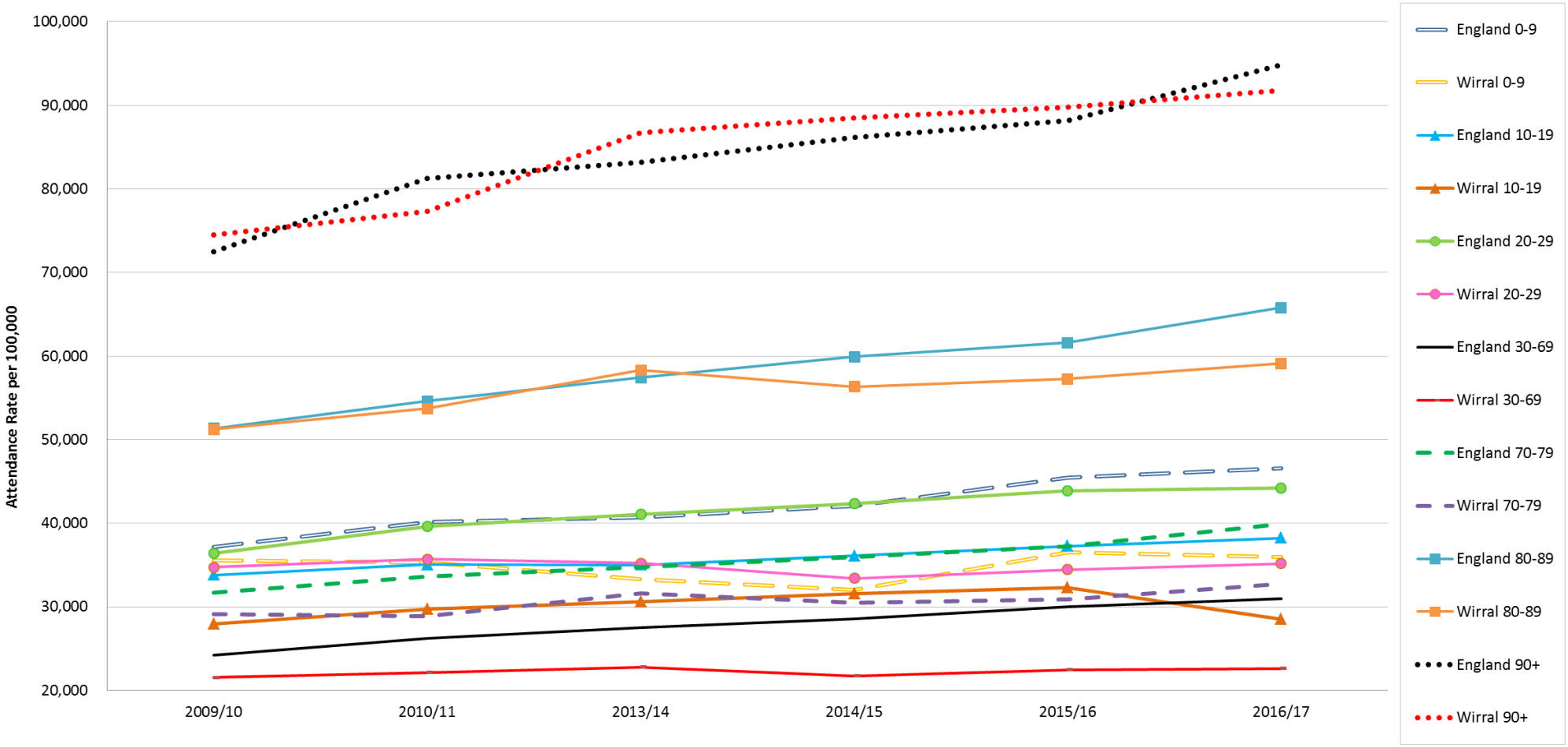


	2009/10	2010/11	2011/12	2012/13	2013/14	2015/16	2016/17
England	30,586	32,880	33,117	34,062	35,269	36,923	37,791
Wiral	28,250	28,646	28,646	29,177	27,936	29,192	29,451

*please note that 2012/13 data is missing from the datasets due to reasons that remain unspecified by NHS Digital. Populations based on ONS/CCG estimates

As the chart shows, rates of A&E attendance have been rising in England over the last 7 years. The rate of increase in England between 2009/10 and 2016/17 was 24% in England. The corresponding figure in Wirral was 4%. It is important to note however, that the steepest rate of increase in attendances is seen amongst the older age groups, in particular the 90+ age group who are likely to have a large number of co-morbidities (see Figure 5 over page). Wirral also has a higher proportion of older people than England overall, meaning that A&E in Wirral is more likely to be dealing with a more complex case mix than areas with younger populations. An indication of the complexity of older patients is demonstrated by the longer waits experienced in A&E. For example, only around one in 10 Wirral patients in their 20s waited for more than 4 hours, whereas more than 4 in 10 of Wirral patients aged over 90 waited longer than 4 hours (see Figure 13). Figure 5 shows the last six years' worth of A&E attendance rate data for both England and Wirral by specific age bands.

Figure 5: Trend in rate of A&E attendances (rate per 100,000), by age band, Wirral and England, 2009/10 to 2016/17



As the chart shows, the highest rates of A&E attendances are in the 90+ age bands, followed by those aged 80-89 – and this is true of both Wirral and England. The age group with consistently the lowest rate of attendances over time is the 30-69 age group. This group is showing a pattern of decreasing attendances in Wirral, compared to a slight increase over time in England. In fact, the most interesting feature of this data is however, that in every single age band, rates in Wirral are lower than those in England.

Figure 6: Percentage of all A&E attendances by 10 year age band, Wirral & England, 2016/17

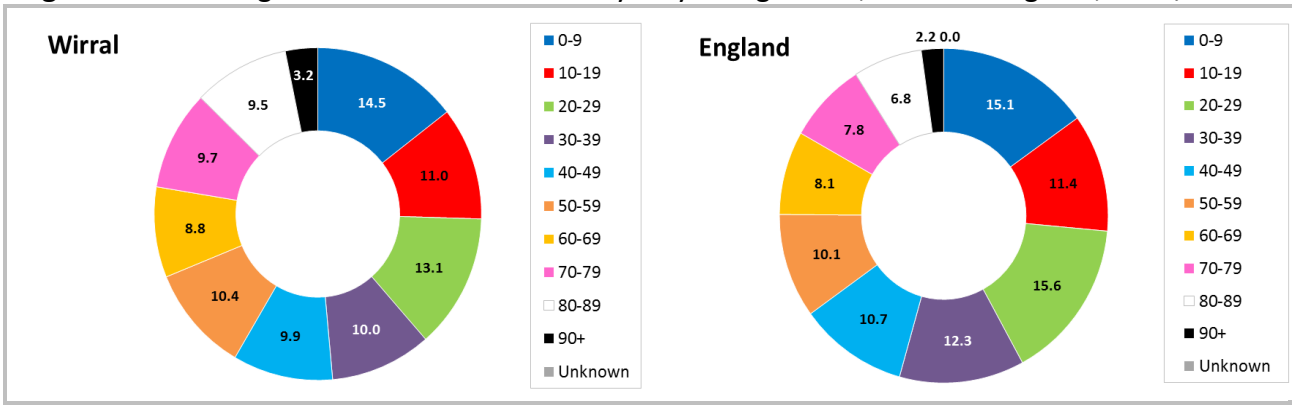
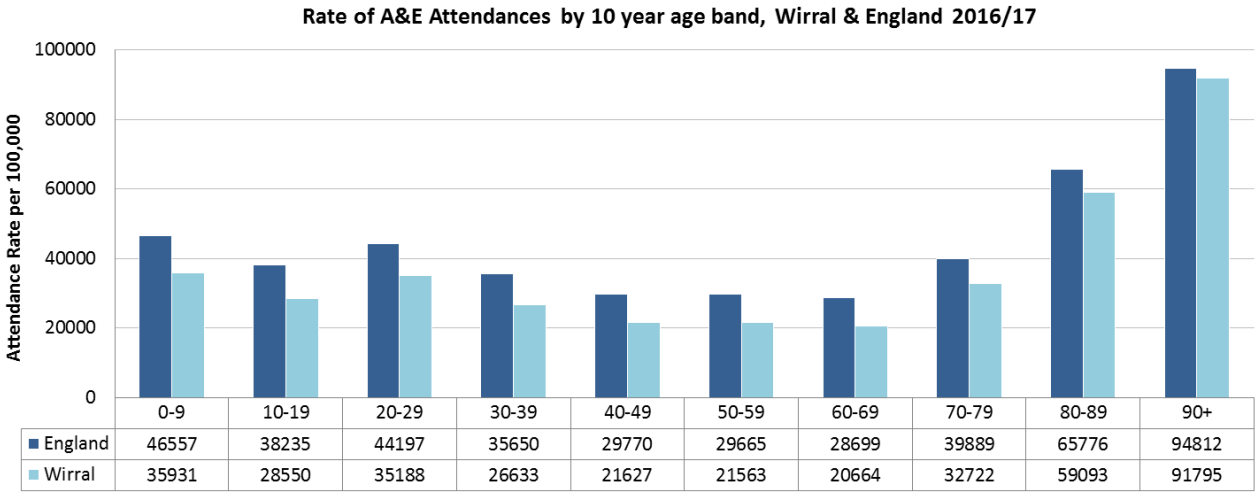


Figure 6 shows some distinct differences between Wirral and England with regard to the percentage of all A&E attendances in each 10 year age band. In England for example, the highest percentage of all attendances are seen in the 20-29 age band, whereas in Wirral, the highest percentage of attendances are in the 0-9s.

The pattern appears to be that Wirral has a lower percentage of all attendances in the younger age bands compared to England, but a higher percentage of attendances in the older age bands compared to England. Given Wirral's older age profile, this is perhaps not too surprising, but it is still an interesting local difference.

Figure 7: Rate (per 100,000) of A&E attendances by 10 year age band, Wirral and England 2016/17

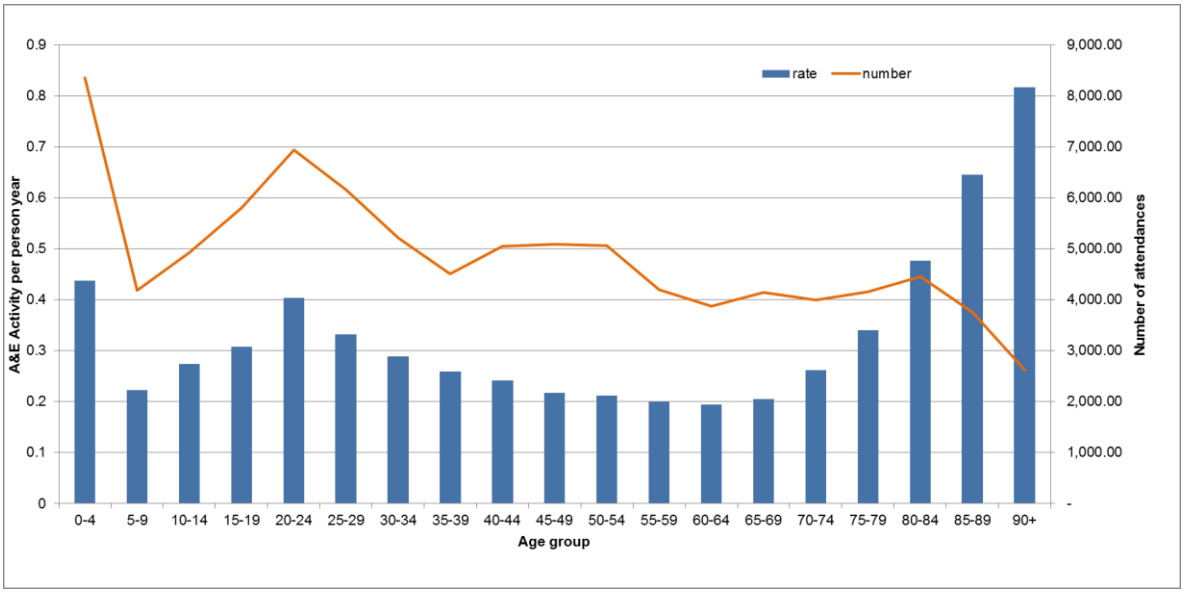


	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+
England	46557	38235	44197	35650	29770	29665	28699	39889	65776	94812
Wirral	35931	28550	35188	26633	21627	21563	20664	32722	59093	91795

Figure 7 shows that the highest rate of A&E attendances in both Wirral and England, are in people aged over 90, closely followed by those aged 80-89. Broadly speaking, Wirral mirrors the national picture, with peaks in the 0-9s, people in their twenties, and then fairly low rates until people reach their eighties and nineties.

Figure 8 below shows similar data to that shown above, except age bands are broken down into 5 year age bands, and both numbers and rates are shown on the same chart.

Figure 8: Rate and number of A&E attendances per person in Wirral, by 5 year age band. April 2013-December 2015 (33 months annualised)



The number of A&E presentations in Wirral appears to peak in the 0-4s and 20-24 year olds (shown by red line on the chart). For 0-4 year olds this is likely to be due to new parents being nervous and illnesses, fever and injuries being common in babies and young children.

For 20-24 year olds, the peak may be due to a combination of inexperience in navigating the healthcare system, alcohol- and drug-related causes such as injuries, self-harm, sport-related injuries, road traffic accidents and students not being registered with a GP at all.

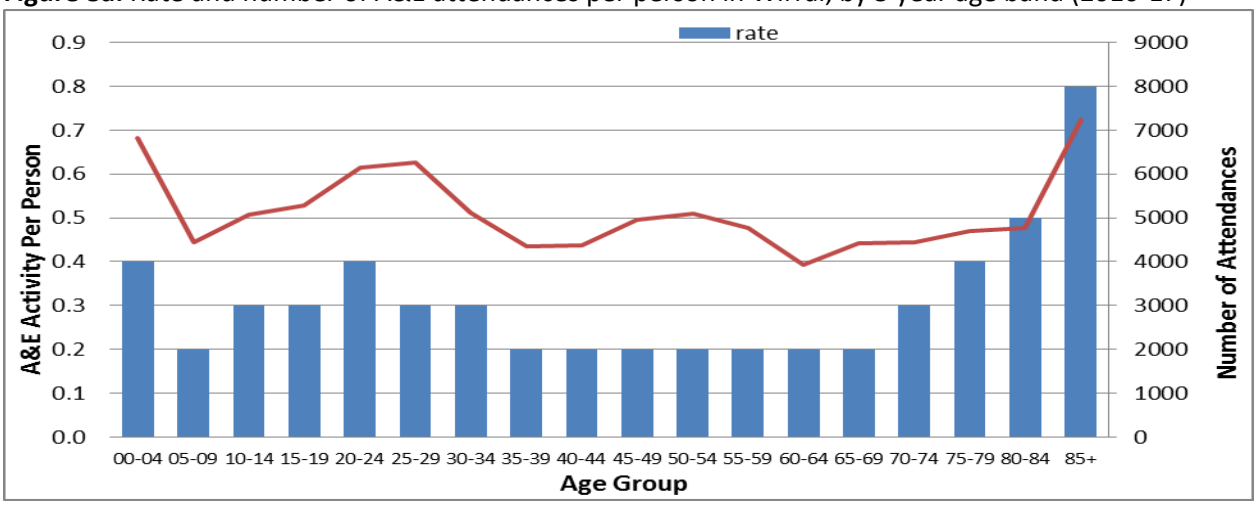
The lowest attendance rates are seen in people aged 5-9, and then those aged 45-69. After the age of 70, rates creep upward again, peaking in people aged 85 and over (the numbers are lower at these older ages, because there are fewer people alive).

In the 90+ age group, attendance rates are more than double those of the 0-4s.

Given that national evidence and local data indicate that older people are much more likely to wait longer to be seen, have higher rates of complex health conditions and are more likely to be admitted, preventing attendances by those in this age group out of A&E should be a priority. This could involve preventing falls, better management of long term conditions and helping community services and residential homes to care for people aged 85 and over.

Figure 8a illustrates the trend is similar when refreshing the data to show 2016\17 only.

Figure 8a: Rate and number of A&E attendances per person in Wirral, by 5 year age band (2016-17)



A&E Attendances by gender, day and month

There appear to be some interesting differences in attendances by gender, and this is shown in Figure 9 below. In children and young people, males have a higher number of attendances than females. Reasons for this are unclear, as there are roughly equal numbers of boys and girls in these age groups in Wirral. In the older age bands of course, there are more attendances in women compared to men, because of their greater longevity.

Figure 9: Number of attendances at Arrowe Park A&E by age and gender, 2014/15 to 2016/17

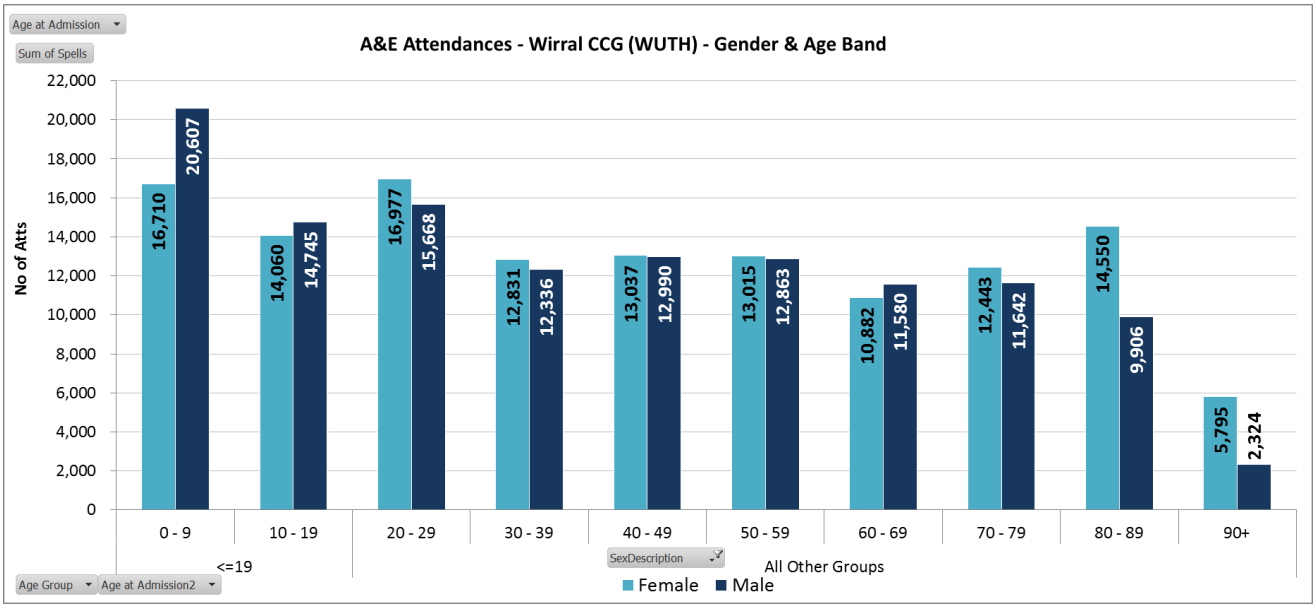
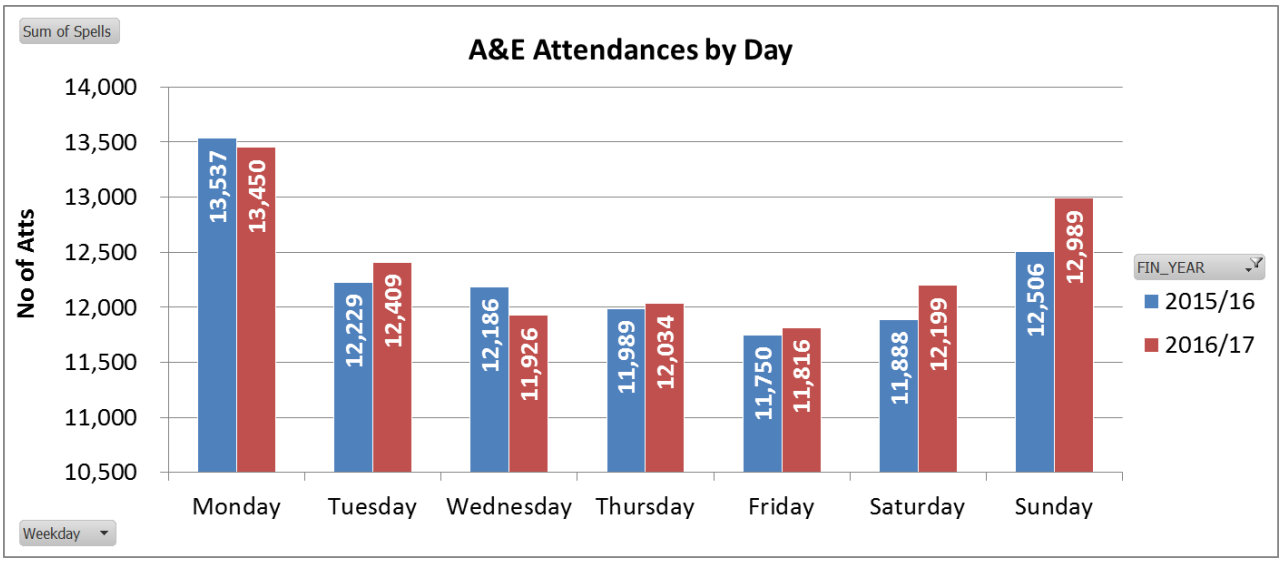
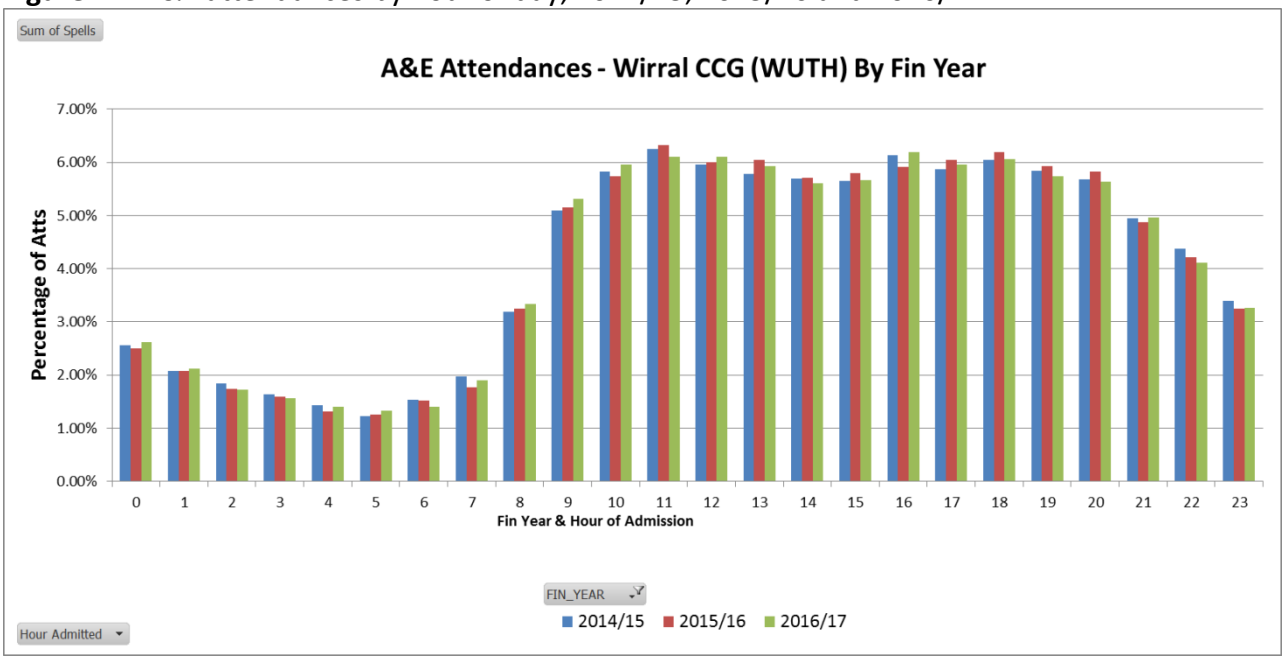


Figure 10: A&E Attendances by day of the week, Wirral, 2015/16 and 2016/17



As Figure 10 shows, A&E attendances peak on Mondays and Sundays. This may indicate use by people who have been unable to access other healthcare services at the weekend.

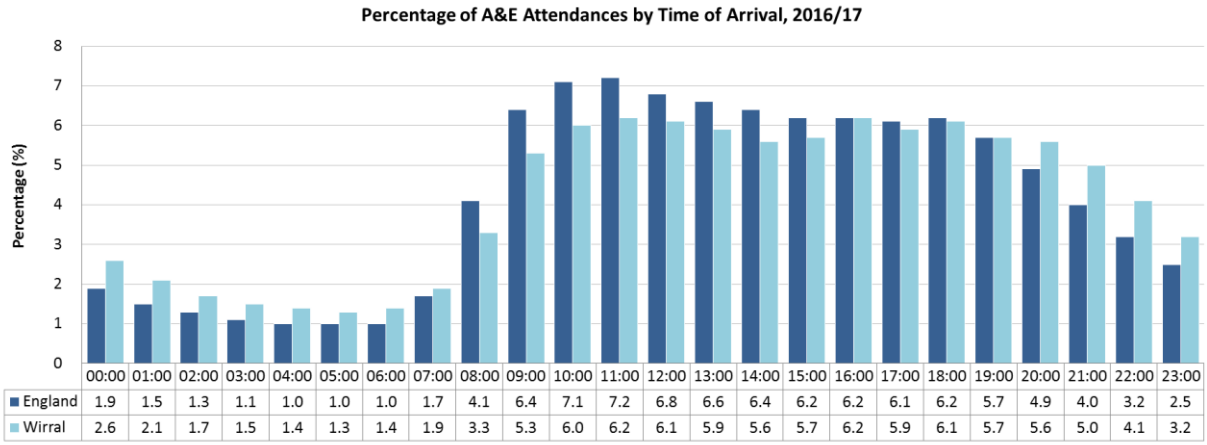
Figure 11: A&E attendances by hour of day, 2014/15, 2015/16 and 2016/17



A&E attendances have peaked between 10am and 2pm and then again between 5pm and 8pm in both of the last three financial years. Although the second peak is when most GPs are likely to be closed, the first peak is when GP services are open. This is interesting and indicates GP opening hours are not the whole story of why people attend A&E.

Figure 12 below, shows the same data as Figure 10 above, except it only shows one year (2015/16) and shows Wirral compared to England.

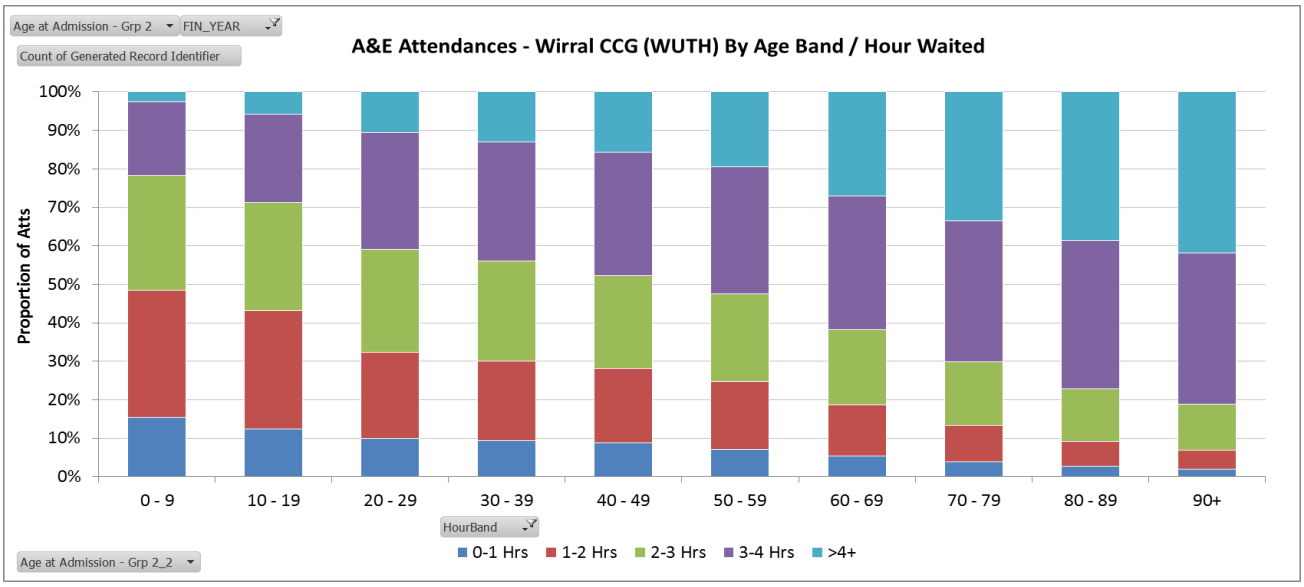
Figure 12: Percentage of A&E attendances by time of arrival, Wirral and England, 2016/17



	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00
England	1.9	1.5	1.3	1.1	1.0	1.0	1.0	1.7	4.1	6.4	7.1	7.2	6.8	6.6	6.4	6.2	6.2	6.1	6.2	5.7	4.9	4.0	3.2	2.5
Wirral	2.6	2.1	1.7	1.5	1.4	1.3	1.4	1.9	3.3	5.3	6.0	6.2	6.1	5.9	5.6	5.7	6.2	5.9	6.1	5.7	5.6	5.0	4.1	3.2

Although the chart shows that broadly speaking, Wirral A&E attendances show a similar pattern to England, a notable difference is that a larger percentage of attendances in Wirral occur when other services are closed (e.g. 7pm to 7am) than is the case in England overall. England appears to have a higher percentage (compared to Wirral) of attendances occurring when other services (such as GPs) are open, namely between 9am-6pm. Reasons for this are unclear, but may suggest that messages about using other services where possible and appropriate, have been taken on board more in Wirral than is the case in England overall.

Figure 13: A&E Attendances by length of time waited



As the chart shows, only around one in 10 patients in their 20s wait for more than 4 hours, whereas more than 4 in 10 of patients aged over 90 waited longer than 4 hours. This distinct age effect, with older people more likely to wait longer in A&E is likely be due to older people being more likely to have multiple and complex health needs which are not easily or quickly resolved. This trend has also been noted nationally.[37]

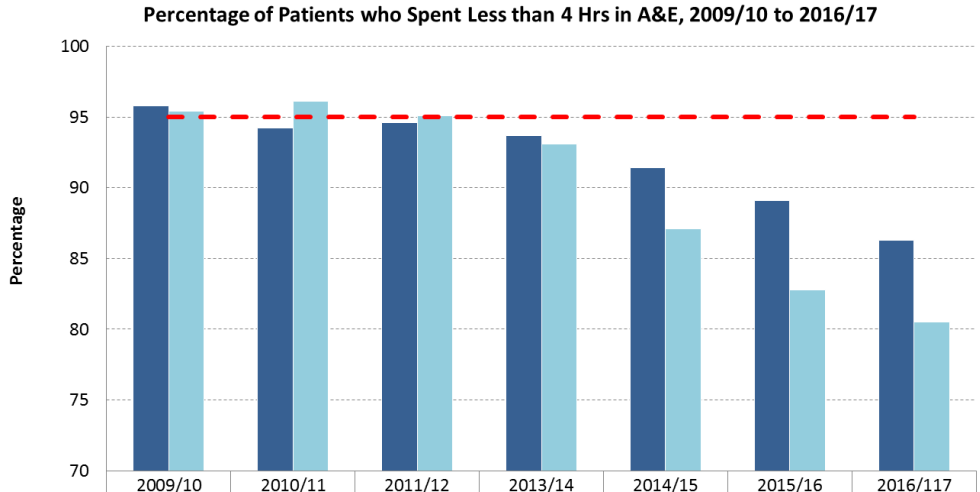
Four hour wait target

The four-hour target for A&E departments was introduced to ensure that by 2004, at least 98% of patients attending an A&E department would be seen, treated, and admitted or discharged in

[37] https://www.kingsfund.org.uk/sites/files/kf/media/alternative-guide-urgent-and-emergency-care-system-apr2014.pdf

under four hours. The target was lowered to 95% in 2010, but by December 2016, just 4 out of 139 hospitals with major type 1 A&E departments were meeting the target.

Figure 14: Trend in percentage of patients who spent less than 4 hours in 2009/10-2016/17



	2009/10	2010/11	2011/12	2013/14	2014/15	2015/16	2016/117
England	95.8	94.2	94.6	93.7	91.4	89.1	86.3
Wirral	95.4	96.1	95.1	93.1	87.1	82.8	80.5
Target	95	95	95	95	95	95	95

As Figure 14 shows, between 2009/10 and 2011/12, achievement of the 4 hour A&E target was higher in Wirral than England for 2 out of the 3 years. From 2013/14 onwards, performance in Wirral has been worse than England – and the trend in both Wirral and England has been a sharp decrease in the percentage of people seen in less than 4 hours. England has not met the target since 2009/10; Wirral has not met the target since 2011/12. Appendix A provides a snapshot of the A&E attendance flow, 2016/17 at Arrowe Park Hospital.

7.2 A&E presentations relating to Mental Health Problems

People with a mental health problem are three times more likely to attend A&E.[38] The following A&E Mental Health data is for presentations at Wirral University Teaching Hospital, Arrowe Park site only for patients aged 18 and over. The recording of these presentations is based on free text 'Presenting Complaint' therefore caution should be used in the interpretation of this analysis as it may not capture the full extent of mental health related issues and the demand on A&E presentations. The data has been analysed by:

- Number of Mental Health related A&E attendances
- Number of Mental Health related attendances conveyed by NWAS
- Number of attendances recorded as Self Harm/Suicide

The total number of A&E attendances presented with a mental health related problem appears to have increased in Wirral over the last 2 financial years. As Figure 14 shows, there have been a total of 1,509 attendances in 2015/16 compared to an increased total of 1,560 attendances in 2016/17. *For patients under 18 there were a further 179 attendances at A&E with a mental health problem recorded in free text, this equates to 10% of the overall activity*.

[38] http://www.nhsconfed.org/news/2016/10/is-mental-health-crisis-care-in-crisis

There does not appear to be a clear pattern on why some months are busier than others. However, similarly to the A&E attendances in Table 3a and 3b, the summer months appear most busy with another peak in October before steadily reducing. The same pattern can be observed for mental health related presentations conveyed by North West Ambulance Service, see Figure 16.

Figure 15: Number of attendances at Arrowe Park A&E with a Mental Health related presentation, by month 2015/16 and 2016/17

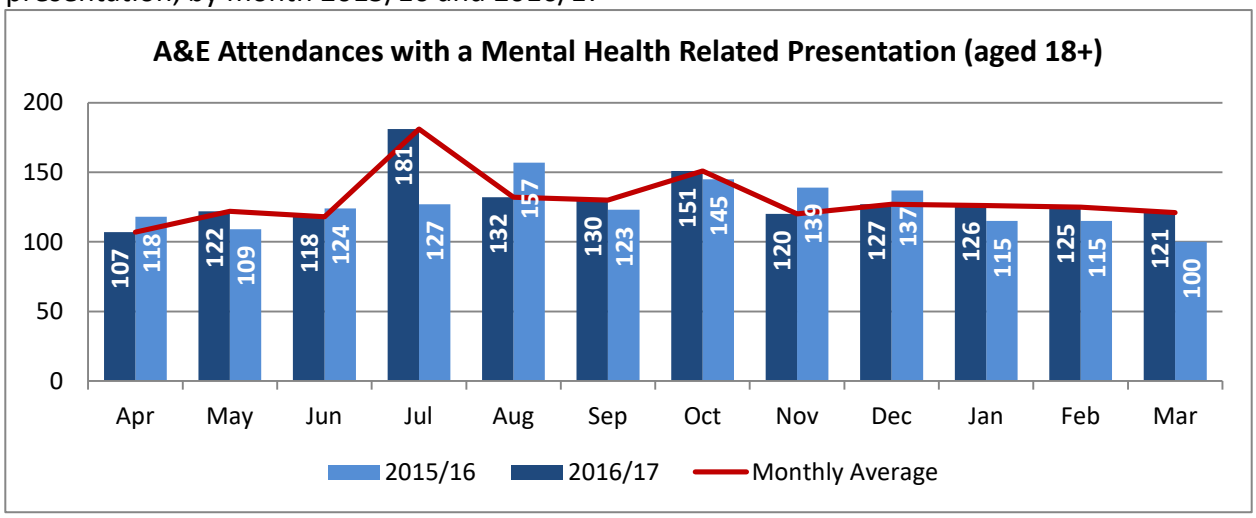


Figure 16: Number of attendances at Arrowe Park A&Ewith a Mental Health related presentation conveyed by ambulance, by month, 2016/17

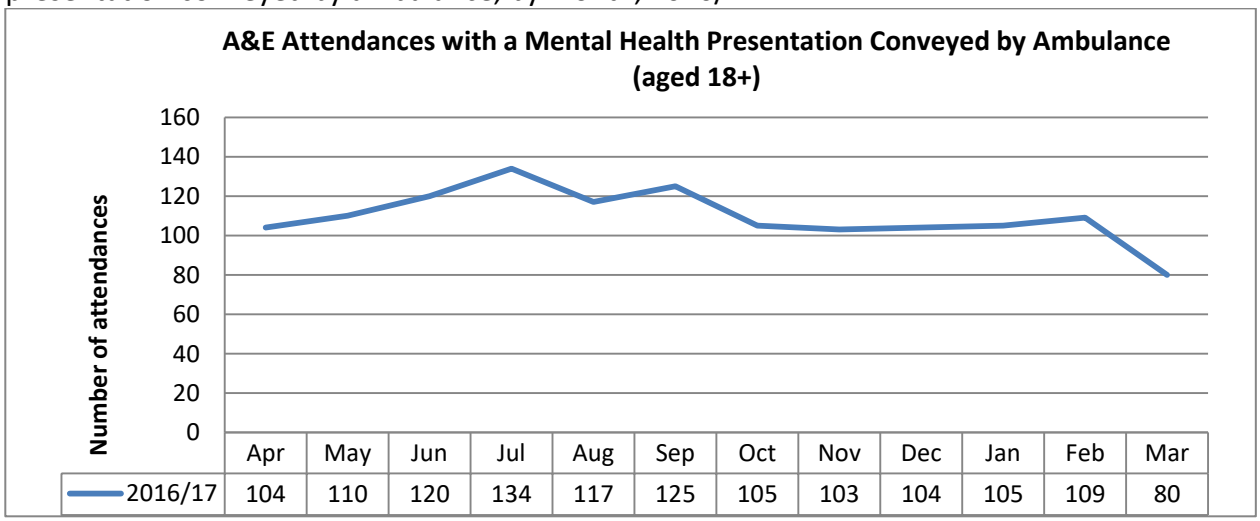
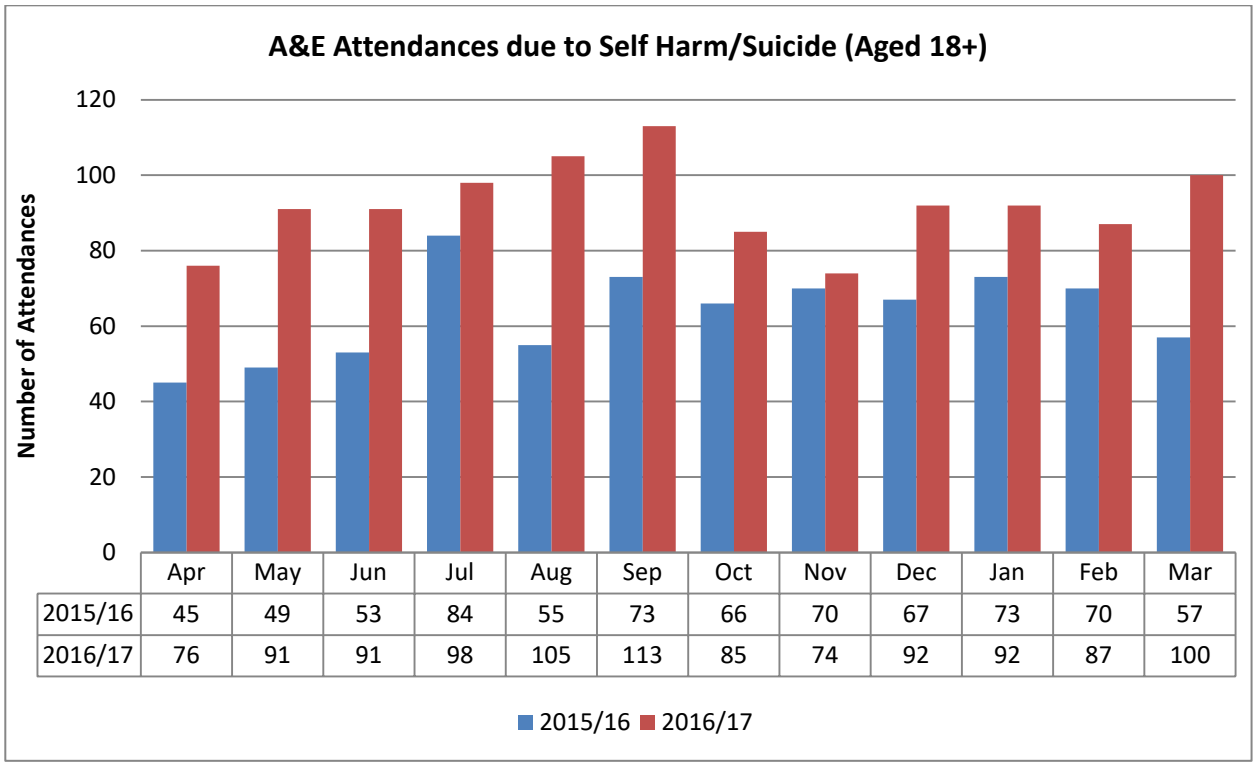


Figure 17 shows you the number of A&E attendances that have been recorded as Self Harm/Suicide by month between 2015 and 2017. The numbers presented with a recording of Self Harm/Suicide appears to have increased by 45% in Wirral over the last financial year.

Similar patterns observed to that of the A&E attendances overall and demand on A&E due to Self-Harm/Suicide, with spring and particularly the summer months higher number of patients presenting with Self Harm/Suicide are observed.

Figure 17: Number of A&E attendances at Arrowe Park A&E due to Self-Harm/Suicide by month, 2015/16 and 2016/17



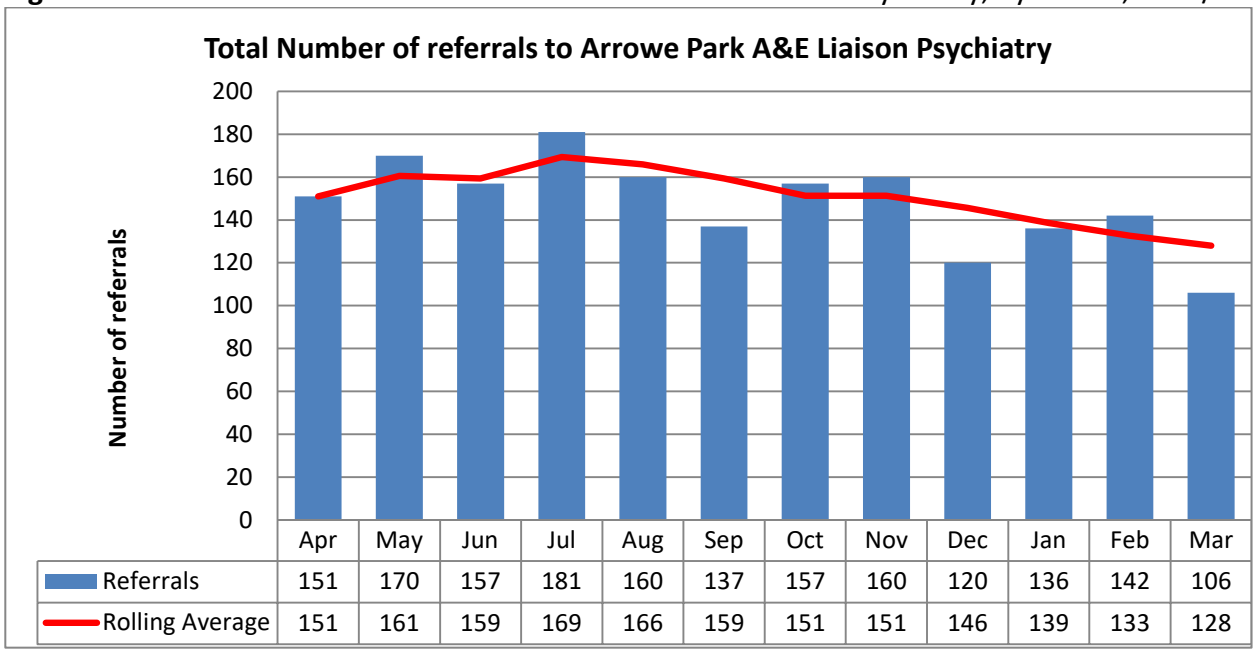
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	45	49	53	84	55	73	66	70	67	73	70	57
2016/17	76	91	91	98	105	113	85	74	92	92	87	100

Liaison Psychiatry Service

The Liaison Psychiatry Service provides mental health assessments to individuals receiving care at A&E who have been referred due to concerns surrounding their mental health and wellbeing. This could include conditions such as anxiety/panic, bipolar affective disorder, dementia, depression, personality disorder and psychosis.

Figure 18 shows the number of referrals to the Liaison Psychiatry Service at Arrowe Park A&E. Referrals are highest in the spring and summer months with the highest peak in the month of July, which is to be expected given this is the busiest time of the year for A&E presentations with a mental health problem.

Figure 18: Total number of referrals to Arrowe Park A&E Liaison Psychiatry, by month, 2016/17



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Referrals	151	170	157	181	160	137	157	160	120	136	142	106
Rolling Average	151	161	159	169	166	159	151	151	146	139	133	128

Source: Cheshire and Wirral Partnership Trust

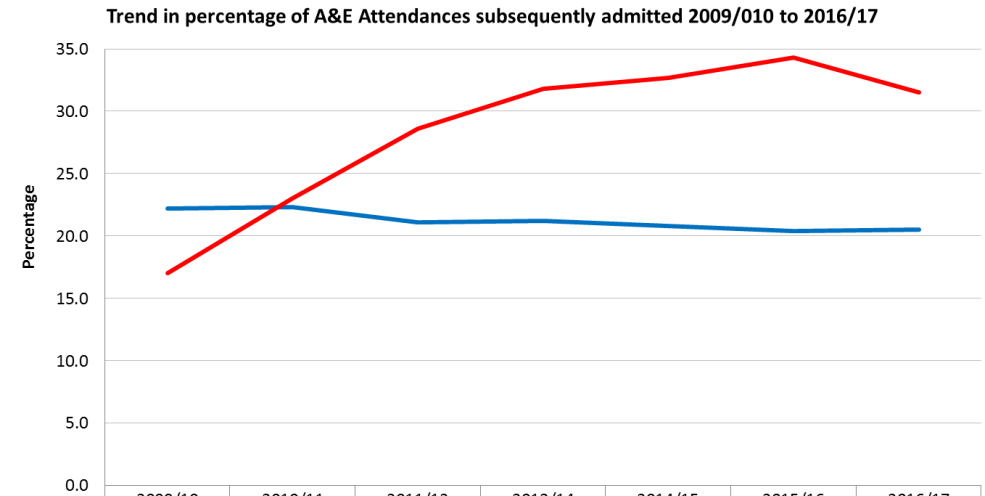
A&E Summary

- The rates of A&E attendances have risen in both England and Wirral over the last 7 years. The steepest rate of increase in attendances on Wirral is seen amongst the older age groups, in particular the 90+ age group who are likely to have a large number of co-morbidities.
- A&E attendances have increased in Wirral for each of the last three financial years – there were over a quarter of a million attendances at Arrowe Park over this period
- There has been an average of 85,100 attendances at A&E for each of the last three financial years. This is an average of 232 per day across the 3 years
- In 2016/17, almost 50% of A&E patients presented at Arrowe Park with a minor case
- Mondays and Sundays are the peak day of the week for attendances
- The summer months of May, June and July are the peak months of the year
- Attendances peak between 10am and 2pm and between 5pm and 8pm. Although the second peak is when most GPs are likely to be closed, the first peak is when GP services are open
- The age groups in which the *number* of attendances peak are the 0-4s, 20-24s and the 80+ age bands
- Attendance *rates* peaks very sharply in the very oldest older people (due to fewer older people surviving to this age, but with a relatively high number of attendances)
- Attendance rates in the 90+ age group are more than double those of the 0-4s
- Older people have longest A&E waits. Only around one in 10 patients in their 20s wait for more than 4 hours, whereas more than 4 in 10 of patients aged over 90 waited longer than 4 hours
- A&E attendances presenting with a Mental Health problem have increased in Wirral in 2016/17, compared to 2015/16
- In 2016/17, A&E attendances recorded as Self Harm/Suicide increased by 45% in Wirral
- A&E Liaison Psychiatry referrals peak in the months between April to July

7.3 Admissions following A&E attendance

The trend in whether patients were admitted following their A&E attendance is shown in Figure 19 below.

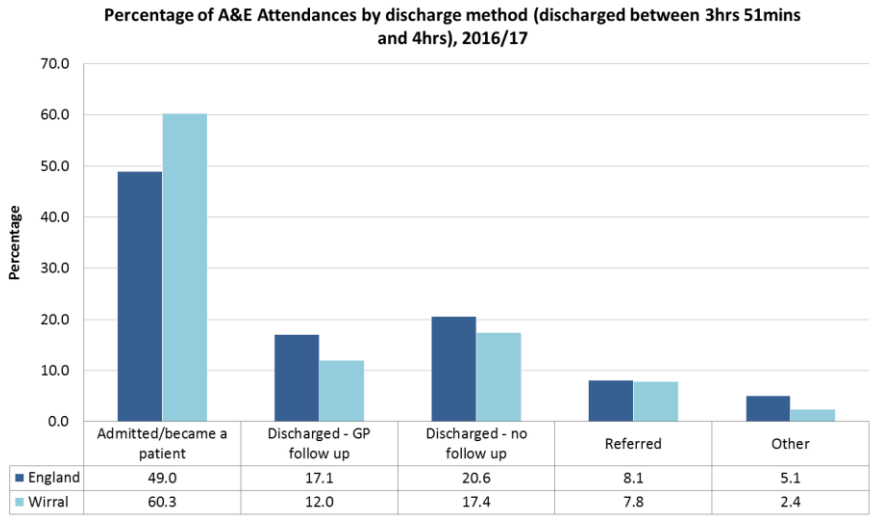
Figure 19: Trend in percentage of A&E attendances subsequently admitted between 2009/10 and 2016/17



	2009/10	2010/11	2011/12	2013/14	2014/15	2015/16	2016/17
England	22.2	22.3	21.1	21.2	20.8	20.4	20.5
Wirral	17.0	23.0	28.6	31.8	32.7	34.3	31.5

Figure 19 shows that for all but one of the time periods shown, a larger percentage of A&E patients in Wirral were admitted compared to England. This difference is considerable and in 2016/17, one in 4 of all A&E patients nationally was admitted (20.5%), compared to almost one in three of all Wirral A&E patients (31.5%).

Figure 20: Percentage of A&E Attendances by discharge method 2016/17



	Admitted/became a patient	Discharged - GP follow up	Discharged - no follow up	Referred	Other
England	49.0	17.1	20.6	8.1	5.1
Wirral	60.3	12.0	17.4	7.8	2.4

Figure 20 shows that compared to England, a much larger proportion of Wirral A&E patients were admitted in the minutes before the 4 hour target (60.3% in Wirral versus 49% in England overall) in 2016/17. A higher proportion of patients in England were discharged compared to Wirral in the time leading up to the 4 hour target (37.7% versus 29.4% in Wirral).

The following figures and tables analyse emergency admissions in Arrowe Park in more detail. Figure 21 shows that the highest proportion of emergency admissions in Wirral between 2014/15 and 2016/17 were admitted via A&E department, comprising just over half (55%) of total emergency admissions. Admissions via GPs have decreased slightly each year since 2014/15.

Figure 21: Number of emergency admissions by admission method, Wirral, 2014/15 to 2016/17

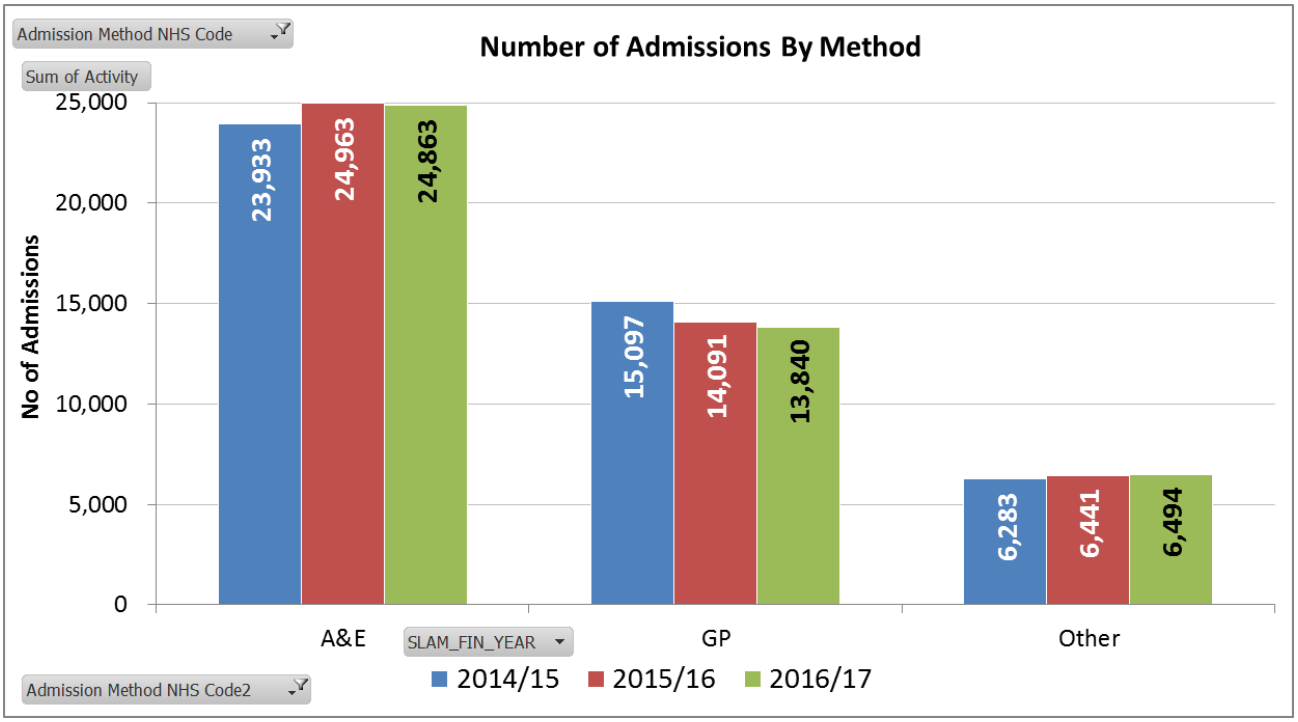
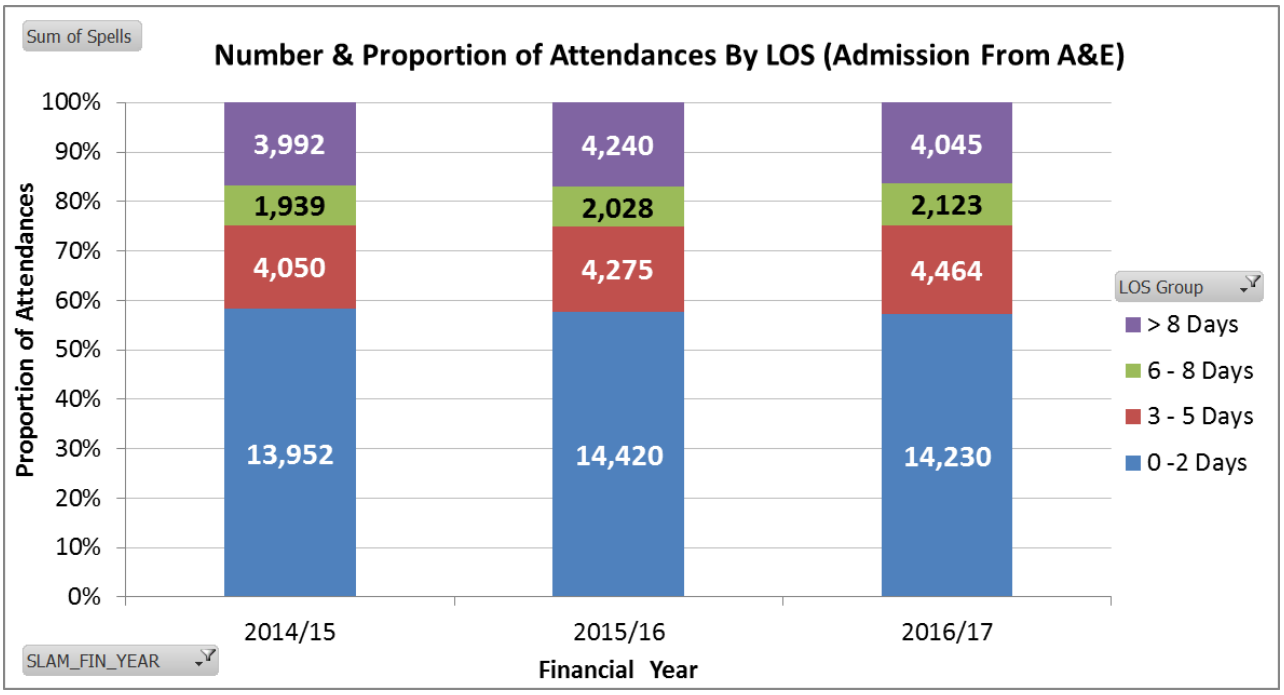


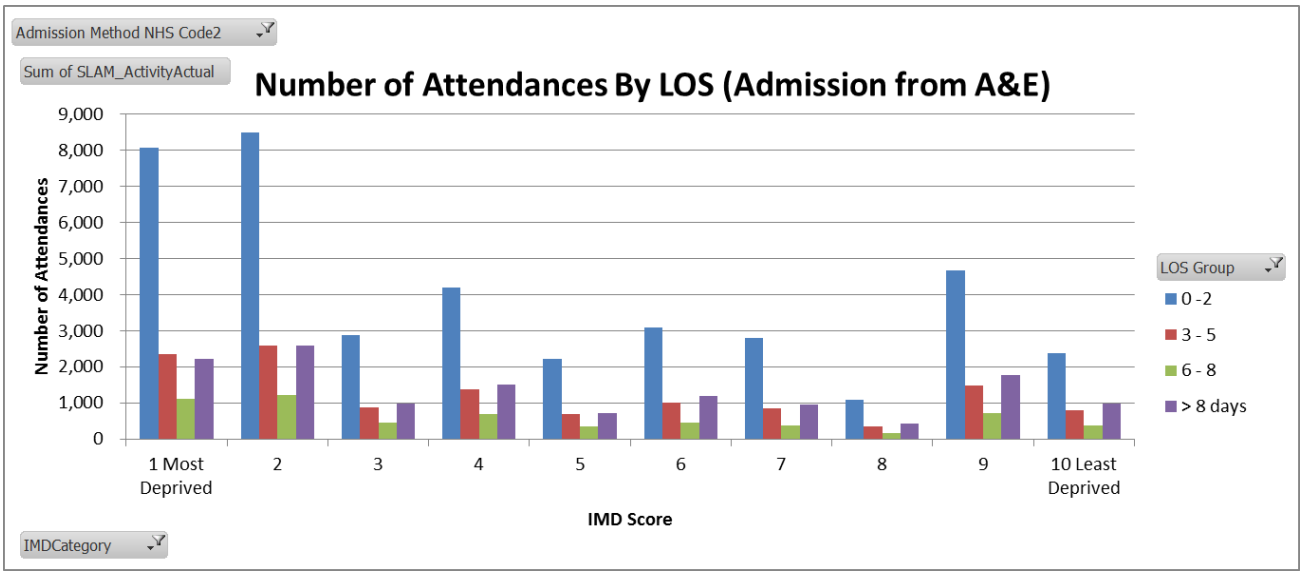
Figure 22 shows that of those emergency admissions via A&E that over half (57%) are admitted and discharged between 0-2 days.

Figure 22: Number and proportion of emergency admissions via A&E by Length of Stay (LOS), Wirral 2014/15 to 2016/17



A high proportion of patients admitted for between 0-2 days in particular, live in the most deprived areas of Wirral, see Figure 23 below.

Figure 23: Number of emergency admissions via A&E, by Length of Stay, by deprivation, Wirral 2014/15 to 2016/17



There are a number of locations/wards that A&E can refer in to that would be considered as an emergency admission via A&E. Figure 24 and Table 5 breaks down the emergency admissions via A&E further by the admission location, length of stay and assessment wards breakdown as follows;

Figure 24: Number of emergency admissions via A&E, by location type and LOS, Wirral 2014/15 to 2016/17

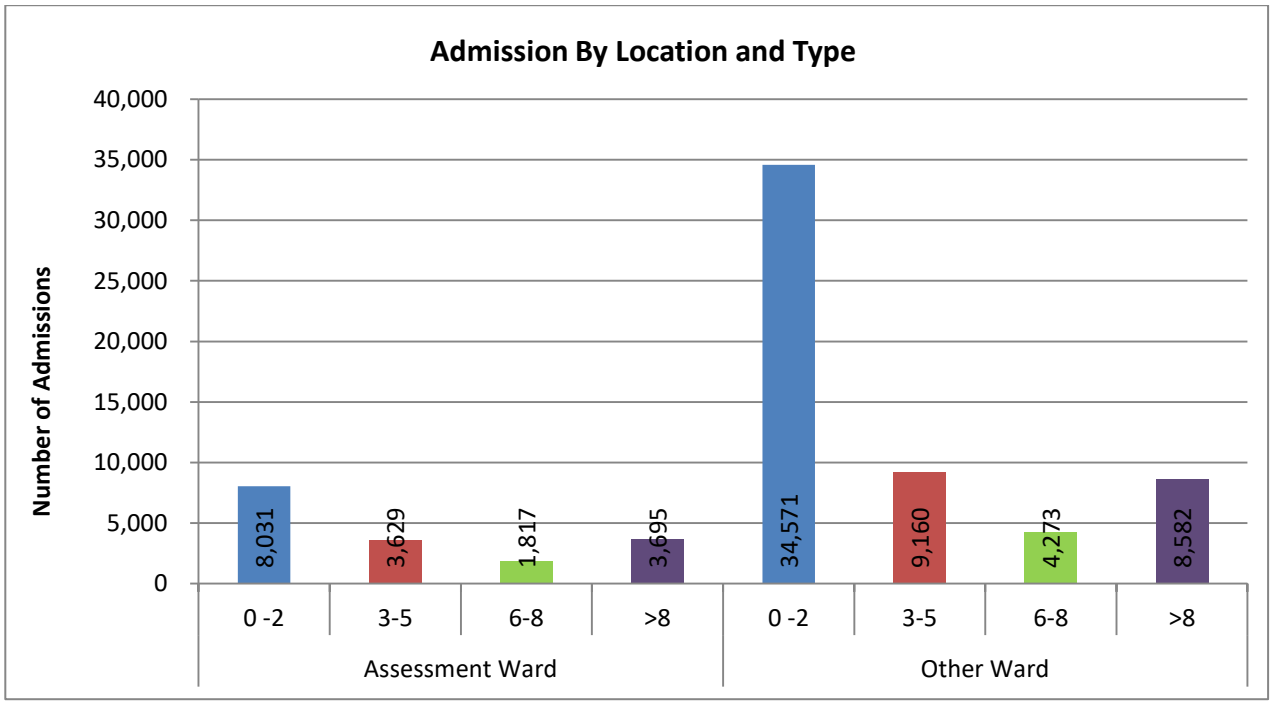


Table 5: % Emergency Admissions via A&E by Admission Location, Wirral 2014/15 to 2016/17

Admission Location	2014/15 (%)	2015/16 (%)	2016/17 (%)
Main Hospital	87.55%	65.83%	65.67%
Acute Assessment Unit	5.32%	15.10%	17.90%
Surgical Assessment Unit	2.81%	7.46%	6.60%
Paediatric Assessment Unit	1.70%	4.86%	4.36%
A&E Observation	1.37%	5.04%	4.47%
Medical Assessment Unit	1.26%	1.70%	1.00%

As the charts above show, the main source of admissions via A&E, particularly for 0-2 days are referred via the a standard ward. Through programme budgeting, emergency admissions via A&E are categorised using primary procedure where available. Almost 40% of activity appears to be for chronic pain, problems of the respiratory system and problems due to trauma and injuries (see Table 6). Nearly half of these admissions are in people from the most deprived areas of Wirral.

Table 6: Description of Emergency Admissions via A&E, based on data from 2014/15 to 2016/17

Description	Number	% of Total
Chronic Pain	8,697	12.53%
Problems of the respiratory system	9,164	13.21%
Problems due to Trauma and Injuries	9,725	14.02%
Neurological	6,518	9.39%
Poisoning	2,629	3.79%
Obstructive Airways Disease	2,234	3.22%
Upper GI	2,340	3.37%
HepatoBiliary	1,555	2.24%
Infectious diseases	2,428	3.50%
Problems of Genito Urinary system	2,744	3.95%
Problems of the gastro intestinal system	1,931	2.78%
Problems of circulation	2,063	2.97%
Problems of the Skin	1,552	2.24%
Cerebrovascular disease	1,856	2.68%
Coronary Heart Disease	1,569	2.26%
Lower GI	1,329	1.92%
Renal problems	1,267	1.83%
Problems of the Musculoskeletal system	1,322	1.91%
Asthma	847	1.22%
Unintended consequences of treatment	1,114	1.61%
Problems of Rhythm	1,238	1.78%
Maternity and Reproductive Health	587	0.85%
Diabetes	470	0.68%
Endocrine, Nutritional and Metabolic pro	530	0.76%
Genital tract problems	603	0.87%

Admissions following A&E Summary

- One in 4 of all A&E patients nationally were admitted (20%), compared to more than one in three of all Wirral A&E patients (34%)
- A much larger proportion of Wirral A&E patients were admitted in the minutes before the 4 hour target, compared to England
- In the period 2014/15 to 2016/17 over half (55%) of total emergency admissions are via the A&E department
- Over half (57%) of emergency admissions via A&E are admitted and discharged between 0-2 days
- A high proportion of patients admitted live in the most deprived areas of Wirral

7.4 Walk-In Centres

The rate of Walk-In Centres (based on 3) in Wirral is 9 per million residents which is higher than the national average of 5.4 per million people (based on Monitor analysis from 2014). If Wirral had two Walk-In Centres instead of three it would be nearer to the national average, with a rate of 6 per million people. But in reality some areas have Walk-In Centres while some areas have none, so they are not equally spread across the population. For the Eastham clinic, around 20%

of activity comes from over the border in West Cheshire CCG. Nationally, 46% of Walk-In Centres are in the most deprived quintile. Victoria Central is in the most deprived 20% of areas nationally, while Arrowe Park and Eastham are not.

Not all areas of England have Walk-In Centres and several have been closed over the last five years. Walk-In Centres are typically located;

- In urban city/town centres such as in a central shopping area or close to a train station
- Within suburban locations, for example, close to or within large residential estates
- Within or on the fringes of commercial/industrial areas, sometimes close to residential estates
- In community hospitals or other community health care hubs; and
- At acute hospital sites, with or without an A&E

In Wirral, the highest proportion of activity is in VCH, followed by the All Day Health Centre at Arrowe Park, with a smaller proportion at Eastham. May appears to be the most common month See Figure 25 below.

Figure 25: Walk-In Centre Activity by Centre and Month, 2016/17

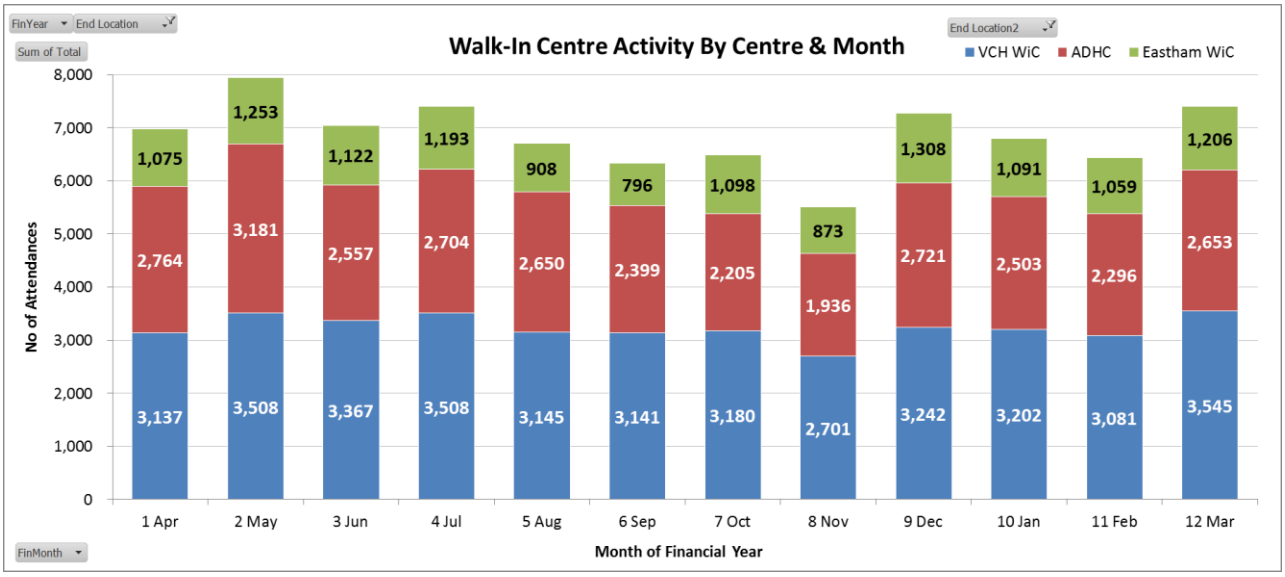
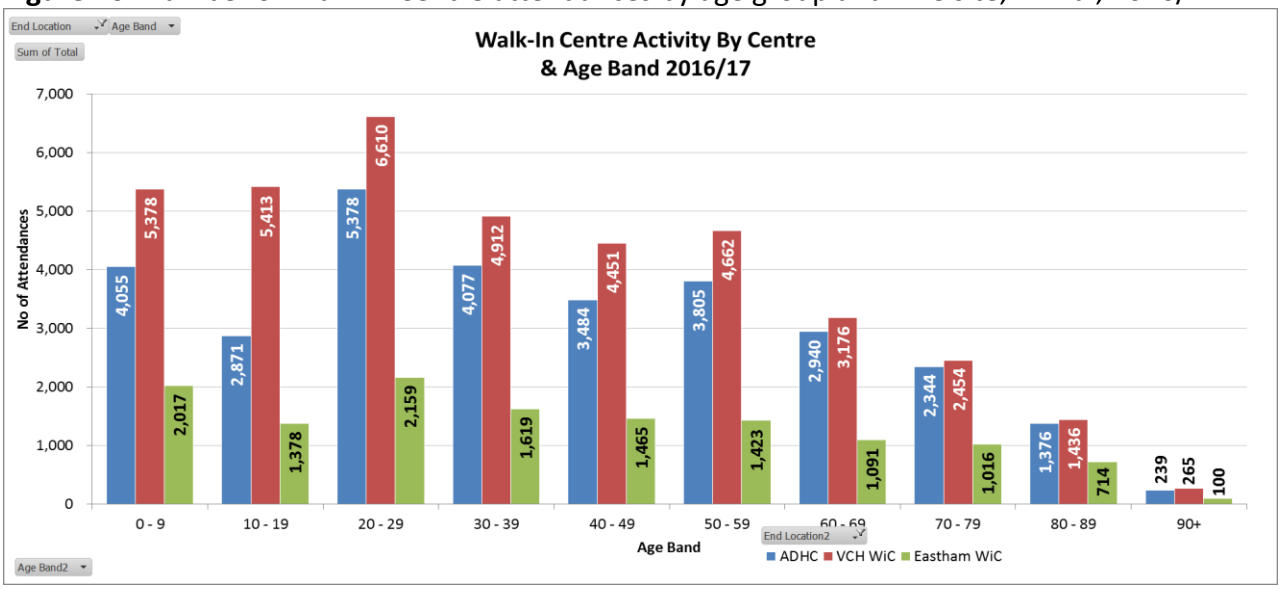
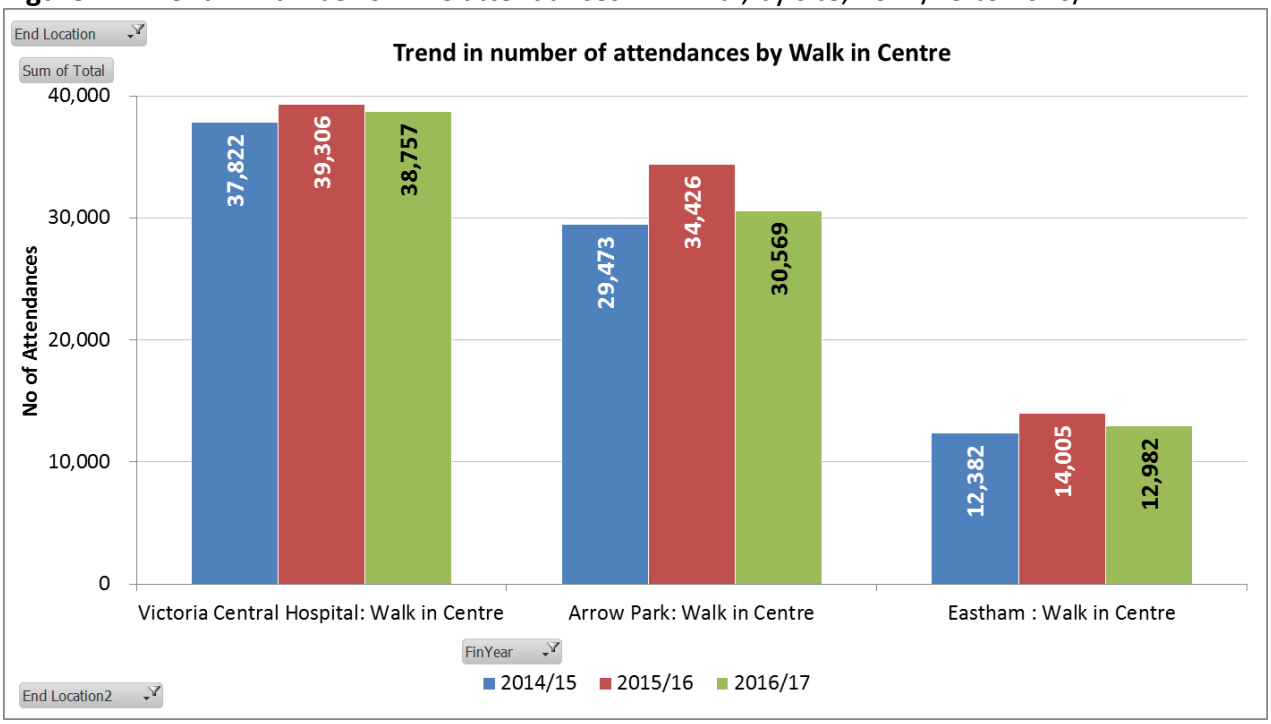


Figure 26: Number of Walk-In Centre attendances by age group and WIC site, Wirral, 2016/17



As Figure 26 shows, similarly to A&E, Walk-In Centre activity appears to peak in younger people aged under 30, particularly those aged 20-29. In contrast to A&E data however, there is no rise in the very oldest old, suggesting usage of WICs are not a popular choice for older people.

Figure 27: Trend in number of WIC attendances in Wirral, by site, 2014/15 to 2016/17



As the chart shows, there is some fluctuation in attendances, with a rise in all three locations in 2015/16, followed by a fall back in 2016/17. Victoria Central Hospital (VCH) is the busiest WIC in Wirral, with 115,885 patient contacts over the 3 year time period shown, compared to 94,468 at Arrowe Park and 39,369 at Eastham.

On average, VCH had an average of 38,600 attendances in each of the last 3 years. Arrowe Park had an average of 31,500 and Eastham WIC had an average of 13,100.

Walk-In Centre activity is coded with a mixture of diagnoses, procedures and other outcomes. A sizable proportion of Walk-In Centre activity appears to be for infections such as sore throats, UTIs, and respiratory infections, as well as wound care (see Table 8).

Table 8: Description of Walk in Centre Activity, based on data from Apr 2014–Jul 2016

Description	Number	% of Total
None recorded	47,532	24.75%
Informed consent for procedure	27,755	14.45%
Advice about treatment given	15,354	7.99%
Dressing of wound	8,516	4.43%
Advice	4,630	2.41%
Upper respiratory infectNOS	4,258	2.22%
Skin/subcutaneous infections	4,257	2.22%
Urinary tract infection	3,872	2.02%
Change of dressing	2,791	1.45%
Acute Tonsillitis	2,700	1.41%
Pain in limb	2,414	1.26%
Has a sore throat	2,384	1.24%
Abdominal pain	1,965	1.02%
Patient walked out	1,915	1.00%
Lower resp tract infection	1,912	1.00%
Disorders of eye and adnexa	1,881	0.98%
Referred - other care	1,679	0.87%
Earache symptoms	1,652	0.86%
Dressing of skin	1,627	0.85%
Viral infection NOS	1,603	0.83%
Otitis media NOS	1,223	0.64%
Patient given advice	1,204	0.63%
Medication given	1,192	0.62%
Knee pain	1,165	0.61%
Backache, unspecified	1,114	0.58%
Rash/nonspec skin eruption	1,105	0.58%
Otitis externa NOS	1,104	0.57%
Cough	962	0.50%
Other skin/subcutinflamdis	960	0.50%

Many of the conditions for which patients attended WICs in Wirral could feasibly have seen their GP or a pharmacist instead (if there was capacity to see them).

Table 9: Walk in Centre Activity by end case type, based on data from Apr 2014–Jul 2016

Case Type	Number	% of total
Nurse Practitioner	98,044	51.1%
WIC Face to Face Triage	40,293	21.0%
Minor Injuries Unit Doctor	25,439	13.2%
All Day Health Centre Doctor	13,724	7.1%
Dressings Clinic	6,424	3.3%
Single Point of Access – Deep Vein Thrombosis	3,967	2.1%
Centre Visit	2,782	1.4%
Single Front Door	888	0.5%
A&E Referral	383	0.2%
X-Ray	47	0.0%
Community Nursing Team	39	0.0%
Other	20	0.0%
Grand Total	**192,050**	**100.0%**

Walk-In Centre (WIC) Summary

- Victoria Central Hospital is the busiest WIC in Wirral, seeing 115,885 patients over the previous 3 years, compared to 94,468 seen at Arrowe Park and 38,369 seen at Eastham Average
- On average, VCH had an average of 38,600 attendances in each of the last 3 years. Arrowe Park had an average of 31,500 and Eastham WIC had an average of 13,100
- Walk-In Centre activity appears to peak in the under 30s, particularly in those aged 20-29 year age groups, in a similar pattern to A&E. In contrast to A&E data however, there is no rise in the very oldest old, where usage of WICs is low
- A sizable proportion of Walk-In Centre activity appears to be for infections such as sore throats, UTIs, respiratory infections and wound care, in other words ailments which could feasibly have been dealt with elsewhere
- The current rate of Walk-In Centres per head of the population (based on 3 sites) in Wirral, is 9 per million residents. This is higher than the national average of 5.4 per million people

7.5 Minor Injury/Illness Services

Minor Injury/Illness services in Wirral are drop-in, nurse-led services, with GP support. Conditions treated at these services include bites, stings, burns, sprains, cuts, chest infections, ear & throat infections, urinary tract infections, minor eye or head injuries. Services can also deal with emergency contraception, dressings and removals of stitches and staples.

Figure 28 below shows the number of attendances per month at each of the three MIUs in Wirral during 2016/17.

Figure 28: Trend in MIU activity by month, year and site, 2013/14 to 2016/17

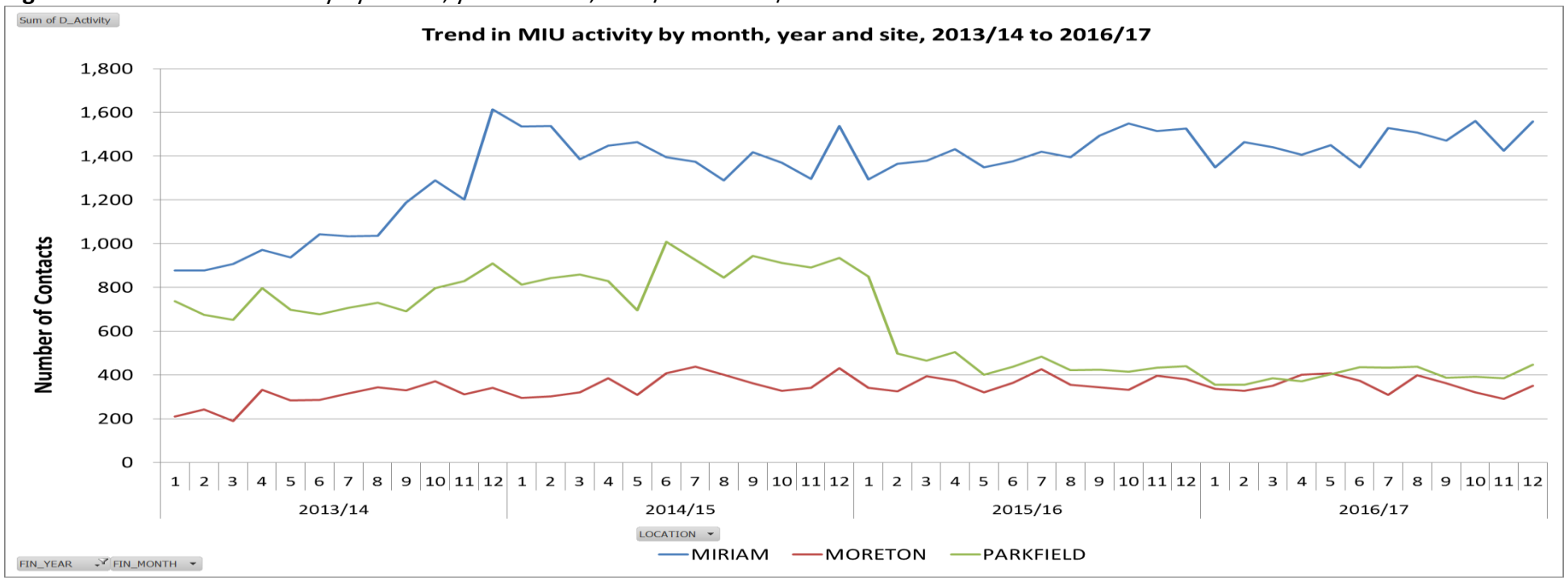


Figure 28 shows that the Wirral MIU with the highest number of attendances is Miriam and this has been consistent over time. In addition, there appears to be an upward trend in usage of Miriam MIU, attendances at Moreton appear fairly stable; Parkfield is showing a downward trend but this is due a reduction in service hours from 48 to 28 hours because of restrictions on space and capacity to operate a 48 hours service.

Table 10 below shows the total number of attendances during 2013/14 to 2016/17 by year and Site

Table 10: Total attendances at Wirral MIUs in 2013/14 to 2016/17, by site

MIU	2013/14	2014/15	2015/16	2016/17	All Years
Parkfield	8,895	10,499	5,772	4,787	29,953
Miriam	12,982	17,052	17,100	17,513	64,647
Moreton	3,556	4,319	4,354	4,231	16,460
Total	**25,433**	**31,870**	**27,226**	**26,531**	**111,060**

Table 11 shows attendances at Wirral MIUs by outcome. Most individuals were discharged without follow up, while 2.1% of patients were redirected to A&E. Of these patients redirected to A&E, the highest number were for limb problems, 'generally unwell', chest pain, eye symptoms, head injury, cough, and back pain. For individuals redirected to VCH, the majority (two thirds) had a diagnosis of 'limb problems' which presumably meant that they needed an X-ray for a potential fracture.

Table 11: Total attendances at Wirral MIUs in 2016/17, by outcome

Outcome	Number	% of total
Discharged	22,853	86.14%
See own GP	1,587	5.98%
Review here	758	2.86%
A&E	577	2.17%
Not Recorded	447	1.68%
VCH	155	0.58%
See own nurse	154	0.58%
Grand Total	**26,531**	**100.00%**

In terms of reason for attending MIUs, the most common reasons were redressing/removal of sutures, sore throat, cough, urinary tract infection, and chest infection (Table 12). Many of these symptoms could be seen in primary care or pharmacy rather than in a specific urgent setting.

Table 12: Total attendances at Wirral MIUs in 2016/17, by reason for attendance

Reason for attendance	Number
Redressing/ROS	4,240
Sore Throat	2,081
Cough	1,915
UTI	1,888
Chest Infection	1,388
Ear Pain	1,372
Rash	1,139
Limb Problems	1,135
Generally Unwell	1,004
Skin Problems	948
Skin Infection	888
Wound Check	835
Eye Symptoms	762
Ear Infection	669
Infection	581
Cuts/Graze/Laceration	543
Removal of Sutures	500
Bites/Stings	492
Minor Illness	468
Advice	459
Back Pain	404
Minor Head Injury	250
Headaches	187
Burns	185
RTA	167
Chest Pain	164
Unprotected Sexual Intercourse	154
Diarrhoea	149
Sore Mouth	131
Fever	127
Foreign Bodies	124
Cyst/Abcess	111
Sprains and Strains	110
Other (less than 100) & Blank	961
Total	**26,531**

Minor Ailments Summary

- Miriam was the busiest MIU in Wirral in 2016/17
- There were over 26,000 attendances to MIUs in Wirral during 2016/17, an average of around 2,212 per month.
- There is no clear seasonality to attendances, except at Miriam, where March has consistently been the busiest month over all 4 years shown. The other 2 MIUs show fairly stable attendances throughout the year
- Most patients were discharged with no additional follow up needed; 2.1% of patients were referred on to A&E
- The most common diagnoses were around wound care and removal of sutures, infections, skin problems, and cuts, grazes and lacerations

7.6 NHS 111

NHS 111 has been in operation since October 2015. Locally, NHS 111 provides triage/assessment of patient symptoms, healthcare advice and/or direction to the most appropriate local service, one of which is the GP OOH service (see section 7.7).

In 2016/17, NHS 111 received 64,171 calls. Figure 28 below shows there were only four months in 2016/17 where calls received fell below 5,000, this was in the months of August, September, February and March. The highest volume of calls was in the month of December, which may reflect Christmas and New Year closures in other services.

Figure 29: NHS 111 Calls Triaged by month, 2016/17

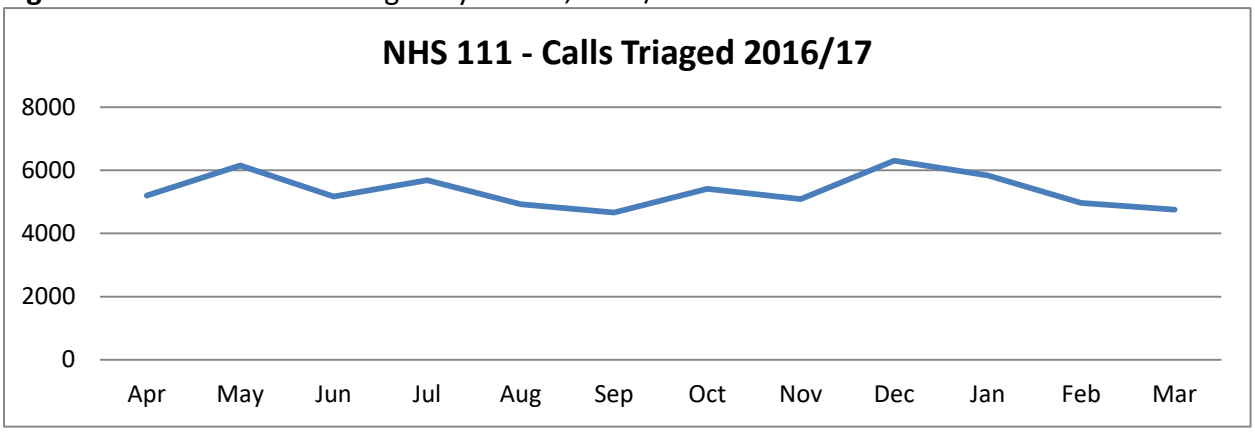
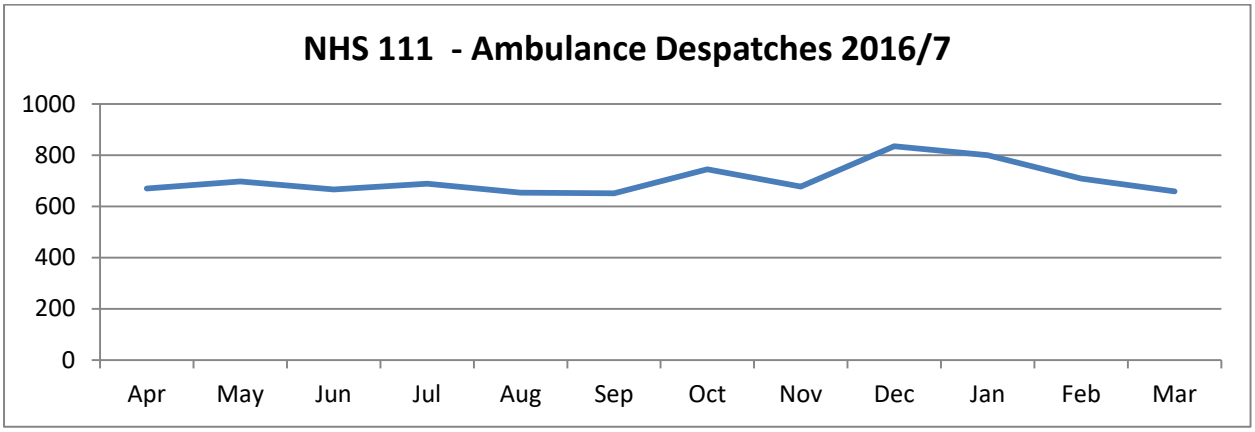


Figure 30 below show NHS 111 ambulance despatches by month in 2016/17. As the chart shows, December and January had the highest number of despatches overall, reflecting the demand particularly in the winter months and at a time when other services may not be available over Christmas and New Year period or out of hours, for example.

Figure 30: NHS 111 Ambulance Despatches by month, 2016/17



NHS 111

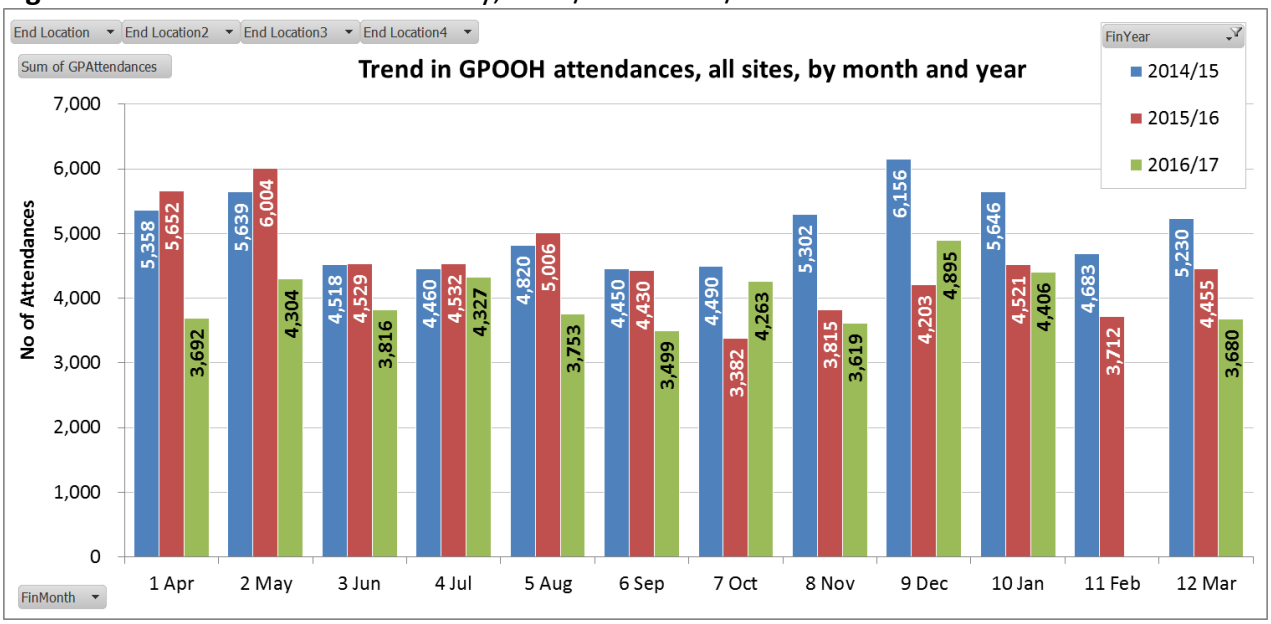
- In 2016/17, calls triaged fell below 5,000 in the months of August, September, February and March. December appears to be the busiest month of the year for calls triaged
- Ambulance despatches via NHS 111 appear to peak in the months of December and January
- There appears to be a relationship between the introduction of the NHS 111 service and the reduction in GPOOHs referrals year on year

7.7 GP Out of Hours (GPOOH)

Wirral GPOOH service is accessed through NHS 111 service and provides urgent medical help and advice for patients outside of usual GP opening hours. GPOOH can include telephone advice, a home visit, or a face-to-face consultation at Arrowe Park. The GPOOH in Wirral operates Mondays to Fridays 6:30pm–8:00am and 24 hours a day on Saturdays, Sundays and Bank Holidays.

Figure 31 below show usage of the GPOOH in Wirral by year and month for the last three financial years.

Figure 31: Trend in all GPOOH activity, 2014/15 to 2016/17



As the charts shows, December and January had the highest number of attendances overall in both 2014/15 and 2016/17 (but not 2015/16), which may reflect Christmas and New Year closures in other services.

Average monthly usage has fallen from 5,500 per month in 2014/15, to 4,500 per month in 2015/16 to 4,000 attendances per month in 2016/17. This appears to relate in part to the introduction of the NHS 111 service that has been in operation since October 2015 where GPOOH referrals have reduced year on year and continues to remain below previous attendance levels.

GPOOH Summary

- Activity has fallen for each of the last three financial years, from 60,800 in 2014/15 to 54,200 in 2015/16 and then 44,300 in 2016/17
- December and January, and to a lesser extent May, appear to be the busiest months of the year
- Average monthly usage has fallen from 5,500 per month in 2014/15, to 4,500 per month in 2015/16 to 4,000 attendances per month in 2016/17

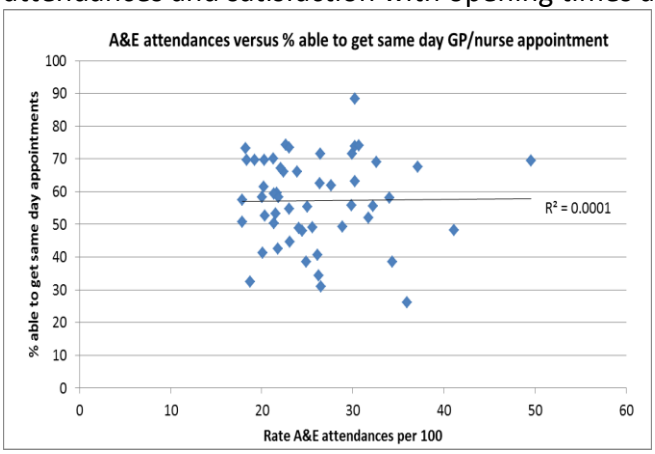
7.8 GP services in Wirral

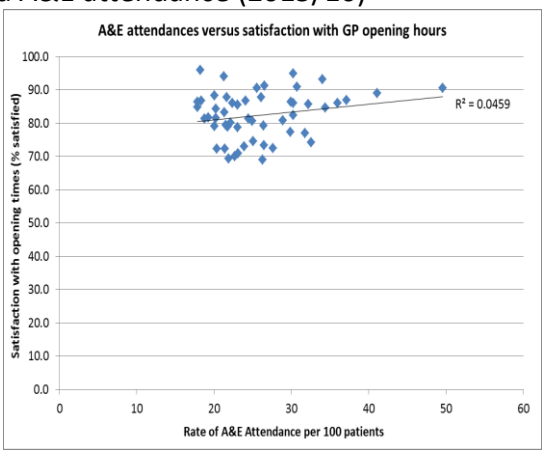
Wirral has a similar rate to England in terms of number of FTE of GPs per patient, but in comparison with other European countries such as Germany, England has more GPs per head of population (although

Germany has a higher rate of hospital beds).[39] The number of Full Time Equivalent (FTE) GPs per head of population in Wirral is around 14% higher in the most deprived areas compared to the least deprived areas[40], but the rate of long term conditions in those aged over 40 is between 1.5 to 2 times higher in deprived areas. This may mean that GPs in deprived areas may have less capacity to deal with urgent care issues.

It is often hypothesised that people attend A&E because they cannot get a GP appointment, or at times when their GP practice is closed. However, responses in 2015/16 by Wirral patients to the GP Survey (which is carried out each year and asks questions such as, "How satisfied are you with the hours that your GP surgery is open?" and how long it took to see a GP or Nurse after contacting the Surgery) do not support this theory. Neither of these measures of perceived access to GPs appears to be correlated with the rate of A&E attendances by the practices patients, as the charts below show.

Figure 32a & 32b: Correlation between ability to get same day appointment with a GP/nurse and A&E attendances and satisfaction with opening times and A&E attendance (2015/16)





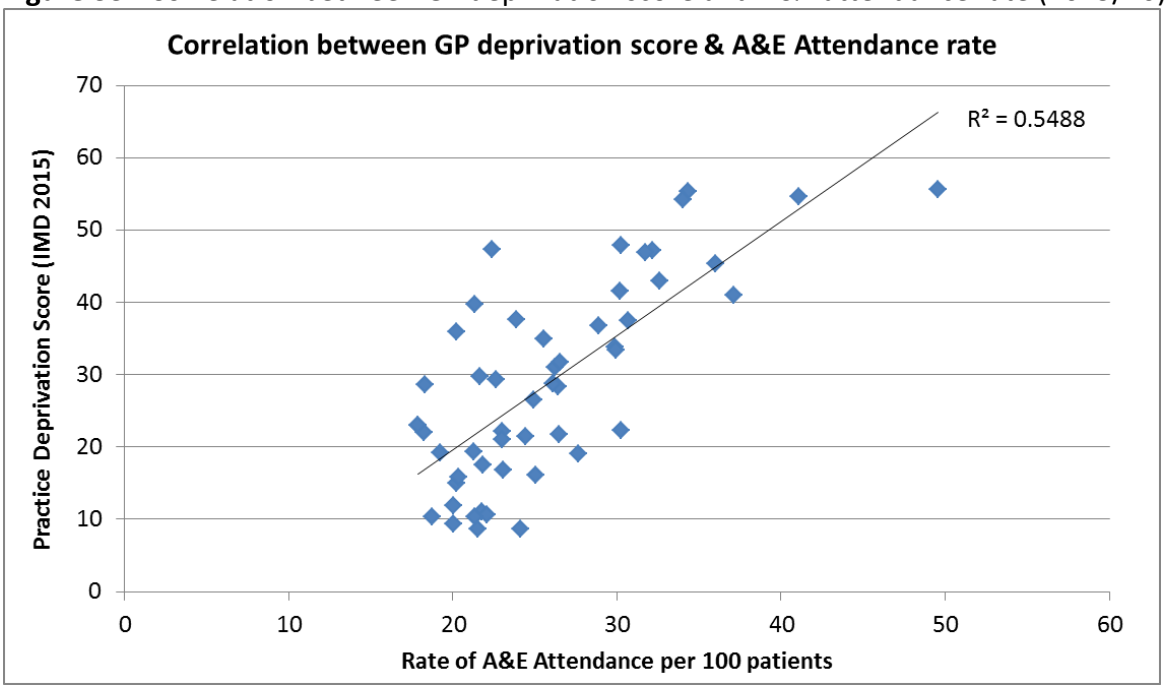
The question in the GP survey the responses shown in Figure 32a refers to was, "Last time you wanted to see or speak to a GP or nurse from your GP surgery: How long after initially contacting the surgery did you actually see or speak to them?" The indicator value is the percentage of people who answered this question with either "On the same day" or "On the next working day". As Figure 32a shows, there is no relationship between the ability to get a same day appointment and the rate of A&E attendances by patients of the practice.

Figure 32b shows the relationship (or lack of it) between A&E attendances and the rate of satisfaction with GP opening hours. There does not appear to be any correlation between these two factors at all. In fact, one of the few strong relationships between A&E attendances and the characteristics of the practice appears to be with GP practice deprivation levels.

Figure 33 below shows the correlation between deprivation score of the GP practice and A&E attendances.

[39] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf p.17
[40] Data from https://www.york.ac.uk/che/research/equity/monitoring/ (GP FTE data is from 2011 so quite dated)

Figure 33: Correlation between GP deprivation score and A&E attendance rate (2015/16)



As Figure 33 shows, there is a very clear relationship between deprivation at GP practice level and the rate of A&E attendances. As deprivation increases, so do A&E attendances.

GP Services Summary

- The number of FTE GPs per head of population in Wirral is around 14% higher in the more deprived areas compared to the least deprived areas
- The rate of long term conditions in those aged over 40 is around double that of the more affluent areas however
- Neither satisfaction with GP opening hours, or ability to get an appointment with a GP in Wirral were correlated with the rate of A&E attendances
- The most striking correlation was between the level of deprivation by GP practice and the rate of A&E attendances (higher deprivation = higher rate of A&E attendance)

7.9 North West Ambulance Service

The North West Ambulance Service (NWAS) Paramedic Emergency Service (PES) provides an accident and emergency rapid response service 24 hours a day across Wirral. Ambulance staff attend emergencies and are trained to provide care at the scene of an incident and/or transport the patient to A&E for serious emergencies. All calls are assessed by the Urgent Care Desk and the most serious will be categorised as Red 1 (8 minute response) or Red 2 (19 minute response) non-life threatening calls are classified as Green 3 & 4 which require a response in 3 or 4 hours respectively.

Through the Better Care Fund a Respond and Refer Service (formerly known as Green Car) is commissioned to respond to lower level acuity care to reduce the conveyance rates to A&E. The aim of this service is to provide treatment and/or signposting to other services rather than a hospital admission. From April 2017, the service is expanding to 16 hours a day, 7 days a week. Ideally this will become the default for patients as the first step in any urgent and emergency care journey that does not require a 999 response.

Table 13: NWAS Respond and Refer Service 2016/17

Referral Information	**2016/17**
Calls received from 999 for Wirral CCG	52,307
Calls received from NHS 111 for Wirral CCG	64,171
Total calls received by NWAS	**116,478**
Calls assessed by Respond and Refer	1,306
Number transferred from NHS 111	113
Number of Respond and Refer patients not conveyed to hospital	570
% of patients who were not conveyed to hospital	**44%**
Number of nursing/care home residences attended by Respond and Refer	72
Number of calls to other residence	1,234
Number of patents attended >65 years	1,038
% over 65 years	**79%**
Number relating to 'Falls'	732
% of call relating to 'Falls'	**56%**
Red calls responded to	44

In 2016/17 ambulance calls peaked in the period between November and January. A target was introduced to ensure that at least 40% of the calls assessed by Respond and Refer were not conveyed to hospital. In 2016/17 four of the twelve months did not meet the target (May, July, September and October). As Table 13 shows, the vast majority of calls assessed by the Respond and Refer service are for residents aged over 65 years (79%) with more than half of the calls relating to falls (56%).

NWAS Respond and Refer Service

- In 2016/17, 79% of calls assessed by the Respond and Refer service are for residents aged over 65 years, more than half of the calls related to a fall

8. Recommendations

The Cheshire and Merseyside Five Year Forward View (FYFV) requires focus on the 'front door' urgent and emergency care services as a priority area. Transforming Urgent and Emergency Care for Cheshire and Merseyside will mean bringing care as close to home as possible.

Urgent and emergency care services need to be responsive to patients changing needs. If the proposals within the consultation are adopted, in the future if a person needs urgent and emergency care they will continue to receive the same comprehensive range of services from the NHS, whether patients access services by walk in, telephone or via the ambulance service. This model of care is in line with the Safer, Faster, Better: *good practice in delivering urgent and emergency care.*[4]

To do this Wirral organisations need to develop a system that is more integrated, making patient care seamless. Following an analysis of the data, a number of key recommendations have been developed, which have been used to shape our proposals. These are described in more detail in section 10.2 but broadly are as follows:

- Ensure that there is simple and convenient access to emergency/urgent care and social care services
- Work with general practices and primary care clinicians to reduce demand on acute care
- Work with NWAS to further reduce the 'conveyance' rate of patients to acute care
- Work with local acute trust, NWAS, primary care and social care to develop a range of responsive integrated community based intermediate care services as alternatives to acute care. To ensure patients are signposted appropriately, supporting improvements in the management of people with long term conditions to reduce demand on acute care, for example.

9. Proposal for future delivery of urgent care

The previous sections of this paper have highlighted the need to transform local urgent care services, not only due to the national mandates, but most importantly to improve the care of Wirral residents by providing effective, seamless care when they need it the most. Therefore this chapter will propose a revised model of care which reflects nationally mandated requirements and the introduction of a revised community offer. Option 1 reflects the current community offer alongside the mandated requirements as outlined earlier in this paper and in section 9.2. In order to provide a more seamless journey for patients, reducing the confusion, we believe a new model of care is needed (section 9.1); options 2 and 3 would enable these improvements in care based on the insight we have gathered. This chapter provides a description of the draft model of care (9.1) along with the benefits and options for consideration (9.2).

9.1 Draft Model of care

Utilising the National guidance, the data in the case for change and the views gathered from local stakeholders, a draft model of care has been designed, led by clinical colleagues and proposed options to deliver this model are detailed below.

As highlighted in the draft model of care the proposal is best considered within the wider health and social care system. This model shows a number of layers of care, with more specialist and acute care at the bottom of the diagram; patients will access varying parts of the model during their lives and some patients may even access care in a number of layers at one time. The care in this model is to be delivered in a person-centered approach with different services working together to enable a seamless patient journey. It describes the care available for the whole of the Wirral population, from babies to the older generations.

As with the existing services provided, the Urgent Treatment Centre and local services will be required to illustrate robust safeguarding and clinical governance policy, procedure and practice with clear responsibility and accountability.

The service model will be supported by extra GP appointments within each area in Wirral, available 8am to 8pm, 7 days a week. This extended access to GPs will be provided through a hub and spoke approach in each of the 9 local areas, with groups of practices providing additional appointments to their populations. It is proposed that where possible this will be integrated and co-located with four Community Hubs. The primary care offer will also include same day appointments booked via NHS 111 for urgent need and will manage urgent domiciliary visits at a time of day appropriate for patients to help to avoid unnecessary admissions to hospital and improve patient experience.

Exact locations for the delivery of local services would be determined following a post consultation decision by the Governing Body and subsequent development of a service specification and potential procurement process. However, proposed localities have been determined through the development process, based on population need. The introduction of a revised model of care would utilise existing estates within the current funding available.

Draft Model of Care

Box 1: Description of the layers in the model of care

- The proposed model is best understood within the wider health and care system. There will be a renewed focus on prevention of ill health and promotion of self-care through a strategy to develop wellbeing, education and community support (the white layer), in partnership with schools, voluntary organisations, pharmacies; and through maximising the opportunities presented by new technologies.
- People will be able to access their usual GP and community services as they normally would when they need them (the blue layer)
- The green layer represents same day urgent appointments for people who are unable to get an urgent same-day appointment with their GP. These appointments will be booked via NHS 111 and will be available in a number of GP practices across Wirral. This service may also provide senior nurse appointments. A specific urgent care service for children as well as a dressing and wound care service will also be available locally.
- Additional GP appointments will also be available in the evenings and at weekends, for people who need them. These will be provided by GP practices working together on a cluster basis and we envisage nine of these clusters across Wirral.
- The next layer the model of care is the Urgent Treatment Centre (UTC) (orange layer) which would provide a single front door for patients walking into the UTC and will triage and clinically assess patients within 15minutes of arrival, and give them an appointment slot within 2 hours of arrival. An urgent treatment centre will be created on the Arrowe Park Hospital site, open a minimum of 12 hours per day 7 days a week. The UTC will be GP led and treat minor illnesses and injuries and will include access to diagnostics (e.g. x-rays, bloods etc.) and will be integrated with A&E to enable consultant advice where required.
- The bottom layer is the **Accident and Emergency** Department located in Arrowe Park which will remain as a Category 1 (major) accident and emergency department.
- **An Integrated Urgent Care Clinical Assessment Service** will provide access to urgent care via NHS 111, either a free-to-call telephone number or online and will provide complete episode of care concluding with either: advice, a prescription, or an appointment for further assessment or treatment.

Urgent Treatment Centre based at Arrowe Park

It is proposed that one Urgent Treatment Centre will be required for Wirral. The existing walk-in centre on the Arrowe Park site will be developed to become the UTC. The reason for basing the UTC at the Arrowe Park site has been taken for the following reasons:

- **It meets population need:** the Case for Change highlighted that due to the size of the population, geography of Wirral and demand for urgent care services, one centre at this location would meet the population need
- **It meets NHS England standards:** one of the National Standards includes having access to an A&E Consultant which would be achievable on the Arrowe park site. There is also the facility in A&E to treat patients who may deteriorate rapidly and require more acute intervention.
- **It would provide a more streamlined pathway of care for patients**: the Urgent Treatment Centre would provide a single point of access at the Arrowe Park Site for patients with an urgent care need. This would be a more seamless pathway for patients, who would be seen by the most appropriate clinician in a timely manner. There is evidence to show the benefits of urgent care services that are co-located within emergency departments, for example co-located services can stream patients through one front door and thus reduce A&E attendances[41].

The Urgent Treatment Centre will meet the national standards along with the additional elements such as the triage of patients and direction to appropriate clinician including access to Psychiatric Liaison for mental health (building on development to meet core 24 standards by 2020/21) as appropriate. It would also offer a wellbeing offer such as voluntary sector information and advice service and a pharmacy onsite and the ability to book appointments directly with some community services e.g. smoking cessation.

Implementation of an Urgent Treatment Centre will enhance patient experience through delivery of additional services, ensuring access to diagnostics to enable more patients to have their needs met without the need to go to A&E. The integration with A&E will provide direct access to the A&E consultants to support decision making within the urgent treatment centre and patients will be seen and treated within a maximum of 2 hours compared to 4 hour A&E standard.

As a result of this proposal, we would no longer have routine walk-in facilities or minor injury services at our current urgent care locations (Walk-in centres and Minor illness/injury units). Our proposed new model of care would see the introduction of an Urgent Treatment Centre, a specific urgent care service for children, a dressing and wound care service as well as an additional 720 routine GP appointments each week.

Integrated NHS 111 and GPOOH service

Alongside the above, Wirral will be developing an Integrated Urgent Care Clinical Assessment Service (IUC CAS) with NHS 111 and GP Out of Hours to enable more needs to be met by NHS 111. The full details of this are specified within NHS England's 'Integrated Urgent Care Service Specification' August 2017.

[41] Shifting the Balance of Care, Great Expectations Nuffield trust March 2017
https://www.nuffieldtrust.org.uk/research/shifting-the-balance-of-care-great-expectations

The introduction of an IUC CAS will fundamentally change the way patients access health services. The model for an IUC CAS requires the following offer for patients:

- access to urgent care via NHS 111, either a free-to-call telephone number or online;
- calls to NHS 111 to be triaged by a Health Advisor;
- access to GP advice 24/7 with support from a multidisciplinary clinical team
- consultation with a clinician using a Clinical Decision Support System (CDSS) or an agreed clinical protocol to complete the episode on the telephone where possible;
- direct booking post clinical assessment into a face-to-face service where necessary through the NHS 111 service;
- electronic prescription; and
- Self-help information delivered to the patient through the NHS 111 service.
- As many clinically appropriate calls to NHS 111 as possible should be closed following consultation with an appropriate clinician, negating the need for onward secondary care referral or additional signposting.

Benefits of the proposed changes to urgent care

Our clinical leads believe that the proposed model will enhance patient safety and improve patient outcomes through delivery of a clearer, consistent model to urgent care in Wirral with closer integrated working between organisations delivering urgent care. This will reduce risk of any patient safety concerns across the urgent care system and improve health and social care outcomes. As noted above, it will be ensured that the services have robust safeguarding practice in place.

The model will provide consistent, standardised care for patients. It will also ensure patients are seen in the most appropriate place. The urgent treatment centre, as an integrated model with A&E, will undertake clinical streaming. It has been evidenced locally and nationally that clinical streaming is an effective method to enable a streamlined pathway of care for patients. Closer working between partners and consistency across community provision would also facilitate evidence based practice and demonstrate clinical leadership and engagement as well as the delivery a high-quality standard of care.

The proposal aims to deliver clinical and cost-effective care as it directs clinical resource to our areas of highest demand. There is greater demand of areas of social economic deprivation. In addition to this, providing a clearer system will ensure patients access the most appropriate service first time, reducing the number of patients visiting more than one urgent care service for the same condition/incident. This would reduce carbon footprint for patients previously traveling to numerous centres to get their needs met.

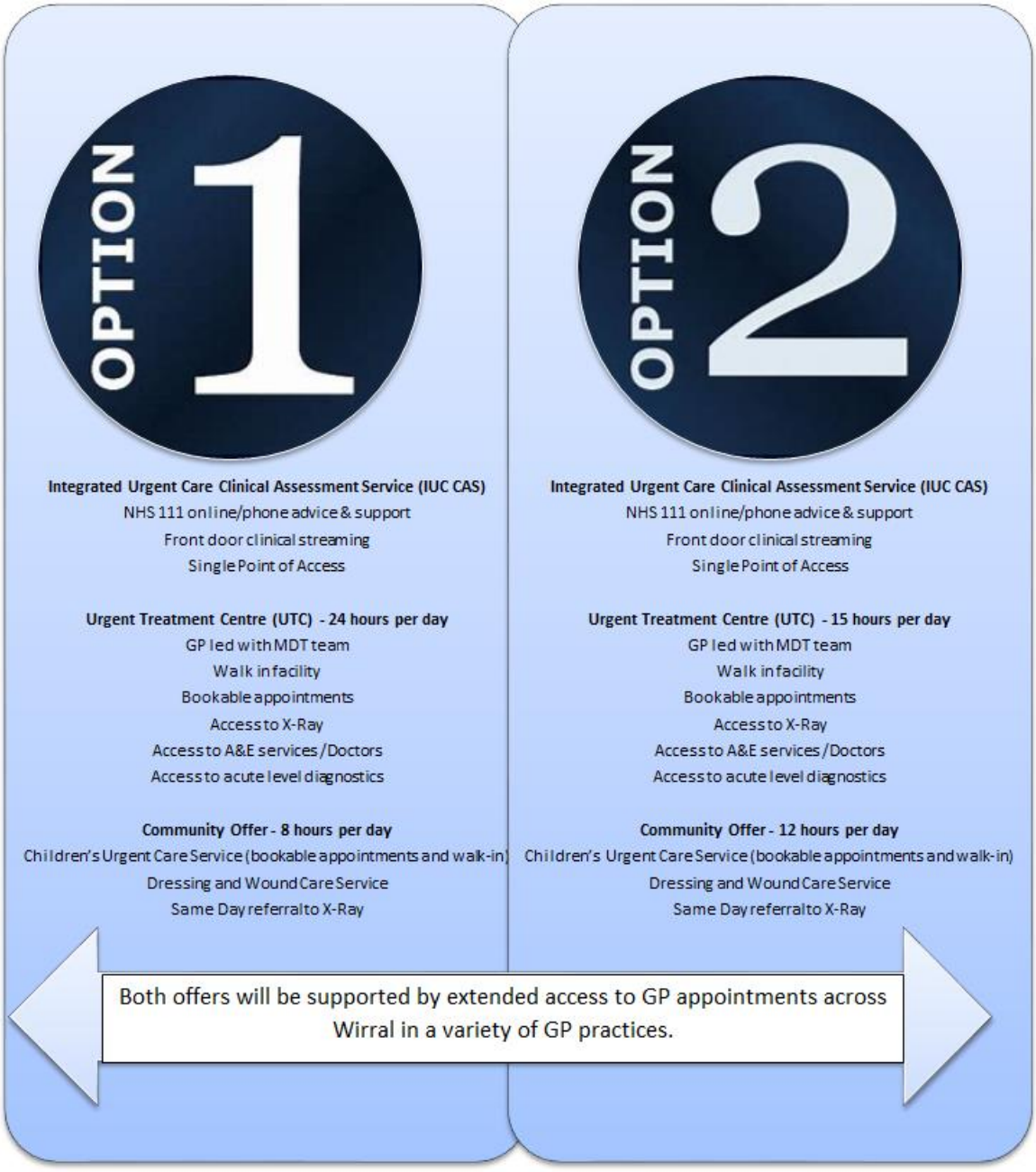
The urgent care model will have enhanced IT access as specified within NHS England's standards referenced above.

Further advantages and disadvantages of each option are described further in the section below.

9.2 Options for consideration

The below table shows the options for the new model of care.

Option Summary - Local services will be delivered across Wirral in line with the place based model which will cover the 9 'neighbourhoods' – see below for further detail.



Place Based Model

The intention to move to placed based care will enable health and care providers to work closely together with a focus on people and improving their health and wellbeing. It will involve bringing together all community based services to provide proactive joined up care as 'One Team', working toward shared outcome goals. Care should be joined up and with a focus upon proactive care in the community which avoids reactive and expensive hospital or long term social care.

To enable delivery of the benefits of place based care, Wirral has been divided into different geographic locations depending on the care needs of that population. These are as below:-

- 51 GP practices
- 9 neighbourhoods
- 4 localities

- 1 Wirral district

Further work has commenced to define these different geographic locations and their role in place based care delivery. The proposed Primary and community care core offer will be via a number of locations serving the 9 neighbourhoods as well as extended access provision; including existing GP provision alongside extended access.

Option 1 would provide the maximum UTC offer of 24 hours 7 day a week care, which would provide an 8 hour per day Community offer. In contrast, option 2 would provide a 15 hours 7 day a week offer, taking the Community offer up to 15 hours per day. However, what must be noted is the impact a reduced Urgent Treatment Centre would have on wider Wirral healthcare issues such as supporting the local A&E Department which is currently under resourced and stretched to capacity.

Provision at existing WIC and MIUs

	Current Provision					
	Victoria Central Walk in Centre and Minor injuries	**All Day Health Centre, Arrowe Park**	**Miriam Minor Injuries and Illnesses Clinic**	**Moreton Health Clinic Minor Injury & Illness Service**	**Parkfield Minor Injury & Illness Service-New Ferry**	**Eastham Walk in Centre (temporarily suspended)**
Opening Hours >12hrs, 7 days	8am-10pm, 7 days	8am-10pm, 7 days	10am-8pm Monday-Thursday, 10am-6.30 pm on Friday and 10am-5 pm at weekends	10am-7pm Mon-Tues, 10am-8pm Wed-Thurs, 10am-6pm Friday	2pm-6pm, Mon-Friday, closed weekends	2pm-10pm Mon-Fri, 9-5pm Weekend
Bookable appointments	✗	✗	✗	✗	✗	✗
Walk in/ unplanned capcity	✓	✓	✓	✓	✓	✓
GP-led (with multi-disciplinary team)	✗	✗	✗	✗	✗	✗
Access to A&E Consultants	✗	✗	✗	✗	✗	✗
Access to X-Ray	✓	✗	✗	✗	✗	✗
Treatment of Minor Injuries	✓	✓	✓	✓	✓	✓
Treatment of Minor Illnesses	✓	✓	✓	✓	✓	✓
Prescribing	✓	✓	✓	✓	✓	✓
Simple diagnostics (bloods, urinalysis, ECG)	✓ ECG and urinalysis	✓ urinalysis	✓ ECG and urinalysis	✓ ECG and urinalysis	✓ urinalysis	✓ urinalysis
Dressings Service/ Wound Care	✓	✓	✓	✓	✓	✓
Routine Phlebotomy	✗	✗	✓	✓	✗	✓

Alongside this:

- Patients have told us that they do not know where to go, the current services are confusing, offering different opening hours and level of services at each site.
- The urgent care data shows us that patient's needs are not being met by the existing service provision and is not achieving responsive, reliable and efficient care.
- The quality impact assessment shows that due to the number of access points with differing provision it does not enable effective partnership working, has multiple access points and issues regarding information flow. This could lead to ineffective multi-disciplinary safeguarding

approaches, variation in care. There is also less opportunity to enable flexible working across the workforce and therefore there are concerns over the sustainability of this workforce model.

- The current offer is not tailored to current health inequalities and population need
- The existing provision, alongside the implementation of the UTC and IUC CAS is not affordable in its current state.

When undertaking a quality impact assessment (QIA) on the current offer, alongside the positive experiences of patient accessing the individual services there were many negative impacts to consider as summarised above. These negative impacts were within all aspects within the impact assessment such as duty of quality, productivity and innovation etc. Alongside negative impacts to patient experience one consideration is the resource impact, as it is mandated to implement an urgent treatment centre this would require additional resources to sustain and would therefore place additional pressure on existing resources. This Case for Change document also highlights why the existing provision does not effectively meet the needs of the population.

This service model will be supported by extra GP appointments within each area in Wirral to be available 8am to 8pm, 7 days a week. This extended access to GPs will be provided through a hub and spoke model in each of the 9 local areas, with groups of practices providing additional appointments to their populations. The primary care offer will also include same day appointments booked via NHS 111 for urgent need and will manage urgent domiciliary visits at a time of day appropriate for patients to help to avoid unnecessary admissions to hospital and improve patient experience.

Proposed Future Service Provision

Service Offer	Local services delivered in the community*	Urgent Treatment Centre at Arrowe Park Hospital
Bookable GP appointments (within 24 hours)**	✓	✓
Urgent care service for children (walk in & bookable appointments)	✓	✓
Dressing & Wound Care Service (bookable appointments)	✓	✓
Routine walk in facilities	✗	✓
Access to A&E services and healthcare professionals	✗	✓
Prescribing	✓	✓
Access to same day X-Ray referral (at a designated X-Ray site)	✓	✓
Phlebotomy	✗	✓
MDT approach	✓	✓

** Locations for the delivery of local services have not yet been determined and form part of the public consultation.*
*** GP appointments will be available in a variety of practices across Wirral*

Considerations and mitigations of new service model

Considerations & mitigations	**Travel Distances** Despite the model offering a higher level of service in local neighbourhoods within Wirral, as well as additional service at the Urgent Treatment Centre, it is recognised that for some patients' additional travel may be required. This may cause difficulty for elderly patients and parents with young children who do not drive/have access to a car. Patients with certain disabilities may find public transport more difficult. Carers may also be impacted by the need to travel further to seek the care the patient requires.	**Mitigation** More GP appointments will be available for patients in Wirral from April 2018 - this will include appointments available from 8am to 8pm 7 days a week within each local area. Feedback from our patients has been that they use walk in centres/minor injuries services because they are unable to access a GP appointment. The extra appointments should mean easier access to a GP closer to home for patients. We will ensure the centres are accessible via public transport and located with easy access from neighbouring areas.
	Bus routes We are also aware that the bus routes to the Arrowe Park site from some areas in Wirral, e.g. Eastham, have changed making access to the site more difficult for people relying on public transport.	**Mitigation** We have included the transport providers within our discussions and will work with them to improve access. We will also explore options around voluntary sector transport.
	Patient Choice The provision of local services delivered from locations within the community plus one urgent treatment centre will reduce choice of locations for urgent care in Wirral. It may create additional choice for some of the other services sitting within the hub e.g. child and family offer, x-ray	**Mitigation** The impact in choice of locations for urgent care will be mitigated via additional GP appointments including same day, as described above.
	Walk in facility Some patients may be dissatisfied that the community centres do not offer a walk in option.	**Mitigation** The lack of 'walk in' appointments will be mitigated by the availability of same day appointments that will be bookable via NHS 111 throughout the day. Walk in appointments will also be available in the Urgent Treatment Centre.

9.3 Financial Considerations

The options have been costed and it is proposed that both models can be delivered within the existing financial envelope.

The current commissioning cost envelope inclusive of A&E, Primary Care Extended Access, Paediatrics A&E, Primary Care Front Door, GP Out of Hours, NHS 111, 3 WICs and 3 Minor Injuries/ Ailments units totals £21.8m (table 18).

Table 18: Urgent Care Financial Envelope

Commissioned Area	£000's
A&E & Streaming	12,061
GP Out of Hours and NHS 111	4,511
Walk in centres and Minor Injuries Units	4,194
GP Extended Hours	1,000
Total	**21,766**

The commissioning envelope is based on the 2017/18 contracts together with the additional monies available for extended hours for GPs. It is expected that the revised urgent care model will be funded within the current funds by reconfiguring the way in which the services are provided.

As part of the consultation there will be specific stakeholder engagement to review the financial considerations of each option in more detail. Further detailed costings will need to be undertaken after the end of the consultation process to update/ validate the assumptions made.

Once a revised model of care is approved and implemented it is likely that connected services such as streaming, GPOOH, extended access to primary care and a reduction in assessment ward usage will be impacted and lead to an efficiency across the system.

10. Conclusion

10.1 Case for change

NHS Wirral CCG in partnership with our colleagues at Wirral Council including Public Health and the Directorate of Adults Social Services and other stakeholders have undertaken a comprehensive review of local urgent care services which describes a compelling case to transform urgent care services locally. This builds on Value Stream Analysis workshops that were undertaken by the CCG in Autumn 2016 and involved local stakeholders including Healthwatch Wirral and representatives of the Patient Voice Group.

These workshops along with additional insights have identified that people are confused about what is offered in relation to urgent care, (other than A&E). It may be that people's lack of knowledge about other options (versus the ease and familiarity of accessing A&E), combined with the fear and stress of being ill results in people resorting to the 'default' of A&E - a choice which they perceive to be the easiest, safest and most reassuring option.

Current performance data shows that there are many people attending A&E whose condition could have been treated elsewhere; such as by general practice or in a walk-in centre. The performance of the A&E system in Wirral has not been satisfactory and the CCG has had clinical concerns due to the deteriorating performance against the constitutional target of 4 hour waiting time. Over the past two months, significant whole system progress has been made in the achievement to ensure over 90% of emergency patients are treated, admitted or transferred within 4 hours. However there is still further progress and improvement required to meet the 95% mandated standard.

It is essential to ensure that there is consistent and clear access to urgent and emergency care and social care services to enable improvements in the health and social care outcomes of Wirral residents. A new national model of care for urgent and emergency services will need to be implemented by December 2019, as mandated by NHS England.

10.2 Proposal

Following an analysis of the data, recommendations were developed and used to develop the proposals and one recommendation has been embedded into existing work as described below:

- Ensure that there is simple and convenient access to emergency/urgent care and social care services
- Work with GP practices and primary care clinicians to reduce demand on acute care (see draft model of care section 9.1)
- Work with NWAS to further reduce the 'conveyance' rate of patients to acute care (not covered as part of this proposal but is being actioned as part of the Urgent Care Operational Group)
- Work with local acute trust, mental health services, NWAS, primary care and social care to develop a range of responsive integrated community based intermediate care services as alternatives to acute care. To ensure patients are signposted appropriately, supporting improvements in the management of people with long term conditions and mental health to reduce demand on acute care, for example.

We have described a proposed model of care which has been developed based on local stakeholder, public and clinical insight, using case for change data and NHS England National Guidance.

The implementation of a revised model of care may result in changes to existing service delivery, potentially re-locating services and staff and changing the focus of the community offer to a more comprehensive, consistent offer. All possible considerations and impact, positive and negative for the public and stakeholders have been considered and will be published on the NHS Wirral CCG website for review as part of the consultation.

A new model of care will improve the patient experience; the local population told us that people do not clearly understand the choices available to them and how to access or use them, and therefore the aim of a new model is to offer consistent, standardised care for patients. It will also ensure that patients are seen in the most appropriate place. It has the potential to enhance patient safety and improve patient outcomes through delivery of a clearer, consistent model across urgent care in Wirral driving closer integrated working between organisations delivering urgent care. Furthermore, by having a proactive approach to planned care and focus on self-care and wellbeing, this model will help to shift the focus of care towards prevention of illness and supporting people in relation to the wider determinants of health.

10.3 Public Consultation

The next steps are to undergo a formal consultation process recommended to gather feedback from the public and stakeholders. As part of a formal consultation, commencing for 12 weeks between September and December 2018, we propose to inform the public about the mandated services whilst asking for their views on the options we have proposed for the community offer.

Monitoring of responses during the consultation period

The communications and engagement plan includes commentary relating to the monitoring of responses. The Wirral Intelligence Service will be monitoring responses and will provide a weekly update to the transformation team. This will enable the team to identify any specific gaps or issues raised which can then be managed in a timely manner, this would include being responsive to individuals, groups or stakeholders or targeting any additional engagement activity that cannot be anticipated at this point.

Decision making process

The criteria by which the CCG will base its decision making process on will be focused a number of issues such as; Equality Impact Assessments and Quality Impact Assessments, issues relating to transportation, service quality, patient safety, clinical efficiency. As well as these issues, we will also take into account results of the public survey and any public feedback received as part of this consultation.

Post consultation, survey responses and feedback will be analysed and a formal report will be developed which will take into account survey responses, feedback from any public events, issues raised via other methods such as telephone and post as well as reviewing the initial feedback from the listening exercise and stakeholder engagement activities that took place earlier in the year. We will be applying weighting criteria to a number of key categories concerning both the urgent treatment centre and the local services in the community such as:

- Accessibility
- Distance
- Parking
- Flexible and convenient appointments

We will take into account the above areas as well as looking at the clinical benefits the options present.

Prior to submitting our final proposal to the CCG Governing Body, we will be subject to formal approval via NHS England.

Governance Structure

As part of the decision making process, we are subject to a number of approvals in terms of post consultation decisions. Our own internal governance process dictates that we present our findings and final proposal to our own internal Executive Management Team for information and review purposes.

We will also be subject to review by NHS England who will have sight of our final report and proposal prior to presenting to CCG Governing Body for final approval in February 2019. In line with this we will also present our final proposal to the Joint Strategic Commissioning Board.

Capital Funding Bid

Wirral CCG has tendered a bid to obtain capital funding to support the implementation of a new, fit for purpose Urgent Treatment Centre (UTC) at the Arrowe Park Hospital site. The clinical benefits for basing the UTC at Arrowe Park are referenced within this document, as well as our full consultation materials. The clinical benefits for this decision are linked with our bid for capital funding. Should we be successful in this bid, it would enable our preferred option of a new fit for purpose build which will maximise the efficiency of the UTC.

Options to proceed in the absence of capital funding

Should we be unsuccessful in our bid for capital funding, our preferred location for the Urgent Treatment Centre remains at Arrowe Park for a number of clinical safety and efficiency reasons highlighted in our consultation document and case for change. Whilst the awarding of capital funding would enable our ideal option; in the absence of such funding we will reconfigure the existing walk in centre at Arrowe Park to become the UTC and undertake minimal internal redesign.

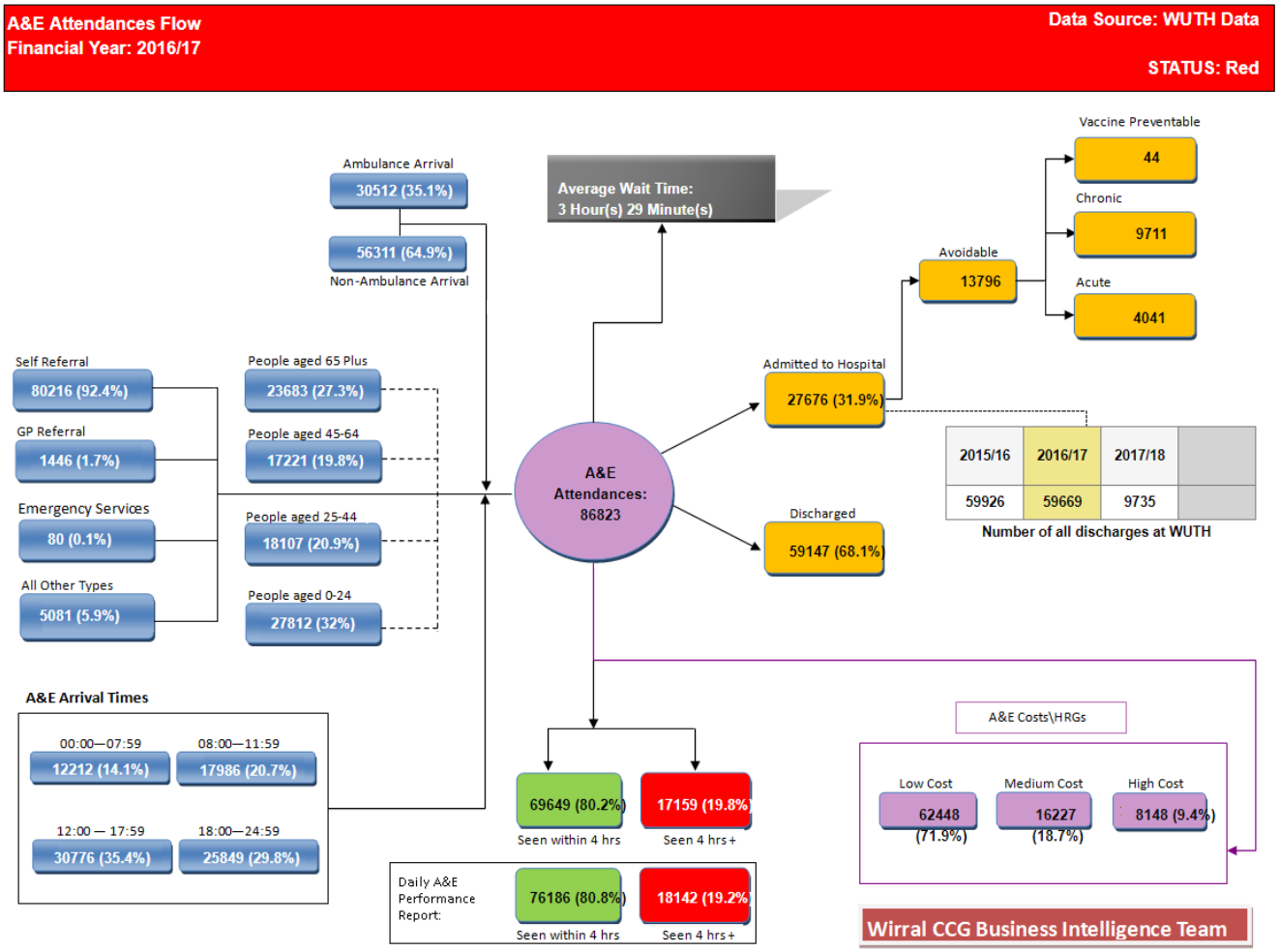
How the service provider for the new care model will be selected

Urgent care services in Wirral are provided by a number of different organisations. Following public consultation and a decision regarding the future service model and location of urgent care services in Wirral, commissioners will work with stakeholders in considering the future provider model and present back to the CCG Governing Body in due course.

11. Appendices

A. A&E attendance flow
B. Supplementary data – A&E performance
C. QIA – Option 1
D. QIA – Option 2
E. EIA – Option 1
F. EIA – Option 2

Appendix A: A&E attendance flow, 2016/17



Appendix B: A&E Performance

The performance of the A&E system in Wirral has not been satisfactory and the CCG has had clinical concerns due to the deteriorating performance against the constitutional standard of 4 hour waiting time target. Since the data has been collected and analysed for this paper, over the past two months, significant whole system progress has been made, evidenced in the Urgent Care plan (see figure below). We have subsequently seen some improvement of stabilisation of the urgent care system. An approximate 10% improvement has been achieved in the 4 hour standard. Whilst there is some daily fluctuation, to be expected, this is being daily monitored. However, there is still further progress and improvement required to meet the 95% mandated standard.