Purpose of this document
This document has been produced to inform the Clinical Board of commissioning intentions for A&E for adults within Central Manchester and will support the design and delivery team in preparing a project plan outlining strategic and operational priorities for delivery of urgent care services.

Scope
Urgent care is currently provided in a range of settings across Manchester, with by far the highest demand being seen in Accident and Emergency (A&E) departments; Central Manchester Foundation Trust (CMFT) has the greatest activity from an NHS Manchester perspective.

Data indicates that minor and standard attendances are the two major components of A&E attendances, and a recent Primary Care Foundation report stated that up to 30% of A&E attendances could be categorised as primary care.

Whilst there are a range of urgent care services suitable for specific patient cohorts, the system is considered to lack overall integration and signposting, making navigation by patients and healthcare professionals difficult and confusing. As a result of this, patients gravitate towards A&E which puts pressure on capacity and the ability to deliver an optimum service.

The initiatives outlined in this brief explore opportunities to improve the service model, involving both pathway and service reform, to reduce A&E attendances and subsequently admissions. This will necessitate a whole-systems approach with partners including:
- NHS Manchester
- CMFT
- Manchester Community Health (MCH)
- PBC and Primary Care
- Manchester City Council (MCC)
- North West Ambulance Service (NWAS)
- Out of hours – Go To Doc

Proposal
To improve navigation and triage within A&E to ensure patients are appropriately streamed to acute services, PCEC or back out into the community. This would ensure delivery of reduced A&E attendances and non-elective (NEL) admissions, particularly non-elective short stay (NELST) admissions. Analysis of 2009/10 NELST admissions data highlighted an overperformance of £800,000 for adult A&E admissions. The following will need to be implemented in order to deliver this proposal:

1. Integration of primary care services into A&E
A pilot period (between 3 and 6 months) during which a primary care presence (GPs and appropriate professionals) will be present in the department to assist with triage if necessary, provide primary care advice and treatment and offer patient education. The GP/primary care professional(s) will support outward and inward facing streaming at point of triage; and investigate the feasibility of developing bookable systems into primary care. PCEC nurses to be included in this pilot as they can offer additional primary care expertise.

Timescale: Pilot to start by winter 2010
2. Triage
Following the review of triage in A&E and PCEC, the agreed actions need to be implemented to ensure effective triage and improved streaming to PCEC. Streaming should increase through the involvement of PCEC nurses in the above pilot, as they are trained to follow protocol.

The review showed that there is a tendency to be over cautious in categorising certain conditions, which requires monitoring. These include:
- Chest pain
- Moderate pain
- Whiplash

Timescale: Review team to report update on implementation of actions to Clinical Board November 2010

3. Communication and patient education
In order to support a sustainable reduction in A&E activity, a clear and consistent message will need to be delivered to the public on the appropriate use of services. These messages will need to be system wide and include:
- Primary care (including the GP in A&E)
- Triage nurses
- Adult Social Care
- North West Ambulance Service – NWAS
- Out of hours - GotoDoc

Patient literature will support the communication of this message, including the NHS Manchester produced ‘Making the right choice’ leaflet and the Choose Well campaign. It is also proposed that Choose Well signage should be introduced within the department; including specific messages such as those in place at Salford FT (Hope).

Timescale: Ongoing; some elements in place September 2010; design team to develop detailed plan and report to Board November 2010

4. Ambulatory Care Sensitive (ACS) Conditions
This builds on potential areas for development identified from the pilot of the ‘Acute Medicine Clinics’. An ambulatory model will be explored to create a ‘virtual ward’ of patients only using services (for example GP, Consultant, Advanced Practitioners and investigations) which truly add value to their treatment. This should result in admission to an acute bed only occurring in the case of an acute illness that requires inpatient care.

Timescale: Project outline agreed by November 2010

Benefits/ outcomes
- Reduced A&E attendances and non-elective admissions (including short stay)
- An integrated primary and secondary care service model
- Improved access within primary care
- Better informed patients

Metrics

<table>
<thead>
<tr>
<th>Item</th>
<th>Target</th>
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<tbody>
<tr>
<td>Increase in proportion of A&amp;E attendances streamed to PCEC</td>
<td>Proposed that at least 30% of attendances should be streamed</td>
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<tr>
<td>Reduction in A&amp;E attendances</td>
<td>It is proposed that the design team develop appropriate metric</td>
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Reduction in non-elective admissions, ordinary and short stay

| Metric to be determined; at minimum recent rises in admissions to be stemmed |
| Reduction in admissions for ACS conditions |
| Work undertaken for SOSF estimated that introducing an ACS model for specific conditions could reduce admissions by 50% (shifting the balance from ordinary admissions to short stay) |

**Links**
- Securing Our Shared Future integrated care programme
- Improved access to primary care
  - Increase urgent and same day access primary care to support assessment and treatment in the community. This would encourage a potential reduction in attendances for minors at A&E and would support CMFT in managing demand. Explore the ability to book GP appointments directly from A&E; telephone and IT links to practices. The model will need to work for ALL patients and not just those registered with a central Manchester GP. Robust links to be developed with A&E departments and primary care across the city to ensure improved access to primary care is available to all presenting patients.
- Out of Hours (OOHs)
  - This will need to function well on a 24 hour basis. Greater support/ education needed for OOHs GPs to ensure acute attendances/ admissions do not increase during the OOHs period.

**Financial Envelope**

*Reduction in Activity*
- An increase in streaming to PCEC to 30% of A&E attendances is estimated to reduce attendances at A&E by 17,138 per annum leading to a saving of approx £230,000.
- Savings from a reduction in A&E attendances to be confirmed.
- Non elective admissions are currently over performing; by around £488k in the first quarter of 2010/2011. By stemming this over performance full year impact for Manchester would be £1.9m.
- Non elective short stay admissions currently over performing, by £77k for the first quarter of 2010/2011 for Manchester. To bring within contracted levels would save over £300k in this financial year.
- Reduction in admissions for ACS conditions has been estimated to deliver potential savings of between £1.22m and £2.1m.

**Recommendation**
The Clinical Board is asked to agree the proposal for implementation by the design and delivery team.

**Suggested membership of a design and delivery team**
- Helen Hosker (PBC Clinical Lead)
- Ruth Cammish – PBC Clinician
- Stef Cain (PBC Senior Manager)
- CMFT Emergency Care clinical / managerial lead
- CMFT Acute Medicine clinical / managerial lead
- Manchester Community Health managerial lead
- PCEC managerial/clinical lead
- Manchester City Council managerial lead
- Potential representation from NWAS and GotoDoc to be considered