County Durham Primary Care Trust
Darlington Primary Care Trust

URGENT CARE SERVICES:

Outline Strategy

Date of issue: 4th February 2008
Version 1.0
urgentcare.review@cdpct.nhs.uk

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1. Purpose of this Document

County Durham PCT and Darlington PCT ("the PCTs") are the statutory NHS bodies established to commission health services for the 630,000 people who live within our borders, as well as those who visit for work or other purposes.

The PCTs are working together to develop improved urgent care services in a way that meets patient needs by providing a seamless pathway. The aim is to develop and deliver a model of service that is effective for at least the next five years and ensures that patients are treated in the right place and at the right time. The PCTs strategy builds upon national, regional and local policies as well as the outcome of stakeholder events held in December 2007.

The nature of urgent care is such that many different agencies may be involved in responding to a patient's needs within a relatively short period of time and often in circumstances that are distressing for the patient and those closest to them. The PCTs wish to design an approach that means that all those involved can focus upon treating the patient's problem rather than dealing with communication and other issues that can currently occur when different agencies' responsibilities combine.

This document summarises the outcome of our stakeholder events that clearly showed the need to commission an urgent care service that is truly seamless and reflects the needs of patients and carers using that service. The PCTs wish to stimulate a debate that will see responses provide breadth and depth to the proposed models of care. County Durham PCT and Darlington PCT wish to do so in a way that focuses upon patients and their pathways through treatment, rather than upon a silo model reflecting historic routes of delivery. We intend to launch a final Urgent Care Strategy at the end of February; the strategy will contain outline or high-level service specifications for the services we wish to commission.

The lead Executive Director at the PCTs for this review is Cameron Ward, Director of Commissioning and Market Development, and queries regarding this document should be addressed to him at:

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Our preferred route for responses is via a specific email address set up for this review, which is urgentcare.review@cdpct.nhs.uk

Further copies of this document are available from our website via a link that may be used to access all material relating to this review. Our website is: www.countydurhampct.nhs.uk

2. Definition and Scope of Urgent Care

The stakeholder events helped to produce the simple definition that:

"Urgent care is an individual's need for care which could not be predicted"

The Department of Health discussion document 'Direction of Travel' describes urgent care as a range of responses that health and social care services provide to people who perceive the need for urgent advice, care, treatment or diagnosis. There is an expectation that these needs will be met on a consistent 24/7 basis with rigorous assessment of the urgency of care and an appropriate and prompt response to that need. It identified some key areas to be addressed:

- Integrated Services
- Information Sources
- Access to Medicines
- Better Communication
- Stronger Public Involvement
- Innovative GP Practice
- Workforce

Using the definition and context above, we believe that it is logical for the scope of urgent care within this document to include:

- Primary care services, both in and out of hours
- Management of patients with long-term conditions
- Nursing and care home urgent care support
- Urgent care 24/7
- Urgent mental health care, including crisis resolution services
- Provision of urgent dental treatment
- Telephone helplines (e.g. NHS Direct)
- Transport to urgent care facilities
- Social Care (e.g. Social Care Direct)
- Pharmacy in respect of urgent medicines

We are *not* seeking to review emergency services such as those sited at A&E departments or delivered via 999 ambulance responses. However, if we are successful, those services will clearly be affected by a reduction in demand as patients whose needs are not of an emergency status redirect to more appropriate urgent care services. The achievement of such reductions is a fundamental objective of our reform of urgent care.

3. The Urgent Care Strategy

The purpose of the strategy is to ensure that urgent care services across the PCTs meet patient needs in a way that delivers value for money. The outline objectives of the strategy are to:

- Produce a single definition for urgent care
- Reduce inappropriate A&E attendances
- Reduce inappropriate acute admissions to hospital
- Provide a single point of contact for patients and carers to urgent care services
- Similarly provide a single point of contact for professionals involved in the care of urgent care patients
- Eliminate unnecessary provision and requests for information such as patient details, e.g. through shared assessment and use of IM&T
- Ensure prompt advice, assessment and treatment
- Align new services to GP opening times
- Provide care as conveniently as possible – e.g. closer to home

The overall objective, therefore, is to ensure effective systems are in place that meets patient demand in a primary or community setting wherever possible. We believe this reflects the needs of urgent care patients and allows emergency services to focus upon emergency patients in a way that will improve the outcomes of their care.

We see the role of our Practice Based Commissioning Groups as central to designing a coherent, planned, framework of urgent care services that is also flexible enough to ensure that local characteristics are taking into account.

The PCTs intend to measure the success of our strategy against the objectives above and the same objectives should be highly visible within the proposed future model of care that is described in section 6 below. That model will be developed by the responses received to this document and we hope to provide a genuine catalyst for debate, which means subsequent documents could have a revised scope and different models of service.

This Outline Strategy has been produced to summarise the outcome of the PPI stakeholder event held in April 2007, the two stakeholder events held in December 2007 and a third stakeholder event on 28th January 2008. The third meeting was informed by a draft working version of this Outline Strategy. This document will be discussed further with stakeholders through February 2008, with the final Urgent Care Strategy being published on 26th February 2008 at a launch event. The final version will be used for any formal public consultation that is required and will contain outline service specifications for some services that trigger formal procurement processes in line with NHS processes.

The Outline Strategy has been deliberately written in a way that focuses upon the main themes that have emerged from stakeholder discussions so far and avoids in-depth descriptions of current service activity and costs. We do not

want historic precedent to limit our initial thinking. We have tried to set out the initial proposed characteristics of the service in sufficient detail to inform a period of consultation with stakeholders that seeks responses upon:

- the value of the proposals in terms of care delivered to patients
- the effective respective roles of NHS and other bodies in providing care
- the practical feasibility of the services proposed
- the timescales for implementing new services and ways of working
- the value for money, or cost-effectiveness, of the proposals
- the best way to measure our implementation through the local set of NHS targets, known as "vital signs"

We would like to receive responses to this document in time to incorporate them in the launch event which we are planning for 26th February, which means we need to receive them by noon on 22nd February. All responses should be sent to:

urgentcare.review@cdpct.nhs.uk

4. National and Local Drivers of Service Improvement

Successive national NHS policy guidance that has been published since 2001 provides a consistent context to our proposed future model of care. A 2004 report by Sir George Alberti, "Transforming Emergency Care in England", recommended that modern services should be based on six principles. We believe that these principles are equally applicable to urgent care.

1. *Personal, individual, high quality service* - patients will receive high quality care, wherever it is delivered, according to their needs
2. *No unnecessary delays* - patients will experience no unnecessary delays
3. *Simple access* - patients will have easy to follow and understandable journeys of care, no matter where they enter the system
4. *Convenience* - care will be provided where it is most convenient for patients.24/7 care, where appropriate, will be available in hospital and community settings
5. *Emergency prevention* - patients will receive care as early as possible. This will help prevent their problems from becoming more serious or even happening at all.
6. *Integrated whole system care* - patients will be able to move from one part of the system to another, without barriers, delays or having to start again.

It is interesting to note how well these principles align to the four characteristics that Professor the Lord Darzi has identified in the "NHS Next Stage Review Interim Report" as elements of the vision for a world class NHS:

- *Fair* – equally available to all, taking full account of personal circumstances and diversity

- *Personalised* – tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice
- *Effective* – focused upon delivering outcomes for patients that are among the best in the world
- *Safe* – as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.

The Department of Health has published a series of guidance on the reform of urgent care that have common characteristics highlighting the need for simplified access, consistent assessment and the right care at the right time.

In addition, the NHS North East has adopted seven aims to set a context to the vision for future NHS services across our region. These are: - no barriers to health and well-being; no avoidable deaths, injury or illness; no avoidable suffering or pain, no helplessness; no unnecessary waiting or delays; no waste and no inequality.

We have incorporated all of these aims and principles into our proposals and we believe that those proposals and the overall approach we are taking is fully in line with the World Class Commissioning competencies published by the DH, and set out in Appendix Two.

The Urgent Care Strategy that results from this review will be implemented through the new mechanisms announced by the DH guidance "*The NHS in England: the operating framework 2008/09" published* in mid December 2007. Our annual Operational Plan will include the Urgent Care Strategy as a discreet section and it will be developed alongside the future Strategic Plan due in autumn 2008. All of the approach will reflect the partnership approach that is emphasised by World Class Commissioning and the NHS Operating Framework, especially in terms of our local authorities.

In recent years the NHS has become accustomed to the need to focus upon a series of important national targets, many of which apply to urgent care. The NHS Operating Framework requires us to continue to demonstrate delivery of targets that will be known as Existing Commitments and several relate to urgent care or areas impacting urgent care i.e. A&E, access to primary care appointments, thrombolysis (clot busting drugs used for the treatment of heart attacks) call to needle times, access to sexual health services and ambulance response rates.

The NHS Operating Framework also announced that PCTs were expected to set priorities for local action linked to "vital signs" – i.e. a series of local targets providing indicators of success in delivering local health goals, drawn from a national indicator set. PCTs have also agreed Local Area Agreement targets with our local authority partners and some link to urgent care services.

The overall performance framework for the NHS is changing and allows more flexibility for us to consider local measures of success and qualitative measures linked to contracts. We shall use the development of this strategy to

consider the most suitable measures for local inclusion and to ensure that we have data systems in place to facilitate such analysis. A key part of this is to investigate comparisons with similar populations elsewhere in order to set challenging but achievable benchmarks and “stretch” targets.

We also wish to develop qualitative performance criteria for urgent care services and to incorporate those requirements within our service specifications. For example, we already have quality requirements set out for our commissioned Out of Hours services and we wish to consider the expansion of these to in-hours services.

The NHS Operating Framework has signalled an invitation for PCTs to develop innovative ways of linking qualitative criteria to Service Level Agreements (SLA) and contracts in a far more explicit way and we intend to respond to this and redress the recent imbalance of focusing upon quantitative measures such as the national 4hr Emergency Care target.

One area for us to explore will be via the requirement for us to have an SLA in place with our in-house PCT provider services by April 2008, so we can consider qualitative and quantitative criteria around urgent care centres and other relevant services such as the work of community matrons.

5. Current Services

This section needs to be read in conjunction with the map forming Appendix One as well as the compendium of statistics that we have prepared in response to helpful suggestions made at the third stakeholder event.

The current service provision does not meet the requirements of the principles consistently identified in national guidance. County Durham and Darlington has a large population that is dispersed across towns and villages with very different characteristics. Physical patient flows reflect a pattern determined by a complex mixture of public transport routes, road links, communal networks and former NHS configurations.

Health services have developed through localised models that mean that out of hours care, urgent care centre provision and community nursing can be varied even though they are only 10 miles or so apart. There are indications of health inequalities reflecting the high levels of socio economic deprivation in some areas as well as the geographical isolation of some communities.

Both the recent stakeholder events and feedback from both the PPI stakeholder event and PCT ‘Big Conversation’ clearly highlighted the absence of a “whole systems” model and suggested a degree of confusion amongst the public as to how to use services in an effective way. This was reinforced in some cases by the experience of health professionals facing a similar lack of clarity. The following sections summarise the current services provided.

5.1 Accident & emergency departments

The main provider of Accident & Emergency services to our patients is the County Durham and Darlington NHS Foundation Trust (CDDFT) with units at three sites – the University Hospital of North Durham (UHND), Darlington Memorial Hospital (DMH) and Bishop Auckland General Hospital (BAGH).

UHND and DMH are the major trauma and critical or complex emergency centres with 24/7 consultant cover. BAGH has 24/7 consultant cover and receives minor trauma and medical emergencies.

In a typical year, between 20-25% of our residents access A&E services outside County Durham and Darlington, mainly at either North Tees and Hartlepool NHSFT or City Hospitals Sunderland NHSFT.

5.2 Walk in centres/minor injuries units/urgent care centre

There is a Walk in Centre in Darlington at Dr Piper House managed by Darlington PCT.

There are Urgent Care Centres at Peterlee Community Hospital and Seaham Medical Centre.

There is a Minor Injuries Unit at Shotley Bridge which is nurse led and currently part of the CDDFT.

5.3 Primary care out of hours services

These services are currently managed in different ways on a locality basis. In Derwentside, the Dales, Durham & Chester le Street and Darlington care is provided by the PCTs at Shotley Bridge Hospital, BAGH, UHND and Dr Piper House respectively. These services use a combination of clinical staff such as salaried GPs, sessional local GPs, Emergency Care Practitioners and Advanced Practitioners to provide care.

In Easington care is provided by Primecare Nestor Ltd at Peterlee Community Hospital.

5.4 NHS Direct

NHS Direct provides patients with the advice and information they need to manage minor illness and self-limiting conditions themselves. They help them to navigate the range of health services available, and access the appropriate level of care to meet their needs. The provision of a textphone service for the deaf and hard of hearing and a confidential interpretation service in many languages, makes them accessible to traditionally harder to reach groups. There is a strong focus on supporting patients to self-care and nearly 40% of calls to

NHS Direct are resolved without the need for referral to another service. NHS Direct is an expanding business with local enhanced services, call streaming for urgent care and long term condition support.

5.5 Ambulance service

Following the publication of the 'Bradley report', which recommended the merger of North East Ambulance Service and the Tees part of Tees East and North Yorkshire Ambulance Service and that the North East Ambulance Service NHS Trust (NEAS) become co-terminus with the North East Strategic Health Authority.

NEAS provides the statutory Ambulance service across County Durham & Darlington, and as such are responsible for providing the 999 (emergency) service, they also provide some non-emergency transport of patients as part of patient transport services (PTS). There are a small number of commercial organisations, which are also providing PTS type ambulance services.

NEAS is the first in the country to implement 'NHS Pathways'. The system has been developed and designed by the NHS for use in the UK and is replacing the American-designed Criteria Based Dispatch system currently in use in the North East 999 Control Room.

NHS Pathways is designed to ensure that each patient receives the most appropriate treatment for their symptoms.

5.6 Non-ambulance transport

There is a complex and inconsistent provision of services currently in place covering journeys between, and to, a wide range of sites delivered by a number of different providers.

5.7 Dental out of hours services

This service is provided at both UHND and DMH as an emergency service with access via telephone triage by Dencall.

5.8 Mental health urgent care

Tees, Esk and Wear Valleys NHS Trust (TEVW) was formed in April 2006 to provide a range of mental health, learning disability and substance misuse services for the 1.4 million people living in County Durham, the Tees Valley and North East Yorkshire. They also provide a range of specialist services to other parts of northern England.

TEVW are responsible for the provision of a range of crisis and deliberate self harm services. These services are accessed through a range of methods including; acute, primary care, social care, police and

self referral which reflects the complexity of the service. Hospital provision for Mental Health patients in time of crisis can be found in West Park, Darlington, The County, Durham and Sandwell Park, Hartlepool.

5.9 Social care

Social Care Direct is a dedicated team of officers who are available to deal with issues relating to social care and health, the service is provided by Durham County Council and Darlington Borough Council. There is an emergency contact number should anyone need to contact the service Out of Hours.

Social Care Direct have many teams available, as well as providing advice on children services, grants, domestic violence, carers etc. The NHS are able to buy packages of care for support and also have available systems like Careline to support people to live independently within their own homes.

In some parts of Durham and Darlington Health and Social care have already began to integrate services with social workers and district nurses working together on one caseload.

5.10 Primary care

The vast majority of patients accessing urgent care do so through appointments with their own GP. Patients find this convenient in most cases and are able to receive continuity of care. We wish that to continue to be the case and support ongoing plans to improve access. Two GP-led health centres will be procured to improve access and equality to services. New and innovative services will be developed and delivered in ways that provide the most convenient access to primary care services. These will target hard to reach groups in order to tackle the wider determinants of health, which include:

- CVD screening
- Worklessness
- Services for travellers and homeless patients
- Sexual health
- Language services

Capacity for primary care dental services will be increased, based upon assessments of local needs with the objective of ensuring year on year improvements in the numbers of patients accessing dental services.

6. Proposed Future Model of Care

The principles on which to base future urgent care services have come from national and local drivers as well as the outcomes of stakeholder events. They are that the service shall be:

- Would remain free at the point of delivery (Bevin 1948)
- Operated 24 hours a day, every day of the year.
- Seamless for patients and shall be simpler to access.
- Delivered primarily by determinations of clinical need and not by patient demand.
- Managed in partnership between organisations, as a truly integrated whole system.

The stakeholder events produced valuable ideas that are summarised in a diagrammatic way in Appendix Three and Appendix Four. Appendix Two shows the principles that emerged, services that were highlighted and how those services link to the seven aims of the NHS North East vision. Appendix Three sets out pathways, interventions and improvement opportunities that begin to form redesigned services.

The key aspects of the suggested pathways are set out immediately below for convenience of response. When the final Urgent Care Strategy is launched on 26th February we expect to issue outline service specifications for redesigned services that we believe will be required to deliver the pathways.

6.1 Single patient contact with the service

It is proposed that a single hub will be commissioned for *all* urgent calls, including in hours and out of hours calls. It is further proposed that a convenient six figure number could be established to facilitate public clarity and ensure a consistently received response.

This arrangement will enable calls to be systematically screened, assessed and filtered, with the response being appropriate to each individual's needs. For example, a small number of patients will, as now, require immediate specialist care and need an ambulance to transport them there. Many more, however, will be directed elsewhere, such as to their GP, a nursing service, pharmacist or self care. A further cohort of patients will require a face-to-face assessment, and will be invited to attend an urgent care centre, or an Emergency Care Practitioner could be despatched.

The intention would be to use IM&T in a way that allows patients/carers the opportunity to enter data once, rather than having to repeat information at serial stages of the pathway. The concept would also use an approach of the service taking responsibility from the patient to contact other services, and then "getting back" to the caller, allowing the patient/carer to focus upon their immediate health problem. It is intended that some patients would have information logged in the

system to allow a prompt, customised, response where their clinical condition means that they are in predictable contact or risk of contact with urgent care services.

Therefore, instead of having several different telephone routes into urgent care services (e.g. NHS Direct, own GP, Out of Hours Service), a simplified two-route system shall be commissioned. A telephone system to handle all urgent but not life threatening calls will work alongside the existing 999 service and will be a 24/7 service. Current GP Practice telephone numbers could be connected to the new system, in the same way as phone systems are currently diverted Out Of Hours.

A single Urgent Care Call Centre will receive all calls from 999, the new single number and from “patched through” GP surgery lines during out of hours, so that all calls can be triaged into three categories: - the immediately life threatening, the urgent and the non-urgent.

Discussion at the three stakeholder events has suggested that the integrated Urgent Care Call Centre could be based on a single site or spread across different locations with IM&T and other technical support providing what is, in effect, a single centre.

The call centre will risk manage all calls received by introducing GPs and/or nurse practitioners as clinical risk managers, call handlers and emergency dispatchers. Clearly, this will require close collaboration between the various provider organisations and professionals involved. It is imperative that all parties enter the new arrangements with the patient’s own needs paramount.

A minority of calls are immediately life-threatening and it is important to identify these quickly with appropriate response by paramedics.

The new model may be summarised by the diagram on the following page.

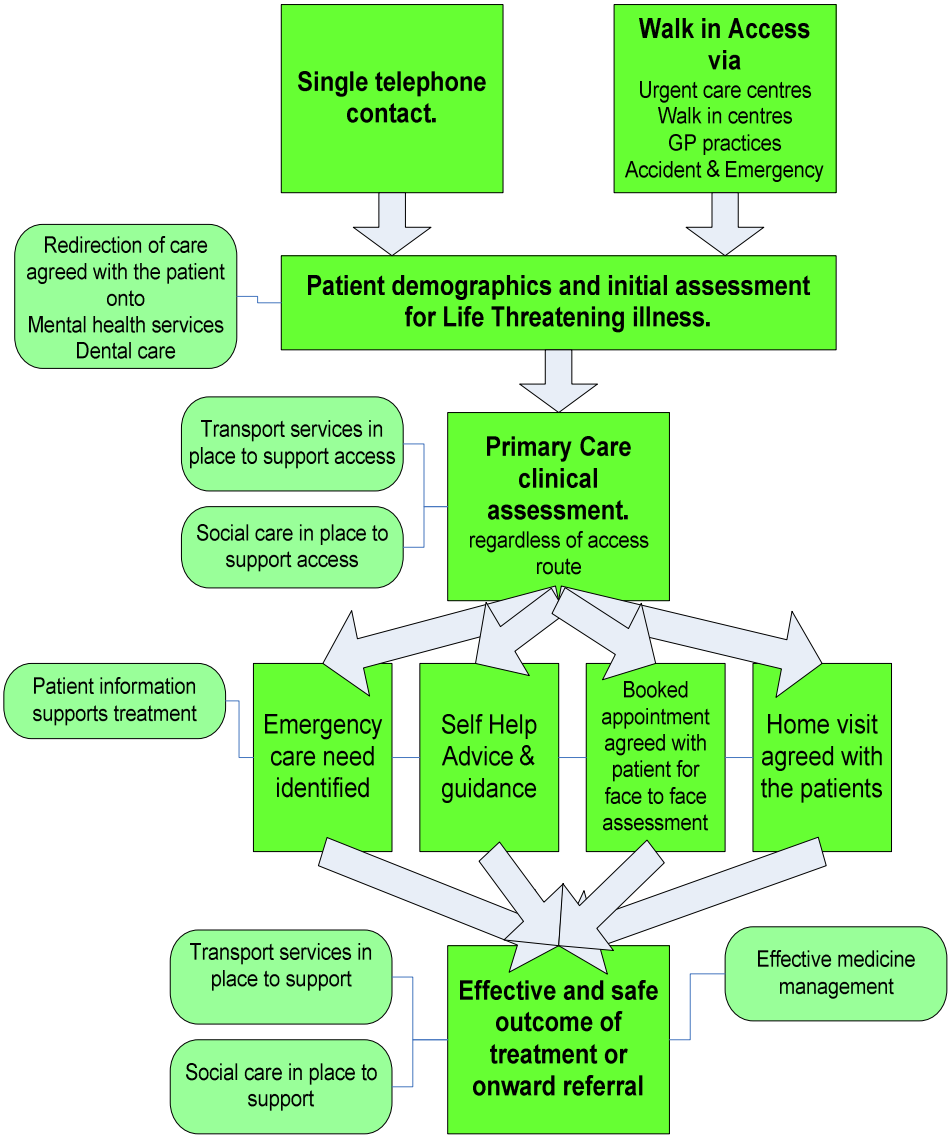
Redesigned
Urgent Care Pathway

Definition: Urgent care is an individual's need for care which could not be predicted.

Underpinning principles:

No barriers to health and well being
No avoidable death, injury, illness
No avoidable pain and suffering
No helplessness
No unnecessary waiting or delays
No waste
No inequalities

Standard: All Urgent Care demand will be first clinically assessed by a Primary Care Practitioner



6.2 Single professional contact with the service

A similar approach is proposed for health and care professionals with a dedicated number accessing a mirror service to that offered to patients. Again, this service will be available on a 24/7 basis and allow access to on-call colleagues, bed managers and other lead staff for all relevant services (e.g. dentistry, hospital, mental health, ambulance, social services and community nursing). This idea received strong support at the stakeholder meetings. The main benefits would be:

- Ease of access to services by professionals
- More efficient and speedier patient management leading to better patient outcomes
- Time savings for professionals especially GPs
- Integration of services and a "whole system" approach
- Centralised data capture and the opportunity for informed analysis

6.3 Physical access to urgent care

For the innovations above to work, we need to ensure that the local composition of urgent care services is formed in a rational way. There needs to be more consistency regarding the roles of important aspects of urgent care, such as community matrons, nursing home staff and community pharmacists. Patient transport, intermediate care and many other services operate in very different ways across the PCTs.

This is not the same as suggesting that all services should be identical. There may be excellent reasons for variation, given the diverse nature of the area and its people. What is suggested is that variation should be deliberate and desired. This is a complex area as it will involve working with partner agencies that are sometimes outside the area. Some 20-25% of our residents attending A&E do so at hospitals such as those managed by City Hospitals Sunderland NHS FT and North Tees and Hartlepool NHS FT.

It is possible that this redesign will mean that we wish to commission different services from those we commission now, or that locations may change to better reflect local patient convenience. Such changes, and innovations such as the single point of access call centre, are likely to require formal procurement exercises.

6.4 Transport

There is a highly varied matrix of local services currently available. We wish to redesign the picture into a more co-ordinated and consistent system that ensures the right kind of services are available for different communities. Our current expectation is that we shall issue a specification focusing upon transport as part of the final strategy and that this will cover all transport issues for urgent care – this will therefore *not* cover emergency ambulance responses as that is

separate from the scope of this review. We will seek to address PTS activity and the transport of patients to and from care homes, hospices, urgent care centres, nursing homes, patient's own homes and A&E where the patient need is urgent as opposed to an emergency. This is not an exhaustive list of such activity.

We have had productive initial discussions with Durham County Council to explore ways to collaborate in this area with the council commissioning such forms of transport.

6.5 Mental health

This was a significant concern raised at the stakeholder meetings. In this review we wish to consider access to Tees Esk and Wear Valleys mental health urgent care services and mental health crisis resolution.

In addition, we intend to specifically examine the best way to provide services to people with a mental health condition who wish to access urgent care services in order to be treated for physical conditions. We believe that patients can experience particular difficulties in such circumstances in ways that require a specific response.

Legislation currently being consulted upon will have an impact on the service provision of mental health care and we need to take that into account. For all of these reasons, we anticipate publishing a specification dedicated to mental health urgent care requirements.

6.6 Medicines management

Again, the stakeholder events highlighted particular suggestions regarding access to prescribed medicines. This applied to both in and out of hours. Examples included availability of medicines to professionals working out of hours, palliative care supply issues and the effective role of community pharmacists. We expect to publish a specification covering medicines management urgent care needs.

6.7 Social care

It has been identified that a small number of patients are admitted into acute care beds as a result of being unable to arrange appropriate social care packages either within a patients own home or by accessing intermediate care facilities within the Out of Hours period. Anecdotal information suggests that once admitted into an acute hospital bed a full range of investigations are initiated and can often result in a length of stay, which is inconsistent with initial presentation. It is anticipated a high-level service specification will be written to address these issues and provide a solution.

7. Service Specification

The PCTs have developed a standard service specification to be used as part of formal procurement exercises. It is not known at this stage what the specific changes are that will result from the final Urgent Care Strategy but we wish to alert service providers to the likelihood of significant changes being signalled.

Where appropriate, the Urgent Care Strategy launched on 26th February will contain outline service specifications set out in the PCTs' standard format. The standard format will cover requirements such as staffing, referral guidelines, facilities management, equipment, clinical governance, quality assurance, corporate governance, performance management and other aspects. It will be apparent from the content above that the shared availability of patient data will be a key point in any specification as well as inter-agency collaboration.

It is noted that the PCTs have contracts and service level agreements in place that contain renewal dates that may conflict with any formal procurement exercises that take place in the future. We also face a period in which NHS organisations will be under pressure to have 2008/09 arrangements in place during March 2008. We are happy to discuss the implications of these factors with other organisations at an early stage.

The timescales below reflect our desire to have genuine engagement and awareness that some service changes (e.g. development of a call centre) would need to be worked up over the summer, published as a plan around October and then implemented from April 2009.

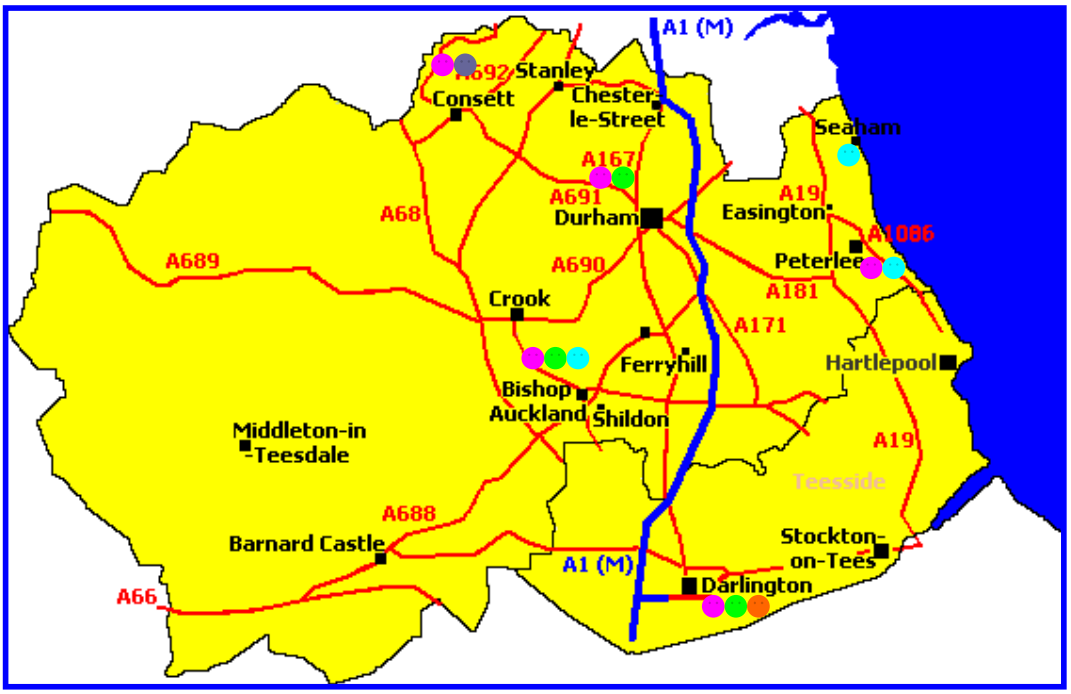
8. Process and Timescales

A summary of the key next steps is:

Outline Urgent Care Strategy published	4th February
Stakeholder discussion and amendment	4th – 22nd Feb
Urgent Care Strategy published/launch event	26th February
Outline Specifications Published	26th February

Appendix One

Current Services: County Durham PCT and Darlington PCT



Key:

- **Primary Care Out of Hours – Darlington Memorial Hospital, Bishop Auckland General Hospital, University Hospital of North Durham, Peterlee Community Hospital, Shotley Bridge**
- **Accident & Emergency Departments – Bishop Auckland General Hospital, University Hospital of North Durham, Darlington Memorial Hospital**
- **Minor Injuries Unit – Shotley Bridge**
- **Walk in Centre – Dr Piper House, Darlington**
- **Urgent Care Centres – Bishop Auckland General Hospital, Seaham Medical Centre, Peterlee Community Hospital**

Appendix Two

Data Summary

The population of Co. Durham PCT and Darlington PCTs is approximately 630,000 and:

- **21% are aged under 18 years;**
- **6.5% of the population are aged under 5 years of age, and;**
- **16.5% are aged over 65 years.**

Accident and Emergency Services:

(source = NHS hospital activity data 2005-06, 2006-07 and 2007-08 for County Durham and Darlington residents)

- **Around 165,000 attendances per annum**
- **20% are outside Co. Durham and Darlington, mainly at North Tees and Hartlepool NHS FT and City Hospitals Sunderland NHS FT**
- **Mondays and Tuesdays are the busiest days**
- **Peak activity is at 9am for weekdays and at 10am at the weekend**
- **Darlington residents are the most likely to attend and those from Durham and Easington have the lowest rates of attendance**

Primary Care Out of Hours Service:

(source = Northern Doctors' out of hours service Jan 2006 – Dec 2007 for Derwentside and Durham localities)

The service is available from 6.30pm to 8am on weekdays and for the whole 24 hour period on Saturday and Sunday.

- **Weekends have twice the rate of calls of weekdays**
- **Calls peak 8-10am**
- **30% of calls relate to patients aged under 18 years of age**
- **17% of calls relate to patients aged under 5 years of age**
- **25% of calls relate to patients aged over 65 years**

Darlington Walk in Centre:

(source = NHS activity data January-June 2007)

The service is open 8am-8pm seven days a week

- **Around 19,000 attendances in six months**
- **Attendances peak in the late morning**
- **Mondays and Saturdays are the busiest days**
- **18% of patients were aged under 18 years of age**
- **11% of patients were aged under 5 years of age**
- **3% of patients attended six times in six months**

Peterlee Urgent Care Centre:

(source = NHS activity data July 2005 – December 2007)

The service is open 24 hours a day, seven days a week

- **Around 41,000 attendances per annum**
- **Attendances peak mid morning**
- **5% of attendances take place between 11pm and 7am**
- **Saturdays and Sundays are the busiest days**
- **42% of patients were aged under 18 years of age**
- **18% of patients were aged under 5 years of age**
- **Under 7% of patients were aged over 65 years**
- **0.25% of patients comprise 2.5% of attendances**

Seaham Urgent Care Centre:

(source = NHS activity data October 2006 – December 2007)

The service is open from 8.30am to 5.30pm on weekdays

- **Around 5,000 attendances per annum**
- **Attendances peak at 9am with a further, smaller, peak at 3pm**
- **Mondays and Wednesdays are the busiest days**
- **46% of patients were aged under 18 years of age**
- **21% of patients were aged under 5 years of age**
- **Under 8% of patients were aged over 65 years**
- **1.4% of patients comprise 6.4% of attendances**

Appendix Three

World Class Commissioning Competencies

1. World class commissioners are recognised as the local leader of the NHS.

2. World class commissioners work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities.

3. World class commissioners proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health.

4. World class commissioners lead continuous and meaningful engagement with clinicians to inform strategy, ad drive quality, service design, and resource utilisation

5. World class commissioners manage knowledge and undertake regular needs assessments that establish a full understanding of current and future health needs and requirements.

6. World class commissioners prioritise investment according to local needs, service requirements, and the values of the NHS.

7. World class commissioners effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes.

8. World class commissioners promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration.

9. World class commissioners secure procurement skills that ensure robust and viable contracts.

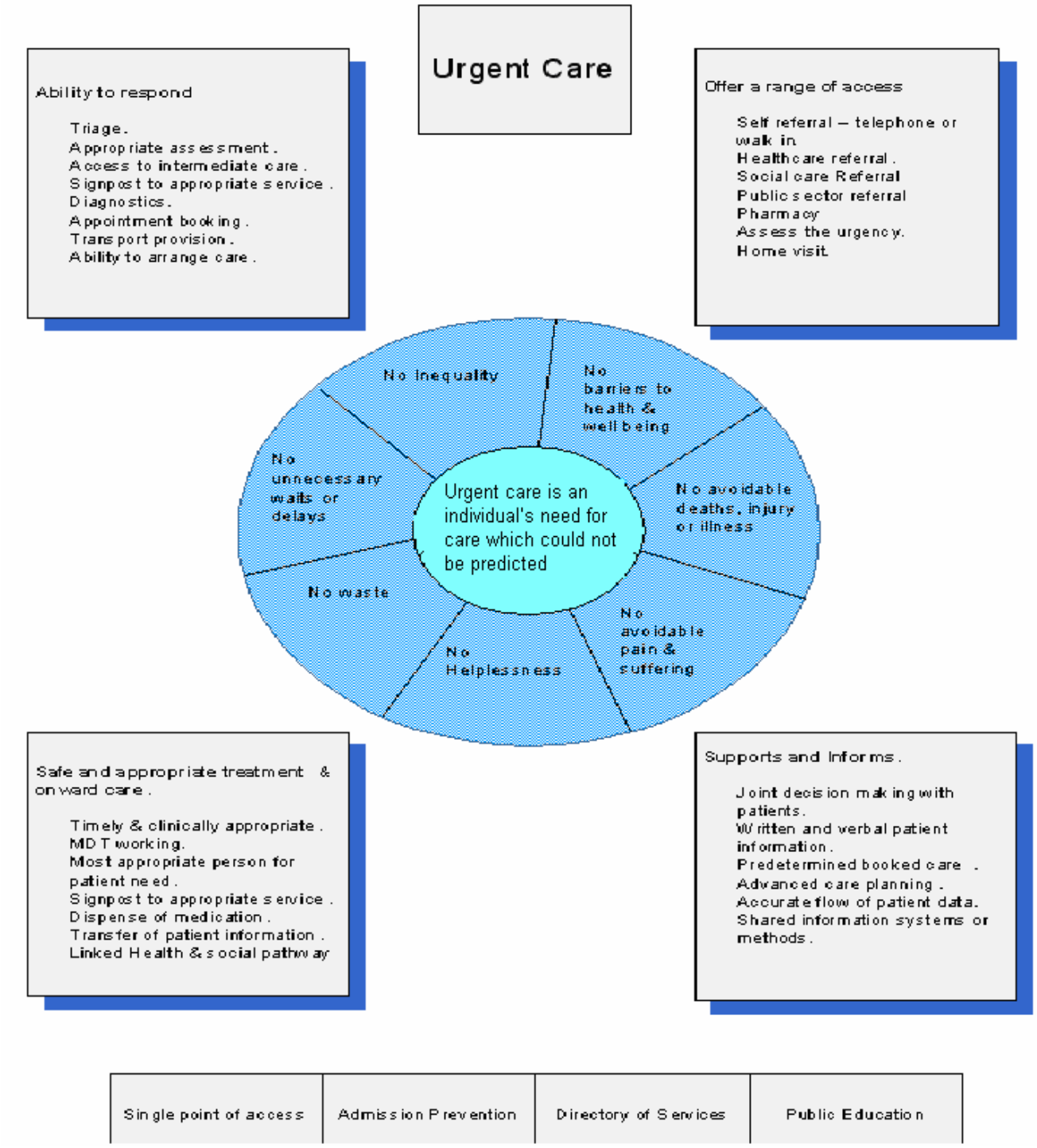
10. World class commissioners effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes.

11. World class commissioners make sound financial investments to ensure sustainable development and value for money.

Source:

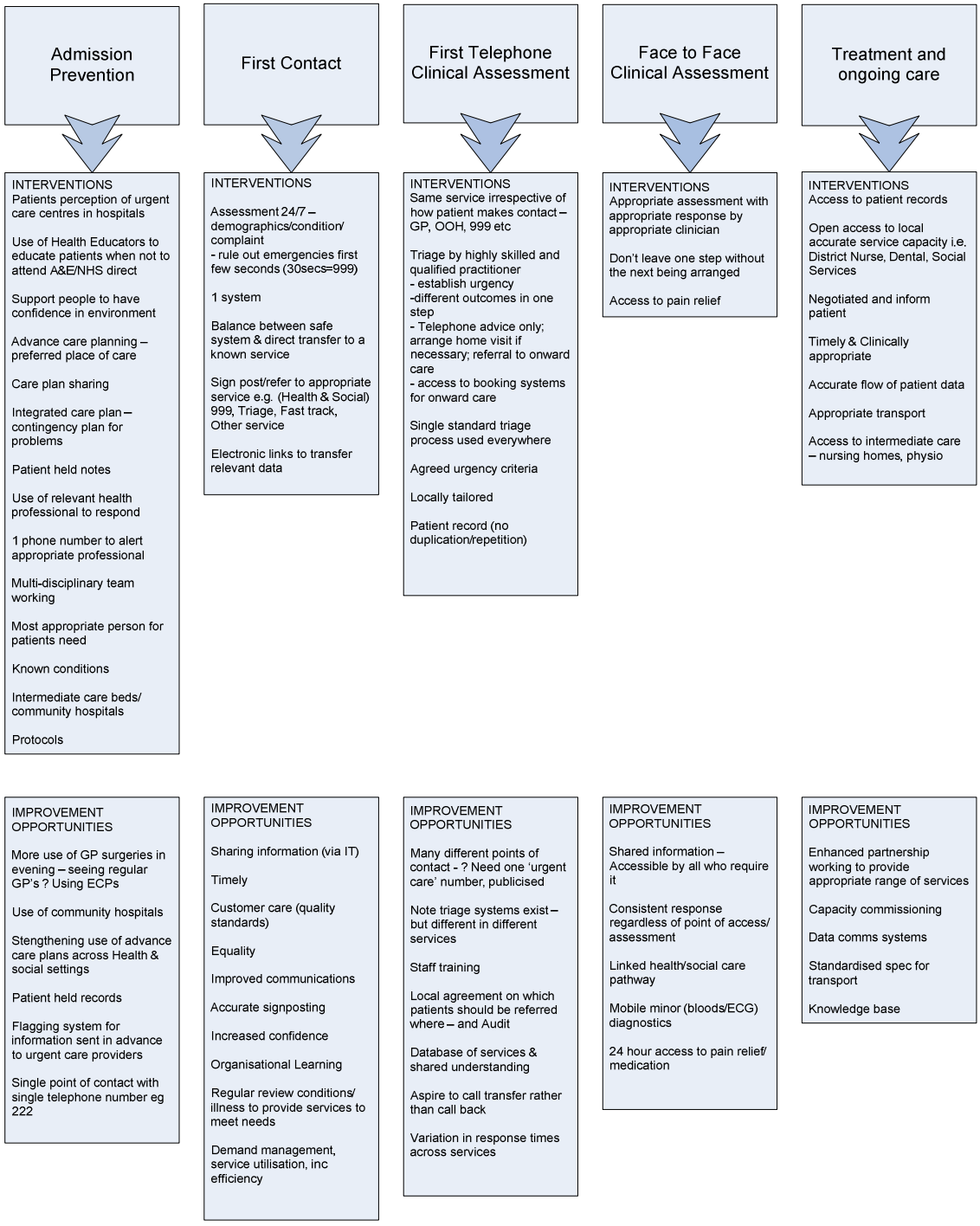
Department of Health (2007) *World Class Commissioning: adding life to years and years to life.* DH London.

Appendix Four



Appendix Five

DRAFT - Urgent Care Stages in pathway



Appendix Six

Glossary

Acute – of abrupt onset, an illness that is of short duration and in need of urgent care. In terms of hospital admissions, an acute admission is defined as one used by a patient with non-elective or emergency care needs.

Common Assessment - a common approach taken to assessment by professionals working across multiple agencies, a single approach to assessment with anticipated uniform outcomes irrespective of the patient's point of entry to the system.

Emergency Care – life threatening and traumatic situations where minutes matter in treating the patient.

Emergency Care Practitioners – healthcare professionals from nursing or paramedic background who have undertaken university training to allow them to work autonomously within primary care, unscheduled care, secondary care settings

Integrated Call Centre – a phone system operating 24/7 alongside the existing 999 emergency service providing a single point of contact

Out of hours - GP out-of-hours services provide essential medical cover during the larger part of the week, they also act as a vital means of managing demand on the rest of the health service,

Practice-based Commissioning (PBC) – a national system for involving primary care professionals in commissioning health services that involves practices working together in local clusters to develop new pathways of care.

Triage - sorting people based on their need for immediate clinical treatment in relation to the benefit of such care, a prioritising process that may be undertaken face to face with the patients or remotely by telephone or internet.

Urgent Care - treatment of illness and injuries of an acute nature that requires prompt attention, but not emergency care.

Urgent Care Centres - a service that is an optional stream for patients attending without an appointment who have a minor injury or illness presentation

Appendix Seven

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