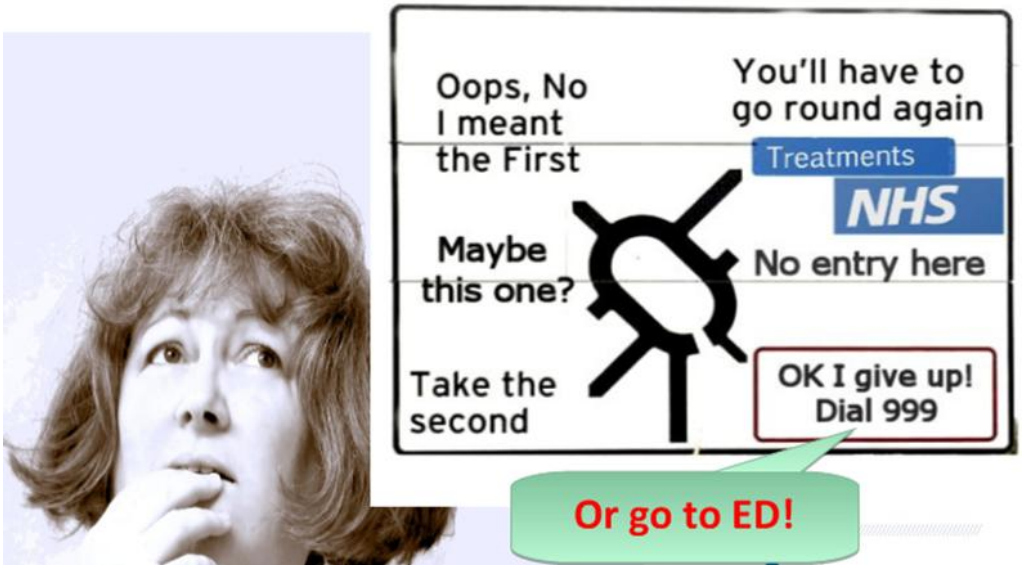
CCG authorisation – Case Study Template		
CCG name: **NHS Croydon Clinical Commissioning Group**		
Case study title: **Urgent Care Redesign**		
CCG case study number: (specify 1 to 5)	1 of 3	**Word length for this case study** 1132 (up to a maximum of 3,000 words in total across the submitted case studies)
Does the case study provide core evidence?	Y	**If yes, state domain criteria by deleting as appropriate:** 1.1c, 1.2f, 2.2b,2.3b, 3.2a, 3.3c, 4.2.1k, 4.3.1a,4.3.1b, 5.1c, 6.1d, 6.2b
Does the case study provide supplementary evidence?	Y	**If yes, state for which domain criteria:** 1.1a,1.1b,1.1d,1.1e,1.2d,1.2e,1.3a,1.4.1a,1.4.1b,1.4.2a, 2.1.1c,2.1.2b,2.2a,3.1.2b,3.1.2d,3.3b,3.3h,4.2.1c,6.2c

Patient groups	**Please tick all relevant:**
• Mothers and newborns	
• People with need for support with mental health	
• People with learning disabilities	
• People who need emergency and urgent care	✓
• People who need routine operations	
• People with long-term conditions	✓
• People at the end of life	
• People with continuing healthcare needs	

1) Context:

The Traditional Patient Journey:

Our frontline experience matched the evidence we gathered, that the majority of A&E attendances were not emergencies but urgent care.



Our Vision :

Patients seen by the right healthcare professional

In the right setting

At the right time, quality and cost.

We undertook a major redesign programme to improve the patient journey, choice, quality and patient safety, leading to financial efficiencies: the Whole System Integrated Urgent & Emergency Care Service, across self-care/prevention, primary, mental health, community, acute and social care.

Involvement

The development of the CCG's vision for Urgent Care was **led by** Dr John Chang and Dr Usman Quraishi, elected urgent care leads of Croydon's Pathfinder CCGs, under the **overall leadership** of Dr Agnelo Fernandes, Croydon CCG's Assistant Clinical Chair.

All member practices were involved through regular **GP Open Meetings**, covering our aims, what the new services could look like, and how clinical risks could be managed. As the strategy progressed we continued using the Open Meetings to discuss implementation issues.

We **refreshed the Urgent Care Network**, to include senior clinicians from acute, mental health, community and social care, GPs, pharmacists, LAS, NHSD and 3rd sector. The Network oversaw the strategy and implementation.

An **Integrated Governance Board** ensured robustly integrated clinical policies for the emergency service and NHS 111 interface. This was made up of GPs, commissioners, ED, UCC, LAS, Social Care, NHS 111 clinicians, managers and governance leads. Stakeholder involvement included patient representatives for both UCC and NHS 111 services.

Our **lead on NHS 111**, Dr Agnelo Fernandes, has become the chair of the London NHS 111 governance group, and GP Dr Farhan Rabbani succeeded him as clinical governance lead for NHS 111 in Croydon, a good example of **clinical leadership development**. Another development is that the CCG has appointed a second clinical leader for urgent care, Dr Karthiga Gengatharan, who has been developing urgent care protocols.

We held **over 100 engagement events**, to develop multi-disciplinary and inter-agency enthusiasm for the strategy and refine proposals. These included other CCGs, patient groups, multi-professional groups, GPs, LMC, LPC, LOC, secondary care clinicians, many community groups, Croydon Voluntary Action, and the local authority's OSC and HWB.

As we developed the NHS 111 protocols, we invited clinicians (including GPs, hospital clinicians and out of hours clinicians) to **"Break the System" events**. They provided challenge by giving clinical scenarios to test the robustness of protocols. All stakeholders were involved in populating the NHS 111Directory of Services.

2) Action

We built a **whole system Vision,** and **implementation Strategy**, during 2010/11**.** This was underpinned by a whole system process map, identifying urgent care capacity and demand across the whole health and social care system, together with bottlenecks causing service fragmentation. We developed **new infrastructure**:

24/7 GP-led Urgent Care Centre, integrated within the Hospital Emergency Department, and integrated with the out of hours primary care service. (Procurement from summer 2011, Live Service April 2012).

12/7 Urgent Care Centre at Purley Hospital, to include diagnostics.

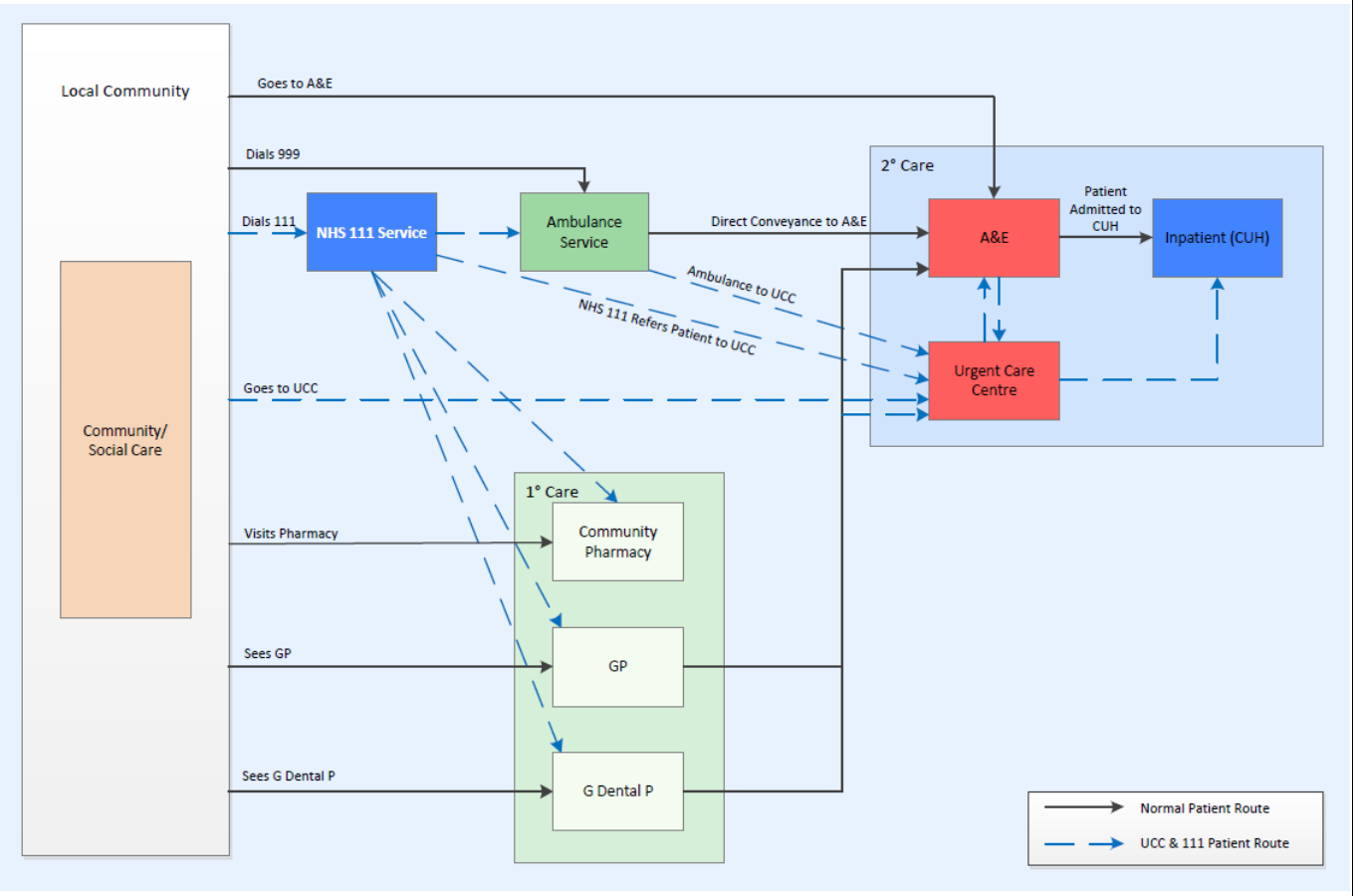
Minor Injuries Unit in Parkway Health Centre

NHS 111 pilot service - pilot for South West London.
(Procurement summer 2011, Live March 2012.)

Locally agreed protocols deployed by UCCs/MIU, ED, LAS and NHS 111 direct patients to the appropriate services.

The **new patient pathways** are shown overleaf, using dashed lines:

New Urgent Care Pathways



GP involvement in re-commissioning

GPs were determined to move from an "In Hours/Out of Hours" culture, to "24/7 urgent care". So we changed to a **single contract** covering both out of hours primary care and the 24 hour Urgent Care Centre.

To **manage potential conflicts of interests**, as many local GPs were interested in being part of providing these services, whilst local GPs were involved in writing the specifications, they were excluded from the procurement phase. The CCG drafted in two GPs from outside London to provide clinical input to the procurement process.

Primary Care initiatives

In summer 2011, our primary care clinical leaders persuaded every practice in Croydon to:

Add an extra phone or in person appointment for every clinician working on Mondays,

Balance their same day, urgent and routine appointments to match demand,

Ensure every COPD patient with pre-exacerbation symptoms has a rescue pack.

The CCG shared the success of this approach with other CCGs, and the approach has spread across South London.

Member practices have also taken part in CCG wide initiatives:

Ensuring over 65s requesting a home visit have a response within 30 minutes,

Training to improve receptionists' use of the urgent care protocol,

A programme to identify 'at risk' patients through risk stratification: individual member practices have decided to join the pilot phase in such numbers (28 of 63) that there is a waiting list to join the programme, which is also running in collaboration with other CCGs in SW London.

9 practices have decided to pilot enabling NHS 111 to book patients directly into practice appointment systems.

Further initiatives:

Alternative Care Pathways enable LAS to convey patients to services other than A&E.

Frequent A&E Attenders are being addressed through a multi-agency project.

Direct admission to MAU.

Health and Social Care Dashboard and **whole system KPIs** enable collaboration.

Pharmacy First promoting self-care for minor ailments via pharmacists.

Follow-ups moved from A&E to Primary Care or decommissioned.

3) Impact

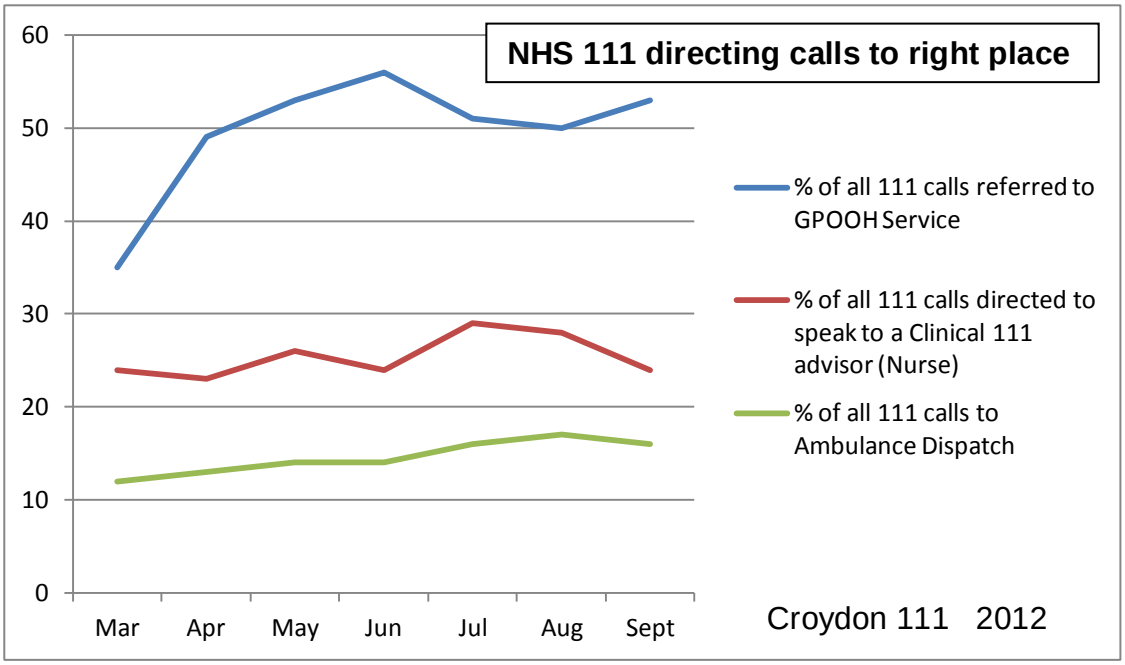
Improved quality of care

We have evidence of less variation, fewer patient complaints, and fewer near–misses.

Fewer patients are being seen by the GP OOH home visit service.

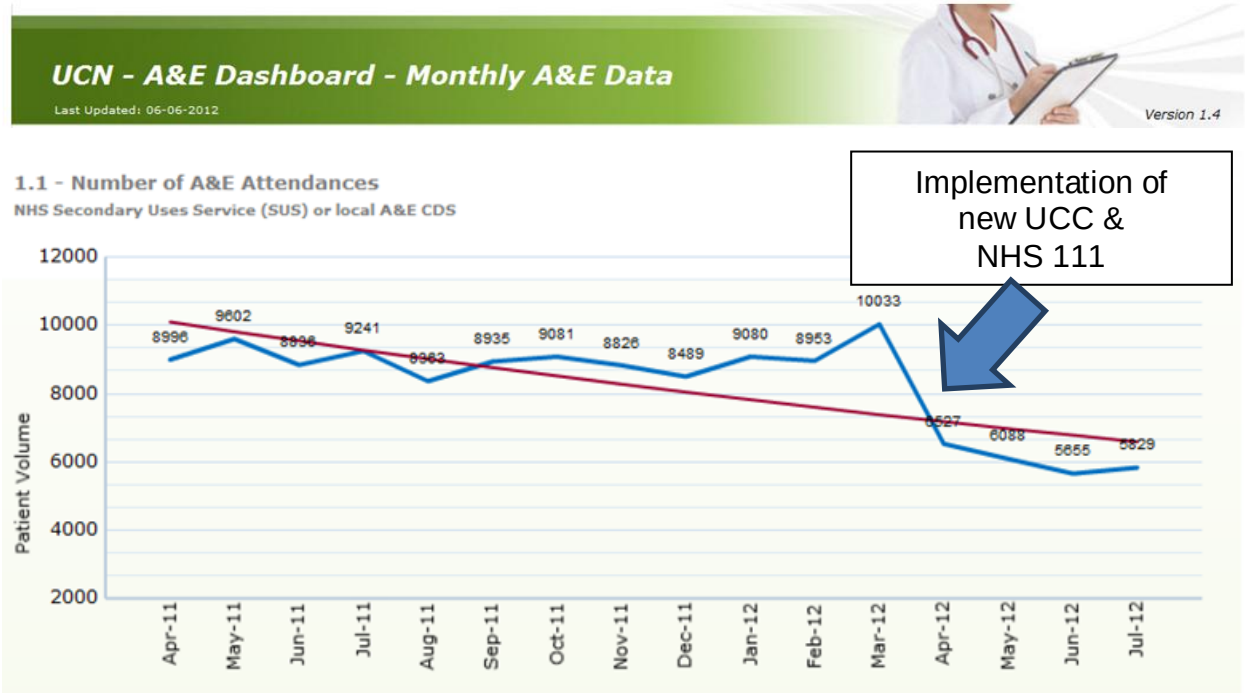
Clinical quality is ensured by the use of the RCGP's Urgent and Emergency Care Toolkit (a contractual requirement for UCC and ED).

More are patients are seen by the right service, first time.



Reduced A&E attendances

In 2012 A step change in attendances occurred when NHS 111 and the new Urgent Care Centre contract commenced, from around 9000 to around 6000 a month:



Financial

For 2011/12, local tariffs were negotiated for the pilot UCC service, creating a contractual saving, ahead of the service change.

The subsequent procurement of the 24/7 UCC (provided by Virgin Care from April 2012), has turned this into a £5.22m gross saving on a recurrent basis, over three years.

Delivery Challenges

Implementation of Urgent Care Services by a non NHS provider on an NHS provider site has been challenging. Whilst the shift in activity into a more appropriate setting has been achieved and there is some evidence to suggest improved handover to GPs and reduced GP complaints there has been some deterioration against the 4 hour wait target in the first six months. Steps to improve performance have been taken through the Integrated Urgent Care Governance Board chaired by a CCG GP and through the A&E Joint Recovery Board, plus joint action planning chaired by a CCG commissioner.

Confidence

Member practices, and organisations across the whole system, have seen visionary ideas delivered, increasing confidence in our clinical leadership, and increased our capability to deliver more in the future.