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Maximising the benefit of phone assessment

Urgent Care Conference 2018: Delivering integrated solutions

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- Introduction
- Indicators that there is an opportunity
  - Use of *line to reduce calls to ambulance service from care homes
  - Impact of phone assessment on cases otherwise referred to emergency department
- A reminder that patients don’t always do what we expect…
- Approaches – possible and provocative
- The importance of integration and analysis

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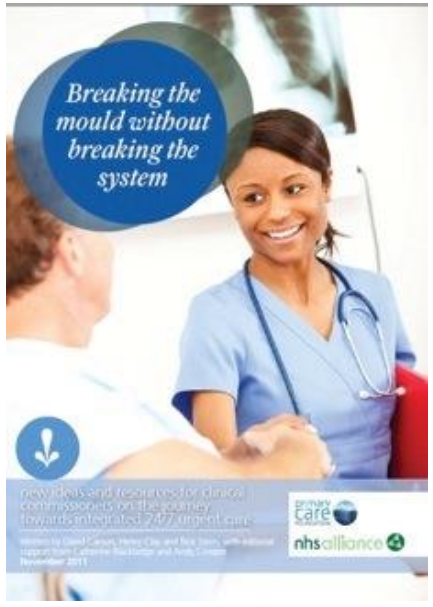
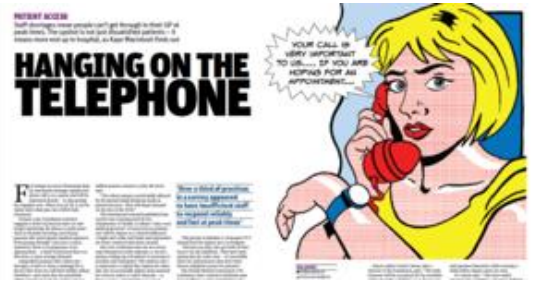
We have looked at urgent and primary care from a number of angles

- Financial/Capacity model for front of Integrated Urgent Care System
- Reviews of urgent care system, 111, OOH etc.
- Reports for Department of Health, NHS England and others
  - Primary Care in A&E
  - Urgent Care in general practice
  - Urgent Care Centres
  - Urgent Care Commissioning guide (with NHS Alliance)
  - Potentially avoidable appointments for GPs
  - Reducing bureaucracy in general practice
- Benchmark of out of hours services
- Projects for
  - Commissioners, particularly CCGs
  - Providers, practices, OOH providers etc.
  - NHS, commercial and mutual organisations





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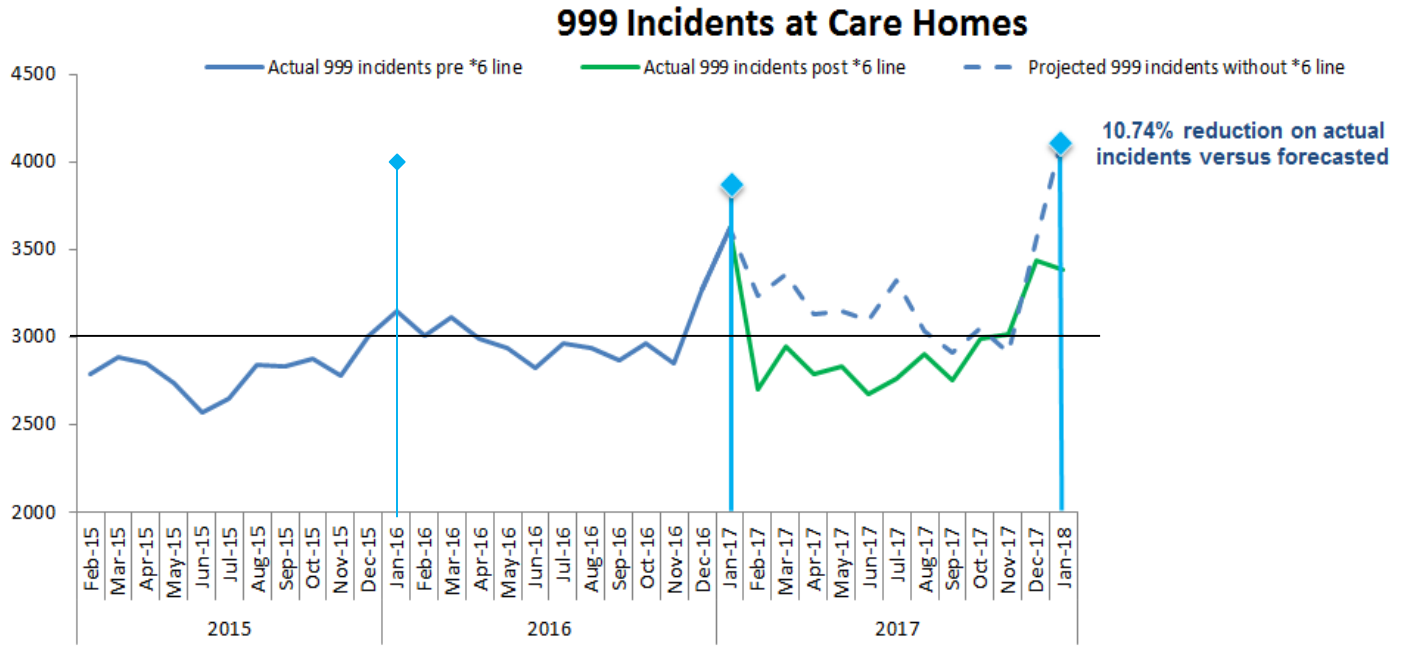
111 *line. Ambulance calls from care homes increasing at 6.5% pa but fell 4.9% (to 10.7% below projection)



February 2017 Heatmap showing time of 999 incidents at Care Homes

Total	Hour																							
Day	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Total
Mon	5	4	7	5	8	7	9	15	17	18	16	20	36	21	27	24	24	16	26	22	17	17	13	8	382
Tue	8	7	6	4	8	7	13	15	13	29	20	24	21	30	22	29	16	14	14	11	11	13	17	11	363
Wed	3	7	5	3	4	9	13	9	12	24	16	31	32	26	23	20	23	24	28	21	13	12	11	18	387
Thu	10	5	7	5	6	4	5	10	16	14	28	13	26	26	19	26	20	24	22	27	18	19	16	14	380
Fri	8	11	2	4	6	9	8	15	16	24	22	26	27	30	32	21	22	23	25	21	11	21	22	9	415
Sat	5	5	7	10	6	10	15	16	19	16	27	24	28	22	20	23	21	19	22	14	15	15	15	17	391
Sun	13	4	7	8	12	6	10	11	17	21	27	23	18	27	25	22	22	17	19	14	18	15	10	15	381
Grand Total	52	43	41	39	50	52	73	91	110	146	156	161	188	182	168	165	148	137	156	130	103	112	104	92	2699

https://www.healthylondon.org/wp-content/uploads/2018/03/PM-5-Responding-to-urgent-needs-at-home-111-star-line-and-AHP-paramedic-collaboration.pdf

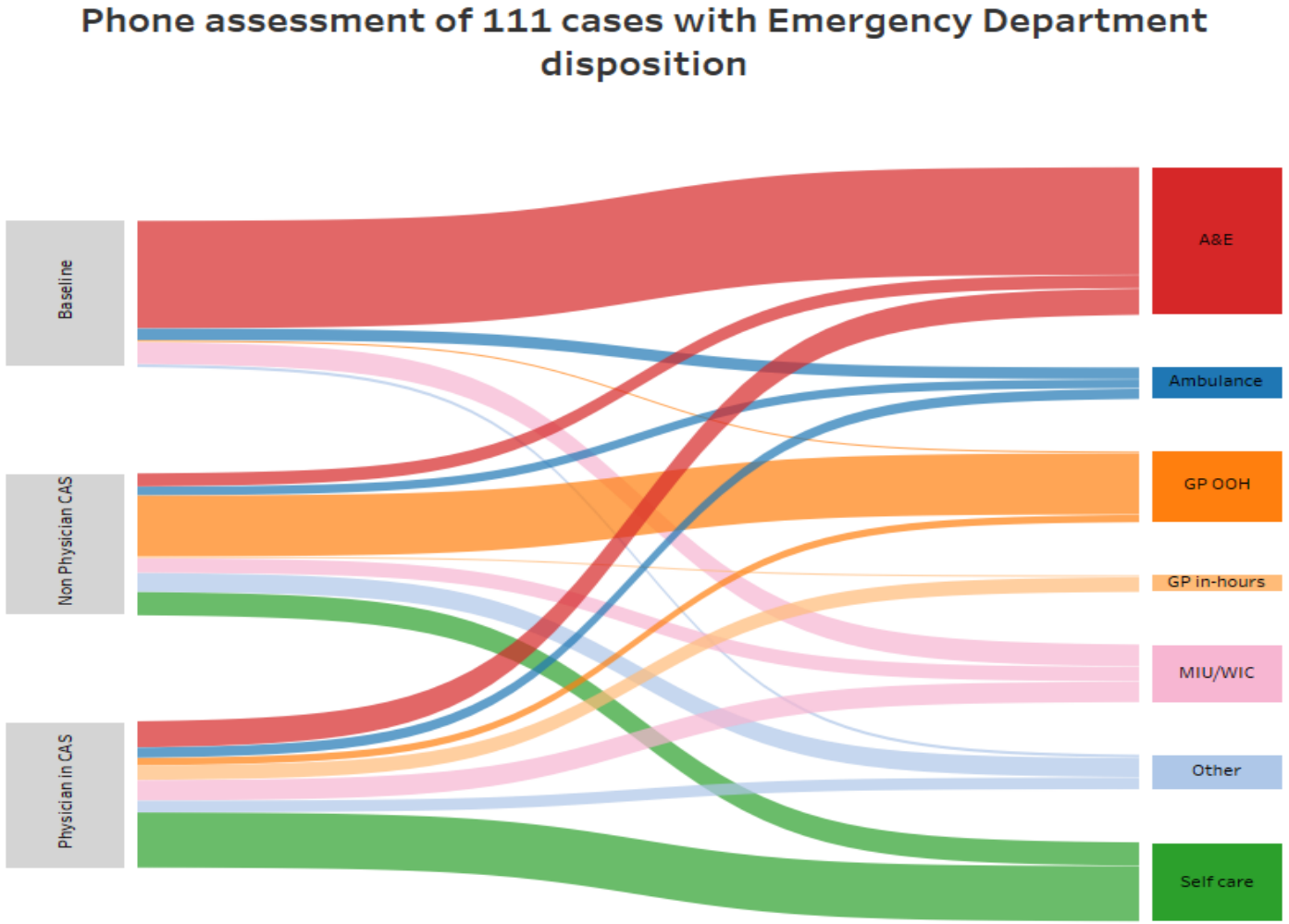
Impact of phone assessment on cases with ED disposition

Team type

Baseline

Paramedics/nurses/ ACPs

Senior Emergency Medicine clinicians



Emergency Dep't

Ambulance

GP OOH

GP in-hours

MIU/WIC

Other

Self-care

Based on unpublished (as yet) work by Bas Sen comparing the dispositions from two trials with the baseline period.
Cases are DX 02 and 03 (ED in 1 hour and 4 hours, excluding certain consditions such as penetrating injury

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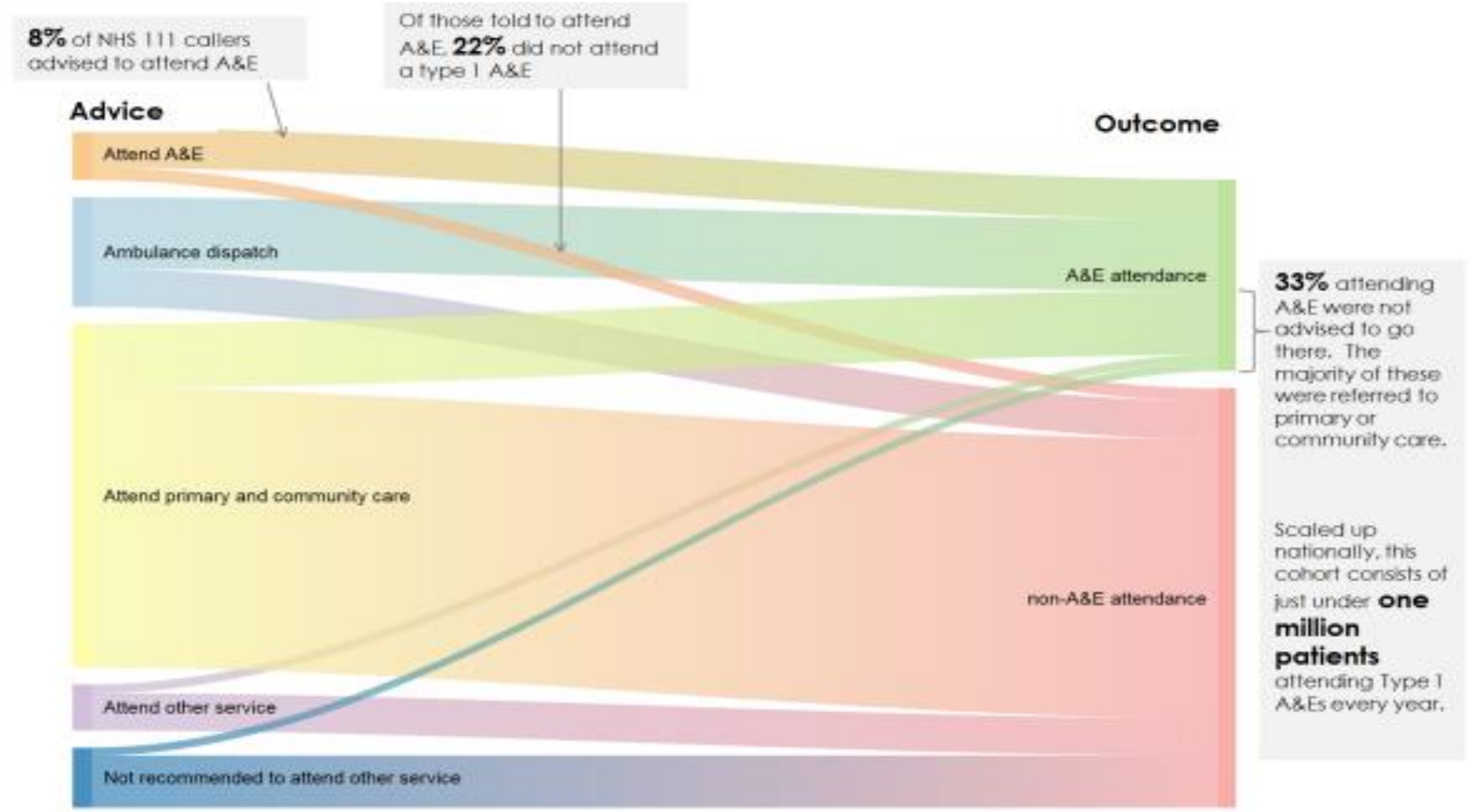
Patients don’t always do what we expect…



Source: NHS England Integrated Urgent Care Service Specification

…which leads to some thoughts about what is critical

- The phone consultation needs to give the caller confidence – whilst also warning them about what to be aware of/look out for
- Whoever is involved in the phone assessment needs to agree the plan with the caller. If they choose to do something different than was agreed then it should be considered to be a failure
- For this to work it is really important to get the right case to the right skill group. Since no skill group is in limitless supply this means being smart and flexible to adjust to varying case mix and different skill mix….
- …and, if we can do it right, it will minimise the occasions when a case is passed for phone assessment from (say) a nurse to a doctor etc. thereby maximising the capacity of the available resource

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Possible approaches - Rules/protocol based approaches

- Based on age
  - Children (e.g. <5 [~ 2%] to CAS for assessment)
  - Elderly (e.g. over 80 [~6%] to CAS assessment)
- Based on characteristics/features of the case:
  - Repeat callers [<0.1%]
  - Those with Special Patient Notes/Predetermined management plan [~4.5%]
- Based on symptoms:
  - Pathways outcome: UTI to CAS assessment & for prescription (if not complex) [<1%]
  - Symptom group e.g 'Unwell Under 1 Year Old' [~2.5%] steered towards face to face
  - Viral symptoms in adults who are not immunosuppressed (sore throats, coughs/colds, earache) directed to community pharmacy

Preferably to GP

Preferably to GP

To pharmacist or nurse under group directive

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Approaches that require training & new behaviours….

…some maybe ‘breaking the rules’

- Use of probing questions – NHS Pathways training…
- Ask patients why they are calling
- Ask patients whether a face to face or phone consultation is appropriate
- Give discretion to call-handlers over who to send case to

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The importance of integration and analysis

- Integration includes:
  - ED know which patients they are expecting and have clinical data from IUC service
  - Patients' use of whole of urgent care system can be understood
  - 'End to end' reviews take place
  - Clinical leads are presented with data on:
    - Number and nature of cases assessed on the phone by more than one clinician
    - Number and nature of cases that went to the ED which when this was NOT expected
    - Number and nature of cases that did NOT go to the ED when this was the agreed disposition

    And this means down to details of (for example) Symptom group, disposition, IUC examination/treatment AND details of treatment, tests, diagnosis by ED
- And we look forward to working with Method Analytics to assemble this information, display it in an intelligible user-friendly way and to working to understand what opportunities it highlights – an integrated urgent care benchmark

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Questions/comments

If there is time now, but certainly over coffee or lunch and as part of the panel discussion