Opinion and debate

Mind the gap! Conflict and cohesion in primary care delivery models

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Key messages

We need to learn from historic changes in accident and emergency (A&E) and urgent care services and identify the conflicts in provision of planned and unplanned care. We have choices as to whom, and how, primary care services are provided in the future. But we will get this wrong if we fail to recognise that the interface between planned and unplanned care needs to be carefully managed. If managed well, we might encounter the opportunity to develop high quality, coordinated and integrated care.

Why this matters to me

I have watched myself and others struggle with the conflict between planned and reactive care, and thought it time to 'name the devil' in order to understand it and think about the choices ahead. Personally, I enjoy being able to deliver both planned and unplanned care to a practice population and would not want to lose either.

Keywords: Integrated Care, Out of Hours, Planned Care, Unplanned Care, Urgent Care

Introduction

Provision of planned care (non-urgent, long-term conditions) and unplanned care (urgent, unscheduled, out of hours) presents modern primary care professionals, commissioners and provider organisations with conflicts both in models of delivery and in the skill mixes and training required. For 20 years we have attempted to resolve this conflict by tinkering with our current systems. Now that value for money within a shrinking financial envelope is paramount, it may help to look back at what has evolved, and then look forward to what excellent primary care could look like. Planned and unplanned care require different delivery models. Constant patient complaints over long waits to get an appointment, versus the need to provide continuity of care, are tearing primary care apart, and will continue to do so until we accept that two services need to run in an integrated way, with clear ways to manage the interface between the two. Some observers predict that the role of the general practitioner (GP) will split, and the 'Unplanned Care GP' could become a different species, with a different training curriculum, different employer, different work pattern and different expectations and outcomes.

History

It is worth looking at accident and emergency (A&E) departments, which have had similar problems to solve. For sound operational reasons, patients with life-threatening 'Majors' and less serious 'Minors' were separated – they were dealt with in the same department but by different clinical teams. There were numerous experiments – GPs employed in A&E, for example. Eventually, with the establishment of PCTs, the 'Minors' were floated off into Urgent Care Centres (UCCs), considered to be a version of primary care, and often commissioned from the private sector, with the remit to prevent as many people as possible crossing the threshold of the A&E department into more expensive secondary care. I am not aware that anyone has seriously contested the thesis that these two groups of patients should have been separated. Clinical needs coincided with institutional splits, and the arguments were all about how to do it.

A&E departments were designed to deal with urgent, unplanned care, where skills involved the rapid assessment and diagnosis of the patient (and in cases where background and history were unknown), followed by immediate treatment, and discharge back to the patient's general practice. These acute settings were joined by walk-in centres, which were also

designed to meet the unplanned care needs that general practices were failing to provide. Such centres were popular with patients because they provided almost instant access, and many were prepared to travel outside of the borough for these services. Some out-of-hours providers, including the cooperatives established in the 1990s, were able to provide daytime urgent care and walk-in care, to complement their original remit. Clinical presentation and management remains mainly medical, and there is no connection, apart from a discharge note, between out-of-hours centres and local general practices.

However, many patients who present to these centres have problems that are actually more to do with pre-existing or long-term conditions, where continuity and a larger multidisciplinary team are essential for effective care outcomes. Thus new practices were spawned, acting as a 'back end' to the new UCCs and walk-in centres, to deal with a 'new' problem. Meanwhile, traditional general practices continued to struggle with an ever-increasing demand for unplanned care, and were effectively exporting this demand into walk-in centres and UCCs. Thus two different models have been trying, and failing, to meet in the middle, as illustrated by these brief cases that I have recently encountered:

Case 1

A general practice with a high population of young adults (with high demand for unplanned care) and also a high prevalence of diabetes, adopted 'Advanced Access', a system for matching supply and demand. Overly-rigid access targets made it impossible to meet both needs so the practice adopted a 'book on the day' system. Patients still had to jump through hoops to get an appointment, and continuity of care, valued by those with long-term conditions, suffered.

Case 2

A new general practice, created as the 'back end' of a walk-in centre near a busy A&E department, was set up with the intention of picking up those patients with LTCs and other needs better met by continuity, rather than episodic care as given in the Walk-in Centre. Despite best intentions, the practice did not have the systems for 'joined-up care' and both performance and staff morale suffered.

Both general practices, although well run, lacked the ability to identify the necessary ingredients for either model of care. In one, the demand for unplanned care overtook its capacity to respond, and in the other, systems designed for unplanned care just did not fit the different needs of planned care.

This second case illustrates most clearly why both types of care need to happen in the same place. In a new service (the UCC), it was recognised that patients were using the service for their long-term care needs, so a 'traditional' GP service was then created to meet that need. Indeed, I would argue that to geographically separate planned and unplanned primary care is artificial and wasteful; causing fragmentation of care in a population that requires both models of service at different times. As healthcare providers we are just waking up to this and now some CCGs are commissioning local unplanned care services from existing practice premises, using existing staff. These co-located clinics may be in the form of local hubs, where a few practices share an extended-hours unplanned service, and such solutions are likely to prove more clinically appropriate and cost effective than using different facilities separately.

The provision of these services through local hubs is being facilitated by the emergence of primary care provider organisations based on CCG localities and covering patient populations of 50 000–80 000. Interestingly, whilst the current talk is of the need for much larger commissioning organisations, this locality network size seems to fit the provider need much better. The development of provider networks enables collaboration not only between practices, but also with other primary care and community providers, and further interfaces with secondary providers such as specialist nursing.

In summary

Unplanned care needs to provide quick access over extended hours and requires flexible capacity, skills in diagnosis, rapid assessment and clinical risk management. It lends itself to shift work, because it does not need teamwork beyond the necessary here-and-now and it has no need to explore the complexity of patients' co-morbidities, nor ensure continuity of care.

Planned care, on the other hand, needs a far more sophisticated understanding of working with patients in different ways and on different levels, and with other team members and between teams. It requires:

- Understanding of care pathways and plans, which are widely shared and used within and beyond different primary care organisations, e.g. GP and Community Trusts;
- Clear guidance to patients on how to access and use services, with a varied range of options including telephone and self-care options, and access to records;

- Understanding that motivation and ownership are developed over time through trusted relationships and continuity of care;
- Leadership of teams becomes a consensual process, with co-design of strategy and service review becoming important to support and motivate team members;
- Multi-professional working and learning, within and across team boundaries;
- Effective and intelligent use of IT systems to enable all staff to communicate, understand immediate tasks and opportunistic possibilities, and record, research and audit clinical data.

Discussion

Lessons from the past help us to recognise the need to carefully manage the interface between planned and unplanned care. I have argued that, unlike the situation faced by A&E departments, there are pressing economic and quality of care arguments to support the provision of unplanned care alongside planned care. Although they require different delivery models, both types of care support the varied and changing primary healthcare needs of a population, and to neglect either will harm patient care. There are implications for workforce training and skill mix, and relationships with other community services. In the light of the recent interest in provider networks, e.g. from the Kings Fund,¹ we can start to ask ourselves the larger

questions about what structures will help primary care teams to deliver high quality, integrated, community-based care. Certainly, my case for maintaining the link between planned and unplanned care would be much easier to implement within a single provider organisation. There are already nascent provider networks in place, which will be able to take on these challenges in an intelligent, coordinated and cost-effective approach.

ETHICAL APPROVAL

This is a personal reflection based on experience and already published work and did not require ethical approval

CONFLICT OF INTEREST

None

REFERENCE

- 1 Addicott R and Ham C. *Commissioning and funding general practice: Making the case for family care networks*. The King's Fund: London, 2014. www.kingsfund.org.uk/publications/commissioning-and-funding-general-practice (accessed 02/04/2014).

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