Spotlight on improvement work:
Derbyshire Health United

#CAAW
November 2018

DHU Health Care

Overview

DHU Health Care is a 'not-for-profit' community interest Company. For 365 days a year, 24 hours a day, we are committed to providing a diverse range of health services to over 5 million patients across six counties.

As a socially conscious community interest company (CIC), our sole aim is to provide the best possible patient care, without being driven to meet the changing demands of shareholders and owners.

Contact details

http://dhuhealthcare.com

The issue:
Currently, there are no centrally located out of hours walk-in services in Patient X's local area, apart from the emergency department. This means that individuals who have no access to a telephone, or are unable to communicate effectively over the telephone to be able to phone NHS 111 to gain access, only have the option of attending the hospital emergency department for out of hours and urgent care. This is unacceptable since many of the care needs they have are not suited to the emergency provision.

Aim and Objectives:
Aim of this project of a change in practice is to evaluate the usefulness of an innovation which seeks to improve access to healthcare for hard to reach individuals in a local area. The objectives of the project are to: 1) trial a new approach for people who come from marginalised groups to access urgent care via the out of hours Primary Care Centre (PCC) 2) Evaluate if people using the changed system, regarded it as meeting their needs 3) Evaluate if people using the changed system, regarded it as an acceptable way of accessing healthcare.

Doing something to make things better:
The purpose of this project is to try to design a process whereby people within marginalised communities can access the local out of hours PCC for urgent care in the same way as anyone else needing to access the service. This is in essence a process redesign which involves understanding if the new process works in terms of providing access, if the public (in respect of people who are currently marginalised) will use the new process and how safe people feel in doing so.

The individual (we will call Patient X in order to maintain their anonymity), came to the attention of the staff at the primary care centre (PCC) as being someone who was unable to access the service as currently constituted. Patient X needed some help with physical care issues as well as support for a mental health problem. Patient X had access to a phone, but was unable to communicate effectively in answering all the questions when calling NHS111, becoming frustrated by the questions and confused, in turn, when frustrated would shout and become verbally aggressive. This would by policy end the call by NHS 111.

After a few attempts ringing NHS111 for assistance, Patient X found the process of making an appointment too onerous due to mental health issues and refrained from accessing the service. This meant that Patient X had no access to 'out of hours' services in Patient X's local area, and therefore should Patient X develop urgent care needs Patient X would go to the local Emergency Department (ED) which is an inappropriate use of the emergency service.

After meeting with Patient X and working alongside them to aid resolution, staff created an identity badge for Patient X. It was made with the official ID Badge making facilities within the Health Care Providers Human Resource Department, so that it would last and not disintegrate and was attached to a lanyard so Patient X could wear it under clothing at all times, thereby keeping it safe. The card contained some basic details about Patient X including name, NHS number and date of birth. Patient X was then instructed that if needing to see a doctor out of hours with anything which was not an accident or an emergency, Patient X could present in person at the centre. The card also has a prompt with it so reception staff would identify Patient X on the system and understand what the purpose of the card was (while the current team are aware of Patient X, they have not all met Patient X and not aware of Mental Health issues, that communication is not a strength and that the patient is not always very good at explaining themselves). Once the receptionist has seen the badge, they could make Patient X an appointment to see an out of hours General Practitioner (GP). Patient X's notes contain a special briefing for the GP highlighting their extensive health needs. As a benchmark of the service before the introduction of the badge, Patient X had no access to the service and was receiving no care from the out of hours provider, admitting to frequently attending the ED.

Conclusion:
The reported success with Patient X only represents a successful service change for one individual. In this case, it could quite easily have been the case that Patient X chose not to use the service, they lost their card or they forgot the process. A locum receptionist or GP might not have followed the process and Patient X could have easily become disenchanted with the service. This would have meant, and still could mean, that the redesign is not appropriate for Patient X. While this project is singular, and it is likely that the novelty of it aided its success, nevertheless it was a success and as such has identified that access to, rather than just provision of, the primary care centre facility needs to be considered. This is of itself an issue which is worthy of note, it was for Patient X, like so many marginalised individuals the process of accessing the service which was proving difficult. This in turn suggests that patient pathways and process mapping of service provision needs to be reconsidered to facilitate hard to reach groups.