

### **1.16.13 Case Study 3: System partner capacity issues**

It is reported that a service that should be open for patients to access keeps reporting that they are closed due to capacity issues, what do you do?

(Maximum Word Count 1000)

Words used = 999

This scenario is a likely occurrence in services where patients can self-present such as walk-in centres and where capacity/flow may be driven by external factors e.g. local health alerts, media-driven concerns, lack of capacity or suitable primary-care services.

Vocare would seek to ensure patients do not loop around in the system while the issue is investigated and resolved and would seek to ensure patients have a seamless journey to an appropriate outcome.

#### **1.16.13.1-Relationship with the service**

We expect that this service would be a key stakeholder relationship that has regular touchpoints with senior colleagues across the organisations and within local forums.

We have strong working relationships with all alliance partners and so would look to support and understand the patient flow/capacity issues experienced, offering support to resolve these episodes.

We would use our existing relationship to make contact to discuss concerns, mitigations and service improvements based on data-driven diagnostics to help mitigate service interruptions.

Our relationships are built on mutual-aid agreements that place the patient at the heart. Although we may know of this disruption, it should not be visible to the patient.

Joint working and agreed pathways would be invoked to ensure patient care is provided across the system. Such activity may mean GP-OOH needs to adapt its protocols to accept/treat the patients rather than signposting them to a service we know is at capacity.

#### **1.16.13.2-Making contact**

Key personnel from Vocare who would be involved in dialogue around the disruptions are the Area Operational Director and our Clinical Leads. Vocare would reach out to the organisation in a supportive manner, offering support and assistance as part of the alliance.

A crucial aspect is a 'no blame' culture with a focus on pathway redesign (if required) that would need to collectively be reviewed by the alliance. We would explore if the service is receiving surges in patient flow and how to support this as providers.

### **1.16.13.3-Evidence of 'closure'**

We will evidence that the service is reporting that it is closed through:

- Pre-formatted returns completed by operational and clinical leads – analysis of data and closures in a given time frame.
- Interrogation of DOS – if service returns or is showing as closed.
- Verification of anecdotal evidence from patients e.g. patient speaks to Vocare service and advises centre is closed – ringing centre for status update.

### **1.16.13.4-When to raise the issue**

Timing would depend on closure frequency e.g. daily for 7 days would be more pressing. As alliance providers, we expect the discussions to resolve the service disruption with collaborative working without needing formal escalation e.g. CCGs/ICS.

The collaborative working model should enable support and agreement of the challenges with potential solutions, with removal of siloed provider working. The system flow is important and all providers will play a part in ensuring this is achieved.

### **1.16.13.5-Raising the issue**

Initial informal discussion with the centre lead would take place to assess cause of issues e.g. which could be a time-limited staffing issue and any support that could be provided. After identifying the root cause, we would look what the next steps could be e.g. joining a joint working party to assess additional options of support across the healthcare provision, ensuring a clear understanding of what is impacted and any unintended consequences.

We would also have collaborative discussion in formal arenas e.g. Contract Review Meetings and the UEC Board with a solution focus and agreed provider support proposal.

### **1.16.13.6-Formal escalation**

Formal escalation would only be undertaken with the ICS as a last resort and after every avenue has been explored between providers to resolve the challenge and provide a solution. The ethos of integrated working is removal of organisational barriers and provider isolation and system solutions are achieved through collaboration.

### **1.16.13.7-Understanding the issue(s) and root cause**

We will offer various solutions to truly understand the issue's root cause. They will be based on experiences of similar services and challenges, potential impact on our service, feedback from health professionals/patients including any data on dates/times/concerns and any unintended consequences.

We will also ensure our team is supportive in interim steps and mitigation while a full understanding is obtained. We have a wealth of experience operationally and clinically in urgent care and these individuals will be available to support in any way required.

#### **1.16.13.8-Support refused**

The challenges may be short term and isolated, therefore the provider could be implementing remedial plans with no support required. If this happens, the offer of support or patient redirection to assist will be maintained and our strong partnership working relationships can be called on when needed.

#### **1.16.13.9-Working with the service to improve the situation**

Depending on the root cause and impact on patient care, we would aim to provide short-term support if appropriate and required e.g. staff to support or increasing Vocare staffing if patient redirection is available to one of our bases or remote support.

Using our experience and relationships we would look at supporting developments of longer-term remodelling, which may include future service changes, modelling assumptions and understanding various change agents that would benefit patient flow and volume management through the system.

A theoretical desktop review of patient flows would be undertaken in the planning stage to ensure all elements are considered and tested by key delivery stakeholders for test/challenge. We would aim to undertake any changes in line with our change process, which incorporates the PDSA cycle to ensure the intended outputs are achieved and sustainable.

#### **1.16.13.10-Previous experience**

Throughout the pandemic, we have experienced several times when primary-care partners have had to close their practice due to staff isolation rendering delivery of a safe service impossible. Each time that this happened, Vocare covered calls from patients to their practice, which absorbed into our daytime service. Vocare staff were able to flex skills sets to provide increased telephony advice service and arrange face-to-face consultations if required.

These requests were responded to by Vocare to first and foremost ensure patient safety but also to contribute solutions to the local health economy at a time for extreme challenge for all system partners.