Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	8 March 2018
Officer	Sue Sutton, Deputy Director – Urgent and Emergency Care, NHS Dorset Clinical Commissioning Group
Subject of Report	**NHS Dorset Clinical Commissioning Group – Integrated Urgent Care Service**
Executive Summary	NHS Dorset CCG is in the process of tendering the existing 111, Single Point of Access (SPOA), GP Out-Of-Hours (OOH) and Night Nursing services together with a new Clinical Assessment Service (CAS) and Urgent element of Improving Access to General Practice Services (IAGPS). These services will be collectively known as the Integrated Urgent Care (IUC) service.
Impact Assessment:	Equalities Impact Assessment: Attached (by NHS Dorset CCG).
	Use of Evidence: Report provided by NHS Dorset CCG.
	Budget: N/A for Dorset County Council.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW

	Other Implications: N/A
Recommendation	The Committee is asked to note and comment on the contents of this report.
Reason for Recommendation	The work of the Committee supports the County Council's aim to help Dorset's citizens to remain safe, healthy and independent.
Appendices	Appendix 1 – Equality Impact Assessment
Background Papers	None.
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Sue Sutton
Deputy Director, Urgent and Emergency Care for NHS Dorset Clinical Commissioning Group
March 2018

1. SERVICE OVERVIEW

1.1 NHS Dorset CCG is in the process of tendering the existing 111, Single Point of Access (SPOA), GP Out-Of-Hours (OOH) and Night Nursing services together with a new Clinical Assessment Service (CAS) and Urgent element of Improving Access to General Practice Services (IAGPS). These services will be collectively known as the Integrated Urgent Care (IUC) service.

1.2 Activity and financial modelling has been undertaken to support service design and the establishment of an appropriate financial envelope for the service. The activity and financial model comprises three components (111/CAS; IAGPS (Urgent) and OOH; and Management and Governance) which are shown at a high level in Figure 1.

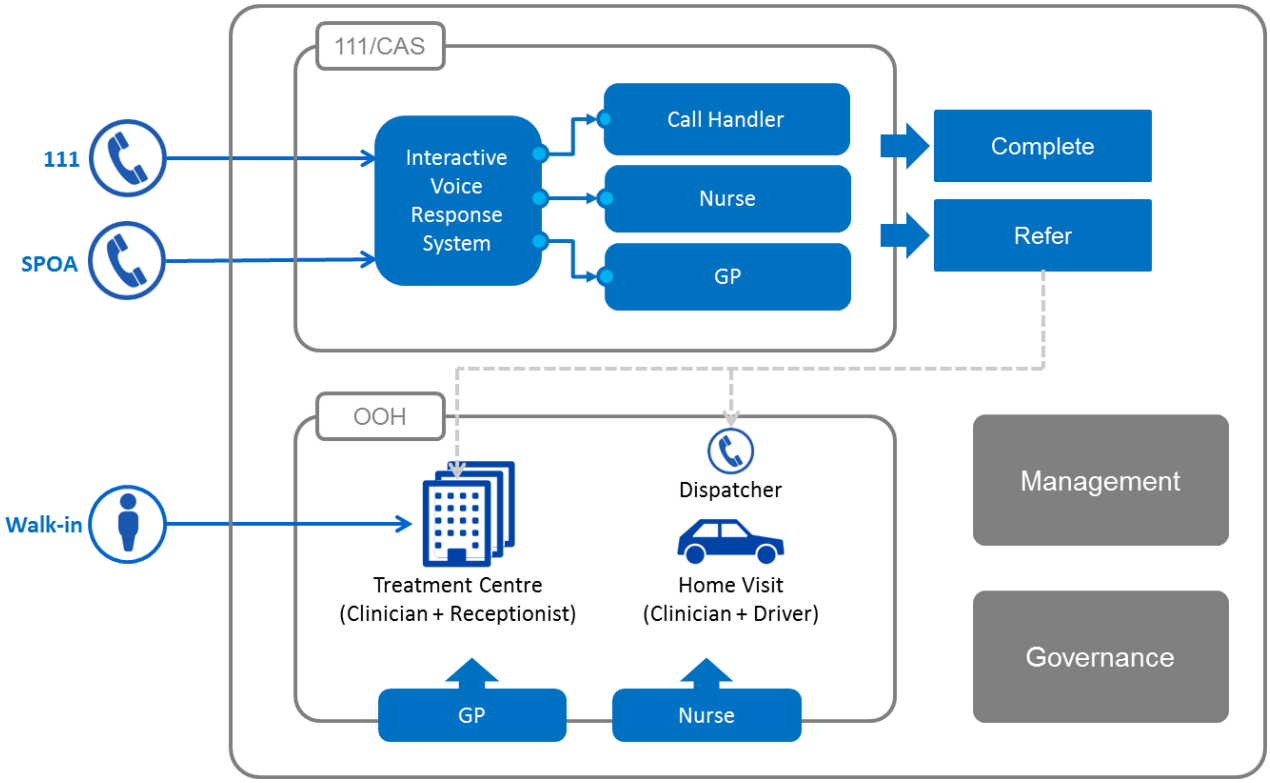


Figure 1 – High level model of the IUC service showing the component 111/CAS and IAGPS (Urgent) and Out of Hours (OOH) services supported by common management and governance systems.

1.3 Calls arrive at the CAS where they pass through an Interactive Voice Response System (IVR), before passing to a call agent. The agent responds to the call and either the call completes, is referred on to another service, or is passed to another agent (clinician, GP) either as a warm-transfer or request to call back. Patients may be referred to the OOH service from 111/CAS (with a booking made).

1.4 The Primary Care service receives referrals from the 111/CAS service, and also walk-in patients. Patients may be seen within the treatment centre, or an appropriate clinician may be dispatched to the patient's home location. Providers have flexibility to choose the most appropriate staff mix to deliver a clinical and cost effective service. The mix of staff and shift patterns are key elements of the staffing model. The skill mix team will align with NHS Dorset CCG's Clinical Services Review (CSR) implementation, linking with community hubs and Multi-Disciplinary Teams (MDTs). Both services are supported by management and governance to provide quality assurance, training, performance reporting and, system development.

1.5 The 111 contact centre is staffed 24/7, with call volumes varying significantly during the day and across the week. The quantity of staff, and staff mix, is heavily dependent upon the performance requirements on the service (calls answered within 60 seconds) and the volume of traffic presented to the call centre. The staffing requirements for clinicians in the national mandated IUC service specification are more relaxed compared with 111 Call Advisers, given the difference in response time to calls (30 minutes compared with 60 seconds). This allows providers to develop more flexible staffing models, including the concept of 'virtual' clinical call advisers who may be located outside of the contact centre. This benefits both providers with economies of scale in 111/CAS contact centre operations, as well as providers who can leverage clinical staff from other services (e.g. using staff in the OOH service to triage CAS calls).

1.6 The population of Dorset is distributed unevenly throughout the county. More than 50% of the population is concentrated in the south eastern corner, around Bournemouth and Poole, balanced against large sparsely populated areas to the north and west. A small, but significant, percentage of GP patients are located across the boundary in surrounding counties. This presents challenges in delivering cost effective, high quality, uniform access to location based services and reasonable response times to patients at home.

1.7 The development of a primary care OOH service gives providers greater scope to develop innovative staffing models using the best skills of GPs, nurses and other allied health professionals. Within the OOH staffing models scenarios have been considered which give a greater preference for either GPs or Nurses to understand how provider costs might change.

1.8 One of the national drivers for establishing the CAS is to increase the number of calls which are completed within the 111/CAS service and not referred to other services (such as emergency treatment centres). It should be noted that the current 111/OOH provider has clinicians in the 111 service that review 20% of calls, and GP telephone triage in the Out of Hours service. Accounting for telephone triage by clinicians in both services, approximately 20% of calls already receive a clinical review. Whilst the national specification calls for over 50% of calls to be reviewed by a clinician, the evidence base quoted is for improvements in systems with no or limited clinical input. The second action to improve consult and complete is to implement a GP Online capability within the 111/CAS. This requires that 20% of the GP consultations are done online, with the expectation that this will improve completion rates and reduce onward referrals. On behalf of the Dorset Accountable Care System community, the commissioner is aiming to procure a joint solution for GP on-line consultations and the IUC/111 on-line service. The timescale for this may precede the award of contract for the IUC service. The successful bidder will therefore need to integrate with the selected 111 Online solution. The supplier is expected to plan for interoperability and to work to exploit all useful features and handover from the 111 Online service as this develops.

1.9 The implementation of IAGPS may impact upon the referrals into the OOH service, though the impact on OOH activity levels is expected to be small given that IAGPS (Urgent) appointments will be delivered by the out-of-hours service, i.e. there is no change in the fundamentals of service provision.

1.10 The development of GP led Urgent Treatment Centres (UTCs) has informed the decision to co-locate, and potentially integrate UTC and OOH services during common opening hours of operation. Within rural areas of Dorset, where activity levels are insufficient to support either OOH or UTC service individually, it may be possible to

signpost patients that would attend a UTC (MIU) or Emergency Department to a more locally provided OOH service.

2. CONCLUSION AND RECOMMENDATION

2.1. The procurement process for IUC services is ongoing. The committee is asked to note the report.

APPENDIX 1 – EQUALITY IMPACT ASSESSMENT

Equality Analysis Form

It is desirable to undertake an Equality Analysis as part of our commitment to patients, staff and the public, to be attached to any procedural document and submitted to others as required or needed. A separate action plan may be needed to mitigate impacts.

Does the proposed policy, or changed practice, impact differentially on any of the protected characteristics (as defined in the Equality Act, 2010)?

Name of Strategy/Policy/Plan: Delivery of an Integrated Urgent Care (IUC) Service for Dorset.

Name of person undertaking the assessment: Rob Munro

Date of the assessment: 05/02/2018

Please consider impact (among others) in terms of:

- **Accessibility;**
- **Communication needs;**
- **Appropriateness of the service;**
- **And any other relevant matters.**

What are the intended outcomes of this work? *Include outline of objectives and function aims*

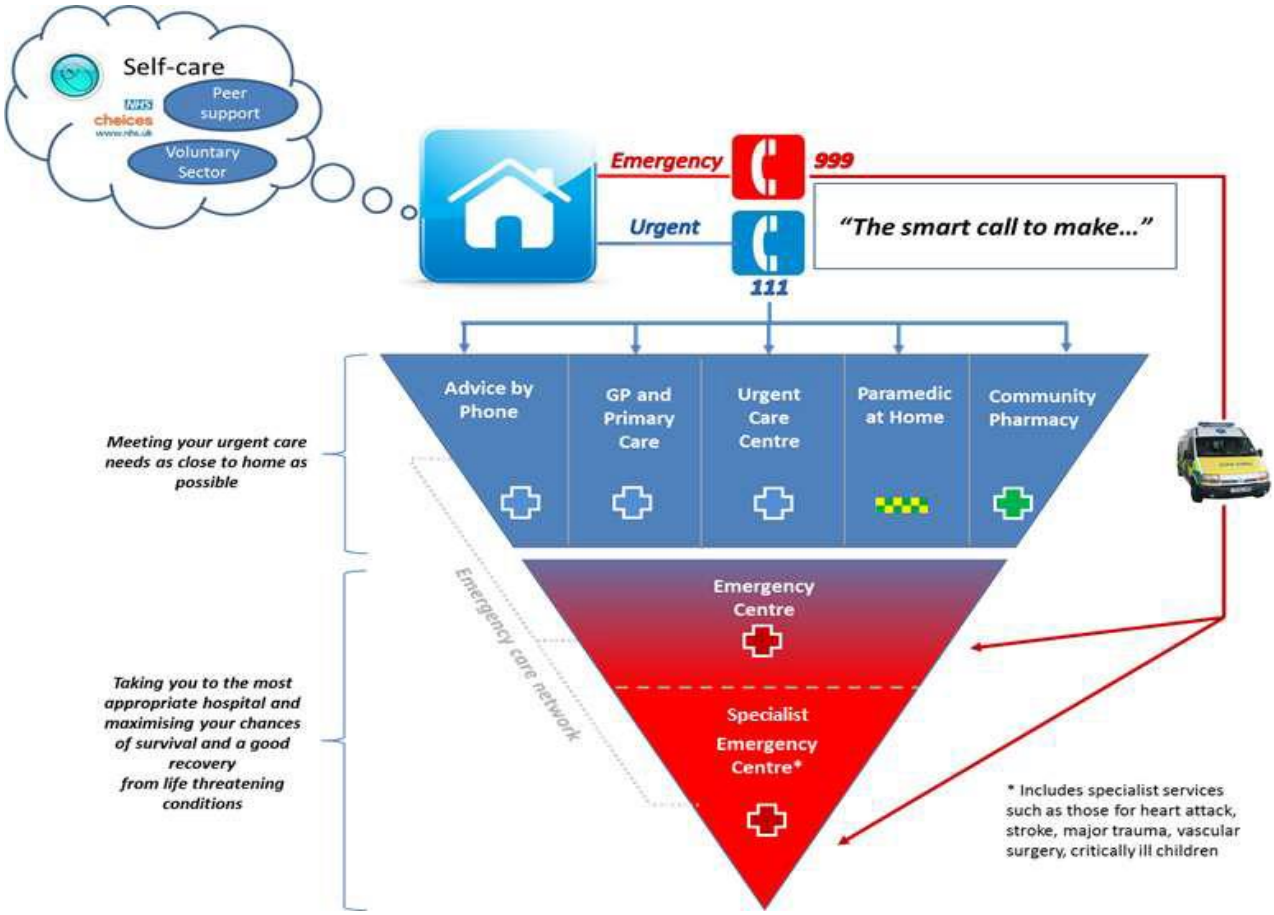
The aim of this project will be to deliver an Integrated Urgent Care (IUC) Service which will assess the needs of people and advise on or access the most appropriate course of action, including:

- Where clinically appropriate, people who can care for themselves will be provided with information, advice and reassurance to enable self-care;
- Where possible people will have their problem dealt with over the phone by a suitably qualified clinician;
- People requiring further care or advice will be referred to a service that has the appropriate skills and resources to meet their needs;
- People facing an emergency will have an ambulance dispatched without delay;
- 999 will continue to provide an emergency service whilst 111 will take all calls requiring urgent but not emergency care.

The Urgent and Emergency Care (UEC) Review (NHSE 2013) sets out a simple vision:

- For adults and children with urgent care needs, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families;
- For those people with more serious or life-threatening emergency care needs, we should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery.

The shape and structure of the future system (NHSE, 2013) has been visually described as:



The IUC Service will form part of the Dorset Integrated Urgent Care System, which will be made up of services working together across the Dorset Health and Care System in an integrated way, cutting across the One Acute Network and Integrated Community Services (ICS) programmes of work within the STP. This will enable more patients to be appropriately reviewed and treated in an out-of hospital environment.

Transforming how UEC Services are provided across Dorset's acute and community settings, enhancing the community offer; reducing inappropriate A&E attendances, inappropriate ambulance conveyances and avoidable admissions is a key component of the STP and the Clinical Services Review.

Alongside the NHS Five Year Forward View and the publication of the Keogh report there are three additional sets of key guidance that are of particular relevance:

- Commissioning Standards Integrated Urgent Care (September 2015);
- Transforming Urgent and Emergency Care services in England. Safer, faster, better: good practice in delivering Urgent and Emergency care (August 2015);
- Integrated Urgent Care Service Specification (August 2017).

The desired outcomes of the IUC Service project are to deliver the 12 National Integrated Urgent Care Commissioning Clinical Standards which are listed below:

- At the heart of the integrated urgent care system will be a 24/7 NHS 111 access line working together with 'all hours' GP services;

- Additional clinical expertise available in NHS 111 call centre, via IVR or via warm transfer (e.g. Pharmacy, dental, MH and GPs);
- Enhanced Clinical assessment of green ambulance dispositions;
- Enhanced clinical assessment of ED disposition, and direct booking from NHS 111 into ED;
- Direct booking from NHS 111 into GP OOHs and, later, GP In hours;
- Direct booking from NHS 111 Community services and 'fast response' multi-professional community team;
- Special Patient Notes (SPNs), End-of-life and Anticipatory Care Plans to be available at the point in the patient pathway which ensures appropriate care;
- Integration via joint management of NHS pathways & capacity by NHS 111 and GP OOH;
- All providers working with IUC demonstrate integration by joint working to manage UEC patient pathways & capacity;
- Local Directory of Services to hold accurate information across all acute, primary care & community services, and to be expanded to include social care;
- Enhance patient experience by early identification of call that would benefit access of clinical adviser not pathways;
- Ambulance services pass green disposition back to the appropriate Clinician within the IUC Service.

Initial impact assessment	**Description of impact, and outline of any mitigation.**
Race / ethnicity / nationality *Attitudinal, physical and social barriers.*	Improving outcomes for all patients should be of benefit to this group, so at this stage we do not anticipate any adverse impact. Ongoing consultations and engagement events will yield more insight into how we can work to minimise the impact around language barriers and multicultural issues. The IUC Service will have a language line in place and will be monitored to ensure the provision of an adequate interpretation service is maintained. For non-English speakers Language Line (tbc) will be used by the service as well as translated leaflets explaining the service being available on the NHS Choices website.
Gender *Men, Women, Boys and Girls.*	This protected characteristic should not have any adverse impact to the new model of the IUC Service in Dorset. Procurement of these models of care will recognise and acknowledge the needs of male and female patients and will continue to be built into any design.
Religion or belief *Christianity, Islam, Non Abrahamic religions, Agnostics, Atheism*	It is not thought that the IUC Service will have any significant impact on religion or belief either negatively or positively, however awareness about places of worship within any proposed clinical hub will still need acknowledgement.

Sexual orientation *Lesbian, Gay, Bi-Sexual and Transgender*	It is not thought that the IUC Service will have any significant impact on either gender either negatively or positively.
Age *Detail across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*	In planning for this procurement, Dorset CCG recognises that overall the population of Dorset enjoys relatively good health with a higher life expectancy than the England average. The IUC Service will reflect the needs of the elderly as well as the young in the appropriateness of its services, accessibility issues and ensuring that communication and interaction systems are of maximum benefit. It is the vision that the introduction of the IUC Service will mean there is less confusion over where to go for urgent care needs for all ages.
Disability *(e.g.) learning disabilities, physical disability, sensory impairment and cognitive impairment.*	Overall it is anticipated that the introduction of the IUC Service will impact in a positive way to what is currently and often confusing urgent care system. However, the quality of the service once "live" is particularly important and regular monitoring will be essential together with appropriate marketing to the individual protected groups. The two key groups identified in Dorset are: • The deaf community: Talk Type (tbc) will be available upon the launch of the service. • Learning disabilities: Easy to read leaflets for the launch of the service.
Marriage and civil partnership. *Part-time working, shift-patterns, general caring responsibilities.*	It is not thought that the IUC Service will have any significant impact on marriage and civil partnership either negatively or positively.
Pregnancy and maternity. *Detail on working arrangements, part-time working, infant caring responsibilities.*	It is not thought that the IUC Service will have any significant impact on pregnancy and maternity either negatively or positively.
Transgender. *This can include issues such as privacy of data and harassment*	It is not thought that the IUC Service will have any significant impact on the transgender group either negatively or positively.
Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*	

Engagement and involvement

Have you engaged stakeholders in gathering evidence or testing the evidence available? If not what do you intend to do?

A patient focus group was held on the 27 October 2016 and gave us the opportunity to seek feedback from a patient/public perspective and provided the group with an understanding as to why we are looking to redesign the current model for urgent care services in Dorset. We have also reviewed any information which has previously been gathered via the CSR engagement events and also the detail provided by Healthwatch.

As part of the procurement process a market engagement event was held on 30 November 2016 with a clinical engagement held on 11 January 2017. Further engagement was carried out during November and December and arrangements have been made to attend GP membership groups and locality meetings to gain feedback. A workshop was held on 15 June 2017, with a second market engagement event held on 29 November 2017.

The need to redesign urgent and emergency care services in England and the new models of care which propose to do this are set out in the Five Year Forward View (5YFV). The Urgent and Emergency Care Review proposes a fundamental shift in urgent and emergency care services and there is evidence available resulting from this review.

If you have engaged groups please list below and include who was involved, how they were involved and the key outputs:

Groups engaged	**Date and type of engagement**	**Outputs from activity**
Patient focus group	27/10/2016 Small focus group	9 attendees were due to attend but only 3 people attended on the day. Discussion focussed on people's lived experience and feedback was captured in two parts: **Part One: What was particular good/positive about your experience of the 111 service?** Attendees had positive experiences of the 111 service and clearly advocated the value of having a dedicated telephone number to ring out of hours. This was seen to be reassuring and effective in terms of signposting for appropriate care/treatment. **Part Two: What could be better/considered when providing a future 111 service?** The strongest message was about a lack of knowledge of the 111 service –

		particularly amongst people who might be older and live alone. Attendees made some suggestions about what might be done to help raise awareness amongst this group. They also felt that a good service is very much dependent on the people employed to deliver it and that thorough training was essential.
Market Engagement Event	30/11/2016 Presentation by Dorset CCG followed by provider 1:1 discussions	Key points which were captured during this event were: • The length of contract should be over a longer term with a clear preference for five plus two. • With regard to funding, majority of providers expressed a clear preference for a block payment with a degree of activity on top. • Direct booking was raised by many of the providers and having an arrangement where OOH were able to book into primary care at the beginning of the day and primary care able to refer patients to OOH at the end of the day; • Thought needs to be given to career pathways within the 111 service; • Most providers were interested in partnering up with a 111 provider.
GP/Clinical engagement	11/1/2017 Presentation by GP Clinical Chair followed by table top discussions	Main points captured from this event were: • Information goes from clinician to call handler then information can be lost in translation. Works better clinician to clinician. • More collaborative working across the board will improve patient experience • Need to look at portfolio working for the next generation of GPs for greater flex in the system/greater

		growth potential in professional development • Next generation of population need educating in the appropriate services and how they should be used. Should be working with schools as the police do. • Concerns around workforce – the national model is not really possible currently if GP focussed.
IUC Workshop	15/6/2017 Presentation by Dorset CCG followed by focussed questions with a Q and A to finish	Main points captured from this event were: • Interoperability between multiple systems is key – previous experience and existing blockers are making some providers uneasy • Getting GPs on board to develop the local offer is crucial regardless of which procurement options is opted for); subsequently the availability and training across the whole workforce will be key to success • The proposed model will encourage the forging, sustaining and improvement of professional to professional relationships, which will lead to more warm handovers, giving the impression of a single of organisation to the public • Skill mix offers a number of effective dispositions NHS 111 from, which in turn offers a wide range of services for patients from the initial point of contact • Integration will allow a patient to be directed effectively from the initial point of contact
Market Engagement	29/11/2017 Presentation by Dorset CCG followed by	Main points captured from this event were:

	focussed questions with a Q and A to finish	• How many times do I have to tell my story, patient needs to be able to only have to tell it once • Information about patient needs to be contemporary and easy for health professionals to locate • Knowledgeable staff. Patients need to feel confident in the staff • Patients should be encouraged to agree to share their records because it supports integration. It is key to help patients understand and build confidence in the service, which will enable them to be treated how they want to be: holistically. • A current lack of confidence in the 111 system is apparent but already signs of improvement been seen by patients – the concept of the CAS was seen as positive. The target of the 50% clinical input will ensure the service is improved, with patients' expectations being able to be managed much more effectively.

Summary of Analysis of the overall impact

Considering the evidence and engagement activity you listed above, please summarise the impact of your proposals. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

The IUC Service is intended to have a positive effect on care access and choice for patients. Modelling criteria and the service specification for this will have been adopted based on an understanding of local need to ensure new models of integrated urgent care have a positive impact on health outcomes.

Engagement with local clinicians, providers and the public will inform new models of care to address concerns raised about accessibility and responsiveness to need.

The IUC Service provider(s) will need to address the needs of diverse populations through offering choice of how services can be accessed and care personalised to meet individual needs of patients and carers.

The IUC Service provider(s) will need to ensure they address the needs of a diverse population, many living with long term health conditions and social care needs. Models of access, advice, assessment and treatment services will consider the needs of patients with the most complex needs to ensure there is appropriate access to care and flexibility of service provision to meet personalised care needs.

- Simpler, more accessible and joined up services;

- Based around primary care and natural geographies and communities;
- Provided by teams working better together;
- Flexible and responsive to people's needs;
- Including social care, mental health and other services, and the voluntary sector;
- Supporting people to look after themselves better, preventing ill health;
- Providing help and support available when people need it.

New models of care will consider how evidence of public health outcomes can inform the design of services to better meet the needs of at risk populations addressing the current gaps in services that exist and providing a better response to health inequalities.

The Accessible Information Standard, implemented on 31 July 2016, aims to provide people who have a disability, impairment or sensory loss with information that they can easily read or understand. This will ensure that all care providers:

- Ask people if they have any information or communication needs, and find out how to meet their needs. Record those needs clearly and in a set way;
- Highlight or 'flag' the person's file or notes so it is clear that they have information or communication needs and how those needs should be met;
- Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so;
- Take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.

Name of person who carried out this assessment: Rob Munro

Date assessment completed: 05.02.2018

Directorate lead: Sue Sutton

Date assessment was signed: 16.02.2018