Surrey Heartlands Partnership and East Surrey CCG

Integrated Urgent Care Clinical Assessment Service (including NHS 111 and GP Out-of-Hours)
Pre-market Engagement Event 4th October 2017

Feedback from facilitated table discussions

The following notes represent the discussions that took place at the facilitated table discussions. The commissioner(s) provide these notes in the spirit of open and honest communication and these notes do not represent the commissioner's position on any of the matters represented but rather the feedback and opinion offered by the variety of delegates present.

CLINICAL ASSESSMENT SERVICE

1.	*Question posed by Commissioners:* **Is there anything in the draft specification that needs revising/considering?**

	Comments from delegates:
	• The specification states all clinicians in the CAS are to use the Clinical Support Tool.
	  o Discussion concluded that exclusions to this requirement could be all clinicians who practice in their own right e.g. GPs , AMPs. The Clinical Support Tool should be available but it is at the discretion of the practitioner as to whether or not it is utilised.
	  o Use of the tool may have been stipulated as there are currently no GPs in the NHS 111 service in Surrey - Lyn Reynolds will clarify if this is an accurate assumption.
	  o Delegates noted that "an accredited Clinical Support Tool" is referenced in the specification in preference to the mandated use of NHS Clinical Pathways.
	• Clarification discussion regarding care navigators.
	  o This role involves
	  a) managing a call within the system including placement to a service that has capacity to speak to/see a patient and
	  b) queue navigation to manage risk across the callers queuing for support.
	  o Acknowledgement that this role is sometimes fulfilled by clinical floor walkers and is not always known as a care navigator so may require definition within the specification.

2.	*Question posed by Commissioners:* **Are you confident that you will meet the Workforce Blueprint requirements, or do you require any assistance/consideration from Commissioners?**

	Comments from delegates:
	• The Workforce Blueprint sets out a career pathway to a Band 9.
	• Recognised challenge's and risks - All services are seeking staff from the same limited/geographical pool of resource; there is a necessity to avoid duplication of services and the resultant competitive pull on the same workforce.
	• An environment and offer needs to be established which will attract staff to working in urgent care Out-of-Hours positions and provide a sense of role ownership and responsibility.
	  o What is the role of the commissioners and the STP to develop an aligned position regards rates of payment and reward for example?
	  o CCGs and GP Federations could take an active role in the development of Out-of Hours staffing models and encourage and enable the expansion of roles to encourage and enable staff to work in an Out-of-Hours environment.
	  o The system needs to take action to combat the impression that Out-of-Hours staff are different to those who work In-Hours.

	○ Addressing the workforce challenge includes identifying ways to make it attractive for senior nurses and doctors, who are about to retire, for example, to work in an Out-of-Hours service. • Commissioners confirmed that the model enables the provider to consider providing CAS staff with the flexibility to be based remotely or able to work from home; it is not necessary to be situated within the CAS itself. • Providers may consider the establishment of staff rotational opportunities across and within provider organisations. The CAS can be staffed by less senior grades with the appropriate supervision and oversight of senior advisors and effective safeguarding and clinical governance systems in place. • Establish Out-of Hours services placement as an integral element of staff training and accreditation? • Stakeholders to work together to widen the scope of current Out-of-Hours opportunities for staff e.g. include home visits, triage, audit, provision into the CAS' and into EDs. • Many new trainees into primary care are seeking part-time working arrangements. The Out-of-Hours option is appealing is this regard as it allows clinical staff to use their expertise on a part-time basis. • Identify a locality and recruit to it specifically in order to build loyalty and encourage role ownership.
3.	*Question posed by Commissioners:* **What data set fields will you require to help model the optimum/most efficient CAS?**
	Comments from delegates: • There is a danger that a CAS with more specialised clinicians will generate more demand or uncover an unmet need. • It would be good to see modelling and learning from those areas that have already gone live which demonstrates that a CAS is effective. • It is possible to route cohorts of calls/early exit calls directly to the CAS but there was concern that this will create further demand. A balance between default routing of calls directly and undertaking initial screening needs to be achieved. • Within the specification it states that 50% of calls are required to have clinical assessment. How is clinical assessment defined - face to face, telephone consultation, booking a direct appointment? ○ Commissioners to clarify this within the specification. • It is crucial to establish the correct service pathways and system interoperability, without which, the CAS will be compromised. • Generic MDS outcomes are required for the tender. • Include data from the RAIDR tool in the tender documents. This will illustrate how many callers continue to attend A&E after calling NHS 111. • An understanding of which professionals are most effective when triaging would be useful. • Comprehensive data/information advising bidders of the service configuration in each local system.
4.	*Question posed by Commissioners:* **The draft specification states that the Provider is to suggest an NHS 111 Online solution, is this right approach?**
	Comments from delegates: • Discussion took place regarding the use of online products by those over 65 years of age. EMIS launched a product which was successfully taken up by patients of this age group though they had a tendency to also book GP appointments. • EMIS did not feel an online solution would need a phased introduction; they have seen immediate uptake in the past.

	• Delegates acknowledged the need to define how a personal conversation could take place either by telephone or real time typing. • Patients need a product which provides enough assurance to dissuade them from visiting another service in addition to the NHS 111/CAS call. • Demand analytics are required for each service. • It will likely be necessary to introduce an online application after launch of the service in order to make the appropriate baseline assessment prior to measuring for success. Without the ability to benchmark the status quo it will not be feasible to measure any change in activity.
5.	*Question posed by Commissioners:* **Are there any specific interoperability requirements you would like to discuss?**
	Comments from delegates: • Acknowledgement that the electronic prescribing service (EPS) will be developed over time. • It would be useful to have details of the software and clinical systems used by key stakeholder (GP practices, Mental Health, Urgent Treatment Centres, and Community etc.) • Provider and Commissioner to jointly develop extending direct booking over the term of the contract • Commissioners to consider providing data for the extended hours period • Commissioners are working hard to facilitate the uptake of extended hours within the primary care community. • The market will need to know the scalability of the services to which the IUC CAS provider will need to interface with and the prioritisation across these for direct booking provision. • The Surrey Heartlands Partnership is obtaining a tool for real time analysis across services which could be utilised by NHS 111. Current tools are SHREWD and Alamac which provide daily system updates. SHREWD pulls data only whereas information can be input to Alamac. • The governance arrangements for direct booking were questioned. Currently a clinician must close a call on the NHS 111 system if a patient does not attend a booked appointment. It was discussed whether governance would sit with the lead provider even if they do not actually provide the service directly. • There is a need to understand the implications on this service of the General Data Protection Regulation which comes into effect in the UK on 25 May 2018. Commissioners undertook to address this issue during the pre-engagement event on 19th October 2017 and to relay this concern to NHSE at the IUC Commissioner event on 17th October 2017
6.	*Question posed by Commissioners:* **Are there any future innovations you would suggest we consider?**
	Comments from delegates: • Speaking to a clinician presents more opportunity for call closure. • Register phone numbers against organisations and patients e.g. Care Homes in order to ensure speed of access to patient records and End of Life Care Plans. • Use the 111 call centre as the single point of access for other services to ascertain shared management/resources etc. to increase efficiencies.

FACE TO FACE TREATMENT

1.	*Question posed by Commissioners:* **Should we release two options for costing commencement of face to face treatment service (e.g. 1 x from 18:30 and 1 x from 20:00)?**
	Comments from delegates: • Delegates queried whether funding would move from one contract to another should this prove necessary to which commissioners responded that would be likely.

	• Should funding be provided to access extended hours hubs, the Out-of-Hours providers will need to see a robust process to avoid simply shifting the peak to 20:00. • There was concern that the available capacity within Extended Access provisions would not be sufficient to meet the Urgent Care requirement and that OOH services would then be forced to meet the same level of activity within a reduced period of operation. • There is a possibility the Out-of-Hours provider will not be able to fill the rota adequately if extended hours are operational in isolation. • Providers must work collaboratively to avoid three services working simultaneously e.g. extended hours, Out-of-Hours, Urgent Treatment Centres. Duplication and the risk of some clinicians not being fully utilised must be avoided. • Comment was made that Extended care should not be a continuation of primary care but is distinctly about access to urgent care. • If Out-of-Hours commences at 20:00 there may not be a need for the currently stipulated continuation of eight bases. • If Out-of-Hours commences at 20:00 it may be very difficult to recruit staff for a short duration e.g. 3 hours or so with shifts starting later and overlapping the less attractive twilight periods more. • Providers require data in order to design how to strategically offer services in a sensible and cost effective configuration. • GPs offering extended hours will only see their own patients (defined by the specification); this may create a two-tiered system and patient dissatisfaction, leaving behind patients of GP surgeries which do not offer the service. • Some patients seeking extended hours appointments may be booked by the GP into an In-hours appointment in preference, thereby reducing the number of available appointments In-hours within a given week. • The GP indemnity issue is a dis-incentive to working in Out-of-Hours services; this is becoming financially incompatible with the requirements of the NHS. • Access to patient records will influence the willingness to work within Out-of-Hours services. • There will always be a demand for an Out-of-Hours service from 18:30 as activity is unlikely to be absorbed by extended hours.
2.	*Question posed by Commissioners:* **Will the new Urgent Treatment Centre Guidance pose a problem for the locations we have outlined?**
	Comments from delegates: • Walk-In Centres and Minor Injuries Units are all to be re-branded as Urgent Treatment Centres. • It must be determined whether IUC providers need to co-locate with all Urgent Treatment Centres. The NHS cannot afford to offer services which replicate other services and are not being fully utilised. • This procurement must generate a model for the future, both clinically and managerially. • The public engagement campaign enquired of people whether they were happy with the current locations of Out-of-Hours services to which they responded positively. Any change to these locations would necessitate public consultation but any negative feelings may be off-set if commissioners are able to guarantee extended hours in any affected locality. The Cranleigh base in particular is very underutilised. • Delegates felt that efficiencies were available if the current out of hours locations were reconfigured/co-located with the urgent treatment centres. • It is possible to use extended nurse practitioners and other AMP staff to staff Urgent Treatment Centres as long as they have access to a GP for advice. There can be a discrepancy in the types of patients AMPs will see e.g. under 2 years old, pregnant, mental

	health which will need to be addressed in the Workforce Blueprint and in providers service proposals. o In light of the above there was discussion around the need to identify different pay scales within the service and create a career structure for staff.
3.	*Question posed by Commissioners:* **What data set fields will you require to help model the optimum/most efficient Out-of-Hours service?**
	Comments from delegates: • Hourly outcome information. • More than appointment time only – ideally when the call was received in the system also to allow for the identification of peak times. o The suggested "shoulder time" was fifteen minutes. o The greatest demand peak is 18:30-20:00.
4.	*Question posed by Commissioners:* **Are there any specific interoperability requirements you would like to discuss?**
	Comments from delegates: • Accessing the summary care record/patient notes whilst in the car would be helpful. o EMIS can be accessed in the car. o The above will enable providers to remain consistent with advice that a patient may previously have been given. This will allow providers to present a consistent approach and avoid patients seeking the solution they want from alternative providers. This will always be caveated against the need for further advice as a consequence of worsening symptoms.
5.	*Question posed by Commissioners:* **Are there any future innovations you would suggest we consider?**
	Comments from delegates: • Online option to accept video conferencing. • Self-triage. • Web chat. • The DOS to be accessible to all services so that A&E, UTCs, Out of Hours also has access to the same services as NHS 111. • Flexible working from home for CAS staff. • SMS to alert clinicians of the need to work for the CAS to combat a bulge in activity. • The co-location of extended hours, urgent treatment centres and Out-of-Hours services, possibly using the same staff members. • Discussion regarding a roving GP during the in-hours period to assist with facilitated discharge had not provided VFM. • Video consultations in care homes had also not worked well. • Comfort calling

Actions to be undertaken by the NWS CCG Procurement Team following this event:

1. Seek permission of NHSE to publish the Online Evaluation and Product Matrix Comparison.
2. Build into the next pre-engagement event the need to address the following IM&T issues:
    a. Definition of the organisations into which interoperability will be required and the priority for these.
    b. Information regarding the General Data Protection Regulation which comes into effect in the UK on 25 May 2018, with particular reference to data sharing responsibility for direct booking/interoperability / PDS etc.
3. Include information about all hubs (Out-of-Hours, Urgent Treatment Centres, Extended Hours locations) in the information released with the tender documents.

4. Post the documents embedded in the service specification to the NWS CCG IUC Potential Provider website separately, for ease of access.
5. Post the output from this event, delegate list and presentation material to the NWS CCG IUC Potential Provider website.