East Sussex Better Together – Urgent Care Redesign Programme Update

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This paper provides a summary update on the progress being made on the East Sussex Better Together Urgent Care Re-Design Programme, including an update on the 111 transformation and re-procurement programme.

1.0 Context

Urgent care is a term that describes the range of services provided for people who require **same day** health or social care advice, care or treatment.

This is different from emergency care provided in our emergency departments (A&E), other hospital departments, 999 and ambulances, which are set up to respond to serious or life threatening emergencies.

Following a national review, NHS England set out very clear commissioning standards in September 2014 to ensure future urgent and emergency care services are integrated and offer a consistent service.

In March 2017, NHS England and NHS Improvement published the *Next Steps on the NHS Five Year Forward View (FYFV)*, which highlighted the importance of delivering functionally integrated urgent care services to help address the fragmented nature of out-of-hospital services. The aim of the FYFV is to provide care closer to people's homes and help tackle the rising pressure on all urgent care services (primary and hospital) and emergency admissions.

In the next steps FYFV publication there are 10 nationally set key deliverables in relation to urgent and emergency care for 2017/18 and 2018/19 and these are set out in annex 1 of this report.

The nationally set commissioning standards and key deliverables are informing and shaping how we – through **East Sussex Better Together** – best organise and provide local urgent care services.

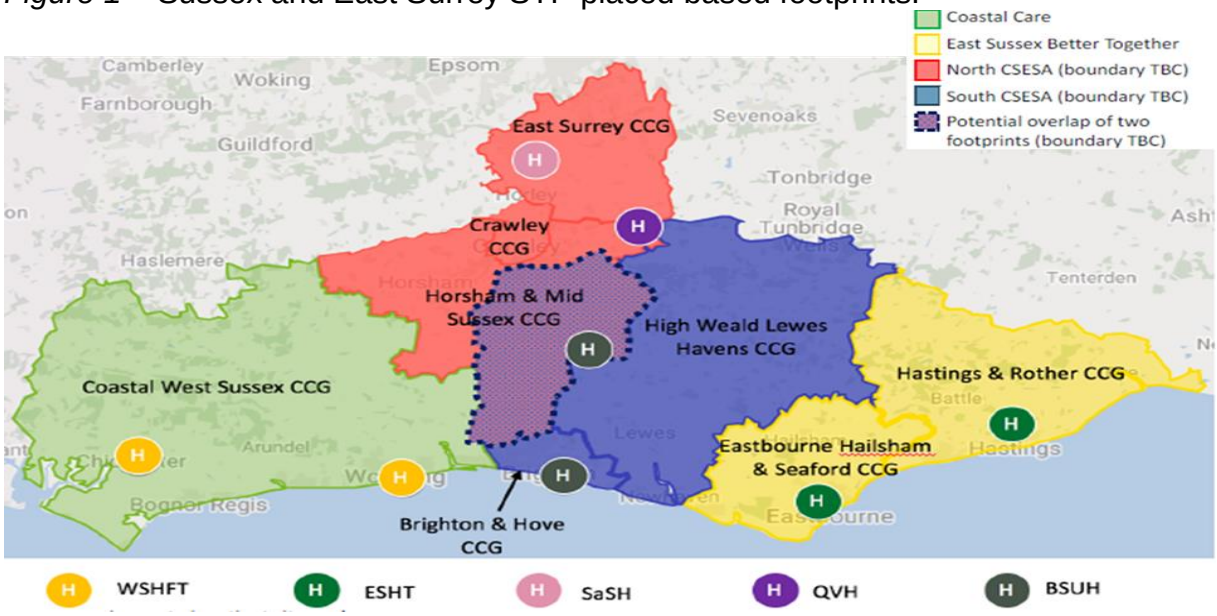
2.0 Introduction

Under East Sussex Better Together (ESBT), the overarching vision for urgent care is to adopt an integrated system-wide approach creating a long term sustainable solution for local people. The model is designed to increase efficiency and productivity of our urgent care system, providing access to the right care in the right place, first time.

The ESBT[1] urgent care re-design and transformation programme is framed within the wider placed based Sussex and East Surrey Sustainability and Transformation Plan (STP). The STP place based footprint for Sussex and East Surrey is set out in the Figure 1 below.

[1] ESBT includes the areas covered by Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG

Figure 1 – Sussex and East Surrey STP placed based footprints.



The ESBT Whole System Urgent Care transformation programme has been led by clinical and managerial leads across local providers and commissioners of urgent cares services. It has been informed by patient experience and feedback. Together we have co-designed and progressed the implementation of a new integrated delivery model of urgent health and social care to improve clinical safety, quality of provision, patient experience and ensure that resources are used effectively across the system.

Following on from the previous paper submitted to the Health Overview and Scrutiny Committee (HOSC) in December 2016, this paper provides a summary update on the progress made to date, including updates on each of the component workstreams underpinning the ESBT urgent care transformation programme.

3.0 Scope

The following services are included in scope as part of the development of an integrated urgent care model:

- NHS 111
- GP (In Hours and Out of Hours)
- Walk-in Centres
- Activity at Accident and Emergency (A&E) Departments
- Hospital Intervention Team
- Mental Health Crisis Support
- South East Coast Ambulance Service (SECAmb)
- Adult Social Care- Emergency Duty Service

In addition, the importance of the Digital Information Management and Technology (IM&T) infrastructure as a key enabler to support integrated working and provision of care is recognised within the programme.

4.0 Service Model

As previously reported a number of stakeholder events have been held in East Sussex to develop the local urgent care service model. These events engaged with the public, voluntary sector, GPs, community services, acute trusts, social services, housing, ambulance trust, mental health services and local clinical commissioners. The outcomes of these engagement events were shared with the HOSC in December 2016.

The service model, attached as annex 2, was agreed by the ESBT urgent care programme board and reflects the commissioning standards for Integrated Urgent Care published in September 2015 by NHS England and it is congruent with the national Integrated Urgent Care Service Specification, which was published recently in August 2017.

Key principles of the model design have been identified as follows:

- The intention is to offer an integrated 24/7 urgent care service.
- There will be a single-entry point via NHS 111 to fully integrated urgent care services, recognising that access to urgent GP appointments remains unchanged.
- A clinical hub (staffed centrally, virtually or a mixture of both) to support people accessing the right service for them, will offer access to a wide range of clinicians such as GPs, pharmacists, dental and mental health services and specialists, and will offer advice to patients and healthcare professionals.
- Clinicians will have a robust accurate directory of services which will enable them to refer patients to the appropriate local service.
- Patients requiring access to face to face Primary Care Urgent Services will be referred from the clinical hub.
- These services will be co-located with hospital emergency departments, which our local stakeholders identified as their preferred location for integrated urgent care hubs.

The three components of the local system model redesign are set out below:

1. The development of our A&E departments into Integrated Urgent and Emergency Care Departments;

2. The re-design and re-procurement of NHS 111 and the development of local clinical hubs providing telephone assessment, triage and referrals co-ordination service in line with recently published national specifications;

3. The provision of 24/7 access to same day general practice (GPs), which includes the future provision of Primary Care Out of Hours (OOH) services and a review of our Eastbourne and Hastings Walk-in Centres (WICs)

An update on the progress that has been made on the three components since the December 2016 report to the Health and Overview Scrutiny Committee (HOSC) is summarised below together with an update on the nationally announced Ambulance Response Programme.

5.0 Integrated Urgent and Emergency Care Department

The enhancement of our A&E departments into fully integrated Urgent and Emergency Care departments is central to the Integrated Urgent Care model and this will be delivered through the introduction of enhanced triage and streaming of patients so they are seen by the service that is right for their needs. This will be enabled by the introduction of a broader mix of staff to better manage people's wide-ranging needs. This approach will ensure that services are better aligned to patients' needs and improve access to A&E for the patients who require this level of care.

During the course of 2017 progress has been made in developing and enhancing our A&E departments as follows:

In April 2017, the Department of Health announced that all systems must have co-located primary care streaming services at Trusts with type 1 A&E [2] departments by October 2017. The development of this service is to help address the increase in A&E attendances. East Sussex Healthcare NHS Trust successfully bid for £1.685m from national funds to support the development of the estates re-design costs required to support primary care streaming at both the Conquest and Eastbourne District General Hospitals (EDGH). The estates works are progressing and the plan is that space to accommodate the new primary care service will be available by the end of October 2017.

In support of the primary care streaming model the role of GPs in A&E has been piloted at EDGH and the learning from this pilot has informed the service model that has been developed to support primary care streaming. The aim is to have the primary care streaming service operational at both hospitals by the end of October 2017. It is important to note that this service is being established to more effectively manage existing A&E demand and should not be seen as an alternative to patients continuing to access their own GP. The most significant challenge to establishing the new service is the recruitment of such a highly specialised and scarce workforce.

East Sussex Healthcare NHS Trust has also developed plans to establish enhanced ambulatory care services as part of the modernisation of the front door service model (people that arrive at the Integrated Urgent and Emergency Care Department). This will enable ambulatory patients (patients who may need to be treated but not admitted to hospital), who require specialist assessment, to be streamed away from A&E and be seen by the relevant specialists rapidly and assessed, treated and discharged on the same day.

[2] A type 1 A&E = A consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

In addition, a re-designed acute and frail medical assessment model for those patients who only require a short period of time in hospital to be assessed and treated is also being developed. This new service model should be in place at EDGH by the end of November 2017 and, subject to capital funding and building works, will be developed at Conquest Hospital by Spring 2018. Development of this service model will ensure that patients are seen by specialist doctors and an integrated hospital intervention team and where possible assessed, treated and discharged within 72 hours, therefore significantly reducing the length of stay required and helping people get home sooner where appropriate.

Progress has been made within the acute hospitals in implementing nationally recognised good practice in the management of patient pathways including: the development of improved multi-disciplinary team (MDT) working and decision making at ward level; regular weekly senior MDT review of all patients with a length of stay of more than 7 days; and the establishment of an integrated discharge team bringing health and social care staff together to manage complex supportive discharge arrangements for people more effectively.

During 2017 there has been investment into a number of key teams to support and improve patient management and discharge planning including the following:

- Community falls and fracture liaison team to identify patients at high risk of falls and implement falls prevention solutions.
- Crisis response team to provide up to 72 hours emergency support as an alternative to A&E and emergency admission.
- A pilot started in August 2017 using the aforementioned crisis response teams to support the discharge of patients who would benefit from being assessed in their own homes rather than whilst they are in an acute bed, referred to as a ‘discharge to assess’ model.
- An enhanced Hospital Intervention Team in the acute hospitals to assess and organise either urgent packages of care or prescribe home aids/support in order to avoid hospital admissions from the A&E department or to enable patients to be managed as a short stay patient with a length of stay of less than 48 hours.
- The development of integrated support workers (ISWs) across adult social care and health to support people in their own homes to avoid admission and to provide step down care to reduce the time patients have to spend in an acute hospital or community bed. Plans are progressing well towards recruiting 100 ISWs by April 2018.

In respect of urgent and emergency liaison mental health services for adults and older adults in acute hospitals, the current on-site service provision at our acute hospitals is limited to 9 hours a day 5 days a week. The local system is therefore working closely with the Sussex STP colleagues to develop a bid to secure national transformation funding to develop 24/7 acute mental health liaison cover in our A&E departments, as set out in the national Mental Health Five Year Forward View.

6.0 NHS 111/Local Clinical Hub Triage and Assessment

The model for a new NHS 111 service has been designed across the Sussex and East Surrey footprint in line with the NHS Five Year Forward View and the redesign of the urgent and emergency care services. NHS England published in August 2017 a National Integrated Urgent Care Service Specification which sets out the outcomes expected for a NHS 111 and integrated clinical assessment services.

The national service specification mandates a combined service model for GP out of hours and NHS 111 services to integrate access to urgent care services by April 2019. This new service will significantly reduce the number of handoffs (being passed between services) that patients currently experience and provide the gateway for patients to access face to face urgent care services across Sussex.

In establishing the new model the preferred option identified is to continue working collectively with Sussex STP colleagues to refine our local Health and Social Care Connect (HSCC) service model [3] and continue to develop the HSCC as an enhanced local clinical service for complex calls within the agreed timescales. In order to underpin the implementation of a new NHS 111 service the developments to our local HSCC model will need to be aligned to the NHS 111 procurement timescales.

In order to deliver these service changes, it is vital that developments are made with the supporting technology to enable patients successful access to services as well as routing of calls to alternative services. We are currently working with our digital colleagues across Sussex as well as locally to deliver these improvements in technology.

A detailed update on the NHS 111 transformation and procurement process is included as annex 3 to this report. It should be noted that this is relevant to the whole of East Sussex, not only the area covered by ESBT.

7.0 Primary Urgent Care Service (PUCS)

The third key component of our urgent care transformation relates to the redesign of primary care to provide consistent effective same day urgent care services. This relates to services currently provided by our General Practitioners within local practices, those provided by the Eastbourne and Hastings GP Walk-in Centres (WICs) and the existing GP Out of Hours (OOH) service provided by IC24, the latter two of which are provided via separate contractual arrangements with IC24. As with the NHS 111 service, the contract end date for GP OOH services has been extended to the end of March 2019 to enable a fully integrated approach to be achieved.

Both WICs contracts have been extended to September 2018 to enable full engagement with all stakeholders to ensure the most appropriate service for the local population is secured to ensure sustainable provision of primary care urgent services.

[3] Health and Social Care Connect (HSCC) offers both the public and professionals a single point of access for adult health and social care enquiries, assessments, services and referrals.

As well as stakeholder engagement and the review of current services to inform future provision, projects are being undertaken to help to address some of the current challenges identified by stakeholders as reported in the paper received by the HOSC in December 2016 as follows:

- Challenge1: Challenged in-hours service provision making access difficult

➢ Within the national General Practice Forward View (GPFV) plans are required to provide extended access service for bookable Primary Care appointments for 50% of the population by March 2018 moving to 100% coverage by March 2019. The CCGs are currently undertaking a pre-market engagement exercise to identify potential providers of the extended access service. This service will give patients the ability to pre-book appointments after 6.30pm and on Saturdays and Sundays where appropriate.

- Challenge 2: Fragmented service providers and delivery

➢ Care navigator training is being offered to all GP practices starting January 2018. This may be on a practice or locality basis. This will enable the navigation of patients to the most appropriate service within the practice or to the most appropriate service within the local area.

- Challenge 3: Increasing unscheduled demand

➢ Focus groups with members of the public are being undertaken and an information pack will be produced to help patients understand the full range of healthcare options available to best meet their need.

- Challenge 4: Increase in complex cases

➢ Support for practices to use alternative methods of consultation where appropriate e.g. remote consultations, on-line advice and guidance, skype and CCG wide training in the Year of Care programme to encourage patient empowerment and a more holistic approach to a patient's needs.

- Challenge 5: Workforce challenges

➢ Ongoing development of skill mix within the practice primary care teams. Primary Care investment within the GPFV, together with additional investment as part of ESBT, is being used to support transformational and innovative workforce changes and upskilling staff within the Primary Care teams to ensure patients can access the most appropriate clinician for their need.

8.0 Urgent Treatment Centres (UTCs)

The *Next Steps on the Five Year Forward View* document, published in March 2017, described a process to end the confusing array of Urgent Care Centres, Minor Injury Units, Walk-In-Centres and other forms of urgent care provision outside of A&E's.

The national requirement is to create a more standardised offer for patients, which will be known as Urgent Care Treatment Centres (UTCs). UTCs will provide a more standardised, consistent offer including:

- A service open 12 hours a day, seven days a week, integrated with local urgent care services;
- Treatment by clinicians with access to diagnostic facilities that will usually include an X-ray machine: and
- Appointments that will be bookable through NHS 111 as well as GP referral.

The national expectation is that the first 150 facilities will be designated by December 2017 with detailed plans to be agreed by 31st March 2018 that will ensure all other systems designate their UTC facilities by no later than 1 December 2019.

The ESBT urgent care programme is currently considering where the development of UTCs and other recent nationally mandated developments sit within the locally agreed service model and will publish its plans early in 2018. We will ensure stakeholder engagement in this programme.

9.0 Ambulance Response Programme (ARP)

The national ARP aims to achieve a more equitable and clinically focused response, meeting patient needs in an appropriate timeframe through better allocation and distribution of resource.

A new series of national standards, indicators and measures has been developed to assist with the governance of the new ambulance operating model that has been developed through the ARP.

SECAmb participated in phase 2 of the national project, and implemented the Nature of Call (NoC) and Dispatch on Disposition (DoD) aspects of the ARP on the 18th October 2016.

NoC is a set of questions used to try and identify life-threatening calls before the main triage assessment occurs, and DoD is a method of dispatching resources when it has been identified that they are required.

The 999 service is currently developing the implementation plan for the remaining phase of the ARP for 22nd November 2017.

10.0 Meeting the workforce challenge

One of the most significant challenges faced by the ESBT urgent care transformation programme is the ability to develop, attract and retain the workforce required to deliver the new service model. The strategy and plan to meet this challenge is therefore an important element of the urgent care re-design programme.

The East Sussex Better Together Workforce Strategy was published in October 2016 which set out the three priority workstreams in terms of focusing workforce

planning support. Urgent Care was agreed to be one of these three priority areas along with Primary Care and Integrated Locality Teams.

The workforce strategy also confirms that targeted workforce plans responding to the needs of specific ESBT initiatives would be undertaken rather than having one overarching workforce plan. This approach was agreed due to the complexity and wide ranging aspects of the ESBT programme for creating integrated care services, with the majority at different stages of development.

This approach has also been reflected in supporting commissioners with the design of the three key components of the local urgent system model redesign. Workforce plans are therefore, at different stages for each of these initiatives.

Each of the workforce plans however, face similar challenges in terms of the national workforce supply issues and how these impact specifically to East Sussex as a place to attract and retain staff, which has its own local challenges such as poor transport links, age demographic perceptions and the draw for staff to work in Brighton or London.

The key urgent care recruitment 'hot spots' are considered to be:

- GPs (in terms of their role in the ESBT Whole System Urgent Care transformation programme)
- Hospital Consultants
- Unregistered nursing staff
- Allied Health Professionals
- Social Workers

ESBT is developing an integrated Recruitment and Retention plan that focuses on addressing these 'hot spots'. For example, the following are an illustrative list of the actions being taken by ESBT Alliance partners to resolve the skills gap in urgent care:

- GP Fellowship role (a joint appointment whereby the Fellow spends 2 days per week in Urgent Care)
- Overseas recruitment campaign
- Recruitment to a Trust Associate Specialist grade
- Offering training placements in urgent care
- Introducing new roles such as Physician's Assistant, Doctor's Assistant, Nurse Associate
- Maximise the benefits from social media in recruitment and to promote ESBT as an innovate and good place to work
- Promote East Sussex as a place to live and work
- Retention initiatives to retain experienced/older workers
- Rotational posts, so that staff experience and become skilled in more than one area
- Talent management and succession planning
- Values based, coaching approach to leadership

11.0 Engaging with people about the re-design of Urgent Care

As previously reported to HOSC we have undertaken extensive engagement with local people to ascertain what is important to them at our bespoke stakeholder events and our East Sussex Better Together Shaping Health and Care Events in 2015 and 2016. This was supplemented with a widespread survey and extensive and focussed engagement with diverse public groups and individuals during August to November 2016. We have also undertaken specific engagement work in local GP practices to understand how people access services and what is important to them. East Sussex Healthwatch has also undertaken engagement on reasons for people accessing urgent care and we collect ongoing feedback through our East Sussex Better Together Public Reference Forum. Outcomes of all of this work have directly shaped and informed the urgent care model design principles.

Whilst the significant requirements as set out in the national Five Year Forward View are broadly consistent with the agreed ESBT urgent care service model it is important that the views of the public and key stakeholders continue to be considered as we take these developments forward locally. Therefore, a further programme of engagement with the public and key stakeholders will be taken forward during the remainder of 2017 and throughout 2018

12.0 Timescales and next steps

As highlighted above, we have made good progress on our local plans and this is resulting in improvement for local people, in particular the development and enhancement of our A&E departments to provide integrated urgent and emergency care services, with further implementation planned. The redesign of NHS 111, in line with national requirements, our primary care urgent services and the requirement to establish a new Urgent Treatment Centre standardised service offering are subject to procurement or re-procurement procedures being followed. This has previously been reported to HOSC and the summary of milestones and timelines are set out below in Table 1:

Table 1: Summary of milestones and timelines:

Key Milestones	**NHS 111 Procurement Timetable**	**GP OOH Procurement Timetable**	**WICs Procurement Timetable**
Implementation	April 2019	April 2019	October 2018
Current contract end dates	March 2019	March 2019	September 2018
Business Case to be completed	September 2017	September 2017	October 2017
Procurement process	March 2018 - March 2019	March 2018 – March 2019	November 2017- October 2018

In addition to the above there is a requirement for systems to ensure that Urgent Care Centres are designated and operational by no later than December 2019 and system plans to achieve this including procurement requirements are required by no later than 31 March 2018.

Recommendations

The Health and Overview Scrutiny Committee members are asked to note progress with the development and implementation of our integrated urgent care service model. Further progress reports can be submitted to the HOSC as requested.

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Annex 1 – Next Steps of the NHS Five Year Forward Views: 10 deliverables 2017/18 and 20/18/19.

- Every hospital must have comprehensive **front-door clinical streaming** (ensuring that patients who attend A&E and can be seen my primary care clinicians are identified) by October 2017, so that A&E departments are free to care for the sickest patients, including older people;

- By October 2017 every hospital and its local health and social care partners must have adopted good practice to enable appropriate **patient flow (**ensuring that patients are cared for in the right place and the right time), including better and more timely hand-offs between their A&E clinicians and acute physicians, 'discharge to assess', 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven-day discharge capabilities;

- Hospitals, primary and community care and local councils should also work together to ensure people are not stuck in hospital while waiting for **delayed community health and social care;**

- Specialist **mental health care in A&Es**: 74 24-hour 'core 24' mental health teams, covering five times more A&Es by March 2019, than now;

- Enhance **NHS 111** by increasing from 22% to 30%+ the proportion of 111 calls receiving clinical assessment by March 2018 so that only patients who genuinely need to attend A&E or use the ambulance services are advised to do this. GP out of hours and 111 services will increasingly be combined. By 2019, NHS 111 will be able to book people into urgent face to face appointments where this is needed;

- NHS 111 online will start during 2017, allowing people to enter specific symptoms and receive advice on management;

- Roll out **evening and weekend GP appointments to 50% of the public by March 2018 and 100% by March 2019**;

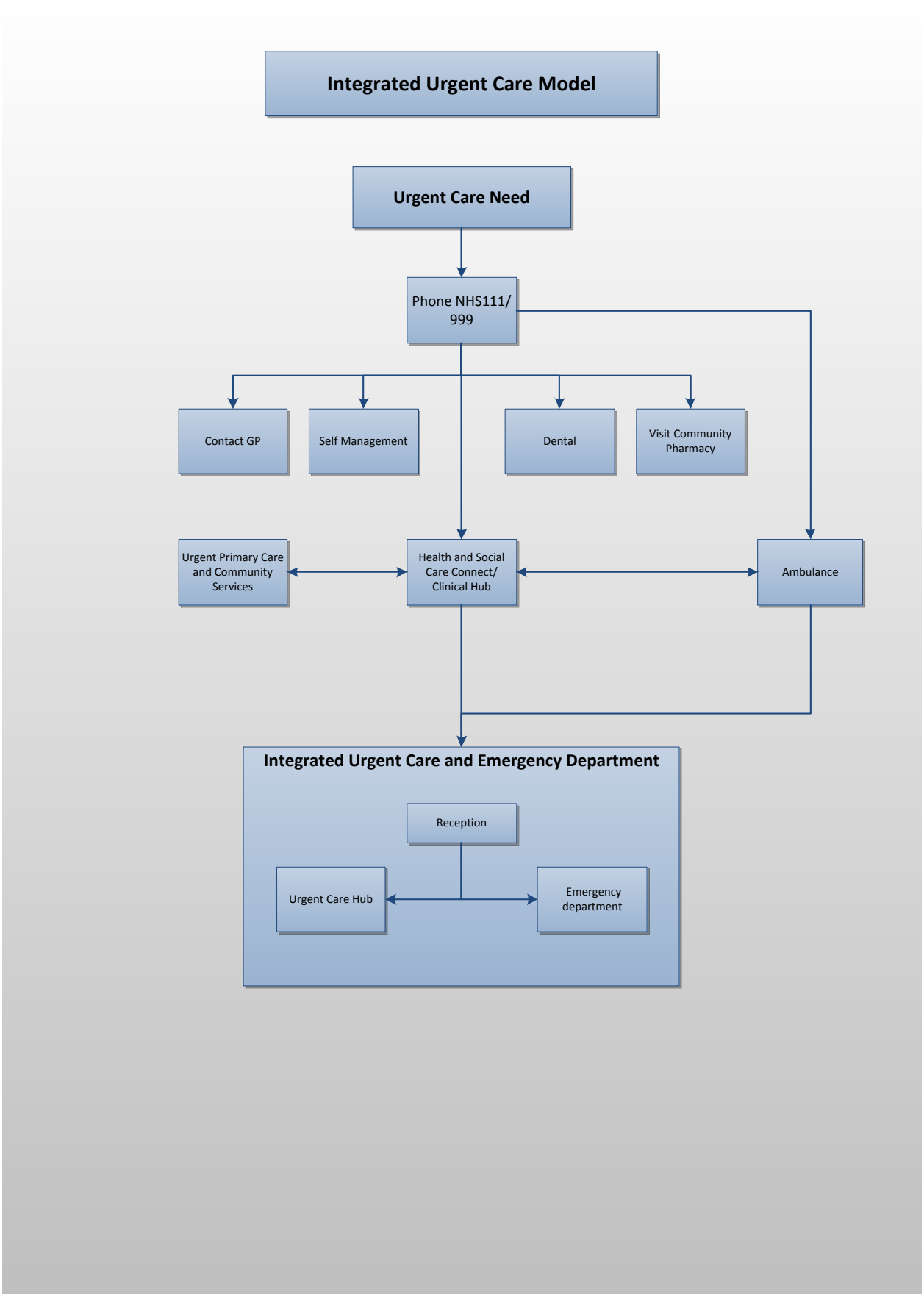
- Strengthen support to care homes to ensure they have direct access to clinical advice, including appropriate on-site assessment;

- Roll-out of standardised new **'Urgent Treatment Centres' (UTC),** which will be open 12 hours a day, seven days a week, integrated with local urgent care services;

- Implement the recommendations of the **Ambulance Response Programme** by October 2017, putting to an end to long waits not covered by response targets.

Web Link: https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

Annex 2 – East Sussex Better Together Urgent Care Service Model



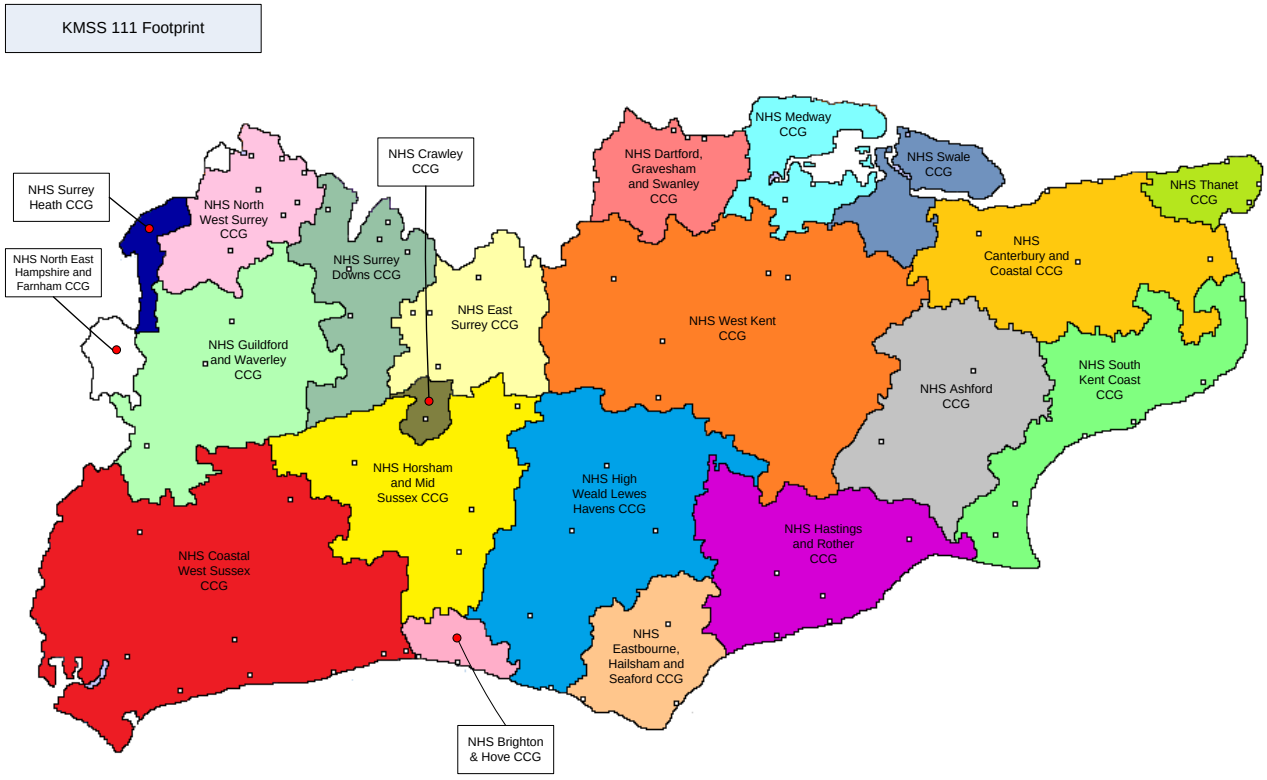
Annex 3 – NHS 111 Transformation and Procurement Programme

1. Background

NHS 111 - is the non-emergency number that people should call if they need medical help or advice but feel it's not a life-threatening situation. There are experienced call handlers and clinicians who are available to assess a person's needs and situation and direct them to the best local services for the care they need. The NHS 111 service is currently provided by South East Coast Ambulance service (SECAmb).

GP Out of Hours (OOH) – the service is provided by Integrated Care 24 (IC24) and works with our local GPs to provide out of hours' services to our local population.

The original contract for the NHS 111 service was a South East regional contract for Kent, Medway, Sussex and Surrey (KMSS) and consisted of 21 CCGs. The original contract expired on 31 March 2017. Out of the 21 CCGs across Kent, Medway, Sussex and Surrey (KMSS), 17 CCGs agreed to a two-year contract extension with South East Coast Ambulance service (SECAmb) until 31 March 2019. This includes the area covered by East Sussex. NHS Swale CCG is the lead commissioner for this service across our area and our local CCGs are involved in this process.

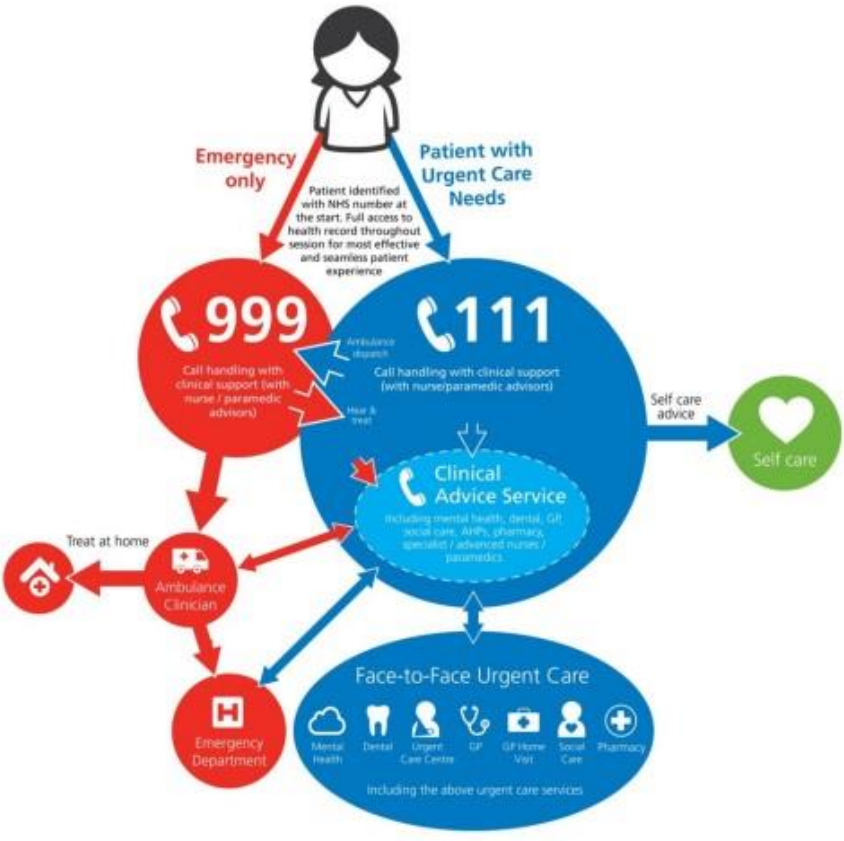


2. 111/Integration of Urgent Care Transformation Programme

In line with the NHS Five Year Forward View the redesign of urgent and emergency care services is developing across the Sussex and East Surrey STP footprint. The integration of urgent care services will provide the Sussex population (1.69m people) with an integrated seamless service for their urgent care needs and this includes the NHS 111 service.

The Urgent and Emergency Care Route Map was published in November 2015 as part of the Keogh Review. Included in the report was the deliverables for NHS 111 and the development of integrated Clinical Assessment Services (CAS).

The CAS modelling is seen as pivotal to bring urgent care services together with an Integrated Urgent Care model and the NHS 111 service is integral within its design - as shown below:



2a. Programme Objectives

The objectives of this programme are:

- To re-procure NHS 111 supported by an integrated Clinical Assessment Service (CAS) with all seven pan-Sussex CCGs
- To detail the options for the design and locations of face to face urgent and emergency care services and procure services as part of the wider urgent care model in line with the national recommendations, best practice and local need
- Ensure that our patients and public, providers, voluntary sector and social care partners are co-designers and formally consulted (as required) on the service model options
- Agree and seek the relevant approval to the chosen service model
- Decommission current services as appropriate
- Procure and implement the new service model
- Ensure the CCGs and local health economy remains on a sound financial footing in the future
- Ensure that the urgent and emergency care model complements and aligns with the aspirations for the Sustainability and Transformation Plan (STP)
- Ensure key lessons learned from other large scale procurements in Sussex (for example Patient Transport Services), but also around the country are followed :-
    - Do not allow the programme to become isolated from the business / services / organisations (need to ensure all stakeholders are aware, understand and support the proposed approach).
    - A phased rollout rather than a big bang approach will be the approach for the go live of this service
    - Transition planning is key and should be tested and robustly challenged
    - As part of the transition planning, there should be specific planning around transfer of key data between the old and new providers. Business critical data should be identified and failure to transfer should be a go / no go issue.
    - Resourcing for procurement should not be underestimated. Key roles should be identified and filled with clear understanding of the requirements for each role and the time commitment required to deliver. The programme will use external sourcing for specialist roles where this cannot be met appropriately from within the organisation(s).

2b. Redesign Principles

In aligning to the national recommendations, a number of principles are suggested:

- The NHS 111 service will be part of an urgent and emergency care system that is able to meet the needs of the whole population, within the resources available, delivering improved quality and patient experience
- The patient will experience a service that is working as one integrated and whole system although provided by multiple agencies
- The patient will be seen at the right time, by the right person with the right skills to manage their needs, in the right place
- The patient will not experience any delay in receiving the most appropriate interventions through the whole pathway being able to respond to unpredictable fluctuations in demand
- Provide highly responsive urgent care services outside of the Accident and Emergency Department (A&E) so people no longer choose to attend A&E when they do not need to
- A single point of access to urgent care services
- Provide improved access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments
- Empower ambulance services to make more decisions to treat more patients and allow them to make referrals in a more flexible way
- Provide better support and education for people to self-care and to enable a greater use of pharmacists
- Improved utilisation of the voluntary sector.

3. The Model

Plans for achieving the vision of an integrated urgent care system will be enabled by progressing procurement of NHS 111 as a single point of entry supported by an integrated Clinical Assessment Service (CAS). A wider, joined-up approach to designing NHS 111 and the CAS will provide a more integrated, effective approach to these services.

The CAS will provide clinical advice to patients contacting NHS 111 or 999 and services, which enable patients to speak to a GP as well as providing clinical support to clinicians, such as ambulance staff and emergency technicians so no decision is made in isolation, as detailed within the Integrated Urgent and Emergency Care Commissioning Standards.

This system will be supported by being functionally integrated with all the local urgent care models that are in development with further support of the model to be achieved by the technical integration of IT systems enabling the sharing of single patient records and the transfer of calls to available services to avoid re-triage at each step. The procurement will include the telephone triage aspects of the current

out of hours' service. The face to face out of hours' service will be delivered locally but will be informed by the outputs from this model.

The model is developed in order to support navigation of patients away from Emergency Departments, when attending with symptoms appropriate for primary care intervention. It should be noted that although emergency services within the A&E departments are not part of this review, they should be positively affected by the programme, as patients attending these departments that do not require this level of expertise should be directed and treated appropriately elsewhere within the urgent care system.

The component parts of the Integrated Urgent Care Service are shown below, aspects of this will be delivered through the NHS 111 / Clinical Assessment Service (CAS) procurement and other functions will be delivered locally.

Key Principles of the new model		
	Current model	**Proposed model**
Contract	One organisation providing NHS111 for all of Kent, Surrey and Sussex OOH services for Sussex and East Surrey - IC24 • Area 1: Coastal West Sussex CCG • Area 2: Brighton & Hove CCG • Area 3: Hastings & Rother CCG, Eastbourne, Hailsham & Seaford CCG and High Weald Lewes & Havens CCG • Area 4: Crawley CCG, Horsham & Mid Sussex CCG and East Surrey CCG	A single contract with responsibility for 24/7 integrated service for NHS 111 across Sussex, and possibly larger. This may be delivered by a single organisation or (more likely) by a group of organisations working together. Access to face to face services would be delivered locally. A single contract, with a clearly designed specification, would make it easier for CCGs to hold providers to account for delivering the right outcomes and care for patients.
Clinical support	Heavily reliant on GPs for clinical support. Recruitment of GPs is increasingly difficult as there is a shortage of GPs nationally.	A range of clinical skills is available (nurses, paramedics, pharmacists and GPs) who could be used flexibly to provide clinical support. This means callers would be directed to the most appropriate clinician for what they need.
Assessment	People who require a GP urgently have to speak to at least two people (typically more) before they can get definitive clinical advice or an appointment.	People would be directed to the most appropriate service; usually by the first person they speak to.
Appointments	Some direct bookings –but patients	Direct bookings for appointments for

	usually need to hang up and call a different number to make an appointment with the appropriate service	identified services. Patients who needs are identified as best et by their GP (in hours) will be transferred to their GP surgery reception and then the processes of the practice will be used to arrange an appointment
Medical history	Services have limited access to special patient notes for people with complex health and/or social care needs, and no access to routine medical history for NHS111 or OOH	Those involved directly in patient care would have consistent access to special patient notes and routine medical history for patients using the service
Equity of access	Access to OOH services is different depending on where people live	Access to OOH services would be the same, regardless of where people live and patients would have more choice
Professional contact	Currently unclear and inconsistent access to clinicians and other professionals	One place for all professionals to go to request advice, information and contact
Signposting	Currently signposting to information or appropriate services is limited (5%)	Increase of signposting (where appropriate and safe) and advice lines with existing conditions e.g. diabetes, cancer

4. Communication and Engagement

A stakeholder mapping has been undertaken to ensure we communicate and engage properly with all relevant stakeholders, including patients and the public. The communications and engagement plan, for the programme, aims to engage and fully communicate the NHS 111/ Integrated Urgent Care programme. It will build people's trust and confidence not only in the 111 service but also in integration of urgent care services.

It will ensure the appropriate information and guidance is available in the right place, at the right time for both internal and external audiences.

Objectives

- To communicate and engage with patients and the public around the re-procurement of the pan-Sussex 111 service - **Public**
- To raise positive awareness of the 111 re-procurement and the changes GPs, Partners and Providers will see – **Clinical Services**
- To communicate and engage internally with staff across the seven CCGs, five acute trusts, three community trusts and two mental health trusts about their

role to support the 111 communications and engagement activity – **Internal Chairs, Executives, Managers and Staff**
- To enhance patients' confidence and engagement with the 111 service and ensuring their voice and experience informs the design and procurement process - **Lay Members, Patients and Public**
- To ensure patients have the information and support to make informed choices about their health care and to encourage patients to use the appropriate services depending on their health care needs – **Public**
- To increase positive awareness and understanding of the NHS 111, pharmacies and the minor injuries unit – **Public**

5. Next Steps and Recommendations

The timescales for the programme are as follows:-

Stage 1: Service Redesign • Soft market testing and development of technology options • Process mapping and pathways • Business analysis & financial modelling • Agreement of operating model and blueprint • Completion of Project documentation • Business case and service design signed off	November 2016 – September 2017
Stage 2: Procurement Readiness • Further patient engagement • Approval of service specification • Procurement Documentation • Clinical engagement	September 2017- December 2017
Stage 3: Procurement - the procurement approach is still to be confirmed • Commencement of Pre-Qualification Questionnaire (PQQ) and Invitation to Tender (ITT) procurement process • Decision regarding appropriate procurement process (most capable provider, open tender)	January - September 2018
Stage 3: Deployment • Development of deployment and mobilisation plan, stakeholder list & benefits realisation plan • Engagement of incoming and outgoing providers in order to facilitate seamless transfer • Management of go-live activities, floor walking support, bug-fix and post go-live evaluation • Management of deployment to steady state and withdrawal, based on agreed criteria • Production of a project exit report detailing actions, issues and lessons learned	September – April 2019
Go Live	1 April 2019

The recommendations to the Health Overview and Scrutiny Committee are as follows:

- **To note the progress that has been made to date with the NHS 111 Transformation and Procurement programme and related next steps.**

- **To receive a further update on the NHS 111 procurement process in December 2017**