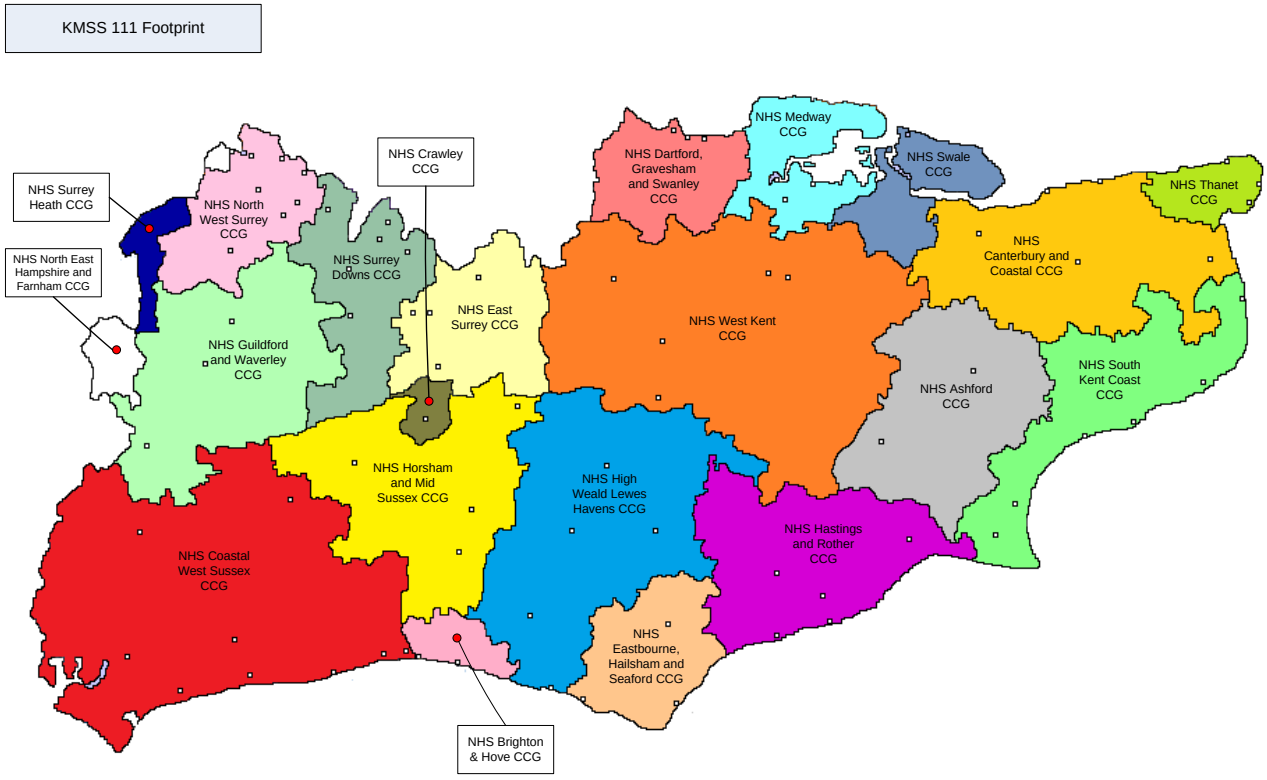
NHS 111 Transformation and Procurement Programme

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.

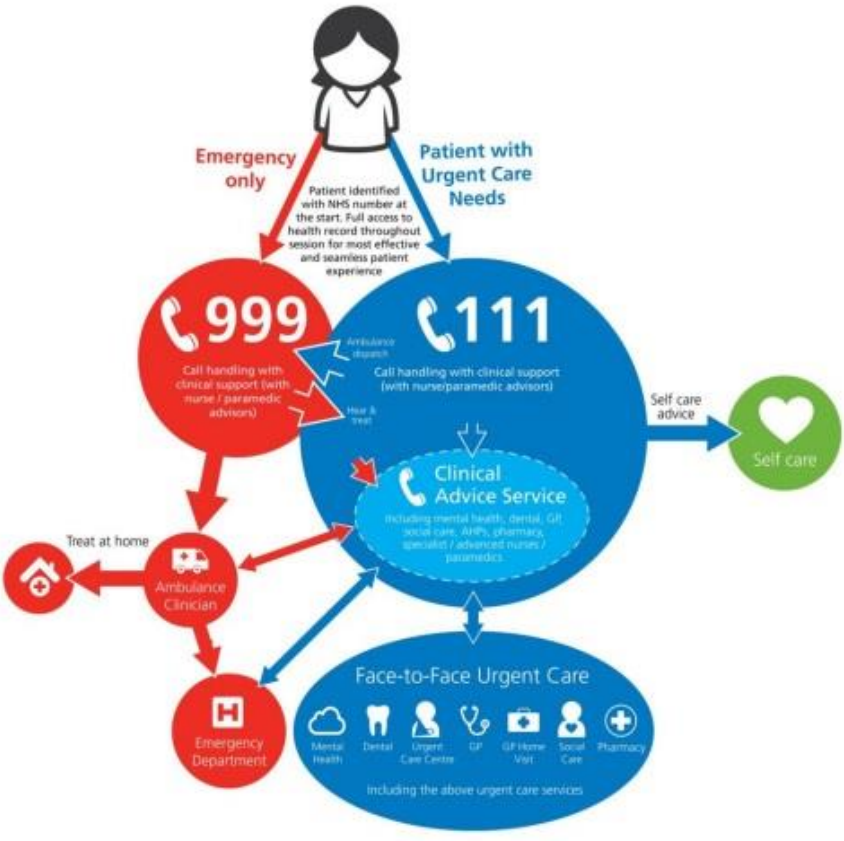


2. 111/Integration of Urgent Care Transformation Programme

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