

Getting to grips with integrated *24/7* emergency and urgent care



a practical way
forward for clinical
commissioners

NHS Clinical Commissioners

The independent collective voice for clinical commissioning groups



**Getting to grips with integrated
24/7 emergency and urgent care:
a practical way forward for clinical
commissioners**

*Produced by the NHS Alliance on behalf
of NHS Clinical Commissioners and
sponsored by NHSCB*

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*All views expressed in this document are
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This report was drafted and developed by Daloni Carlisle

F oreword

The NHS Alliance has maintained a strong focus on clinical commissioning and how it impacts on urgent care through an active Urgent Care Network as well as more recently through the collective voice of NHS Clinical Commissioners. In December 2011 we produced an extensive resource for local urgent care commissioners 'Breaking the Mould' which emphasises the importance of finding local solutions for improving integrated care for patients. We have been involved from the earliest discussions in working with the Department of Health on NHS 111. We have also prepared two NHS Alliance Discussion Papers exploring the issues involved in implementing NHS 111. In June 2011 'A new approach to 111: re-establishing general practice as the main route in to urgent care' advocated greater flexibility and explored the opportunities for a new model that put General Practice at the centre of NHS 111. In January 2012 'NHS 111: getting lost in translation?' raised concerns from CCG leaders that they are insufficiently engaged in this initiative.

We were keen to work with partners across the system to address these concerns and ensure that the implementation of NHS 111 is seen as part of developing an integrated local urgent care strategy and in July 2012 we organised two workshops, one in East Kent and the other in the North West. These sessions involved a wide range of local national partners including members of the public and patients, GPs, local acute hospitals, ambulance staff, urgent care providers, mental health staff, national advisors, Department of Health and national commissioners of urgent and emergency care.

By focussing on two very different health communities, a wide range of CCGs across the North West of England as well as four CCGs working together across East Kent, we have tried to highlight some of their learning as a way of preparing others across the country. Their debate and discussion, across a wide range of stakeholders and including enthusiasts and cynics, have helped focus on some of the key issues that need to be addressed by everyone. This report highlights the opportunities for the new clinical commissioners in developing an integrated approach to urgent care, as well as the risks if we get it wrong.

The over-riding message from both these health communities was very clear. There is a need to reinvest CCGs with ownership of the NHS 111 program by offering genuine choice in how it is delivered, taking advantage of local innovation and pre-existing developments in the urgent care arena.

We hope that this report will help focus the minds of all CCGs as they look beyond authorisation to the complex strategic issues they will need to manage in the future.



Rick Stern
Chief Executive, NHS Alliance

Executive summary

This report was developed from two meetings held by the NHS Alliance, on behalf of NHS Clinical Commissioners, in July 2012 with those involved in urgent care in East Kent and the North West. It considers the challenges and opportunities facing urgent care commissioners as they strive to develop an integrated 24/7 service while also introducing NHS 111. It offers some thoughts about what those challenges and opportunities might be and some questions that clinical commissioning groups may wish to consider.

Challenges

- * Understanding what successful implementation of NHS 111 will involve and how NHS 111 will impact on different elements of the urgent care system.
- * Improving the engagement of general practice with the urgent care agenda to support integration.
- * Ensuring that long-term conditions management is integrated into urgent care.
- * Developing metrics to measure outcomes in urgent care.
- * Developing the information systems and feedback loops to pass information between NHS 111 and the urgent care system that will support continuous improvement.
- * Sharing information about patients across the integrated urgent care system and getting the IT systems right.
- * Addressing perverse incentives in the existing system that reward hospital admission rather than the prevention of admission.

Opportunities

- * Using the opportunity of introducing NHS 111 to increase dialogue between all players in the urgent care system, including between providers and commissioners, and to develop a culture that is supportive of true collaboration and integration.
- * Using the opportunity of introducing NHS 111 and the Directory of Services to identify gaps in the urgent care system and stimulate innovative responses.
- * Developing consistency across the urgent care system including a common triage process and Directory of Services that includes the ambulance services.
- * Developing shared improvement plans to address known issues.
- * Defining the role of primary care in urgent care around management of long-term conditions with outcome measures and process measures, such as reducing A&E attendance or hospital admission.
- * Developing better informatics – measuring the right things and making decisions based on data.
- * Improving the care of people with long-term conditions.

Key questions for clinical commissioning groups

Moving towards an integrated urgent 24/7 emergency and urgent care system while at the same time introducing NHS 111 clearly presents some challenges. From the discussion in the North West and East Kent, the following are useful thinking points for CCGs as they embark on this journey.

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1. How well engaged are GPs in urgent care and development of a local urgent care strategy? Are they ready to innovate, especially around access?
2. How well understood is the need for long-term conditions management to be integrated into urgent care?
3. How well engaged is the CCG in the local implementation of NHS 111?
4. How well understood is the impact of NHS 111 on out of hours providers?
5. How well developed are plans for information sharing?
6. How well developed and understood is the Directory of Services? How will the CCG understand and act on the intelligence its use provides about service gaps, for example?
7. How well understood is the CCG's role in developing clinical governance of NHS 111?
8. How well developed is the financial modelling around urgent care?
9. How well understood are patient pathways in urgent care?

/ntroduction

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he Department of Health has a vision for urgent and emergency care.

“The Department’s vision for urgent and emergency care is of universal, continuous access to high quality urgent and emergency care services. In practice this will mean that whatever our urgent or emergency care need, whatever our location, we get the best care from the best person, in the best place and at the best time.”

Achieving this requires two components: fully integrated services available 24/7 and a simple way for patients to access them. Integration is

being left to local commissioners and service providers; access is being developed through the “nationally specified, locally commissioned” NHS 111 service, now rolling out across England.

In July 2012, the NHS Alliance, on behalf of NHS Clinical Commissioners, facilitated two workshops – one in East Kent and one in the North West – to consider the challenges and opportunities faced by commissioners and providers of urgent care as they strive to develop integrated urgent care services accessed through NHS 111.

Integration is being left to local commissioners and service providers; access is being developed through the “nationally specified, locally commissioned” NHS 111 service, now rolling out across England.



The case for integrated urgent care

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rgent care leads to at least 100 million NHS calls or visits a year. It represents about a third of the overall activity in the NHS and more than half the cost. Yet despite this, it has been argued that urgent care has not received the same focused attention to its organisation as has planned care¹. As a result, urgent care services are often highly

fragmented, leading to confusion among patients about how and where to access the care they need.

That seems to be changing in the light of the inexorable rise in A&E attendance and emergency admissions to hospital. In the last three years attention has turned to developing integrated urgent care services that will help prevent unnecessary emergency admissions and reduce inappropriate use of A&E and ambulance services. In 2011, for example, The King's Fund identified developing a more integrated approach to urgent care as one of its Ten Priorities for Commissioners².

The NHS Alliance and Primary Care Foundation have developed a series of resources to support the development of integrated urgent care services. In November 2011 the two organisations argued that commissioners need to focus on six crucial themes to develop integrated services:

- * Building care around the patient, not existing services.
- * Simplifying an often complicated and fragmented system.
- * Ensuring the urgent care system works together rather than pulling apart.
- * Acknowledging prompt care is good care.
- * Focus on all the stages for effective commissioning.
- * Offering clear leadership across the system, while acknowledging its complexity.

The role of the ambulance service as a lever for change is significant and should not be forgotten in the focus on the NHS 111 service. The National Audit Office June 2011 review of ambulance services³ supports this with key recommendations for a more integrated urgent and emergency care system to deliver significant overall savings. Locally this translates into collaborating with ambulance services to:

- * Reduce conveyance to hospital and therefore reducing A&E attendance where patients can be treated elsewhere
- * Reduce duplication through the use of a common triage process and Directory of Services
- * Focus on outcomes rather than processes.

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¹ Breaking the mould without breaking the system. New ideas and resources for clinical commissioners on the journey towards integrated 24/7 urgent care. Primary Care Foundation and NHS Alliance. November 2011. Download from <http://www.nhsalliance.org/press-releases/article/date/2011/11/taking-a-hard-look-at-urgent-care/>

² Ten priorities for commissioners. The King's Fund. 2011. http://www.kingsfund.org.uk/current_projects/gp_commissioning/ten_priorities_for_commissioners/urgent_care.html

³ Transforming NHS ambulance services. NAO. June 2011. http://www.nao.org.uk/publications/1012/nhs_ambulance_services.aspx



NHS 111: a brief history

"N

NHS 111 is a new service that's being introduced to make it easier for you to access local NHS healthcare services. You can call 111 when you need medical help fast but it's not a 999 emergency. NHS 111 is a fast and easy way to get the right help, whatever the time."

NHS Choices website

NHS 111 was born out of the confusion among the general public about which of the myriad urgent care services they should contact when they have an unexpected, unplanned healthcare need – and what number to call, when. It was conceived as a new, free to use telephone-based service for accessing urgent care encompassing telephone clinical assessment and advice or referral to an appropriate healthcare provider within a single contact. In addition, it was envisaged that NHS 111 would relieve some of the pressure on emergency care services, reduce duplication and inefficiency in the emergency and urgent care system and enhance the quality of service for patients.

NHS 111 was approved for use in 2009 with the first four pilots going live in 2010 and additional areas joining the programme in 2011. The Department of Health committed the NHS in England to rolling out NHS 111 nationally by April 2013. It was to be a “nationally specified, locally commissioned” service to ensure a level of consistency but with the chance to innovate within this. Local clinicians were to take the lead in planning for the roll out of NHS 111, developing a comprehensive directory of services and the associated referral protocols to underpin the service. They would determine which software to use and to take the lead in ensuring effective clinical governance and safety across the entire patient pathway, not just the NHS 111 call handling service⁴.

But very quickly stakeholders expressed concerns. Clinical commissioning groups in some areas were not ready to start this complex work. The initial evaluation⁵ showed a wide variation in the number of calls to NHS 111 that were transferred to a clinician, to the ambulance service and to A&E. The GP out of hours providers raised concerns about the impact of NHS 111 on their service. The DH has worked to address these teething problems and in June 2012, after lobbying from the NHS Alliance, Primary Care Foundation, BMA and others, secretary of health Andrew Lansley announced that CCGs in exceptional circumstances may delay the roll out by up to six months.

Local clinicians were to take the lead in planning for the roll out of NHS 111, developing a comprehensive directory of services and the associated referral protocols to underpin the service.

Today, the DH argues that the overall programme for national implementation is on course. Additionally, a survey of 1,700 users carried out by the University of Sheffield NHS 111 evaluation team showed high levels of satisfaction with the service.

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⁴ Letter from David Flory, NHS deputy chief executive to SHAs. August 2011. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129104.pdf

⁵ Evaluation of NHS 111 pilot sites. Second Interim Report, University of Sheffield. <http://www.connectingforhealth.nhs.uk/systemsandservices/pathways/news/2ndnhs111report.pdf>



The Workshops

In July 2012 the NHS Alliance, supported by the Department of Health, ran two workshops to explore commissioning coherent integrated 24/7 emergency and urgent care – one in East Kent and the other in the North West. Around 100 people attended, including health professionals, senior managers, service users and patients. They came from patient representative forums, primary care, acute care, community services, social care, clinical commissioning groups, ambulance services trusts and ambulance service commissioners and out of hours providers. The meetings aimed to develop understanding of what helps better integration of urgent

care, what gets in the way and what people can do about it.

The meetings took place against the backdrop of a service in flux. In addition to the wider NHS reforms, the QIPP agenda, the development of CCG capacity and capability and the need to manage the ever increasing demand on A&E services and ambulances, both areas were in the throes of implementing NHS 111.

Just one month prior to the meeting, South East Coast Ambulance Service (SECAmbs) and the OOH provider Harmoni were named providers for NHS 111 in Kent, Sussex and Surrey. East Kent has been an integrated care pilot looking specifically at the primary/secondary care interface since 2008. Work was also underway by clinical commissioning groups to refresh the urgent care strategy for East Kent in place since 2009.

The picture across the North West was more varied. Those people from Lancashire were looking back over their experience with an NHS 111 pilot; people from other parts of the region were looking at how to develop the service ready for April 2013. Additionally, work was underway to develop local urgent care strategies.

Despite the different local contexts, each workshop identified a similar range of challenges and opportunities.

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Challenges for developing integrated urgent care

Include long-term conditions in the urgent care strategy

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n urgent care strategy seeks to avoid unnecessary hospital admission, A&E attendance and ambulance dispatch and move more care to the community. It is based on understanding the interdependencies within

the system and must include care of people with long-term conditions. This in turn places general practice at the heart of urgent care and implies a need for "primary care 24/7".

"I do not think you can separate long-term conditions care and urgent care."

The consensus from the group was that improving urgent care required them to look at the whole urgent care system, not just its constituent parts. They recognised a need for services to be more closely integrated and suggested that this would require partnership working.

"We will not reduce admissions if we do not change the urgent care system."

But they warned that there were several barriers, including:

- * Silo mentality;
- * Perverse incentives that reward hospitals with income for A&E attendances but not for avoiding them;
- * Lack of an IT-enabled shared care record across the system;
- * The difficulty of co-ordinating care across a pathway with multiple providers.

"Each individual provider of urgent care works very well – the out of hours service, the rapid response nursing teams, the GP appointments – but it does not seem to flow for the patients. They stop and start across the system. Throw mental health issues in as well and it falls apart completely. We need to make the system flow more smoothly."

"We know people are being admitted to hospital because secondary care do not understand the infrastructure in the community."

"How do we bring the different players in the system together? I have not seen anyone nail this across urgent care."

"The current environment drives competition between commissioners and providers. If you commission across a pathway, how do you allow providers to get a share of the work? We need a culture of trust and support."

"We feel as if we are pitched against each other when what we all want is shared risk around the finance and collaboration."

Empowering patients

There was agreement at the event that patients need support to manage their own care better, especially in long-term conditions. This would not only improve outcomes but also reduce demand on urgent care services.

"A lot of people turn up in the urgent care system because they do not feel confident about looking after their own long term condition or their children's health. If we can somehow turn that around so people feel more confident we will reduce demand on the system."

Are GPs ready to engage?

There were different views about GPs' readiness to engage in an integrated system or with the notion of primary care 24/7.

On one hand, there was a feeling that the move to clinical commissioning and the focus that NHS 111 is bringing to urgent care is an opportunity for innovation and integration.

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GPs at the event were passionate about their role in urgent care and recognised that their role in supporting people with long-term conditions was a crucial element of reducing or managing demand for urgent care.

"The majority of people with long-term conditions do not want to go to hospital so how do we find a safe system? If we provide the right care in chronic disease management then urgent care will not be nearly so difficult."

"There is a real opportunity for clinical GP engagement."

On the other, there was feedback about the lack of engagement by some GPs in urgent care systems. In some cases this was because they were simply too busy; in others it was felt that there was a lack of tangible opportunities. There was also concern expressed that many GPs have abrogated responsibility for out of hours care entirely to out of hours services and this diminished their understanding of and engagement in the wider urgent care system.

"One of the things that is affecting my world is the complete removal of the responsibility that GPs have to contributing to work in the out of hours period. I am not arguing to a return to the old days but we need something to support GPs in their decision to contribute to working in out of hours."

"When patients ring 111 and the result is that they need to see their GP, there is no right for 111 to give the patient an appointment. The call closes with 'you need to see your GP' but sometimes they have already tried that. We must sort out access in primary care. Sometimes access is poor because practices are not doing it well. Mostly it is because general

practice is under pressure. We need to innovate in general practice."

Others at the meeting came at the topic from a different angle. There was an assumption in much of the conversation that urgent care deals with "middle England" – the people who are articulate and know their way around the system. But what about disadvantaged groups such as elderly people with cognitive impairment? They too need to understand how to access services, which implied a role in urgent care for the voluntary sector.

Lack of data and lack of rigour in urgent care

Currently too little is understood about the demand for urgent care and too little attention is paid to using the evidence base either to plan or to improve services. There was a call for:

- * A public health urgent care needs assessment.
- * Evidence based interventions.
- * Strategic finance modelling.
- * Improved contract and project management skills.

"We need a public health urgent care needs assessment so that we can commission not on anecdote but on evidence."

"I am concerned about the poor quality of project management and lack of experience of commercial matters. We end up with poor quality projects as a result."

Developing common metrics and using information

The different parts of the urgent care system each have different performance measures. In A&E there is the four-hour wait; out of hours services have time responses built into their contracts as do ambulance services. There is a need for common metrics across the system.

"It is important that we have a common way of measuring this system. Are there a few simple measures that would work across the system?"

The information systems and informatics across urgent care is highly variable. Primary care and out of hours services, for example, have good information captured in electronic systems. Community services have much less well-developed IT and datasets. Integrating urgent care demands good information systems and sharing of information, not least to understand where there are gaps and bottlenecks in the system and whether this is down to lack of capacity or capability.

Sharing patient data was felt to be very important. Currently it is impossible to track the patient journey through urgent care at an individual level as each provider codes patients in different ways.

Information sharing

Sharing patient data was felt to be very important. Currently it is impossible to track the patient journey through urgent care at an individual level as each provider codes patients in different ways. It is possible to track a patient's journey in the ambulance, then in hospital, and then in community or primary care services but not to join this up. End of life care plans are not shared across the system, for example, so patients can end up dying in hospital rather than at home when simple communication about their needs might have prevented this.

Urgent care needs to look creatively at information governance, clinical governance and to think creatively about building services around patients – and to do this requires shared information.

Financial risk sharing

This was felt to be a real obstacle to innovation. Acute providers have no financial incentive to avoid hospital admission as they are paid for activity. The group felt there was a need for new financial risk sharing mechanisms.

"One of the things that gets in the way of innovation and transformational change is the lack of financial risk sharing. We get so entangled with the money that it stops us from achieving what we want. We have the ideas but it is how to put these into practice?"



Challenges to successfully implementing NHS 111

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any people felt that NHS 111 was “a good idea” or “the right thing to do” but there was anxiety around how well patients and GPs understood the concept. People working or living in areas that had yet to implement NHS 111 were worried that its launch would lead to a surge of activity and recognised the need to be prepared. Some of the anxiety seemed to stem

from a fear of the unknown as experts on hand were able to answer some of the more straightforward questions from the floor.

“People do not understand it. I would say 99% of the general practices in my area have no idea what’s coming.”

“From a patient point of view, urgent care is very confusing. You have walk in centres, A&E, community access. Something that simplifies this is a good idea and if NHS 111 enables that signposting to be clearer then it is a good thing. But I suspect the public know nothing about it and we need to get the messages out there.”

"My big concern about NHS 111 is to know whether the system will be able to cope. There is potential for a surge in activity and I am not sure that's well understood. The last thing we need is to introduce 111 and for it to be a disaster. It must be carefully handled."

"It is happening on April 1 2013. What is going to happen and what are the implications and are we anywhere near ready?"

"We are clearly not ready but have a plan to get ready."

"The underlying theme here is that NHS will put up a lovely front door with nothing behind it – like a Hollywood set. So surely we need to make sure that the outputs are clearly defined and well understood, and that a multiagency project team is established to make sure that each organisation delivers on milestones. This will ensure that your fears are not forthcoming and that the front door opens on an established directory of services, where every provider understands what they are doing, and what customers want at the times they want to interact with the services."

There were a multitude of questions at both workshops about how calls to NHS 111 will be handled. Will callers get to the right service to meet their needs? Will those services open at the times people need them? What happens at the interface between in hours and out of hours services? Can NHS 111 integrate existing care plans, for example end of life care plans in which people express a wish to die at home? How will commissioners respond when NHS 111 identifies gaps in existing provision? Getting this right implied better co-ordination of urgent care.

A repeated theme was the impact on out of hours services that receive the bulk of referrals from NHS 111. The lesson from pilot sites was very clearly to involve OOH early in setting up NHS 111 services to understand and mitigate the risks.

"Success for me would be that NHS 111 does not destabilise out of hours. We are on a block contract and if calls go up 30%, as has been reported, then we are in big trouble."

However, there was some optimism that NHS 111 will stimulate service improvement and innovation.

"NHS 111 is a positive force for change. It is shaming a lot of the urgent care system and helping to drive change and improvement as well as integration. It fosters great team working by getting people to talk to each other, sometimes for the first time."

"The best thing we will get out of NHS 111 is data. When a patient goes to 111 they are given a code and a detailed level of coding; it's like a bar coding exercise. We will be able to

work out what is going on in the system and what you need to be providing. The data will revolutionise urgent care."

"We see NHS 111 as an enabler to help us address issues that we are already aware of."

The perceived challenges were broadly identified as:

- * The short timescale;
- * Complex contracting for commissioners across the urgent care system and similarly complicated accountability;
- * Developing the Directory of Services – who will be responsible for developing it and how will it be kept up to date to reflect day to day changes in services?
- * Developing outcomes and key performance measures as well as the associated metrics;
- * Whether there will be services available to meet the needs of people calling 111;
- * Impact on OOH, ambulance service and A&E, with each sector fearing a surge in demand with the introduction of NHS 111;
- * Managing expectations.

Where does NHS 111 fit in an urgent care strategy?

NHS 111 has its place in an integrated urgent care strategy as an overlay helping to signpost people through the system to get the right care at the right time. Unless the system is easy to navigate and use, patients will continue to use A&E.

"We see lots of hope invested in NHS 111 – that it will revolutionise services on the ground. But it can only work with the services that are already there. If all you do is introduce 111 without trying to address things like making sure your

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services are responsive, it will not give you the result you hoped for."

"111 is just a telephone number. It is what lies behind it that is important and how it operates as part of an integrated, 24/7 urgent care system."

"If people go to A&E because they cannot get an urgent GP appointment, if they call NHS 111 and all the call handlers can do is refer them to A&E, then nothing changes."

"How can it be as easy to treat someone in the community as it is to send someone to A&E? Until we do that, people will continue to send patients to A&E."

"Will 111 call handlers have a system to refer to seven days a week? Or just five days a week and sometimes only until 5.30pm?"

Continuity for the caller

One challenge discussed concerned continuity: will the patient calling NHS 111 find themselves passed from pillar to post and end up frustrated? Or will they get a coherent response to their needs where they are directed to the right place at the right time? Will they have access to advice from health professionals in the same way as provided by NHS Direct?

Representatives of NHS 111 teams at the meetings agreed that continuity was a difficult issue and one that would require early and meaningful engagement from providers and commissioners.

"One of the features of NHS 111 is the wide range of requests coming in, whether it is about health information that would previously have gone to NHS Direct or people who require a visit to their GP. Our staff need to be supported in managing these calls and we are aware that we do not want to produce a system where we pass the patient on. That may not be the same as bringing other people in to maintain the continuity. We have a lot of work to do and this is the moment for engagement. We want to engage now at this early stage to get a service that is right for patients from the get go."

Dr Jane Pateman, medical director, SECAmbs

Consistency of services

One of the issues highlighted repeatedly across England by the Emergency Care Intensive Support Team is lack of consistency of services. As Dr Sally Herne, ECIST intensive support manager pointed out: if you have six minor injuries units all with slightly different offerings and slightly different opening times, referral to/deflection from A&E tends to operate on the basis of the lowest common denominator. It is also difficult to complete a handover in any timely way.

She also highlighted complexity of services, recalling the story of a GP presented with an elderly patient who was insulin dependent and lived alone but had broken her arm and was unable to inject herself or carry out basic daily tasks such as cooking and dressing. The GP had ten minutes between appointments to find a community service that would pick up the referral. In each case the response was "that's not us" and by the end of the ten minutes no solution had been found for the patient. This anecdote illustrated the need to simplify existing services, she suggested.

"If you cannot pass someone on and know that they will get a good solution in ten minutes then the system is too complex."

Dr Sally Hearne, director, ECIST

Capacity management

NHS 111 is likely to be the first point in the NHS to see demand building up in the system – for example by experiencing a surge of calls in a flu outbreak. Work by ECIST suggests that the ability to escalate early to meet rising demand is the most effective way of preventing bottlenecks building up.

Impact on out of hours providers

Another recurrent theme was the impact of NHS 111 on out of hours providers, with some evidence presented from both national and local perspectives that there are both positive and negative impacts. Inevitably, the change from out of hours providers taking calls direct to the NHS 111 scenario, in which calls go first to NHS 111 then to out of hours as appropriate for clinical assessment, changes the focus of out of hours services. Some sites have found this helpful and others not.

Out of hours providers were concerned that there was insufficient evidence for them to predict the impact on local services and therefore little capacity for planning. The final report of the pilot site evaluation by Sheffield University is therefore keenly anticipated.

One issue to consider was whether to allow 111 to book direct into GP OOH services or to keep booking with the GP OOH service.

"If we shift stuff into the OOH period because that's where people have landed after their 111 call there will be a significant impact. You only have to have a small increase in calls to OOH services to see a big effect downstream."

"We know that the majority of calls made to NHS 111 land in OOH. We have major worries about whether we will be able to provide a healthy service."

Getting the Directory of Services right

The Directory of Services – the DoS – underpins NHS 111. It lists the local services and the skills they have on hand as well as their opening hours and contact details. Call handlers receive an incoming call from a member of the public and ask questions guided by an IT-based clinical assessment system. This identifies the clinical skills that are required to treat the caller, enabling the NHS 111 call handlers to search the DoS for the local services with the necessary clinical skills available. Patients are then directed to the best-placed local service to meet their needs.

The consensus at the meetings was that a reliable, up to date and relevant DoS is essential to the success of NHS 111. Discussion around the DoS included the issues of how to make sure it is populated by relevant local services that have the capacity to respond. Call centres in NHS 111 are likely to be regional – and therefore cannot rely on call handlers having any knowledge of local services. The issues of consistency, continuity and demand management also feed back into the DoS. If services are variable or there are gaps (for example, the district nursing day staff finish at 5.30pm but the night shifts do not start until 7pm; or the only nurse able to catheterise patients in the community hospital works Monday to Thursday and every other Friday), this will limit the ability of call handlers to refer patients to the right place for the right treatment at the right time.

One concern centred on whether the DoS could or should be updated real time. Providers must be aware of the need to update the DoS with the latest information – for example staff sickness limiting their capacity to respond. Those with experience of managing a DoS in pilot sites shared their experience of dashboards which show green, amber and red warnings for services.

“It has to be real time system and providers need to be aware of the need to update the DoS otherwise we will become headless chickens.”

The advice from those with experience of NHS 111 was clear: commissioners must ensure proper resources are allocated to developing the DoS and maintaining it.

The question also arose of whether the DoS should include “softer” services for callers with a non-urgent need who nevertheless required a response such as third sector support services. On the whole this was felt not to be the right approach.

“There is a danger that if we include these services on the DoS that we are setting the bar so high it becomes the meaning of life and everything. We would be setting ourselves up to fail.”

Can NHS Pathways be changed to suit local needs?

Concern was raised about the ease of tailoring NHS Pathways (and by implication other NHS 111 call handling software) to suit local needs. One anecdote involved a pathway in which a patient is asked about pain in the back designed to elicit information related to a serious condition that would require an ambulance. However, the pathway also dispatched an ambulance for a young man who had cricked his back playing football. There was a desire to understand how such situations might arise and how to tweak the clinical algorithms – but a recognition that this was difficult and time consuming. There appeared to be low awareness of the existence of the clinical structure, safety and governance arrangements that exist nationally within NHS Pathways⁶.

Where does social care fit in?

This was a subject around which there was little or no clarity. There seemed to be no mechanism for referring 111 callers to social care yet there was a perceived need for this to happen and an acknowledgement that this was desirable but may take time to deliver. It is important that same day access to re-ablement services is part of the offer of the council and, for short-term interventions crucial to avoiding admission / re-admission, there is not a bureaucratic process for approving new packages.

“Social care is fundamental and social care leads have not been involved. It will require a huge culture change to involve social care as they do not regard themselves as an emergency service. If they have to respond urgently it will require a huge change.”

“NHS 111 will start to flesh out where we have not got responsive social services but this will not be sorted by April 2013. It is an evolution.”

⁶ For more detail see <http://www.connectingforhealth.nhs.uk/systemsandservices/pathways/about/clingov>



Some useful lessons from the national pilot sites

Getting ready for NHS 111

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hil Bastable from the Department of Health NHS 111 team, made some points about readiness for NHS 111:

- * NHS 111 is nationally specified but locally commissioned, giving room for local innovation and variation.
- * Success depends on stakeholder engagement.
- * Pre go-live testing is vital.
- * NHS 111 will not work without an accurate, robust and comprehensive Directory of Services. Spend time and effort developing it.
- * Spend time and effort resolving the IT interoperability challenges.
- * The marketing strategy is key.
- * It takes time to embed NHS 111. Call handlers need time to gain confidence; ambulance services need time to understand the impact of NHS 111 being able to dispatch ambulances immediately; A&E departments need time to understand the impact on their service.

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- * Clinical commissioning groups need to manage their expectations around seeing immediate savings and benefits.

Lancashire went live with NHS 111 on 29 November 2011. It is a large area, population 1.3m, with a complex array of existing urgent care services. Chris Endersby, programme manager for NHS 111 in the North West, made the following points about readiness for NHS 111:

- * Urgent care providers need to have confidence that NHS Pathways will direct people to the right place. Commissioners and NHS 111 providers need to develop this confidence, for example through visits to GP practices.
- * There is a need to work closely with providers of urgent care, especially out of hours providers who will receive the bulk of the referrals from NHS 111. Each OOH provider works differently, and each will have specific information requirements. Anecdotally, the introduction of NHS 111 has seen a surge in demand for OOH services, possibly because of marketing and the ease of making contact. This all needs to be understood and managed.
- * Make sure the IT works.
- * Carry out end-to-end testing with urgent care providers.
- * Encourage feedback and respond to it.
- * Address “noise” in the system and make use of clinical advisory groups to do this.
- * Ensure proper resources are allocated to developing the Directory of Services, maintaining the DoS, information governance and clinical governance.

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The opportunity for innovation

A

repeated theme throughout the meetings was the opportunity for innovation that would come from clinically-led commissioning developed under the umbrella of an urgent care strategy. The consensus was that NHS 111 offers the opportunity to gather information about gaps in the urgent care system and to commission new

or innovative solutions. Primary care and management of long-term conditions must be at the heart of a collaborative approach.

The opportunities identified included:

- * NHS 111 is in its early stages and providers are actively seeking to engage as widely as possible. Commissioners and providers should take full advantage of this.
- * Engaging early with NHS 111 offers the opportunity to share in developing the crucial clinical governance and information governance – not just for today but moving onwards.

A repeated theme... was the opportunity for innovation that would come from clinically-led commissioning developed under the umbrella of an urgent care strategy. The consensus was that NHS 111 offers the opportunity to gather information about gaps in the urgent care system and to commission new or innovative solutions.

- * The introduction of NHS 111 will bring a new level of data to urgent care services. This will be made best use of if an information sharing culture can be established bringing in general practice, ambulance services, A&E and community care. This will enable service providers and commissioners not only to identify gaps but also to plan services and develop risk stratification. Ideally, urgent care services want to track patients through their urgent care journey.
- * NHS 111 may highlight access issues in general practice and stimulate the wider use of interventions such as telephone consultations.
- * Removing perverse financial incentives will help support commissioning alternatives to hospital care.
- * Introducing financial modelling will support commissioning of cost effective services that add value.
- * Developing the DoS as a joint enterprise across the urgent care system will enable commissioners to understand where appropriate services should sit and support intelligent commissioning that ensures patients receive the right care in the right place.

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Key questions for clinical commissioning groups

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oving towards an integrated urgent 24/7 emergency and urgent care system while at the same time introducing NHS 111 clearly presents some challenges. From the discussion in the North West and East Kent, the following are useful thinking points for CCGs as they embark on this journey and explore how best to engage, understand and develop their plans.

1. How well engaged are GPs in urgent care and development of a local urgent care strategy? Are they ready to innovate, especially around access?
2. How well understood is the need for long-term conditions management to be integrated into urgent care?
3. How well engaged is the CCG in the local implementation of NHS 111 ?
4. How well understood is the impact of NHS 111 on out of hours providers?

Moving towards an integrated urgent 24/7 emergency and urgent care system while at the same time introducing NHS 111 clearly presents some challenges.

5. How well developed are plans for information sharing?
 6. How well developed and understood is the Directory of Services? How will the CCG understand and act on the intelligence its use provides about service gaps, for example?
 7. How well understood is the CCG's role in developing clinical governance of NHS 111?
 8. How well developed is the financial modelling around urgent care?
 9. How well understood are patient pathways in urgent care?
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How well engaged are GPs in urgent care and development of a local urgent care strategy? Are they ready to innovate, especially around access?



C onclusion

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here are both challenges and opportunities ahead if urgent care is to move beyond being a response service to one that actively prevents costly admissions and A&E attendance. The greatest challenge perceived is the task of integrating urgent care across primary, secondary and community care. Primary care must maintain a central role in delivering urgent care and that getting urgent care right is to a large extent dependent on getting the care of people with long-term conditions right.

There is some anxiety around the impact of NHS 111 both in the short term if demand surges as a result of publicity about the service and perhaps longer term on the service level that out of hours providers will be able to deliver if they are negatively impacted by NHS 111.

However, there is also optimism that NHS 111 and the advent of clinical commissioning will present opportunities for innovation that, if grasped, will see the transformation of urgent care into an integrated, 24/7 service that is easily accessible.

R

esources

NHS ALLIANCE URGENT CARE NETWORK

This website offers a wide range of papers and updates to support members and influence national policy.

GUIDANCE FOR COMMISSIONING INTEGRATED URGENT AND EMERGENCY CARE: A 'WHOLE SYSTEM APPROACH'

This report was published by the Royal College of General Practitioner's Centre for Commissioning and is a guide for commissioners.

DEPARTMENT OF HEALTH URGENT AND EMERGENCY CARE WEBSITE

This website brings together the Department of Health's policy on urgent and emergency care.

EMERGENCY CARE INTENSIVE SUPPORT TEAM

ECIST – part of the NHS Interim Management and Support unit – focuses on improving performance, quality assurance and programme enhancement in NHS emergency and urgent care. Assignments typically include working with local health communities jointly to diagnose areas for performance improvement; supporting implementation planning and delivery; and transferring knowledge to produce sustainable and resilient solutions. The website contains information and publications.

NATIONAL AMBULANCE COMMISSIONERS GROUP

The NACG is supported by the NHS Confederation and brings together the lead commissioners and contract holders for each of the ambulance services in the UK. It has produced a policy paper on achieving integrated unscheduled care available through this website.

PRIMARY CARE FOUNDATION

The Primary Care Foundation was established to support the development of best practice in primary and urgent care. This website offers a range of tools and published resources as well as information about benchmarking out of hours services.

Our collaborators

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Mark Jones, Chair of the East Kent Urgent Care/LTC Integrated Care Board and Nigel Wylie, Chief Executive of Urgent Care 24 who helped chair the meetings in East Kent and the North West respectively.

Mark Docherty, Chair of the National Ambulance Commissioners Group

Mark Spencer, GP Mount View Practice, Fleetwood and Medical Director, FCMS

Neil Kennett-Brown, Director of London Ambulance Commissioning

Russell Emeny, Stephen Duncan and Sally Hearn of the NHS IMAS Emergency Care Intensive Support Team

Chris Boyce, Strategic Relations Director for NHS 111 at the Department of Health

Ray Montague, founding director of Brisdoc Healthcare Services

Peter Thomas, Urgent Care Lead, NHS Bury

Chris Endersby, Programme Manager for NHS 11, NHS North West

Phil Bastable, Department of Health NHS 111 team

Katie Marr, Project Manager for NHS 111 Implementation, South East Coast Ambulance Service

Daloni Carlisle, freelance journalist, who helped draft and develop this report

And all the people who attended and shared in this lively discussion.

About NHS Alliance and NHS Clinical Commissioners

N

NHS Alliance is the leading independent voice for primary care, bringing together patients, frontline staff, providers and commissioners bound the common values of the NHS. Its core purpose is to work collaboratively to improve health care within a sustainable NHS, facilitating new and better ways of delivering services through its networks and campaigns. It welcomes patient-focused organisations and individuals of all disciplines, representing them to government and its agencies to influence policy in the interests of all its members.

N

NHS Clinical Commissioners (NHSCC) is a new membership service that is being established to give clinical commissioners a strong, independent collective voice. It is being set up by a coalition of the NHS Alliance and the National Association of Primary Care in partnership with the NHS Confederation.

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info@nhsccl.org

01777 800647

NHS Alliance www.nhsalliance.org

NHS Clinical Commissioners
The independent collective voice for clinical commissioning groups

