NHS
West Kent
Clinical Commissioning Group

Re-procurement of the West Kent Out-of-Hours service

October 2014

Patient focused,
providing quality,
improving outcomes

1. Purpose of the report and summary of key issues

This report outlines the process for the re-procurement of primary care services that delivers urgent and emergency care. The key issues and actions for note are:

- Part of the new model of primary care defined by mapping the future will include redesigning the traditional out-of-hours service so that it becomes an integral part of new primary care rather than a separate element.
- In order to comply with NHS financial regulations and competition rules, NHS West Kent CCG is required to re-tender West Kent out-of-hours provision.
- NHS West Kent CCG currently commission three core primary care services that deliver urgent and emergency care. They are an out-of-hours service, an enhanced rapid response service, and GPs working in A&E to see and treat primary care type patients.
- The CCG proposes to combine these services into one contract in order to improve integration and reduce fragmentation. This will enable us to treat patients with the best care in the best place in the fastest time.
- The main focus is on provision at A&E as the aim is to provide services to patients in a way that matches people's behaviour. West Kent is seeing a year on year increase in the numbers of A&E attendances with the majority of activity between 9.00am – 7.00pm. It may therefore be the case that there will no longer be out of hours bases in Tonbridge, Sevenoaks or Cranbrook, though the provider of the new service will need to demonstrate they can meet all the needs of the West Kent resident population.
- A service specification has now been drafted for consideration

2. Current Service Provision

NHS West Kent CCG currently commissions three core primary care services that deliver urgent and emergency care. These are an out-of-hours GP service, an enhanced rapid response service to support people with acute medical conditions in the community and GPs working in A&E to see and treat primary care type patients.

The current contract for out-of-hours is provided by IC24. The service has bases at Maidstone A&E department, Tonbridge Cottage Hospital, Cranbrook Community Health Centre and Sevenoaks Minor Injuries Unit. These centres are open between 6.30pm – 9.00am on any day from Monday to Thursday and between 6.30pm on Friday and 8.00am on the following Monday (so open throughout the weekend) and also between 6.30pm the night before bank holidays until 8.00 am on the next working day. In 2013/14 a total of 41,486 patients accessed out-of-hours services, in West Kent, with approximately 40 per cent of patients receiving telephone advice, 50 per cent being treated at the out-of-hours treatment centres and 10 per cent treated at home.

Kent Community Health NHS Trust (KCHT) is currently commissioned to pilot an enhanced rapid response service (ERRS). The enhanced rapid response supports people (particularly those who are frail and elderly) who have acute medical conditions which can be treated safely and effectively in the community. Patients are admitted into a virtual ward following clinical assessment within two to four hours of referral and the service is available 24/7.

The enhanced rapid response service is an integrated service being delivered by the community and acute trusts and the workforce includes consultants, medics, enhanced practitioners and therapists. There are robust pathways with A&E, GPs, community nurses, community hospitals, social services, the mental health trust, out of hours, the ambulance service and voluntary sector including hospices and the dementia crisis service. From November 2013 to July 2014, they received a total of 3,774 referrals. The care provided by the ERRS team meant that these patients could be treated and remain at home, with a range of conditions that would normally result in a hospital admission. These include cellulitis, urinary tract infections and COPD.

The GPs in A&E see and treat patients who are assessed as appropriate to be seen by primary care. These are patients arriving in the A&E department by their own efforts who are assessed by the A&E triage nurse as suitable to be seen by the GP in A&E. The GPs also advise patients on alternative, more appropriate services (particularly primary care) that they could have contacted and how they can be accessed.

The contract for West Kent out-of-hours provision is coming to an end. In order to comply with NHS financial regulations and competition rules, NHS West Kent CCG is required to re-tender West Kent out-of-hours provision.

3. NHS West Kent CCG Strategic Direction

A key aspiration of the NHS West Kent CCG Strategy, Mapping the Future, is to develop a new model of primary care. Part of that new model will include redesigning the traditional out-of-hours service so that it becomes an integral part of new primary care rather than a separate element. The aspiration is that they will take on a wider range of functions supporting GP practices and will include supporting the provision of in-hours urgent care, incorporated within GMS and PMS contracts. This will include multidisciplinary teams providing urgent care flexibly, for patients who require urgent or emergency care, such as primary care type patients who attend A&E.

The CCG are working towards delivering a network of integrated services that are able to treat patients in their own home or normal place of residence, preventing unnecessary hospital attendances. This includes working towards hospital at home and virtual ward models of care, in order to treat a greater number of acutely unwell and ambulatory care patients in the community.

The CCG's Clinical Strategy Group (CSG) carried out a detailed review to scope out the future model of out-of-hours provision for West Kent. The CSG wanted to consider which model is the most appropriate for urgent care services in West Kent. A comprehensive data pack was collated to help inform and guide the decision making process. The pack included information on: local need and

population changes, strategic drivers, finance, activity, performance and service and procurement options. The following options were considered:

- **Option 1:** A re-commissioning of out-of-hours services as per the current service specification i.e. more of the same with no additional services.
- **Option 2:** Commissioning a service that continues to focus on out-of-hours provision but which encompasses a much broader provision of types of care available
- **Option 3:** Commissioning a service that provides 24/7 urgent care. This service will move away from the traditional approach of providing in hours and out of hours provision separately and will provide urgent care services 24/7 through a range of schemes
- **Option 4:** Decommissioning current OOHs provision with an expectation that the activity will be managed elsewhere in the system

The CSG agreed that out-of-hours procurement should take place over two phases. For phase one the following was recommended:

- Procuring service model option 2: commissioning a service that continues to focus on out-of-hours provision but which encompasses a much broader provision of types of care available.
- For the next two years the broader provision of care will be contained to just the inclusion of an enhanced rapid response service and GPs triaging and treating primary care type patients attending A&E. These are patients who present directly to A&E and are not triaged by NHS 111
- To procure the services within one contract in order to improve integration and reduce fragmentation. This simplification of the system will improve efficiencies as well as helping to ensure patients access the right treatment in the right place
- The out-of-hours provider will need to have the IT solutions to enable access to shared care plans.

It is recommended that this service would be contracted for two years, 2015 - 2017, allowing the CCG more time for the development of phase two in which the CCG will procure a more complex and comprehensive urgent care service through a process of competitive dialogue that would engage all the key providers locally.

4. Evidence Base for the Revised Model

The entire urgent care needs of the population cannot be delivered within the same framework and resources as emergency care. It is not appropriate for accident and emergency to be regarded as the place to treat ‘anything and everything’ or for the emergency department to be the place people default to. It is, however, unreasonable to expect patients to determine whether their symptoms reflect serious illness or more minor conditions.

The growing body of evidence that primary and community teams should be physically co-located within the emergency department to bridge the gap between hospital and primary and social care and to support vulnerable patients is persuasive. The teams co-located within emergency departments should include primary care practitioners, community teams, social workers and mental health professionals[1]. Co-location enables patients to be streamed following a triage assessment. This also enables collaborative working including sharing of diagnostic facilities; reduces duplication of administrative tasks; and permits patients to be easily re-triaged should further assessment require so[2].

Evidence suggests that General Practice provides urgent care more cost effectively than A&E, where cases are appropriate to primary care. General Practice continues to deal with most of the urgent care activity during usual opening hours. There is little room, however, to increase activity in primary care, and it is currently not configured to tackle the activity out-of-hours. It has been proven, however, that effective reorganisation of primary care out-of-hours services can result in the numbers of referrals to A&E reducing and an increase in the use of out-of-hours[3].

The urgent care system is complex and often disorganised with systems that are difficult for people to understand. This can lead to fragmentation of service provision, impacting on quality of care and efficiency of the system as a whole. Healthcare organisations should be seen as conglomerates of smaller systems, a microsystem, and not coherent monolithic organisations[4]. Microsystems are defined as small, functional, multidisciplinary front line units that provide the majority of healthcare to patients[5]. There is a growing body of evidence for the effectiveness of microsystems as an approach to improve healthcare and the integration of services[6]. Excellent services are attainable in microsystems that understand what really matters to a patient and family and have the capacity to provide services to meet the patient's needs[7].

Critical to the success of a model where you have integrated primary care units within A&E units, is ensuring that services are clearly defined locally. Clear boundaries between primary care, MIUs and A&E need to be defined locally for patients[8]. In addition, commissioning a primary care assessment unit in A&E should be strategically aligned to the reorganisation of local out-of-hours services and community services that provide reactive, urgent care provision to the local community [*ibid.*].

Patients attending A&E departments with minor illnesses, which were assessed by GPs as capable of being managed in a general practice setting, make up approximately 10 – 30 per cent of the average caseload of a UK A&E department[9]. There is a growing body of evidence that a true see and treat model within A&E, delivered by primary care practitioners, can impact on waiting times and reduce

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[1] The college of Emergency Medicine (2014) Acute and emergency care: prescribing the remedy

2 NHS England (2013) The Keogh Urgent and Emergency Care Review – end of stage 1 engagement report. www.nhs.uk/NHSEgnaldn/keogh-review/Documents/UECR/Ph1Report.FV.pdf

[3] Van Uden C.J., Crebolder H.F. (2004) Does setting up out of hours primary care co-operatives outside of a hospital reduce demand for emergency care

[4] Mohr. J.J (2004) Integrating patient safety into the clinical microsystem. Quality and Safety in Healthcare

[5] Batalden, P.B. (2003) Microsystems in health care: part 9 : developing small units to attain peak performance. Joint Commission Journal on Quality and Safety

[6] Wasson, J.H (2003) Microsystems in health care: part 4: planning patient centred care. Joint Commission Journal on Quality and Safety

7 Williams., I. (2009) Clinical microsystems in the NHS: a sustainable method for improvement? Journal of Health Organization and Management

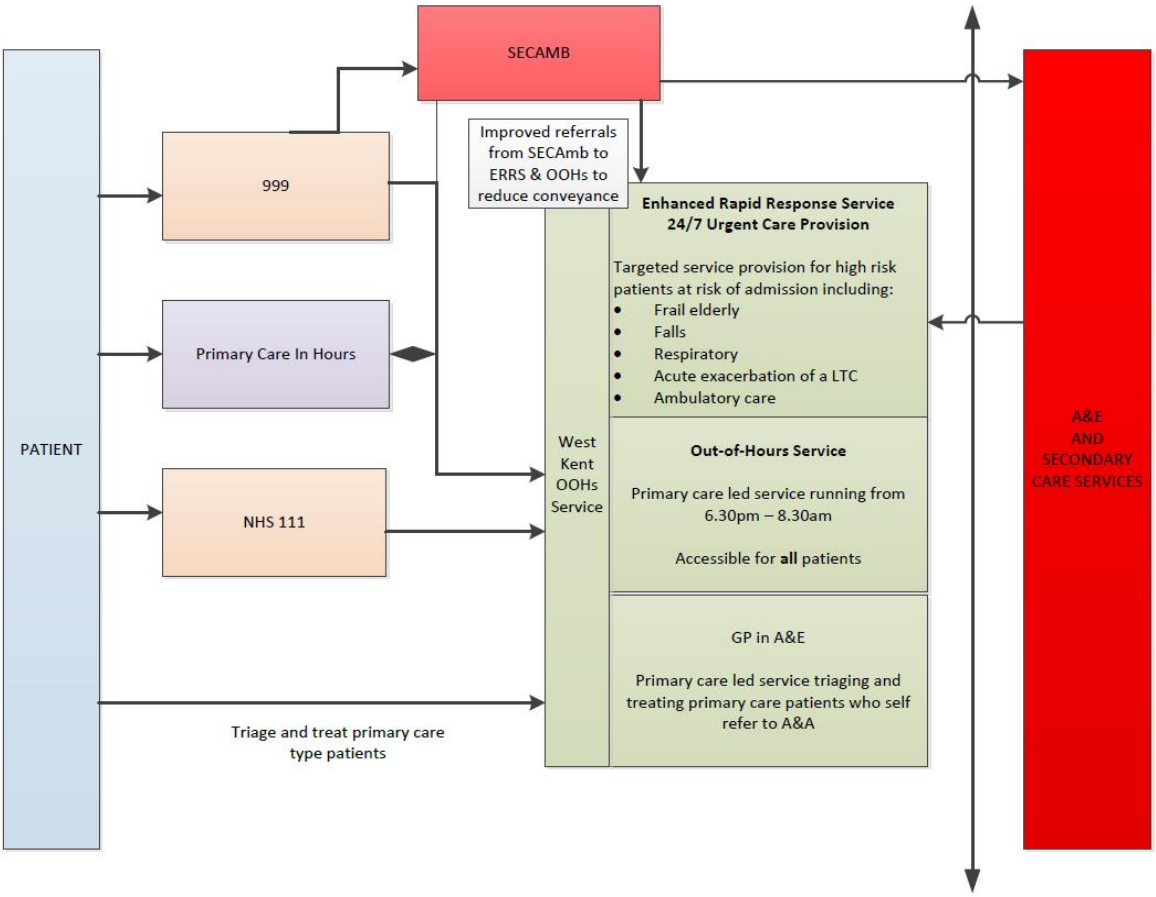
[8] Sanders J. (2000) A review of health professional attitudes and patient perceptions on inappropriate A&E attendances. The implications for current minor injury service provision in England and Wales

[9] Primary Care Foundation, DH (2010) Primary care and emergency departments

emergency admissions and diagnostics [*ibid.*]. There is also some evidence that it can result in a shift of emergency consultations from secondary to primary care[10].

Primary care can play a key role in changing culture communication and treatment within A&E. Primary care practitioners are seen to enhance emergency departments by bringing vital skills and expertise to a multi-disciplinary team, though it is important that there is a clear recognition of the skills of each group of clinicians and mutual respect[11].

5. West Kent Urgent Care Model 2015 - 2017



6. Scope of the integrated primary care urgent and emergency care service

A service specification has now been drafted, for review and sign off. The service will deliver both urgent primary care and hospital at home services for West Kent residents, through the integration of out-of-hours provision, the GPs in A&E and the enhanced rapid response service. The CCG is of the view that at this time there is no substantial alteration to current service provision, as all components of the new procurement are currently in place.

[10] Kool RB, Homberg DJ, Kamphuis HC. Towards integration of general practitioner posts and A&E departments: a case study of two integrated emergency posts in the Netherlands

[11] Kool RB, Homberg DJ, Kamphuis HC. Towards integration of general practitioner posts and A&E departments: a case study of two integrated emergency posts in the Netherlands

The team delivering the service must be multidisciplinary, in order to meet the requirements and needs of patients for both a primary care service and a hospital at home service. The service will be contracted to provide out-of-hours primary care medical services; based at primary care medical assessment units, co-located within the two A&E units in West Kent. The provider may wish to identify further community settings, for out-of-hours treatment centres, as deemed appropriate, to ensure all the needs of the West Kent population are met.

It should be noted, however, that the main focus is on provision at A&E as the aim is to provide services to patients in a way that matches people's behaviour. West Kent is seeing a year on year increase in the numbers of A&E attendances with the majority of activity between 9.00am – 7.00pm. It may, therefore, be the case that there will no longer be out of hours bases in Tonbridge, Sevenoaks or Cranbrook, though the provider of the new service will need to demonstrate they can meet all the needs of the West Kent resident population.

7. Benefits to patients

The primary care medical service element will not solely focus on out-of-hours provision but must extend to normal working in order to triage and treat primary care patients attending A&E both in-hours and out-of-hours. This will help patients with primary care treatable conditions get the right care whatever time they attend A&E and will support patient flows through the hospital during its busiest periods.

All patients who are assessed as potentially needing a hospital admission will be further assessed for suitability for the hospital at home service. These may be patients who are triaged and assessed through the primary care medical assessment units or by a health professional, triaging a patient within their own home, who refers on to the hospital at home service.

The service will also work closely with MTW's discharge teams and primary care teams to facilitate early discharge of patients, providing a step down service for patients who are assessed as being medical fit.

There must be leadership and oversight from a specialist acute physician, in order to assess and agree treatment and care plans, and provide ongoing monitoring as appropriate, for those patients who are deemed suitable for the hospital at home service. This is critical to ensure appropriate clinical governance, patient safety and quality of care is maintained within a virtual ward model of care.

The provider must ensure all appropriate support and resources are in place, including nursing and therapeutic services and prescribing, to provide the appropriate level of care for patients within the primary care medical assessment units and within the community.

Each of the services currently commissioned that the CCG is looking to integrate and commission under one contract, already clearly demonstrates good patient outcomes. Moving to a single contract will further strengthen those outcomes plus, as outlined above, it will improve integration between out-of-hours care and the enhanced rapid response service, improving outcomes for patients.

Integration of the services and co-location within the acute setting will ensure the service is built on best practice. This will direct patients to the right care, first time, reducing repetition of assessment, delays to care and unnecessary duplication of effort. This will result in the following benefits for patients

- Patients are helped to navigate the health system and directed to the service that is best able to give them the help they need, as close to home as possible
- Services built around the patient through improved integration of services across primary, community and secondary care services. This will enable us to treat patients with the best care in the best place in the fastest time
- Improved care for elderly patients with multiple health conditions who will undergoing investigation by multidisciplinary teams, not necessarily within the setting of the emergency department
- Access to specialists teams when appropriate
- Improved patient and carer satisfaction due to increased admission avoidance
- Reduction in unnecessary diagnostics

8. Procurement Process & Timelines

The CCG is in the process of giving notice to all three services currently delivering primary care urgent and emergency services. Their contracts will cease in June 2015, giving the CCG nine months to complete the procurement and mobilisation of the new service. There is a small project group overseeing the process, made up of a number of local GPs, KMCS and the CCG Urgent Care team. The project group is set up to oversee the procurement process including overseeing the following workstreams:

- Development of the service specification and required patient outcomes
- Consultation with CCG members
- Equality impact assessment
- Agreeing the financial scope of the service
- Development and delivery of a patient engagement strategy
- Development and delivery of a market engagement strategy
- Review of premises, workforce and IT
- Procurement and tender process
- Mobilisation of the new service

The CCG is currently working to the following timetable for the procurement.

July / Aug / September	Oct / Nov / Dec / Jan / Feb / Mar	April / May / Jun
Service specification development Member consultation PPG engagement	Public Engagement Market testing events Procurement	Contingency planning New service mobilisation

The CCG is currently in the process of consulting with its members on the draft specification. Following clinical engagement the CCG will also look to engage with patients and local stakeholders, including the Local Authority Districts, Kent Health Overview and Scrutiny Committee and local Providers. The feedback received from primary care, patients and other stakeholders will be used to further develop a service specification we believe will meet the urgent care needs of West Kent, with its increasing ageing population and numbers of patients suffering from multiple long term conditions.

9. Questions for Health Overview and Scrutiny Committee

- Is the CCG consulting widely enough and is there more we could be doing?
- Does HOSC believe this to be a substantial change to current service provision requiring formal public consultation?