Dartford, Gravesham and Swanley Clinical Commissioning Group (DGS CCG)

Swale Clinical Commissioning Group (Swale CCG)

Urgent & Emergency Care Programme Update

Report prepared for:	Kent County Council [KCC] Health Overview and Scrutiny Committee [HOSC] 27 January 2017
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1. Introduction

1.1 This report has been prepared by DGS and Swale CCGs to provide the Committee with an update on the urgent and emergency care programme which underwent a national pause between July and October 2015, and with an amended focus and scope than the initial work (in line with the Commissioning Standards – Integrated Urgent Care (September 2015)), has been restarted again in both CCGs since May 2016.

1.2 The CCGs have conducted initial engagement activities with GPs and wider stakeholders including patients, and voluntary organisations. Efforts at collaborative working across organisational boundaries have also been started as there is a realisation that successful achievement of the goals for urgent and emergency care lies in working together.

1.3 The CCGs propose to present the case for change and proposed clinical models to the Committee in March 2017 to determine if the Committee considers the proposals to be a substantial variation and if a period of formal consultation with the Committee is required.

1.4 The CCGs intend to embark upon a public consultation after the period of purdah ends in May 2017 as the changes to the urgent and local care models are considered to be significant enough to require this.

1.5 The Committee is asked to note the content of the report.

2. Where have we been?

2.1 In November 2013, the Keogh Review - End of Phase One Report outlined the case for change and proposals for improving urgent and emergency care services in England. The report highlighted five areas for the future of urgent and emergency care;

2.1.1 Provide better support for people to self-care

2.1.2 Help people with urgent care needs to get the right advice in the right place, first time

2.1.3 Provide responsive urgent care services outside of hospital so people no longer choose to queue in the Accident & Emergency (A&E)

2.1.4 Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise the chances of survival and a good recovery

2.1.5 Connect all urgent and emergency care service together so the overall system becomes more than just a sum of its parts

2.2 The findings of this report were further supported by the publication of the NHS Five Year Forward View in October 2014, which stated that urgent and emergency care services will be redesigned to improve integration between emergency departments, GP out-of-hours services, urgent care centres, NHS 111 services and ambulance services.

2.3 Between February and May 2015, both DGS and Swale CCGs, in partnership with Medway Clinical Commissioning Group (Medway CCG), pursued a programme of activity across North Kent which began to look at urgent care. In both DGS and Swale CCGs, patient and clinician reference groups were held and a preferred solution was identified which was based around a hub and spoke model. Swale CCG made further progress and held both a GP Engagement Event, and a Market Engagement Event.

2.4 In June 2015, DGS CCG took a local decision to pause the programme due to the recognition of the emerging impact of the Ebbsfleet development on the local health economy; an impact which required further analysis before the programme could be moved any further forward.

2.5 In July 2015, a national programme pause was applied. CCGs received a letter from Dame Barbara Hakin which focused on the need to ensure a functionally integrated 24/7 urgent care access, treatment and clinical advice service incorporating NHS 111 and out of hours. With NHS 111 previously out of scope of the urgent care redesign, programmes were paused pending publication of further guidance.

2.6 In September 2015, guidance was published within the Commissioning Standards Integrated Urgent Care, which focused urgent care redesign on the planned reconfiguration of urgent and emergency care services to enable 'commissioners to deliver a functionally integrated 24/7 urgent care service that is the 'front door' of the NHS and which provides the public with access to both treatment and clinical advice'.

2.7 In October 2015, the national programme pause was lifted, and in May 2016, the DGS CCG local programme pause was lifted.

3. Where are we now?

3.1 Since June 2016, the urgent and emergency care programme has been re-established albeit with a different scope than that which was originally used before the national pause in July 2015.

3.2 The scope of the programme now falls in line with the Commissioning Standards - Integrated Urgent Care (September 2015) focusing on the following:

3.2.1 The commissioning of NHS111 as the telephony single point of access for urgent care providing a call handling, initial triage and signposting service.

3.2.2 The provision of an Integrated Clinical Advice Service (ICAS) to support NHS111 with telephony clinical triage, multi-disciplinary team advice, guidance and referral, ensuring no decision is made in isolation.

3.2.3 The GP out-of-hours service (including base sites and home visits).

3.2.4 System interoperability to enable greater integration.

3.3 Other face-to-face aspects of urgent and emergency care services, and the points at which urgent and emergency care overlaps with the requirements and proposals laid out for the General Practice Forward View, and the Sustainability & Transformation Plans [STP], are also being reviewed i.e.:

3.3.1 Extended primary care access by March 2019 (General Practice Forward View) and provision of urgent same day bookable appointments within primary care.

3.3.2 Primary care managed urgent care service to support the acute trust to avoid unnecessary ED attendance and/or hospital admission, deliver the 4 hour ED standard and meet ambulance handover times.

3.3.3 Workforce and workload issues.

3.3.4 Increased use of technology and improved interface between general practice and hospitals.

3.3.5 Preventative support services and the ways in which self-care can be encouraged from NHS111 and ICAS without the need for a face-to-face consultation, where clinically appropriate.

3.3.6 Increase efficiency and implement demand reduction measures whilst addressing predicted growth.

3.4 To provide economies of scale, and to ensure resilience for the NHS111 and ICAS services, DGS, Swale and Medway CCGs have agreed to pursue procurement of a single NHS111 service across North Kent, that is functionally integrated with three local urgent care models (one for each CCG area). Discussions are underway to determine if the geographical scope for the telephony based NHS111 service can be extended further across Kent, Surrey and Sussex. The outcome of these discussions is not yet known.

3.5 DGS CCG has carried out a GP Engagement Event in November 2016, and both DGS and Swale CCGs hosted a whole systems engagement event on 23rd November 2016, which saw over 80 attendees from across health and social care in North Kent. The event brought together patient representatives, voluntary sector organisations, hospital clinicians, GPs, out-of-hours providers, community staff and commissioners to collaborate and discuss possible future models of care in DGS and Swale CCG areas. Presentations and workshop sessions allowed the delegates to work together to tackle issues and focus on improving patient access,

promoting appropriate health services and breaking down organisational barriers to improve patient experience. This was a positive first event, and strong commitments were made to keep the momentum going throughout the review process which is anticipated to continue throughout next year.

3.6 Opportunities to collaborate with partner organisations are also currently being explored. In DGS CCG, a co-design group has been established to explore how the acute trust can be supported to ensure that, where clinically appropriate, patients who present at the acute trust can be triaged, treated and discharged in primary care without having to access secondary care. There is a general realisation that successful achievement of the goals for urgent and emergency care lies in organisations working together. From the co-design group work other benefits of collaboration have been identified e.g. opportunities to improve recruitment and retention across organisations and these will be further explored.

4. Next Steps

4.1 By the end of 2016 to:

4.1.1 Determine the geographical scope of the procurement activities for NHS111

4.1.2 Determine the geographical scope for the provision of the ICAS

4.1.3 Agree 'go live' dates across participating CCGs and with the current providers of services

4.1.4 Ensure contracts are in place to secure seamless service provision for all relevant services so that patients are not disadvantaged in any way

4.2 By March 2017 to:

4.2.1 Further engage with the public to assist in the formation of the case for change, and in the co-design of a proposed model

4.2.2 Present the case for change and proposed model to the HOSC on 3rd March 2017 to determine if the Committee considers the proposals to be a substantial variation and if a period of formal consultation with the Committee is required.

4.3 By the end of May 2017 to:

4.3.1 The CCGs intend to will embark upon a public consultation after the period of purdah ends as the changes to the urgent and local care models are considered to be significant enough to require this.

5. Conclusion and Recommendation

5.1 The Committee is requested to note the content of this update report on the Urgent and Emergency Care Programmes for DGS and Swale CCGs and to advise on how the Committee wishes to be engaged in the future.