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NHS England Regional Directors
NHS Improvement Executive Regional Managing Directors
General Practitioner Committee
Royal College of General Practitioners
NHS 111 Clinical Leads – Regional and Local
NHS 111 Providers
Association of Ambulance Chief Executives
IUC Workforce Development Programme Inter-professional Advisory Group Members
Health Education England

25 August 2017

Dear Colleague

Next Steps on the NHS Five Year Forward View - A National Service Specification for Integrated Urgent Care Services.

This letter sets out the key actions required from commissioners of an integrated urgent care service. It also describes the Clinical Assessment Service, outlines the key measures and details the underpinning technology for integrated urgent care services. There is an attached appendix describing in more detail some of the other key requirements.

Introduction

Earlier this year, NHS England and NHS Improvement published the *Next Steps on the NHS Five Year Forward View* which highlighted the importance of delivering a functionally integrated urgent care service to help address the fragmented nature of out-of-hospital services. Our aim is to provide care closer to people's homes and help tackle the rising pressures on all urgent care services (primary and hospital)

and emergency admissions.

The opportunity to improve the patient's experience of, and clinical outcomes from, urgent care is huge. NHS England has worked to develop a new national service specification for the provision of an integrated 24/7 urgent care access, clinical advice and treatment service which incorporates NHS 111 call-handling and former GP out-of-hours services. This new specification is just the starting point to revolutionise the way in which urgent care services are provided and accessed. It is our expectation that a new Clinical Assessment Service (CAS) – accessed through the NHS 111 telephone number - will become the key co-ordinating function for all urgent care needs. The CAS will know the current demand on services and be able to direct patients to the most appropriate service which is available, including those it delivers itself. Services commissioned in this way will move us to a consistent 24/7 urgent care offer for patients.

We will be measuring the success of this new service on:

- Percentage of calls completed with the right clinical advice that avoids unnecessary visits to other NHS services.

- Relieving workload burden from GPs by resolving those matters that can be satisfactorily resolved over the telephone and where they cannot, guiding the patient into the appropriate local urgent primary care pathway. We will monitor the level of self-care dispositions and direct appointment bookings.

- Relieving the burden on A&E departments by resolving those matters that can be satisfactorily resolved over the telephone, guiding patients to urgent treatment centres or booked GP appointments where appropriate and only sending patients to A&E where the A&E is the best location for the care they need.

- Reducing the burden on 999 services, ensuring only those patients which really need an ambulance are sent one.

The specification outlines the steps that commissioners must take to deliver transformation and to move from an 'assess and refer' to a new 'consult and complete' model of service delivery.

Around the country, commissioners have adopted a range of models for the provision of NHS 111, GP Out-of-Hours (OOH) and urgent care services. In some areas a comprehensive model of integration has been implemented. More often, however, there are separate working arrangements between NHS 111 and OOH services; and a lack of connectivity with community, emergency departments and ambulance services. This position reflects the way that policy has evolved; but it no longer fully meets the needs of patients, health professionals or the wider health and social care system.

The specification recognises the vital importance of the workforce to the success of these services. There is a requirement for careful planning and implementation of the products of the joint national Integrated Urgent Care / NHS111 Workforce Development Programme which will provide a career structure for staff, supporting providers to recruit and sustain a high quality workforce, from those taking the NHS111 calls to the health and care professionals working within the CAS, enabling better patient care and high quality clinical outcomes.

Key elements of an Integrated Urgent Care Service - action required by all NHS 111 and OOH commissioners

1. Deliver 'Consult and Complete' by increasing clinical consultation to calls in 2017/18

Commissioners must ensure that as many clinically appropriate calls to NHS 111 as possible are closed with self-care advice without onward referral to primary care or community services. By the end of 2017/18 it is expected that more than 50% of calls to NHS 111 will lead to the patient speaking to a clinician within the clinical assessment service. **NHS England will assure delivery of this target through the revised Minimum Data Set submissions.**

2. Develop Lead Commissioner Arrangements

By 30 September 2017, commissioners are expected to have in place an agreement describing the organisations involved in their current, or proposed, Integrated Urgent Care Service.

3. Develop a Collaborative Provider Arrangement

Commissioners must ensure that where possible arrangements are instituted which allow collaboration between providers. This is essential in order to provide a seamless patient experience and an efficient system. These arrangements can be formal or informal in their nature encompassing contractual obligations or non-contractual documents describing inter-organisational working.

4. Model the Financial and Workforce Impacts

When planning the re-procurement of IUC, or changes to existing contracts, the financial impact across the whole urgent care system should be taken into account. Commissioners should evaluate cost savings generated by an integrated model and should model these potential savings in order to ensure the optimum IUC design for their locality. Whole population financial planning should be considered in order to get the best overall value across the STP footprint.

5. Undertake an Immediate Gap Analysis

It is acknowledged that moving to this new position from where we are now is

complex. However, as a number of areas have already achieved this, commissioners will be required to move all existing contracts to deliver this new service specification by **no later than the end of financial year 2018/19** improving patient care and service efficiency as a consequence.

To deliver full England coverage by this date, commissioners, in conjunction with their STPs, and supported by NHS England central and regional teams, are required to undertake an immediate gap analysis to establish how their existing Integrated Urgent Care Services/contracts align with the requirements of this national service specification – taking urgent remedial actions where the two are not fully aligned. **NHS England will require delivery assurance of these plans by 30 September 2017.**

6. Initiate immediate contract variations or re-procurements to deliver the new service specification

Where current NHS 111 and OOH services remain separate – commissioners must develop urgent contract variation, or procurement plans that ensure the new service specification can be fully delivered – allowing for operational lead-in times – by 31st March 2019 at the latest. However, given that this vision has already been widely communicated, there should be ample opportunity to make these variations or begin the re-procurements in the remainder of 2017/18. **NHS England will seek delivery assurance of these plans by 30 September 2017**.

7. Roll-out of NHS 111 Business Intelligence Tool - Disposition and Outcome monitoring

Commissioners must ensure that all providers of Integrated Urgent Care Services routinely provide data to support the nationally available, interactive NHS 111 reporting dashboard commissioned by NHS England, and being delivered by the North of England Commissioning Support (NECS) in collaboration with other NHSE CSUs. This will ensure commissioners have a complete understanding of NHS 111 system impact - in particular information from NHS 111 call activity through to subsequent linked secondary care activity. In relation to A&E attendance, this will allow a comparison of what patients are recommended to do by NHS 111 with what they actually do – and looking at how factors such as clinical call handling can change these behaviours.

We expect local healthcare systems to use this data, and analysis tool, to optimise local services so that only those patients who genuinely need the services of A&E go to an emergency department.

The Clinical Assessment Service (sections 5.3 & 5.4 of the specification document)

Our vision to implement a consult and complete model for Integrated Urgent Care will fundamentally change the way patients access health services. **It will mean**

patients will receive a complete episode of care concluding with either: advice, a prescription, or an appointment for further assessment or treatment.

We expect that the CAS will immediately begin the move towards being able to:

- Provide access to a wide range of clinical expertise in urgent and emergency care –in order to be able to assess a range of conditions from medical problems, to medication inquiries, to mental health and maternity issues;

- Enhance patient experience by ensuring early streaming of calls that would benefit from access to clinical expertise;

- Ensure that as many calls as possible and clinically appropriate will be managed and resolved on the telephone without the patient needing to physically visit another NHS facility;

- Clinical support will need to be scaled to offer the right level of service to patients with clinicians operating on a c*onsult and complete* basis, which will require 24/7 availability of a GP as well as other clinicians as necessary;

- Offer direct booking of those patients requiring urgent face-to-face treatment following telephone based clinical input;

    - To achieve this it is imperative for NHS 111 providers to join forces with local Out of Hours providers as soon as possible;

    - Where a booking is required to primary care within the in-hours period the booking will only come from a clinician**;**

- Offer an opportunity for a unified CAS that also supports 999 ambulance services where appropriate to do so;

- Ensure where patients needs a prescription they receive one using facilitating technology such as the electronic Prescribing Service (EPS)

Technology

To support the transformation in the role of NHS 111, NHS England, working with NHS Improvement and NHS Digital, will guide the implementation of supporting services and technologies, including:

- Urgent Treatment Centres (UTCs): Guidance on UTCs is available on the NHS England website[1]. All UTCs will be expected to have a clinical workflow system with specific ability including but not limited to:

[1] https://www.england.nhs.uk/urgent-emergency-care/urgent-treatment-centres/

- The ability to send and receive patient transfers and referrals.

- The ability to share appointment availability and receive direct appointment bookings from other Integrated Urgent Care services (including NHS 111).

- The ability to access key patient information, such as the Summary Care Record, other local care records, care / crisis plans, and key patient flags.

- The ability to offer electronic prescriptions via the NHS Electronic Prescription Service.

- NHS 111 online: In 2017 patients expect to be able to access healthcare via digital channels. As defined in the Five Year Forward View Next Steps published in April 2017, all NHS 111 services are required to have an online service in place by December 2017.

- Direct booking to primary care and urgent treatment centres: In 2017 patients expect to be able to access healthcare via digital channels. As defined in the Five Year Forward View Next Steps published in April 2017, all NHS 111 services are required to have an online service in place by December 2017.

- Prescribing from 111: Integrated Urgent Care must deliver access to medicines and devices through the issuing of NHS prescriptions. This will be achieved through integration with the Electronic Prescribing Service (EPS).

The changes outlined in this letter and the accompanying service specification are challenging, requiring a degree of organisational and cultural change. However, the implementation of IUC is an important step that we need to take to deliver the five year forward view and achieve consistently high standards for patients across the country.

If you have any queries on the contents of this letter then please contact: england.integratedurgentcare@nhs.net.

Yours sincerely

Matthew Swindells
National Director, Operations and Information

The sections below reflect some of the key headings in the new Service Specification and give additional detail of what is required for commissioners to move to the new IUC model.

The Future CAS

Over time the CAS will continue to evolve, and will:

- Manage urgent appointment bookings, providing the access point for urgent care GP appointments, allowing GP surgeries to focus on scheduled and LTC care. It will be able to book patients 24/7 into Urgent Treatment Centres and Out of Hours Treatment Centres.

- Send a text message confirming appointment details and change or cancel appointments if necessary.

- Be *the key access point* for all urgent care services including the co-ordination of near-patient testing prior to clinical face-to-face (live or virtual) appointments, and enabling all prescriptions to be electronically prescribed and delivered to house bound patients.

- Develop into a single point of access for both urgent health and social care services, becoming the coordination and delivery centre for all clinical hospital discharge support services; community IV services, home visiting multidisciplinary clinical services, mental health and will integrate all specialist care clinicians.

- Use appropriate technology such as picture image sharing ability, video consultation technology and new patient wearable technology data sharing ability to maximise the number of consultations that can be completed within IUC.

Lead Commissioner Arrangements

As stated above, it is vital that lead commissioner arrangements are implemented. An agreement should be put in place; this agreement should set out ground rules for collaboration and cooperation and describe the 'boundaries' of the service. In doing this, CCGs must also consider the lead or co-ordinating commissioner arrangement for this new Integrated Urgent Care Service, bringing commissioners together to commission an integrated service serving a wider area. Where possible IUC services should always be commissioned across a wide area (e.g. STP-level as a minimum and potentially across multiple STP footprints) using a single CCG as the Lead Commissioner.

Collaborative Provider Arrangements

The current provider system is characterised by a range of provider organisational types, with a wide range of services provided, across a mix of geographical footprints and with variation in investment levels. Commissioners should continue to promote a healthy and diverse provider market. Both larger and smaller providers will have an important part to play in delivering a successful and integrated service. However, call centre management (Erlang efficiency) and operational resilience, demonstrates that **call-handling should only be undertaken at scale**. Conversely Clinical Assessment Services are likely to be more locally based and recognisable to local clinicians.

In doing this, commissioners will need to ensure that the current provider market continues to be developed and is not destabilised in any way. There should be ample opportunity for any willing provider to meet the new service specification - particularly in collaboration with other providers. To reiterate what we have said previously, NHS England has no expectation that any organisation should merge.
In some localities OOH services are retained or sub-contracted directly by general practice. Commissioners will need to engage with those practices as part of this process in order to best achieve the aims of an integrated service.

Clinical governance

We will continue the high clinical governance standards achieved in NHS 111 and ensure these high standards are spread throughout IUC.

In particular, systems will be developed to safeguard patients (vulnerable groups) who miss appointments with an automatic cross checking process in place to monitor if patient accessed different service.