

Our Ref: BH/2015/253

Publications Gateway Ref. No. 03568

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To:

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Cc:

Regional Directors
General Practitioner Committee
Royal College of General Practitioners
NHS Alliance
NHS 111 Clinical Leads – Regional and Local
NHS 111 Providers

3 July 2015

Dear Colleague

Commissioning a Functionally Integrated Urgent Care Access, Treatment and Clinical Advice Service

As you will be aware, over last winter local health services responded to the highest ever number of NHS 111 calls, ambulance calls, A&E attendances and emergency admissions in NHS history. The NHS and its staff responded magnificently to these difficult circumstances and worked tirelessly to find solutions.

However, far too often the arrangements for access into urgent and emergency care are confusing for patients and professionals alike. It is clear that we need a fundamental redesign of the NHS urgent care 'front door': A&E; GPs; 999; NHS 111; Primary Medical Care Out of Hours (OOH); community; and social care services, as part of the broader programme of care transformation set out in Sir Bruce Keogh's Urgent and Emergency Care Review and later in the NHS Five Year Forward View. I wrote to NHS 111 commissioners earlier this year ¹ to outline how they could begin this redesign by using the work completed as part of the NHS 111 Learning and Development Programme to introduce greater clinical input to managing NHS 111 calls.

¹ Publications Gateway Reference No.02919

The current position

Around the country, commissioners have adopted a range of models for the provision of NHS 111, OOH and urgent care services in the community. In some areas a more 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 interconnectivity with community, emergency departments and ambulance services. This position is entirely understandable given the way that primary care, OOH and NHS 111 policy has evolved; but it no longer fully meets the needs of patients or health professionals.

This letter builds on the recommendations in my earlier correspondence and outlines the steps that commissioners should consider in relation to an essential part of this transformation: a functionally integrated 24/7 urgent care access, treatment and clinical advice service (incorporating NHS 111 and OOH services), referred to here as an **integrated service**.

New Commissioning Standards for an Integrated Service

It will be imperative that we work together on the new clinical model and commissioning standards for the integrated service and do so in close collaboration with key stakeholders. We will build upon the existing commissioning standards for NHS 111 by including further important elements from the NHS 111 Learning and Development Programme, the wider Urgent and Emergency Care Review and by taking into account the standards that OOH providers are required to meet.

There will be widespread engagement on these components prior to the publication of a revised set of commissioning standards and associated procurement guidance (with due consideration of Patient Choice and Competition Regulations) by the end of September 2015. NHS England will be holding a number of workshops in each region over the next three months, which will offer an opportunity for you and to your organisation to input into the design of this new service.

Workshops will be held on:

- South: 23 July.
- North: 14 July and 11 August.
- London: 7 August.
- Midlands and East: 24 August, 25 August and 21 September.

Annex One provides some early thoughts on the additional components of the service to be included in the commissioning standards. Clearly, these are important changes to the way services are currently delivered, requiring a significant change management programme.

Further procurements of NHS 111 and OOH services should be suspended (whatever stage of the procurement has been reached) until the end of September, to allow completion of the consultation and the release of the revised commissioning standards and supporting procurement advice for integrated services. If the suspension in service procurement will cause contractual or service difficulties, please discuss this with your local NHS England Director of Commissioning Operations.

Developing a Lead Commissioner arrangement

At present the core NHS 111 Service is specified nationally through published commissioning standards so that a consistent identity and quality of service is maintained across the country. The service is then commissioned locally by CCGs in a way that is most appropriate for a given area. The responsibility for commissioning OOH has been delegated to CCGs since 2013. Where practices remain opted in, CCGs are responsible for assuring the quality of OOH services provided. These arrangements have led to a number of providers holding multiple contracts for NHS 111 and OOH services for different CCGs.

The lead or co-ordinating commissioner arrangement should be considered, in which commissioners serving a wider area are brought together to commission an integrated service. This has been shown in a number of areas to be an effective model for engaging with providers (particularly those that deliver services over an area covering a number of CCGs) and to effect strategic change. The Urgent and Emergency Care Review envisages that an area covered by an Urgent and Emergency Care Network will, in most cases, be the most appropriate level for agreeing how a service such as an integrated service should be commissioned.²

Developing a Collaborative Provider arrangement

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 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, to achieve integration and the revised commissioning standards, providers will need to collaborate to deliver the new investment required in technology and clinical skills, and to ensure that services are aligned. It is for this reason that commissioners should consider using the procurement process to encourage NHS 111 and OOH organisations to collaborate or work within a lead provider arrangement, to deliver the specification for the integrated service.

² Urgent and Emergency Care Networks will improve the consistency and quality of urgent and emergency care by bringing together System Resilience Groups (SRGs) and other stakeholders to address challenges in the urgent and emergency care system that are difficult for single SRGs to address in isolation. This will include co-ordinating, integrating and overseeing care, and setting shared objectives for the Network where there is clear advantage in achieving commonality for delivery of efficient patient care. Again we will test this through our engagement process, as is understood that there are a range of local factors that will need to be taken into account.

In doing so, 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 in collaboration with other providers. To be clear, 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.

Elements of the contractual change

The 2015/16 NHS Standard Contract has been adapted for use for NHS 111 services and must be used for any NHS 111 contracts resulting from current or future procurements. Where NHS 111 and OOH services are being procured from the same provider, this may be contractually accommodated by inclusion of Schedule 2L of the NHS Standard Contract (Provisions Applicable to Primary Care Services), which has the effect of making the contract compliant with the APMS Directions. We will consider with the NHS Standard Contract Team whether any further amendments are needed to the Contract for 2016/17, to ensure that it remains fit for purpose for use in NHS 111/ OOH procurements.

In undertaking this work, we will also ensure that local NHS standard contracts reflect the aspiration for a co-ordinated and consistent payment approach across all parts of the urgent and emergency care system. This will ensure providers are incentivised in three ways to deliver the best possible services:

- Capacity: core (to cover fixed in-year costs to reflect the “always on” nature of urgent care services);
- Volume: variable demand; and
- Quality: core.

An Integrated Service - action by all NHS 111 and OOH commissioners

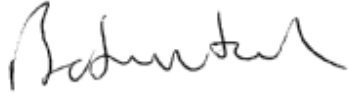
It is acknowledged that moving to this new position from where we are now will be complex. However, commissioners should, over a period of time, be able to move all existing contracts towards the new model and to improve patient care and service efficiency as a consequence.

Given this complexity, and acknowledging that there is more work to be done together on the detailed design of an integrated service, the necessary contractual changes and financial modelling, it is important that commissioners and providers have the opportunity to consider these changes and to attend the regional workshops. This time can also be used to develop local plans for achieving integrated services.

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The changes outlined in this letter are complex, requiring organisational and cultural change. However, it is an important step that we need to take, working together to achieve consistently high standards for patients across the country.

Yours faithfully

A handwritten signature in black ink, appearing to read 'Barbara Hakin', written in a cursive style.

Dame Barbara Hakin
National Director: Commissioning Operations

Annex One – A new service specification for an Integrated Service

Sir Bruce Keogh's Urgent Care Review, and more recently, the Five Year Forward View, both advocate a fundamental redesign of the urgent care 'front door' - including a more coherent 'all hours' telephone, 'consult and treatment' and clinical advice service for patients and health professionals alike. We now have an opportunity to begin the implementation of this vision and the first step is to set out, or 'specify' the key components of such a service.

At present, the NHS 111 Commissioning Standards (available at <http://www.england.nhs.uk/wp-content/uploads/2014/06/nhs111-coms-stand.pdf>) describes the core requirements and standards for the NHS 111 service and repeats that commissioners may wish to enhance and add to these requirements to ensure that local specifications for NHS 111 are comprehensive and appropriate for their local area.

In addition the National Quality Requirements (NQRs) specify how local OOH services should be performance assessed by local commissioners (available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137271)

This annex does not rehearse the current commissioning standards again for NHS 111 or OOH but instead proposes components of a new service specification that should be applied by local commissioners to initially provide a fully integrated service. This new service specification for call handling and 'consult and treatment' services would also allow commissioners to specify a further enhancement – namely a 24/7 urgent care clinical advice service - 'hub'. If the service is commissioned in this way it would move us away from the rather outdated notion of 'in' and 'out-of-hours' services.

In addition to the current, core components of the commissioning standards, as part of the review of those standards we will be consulting on the appropriateness of the following enhancements:

- At the heart of the integrated urgent care system will be a 24/7 NHS 111 access line working together with 'all hours' primary care services;
- Patients will normally speak first to a call advisor who will use the clinical decision support system to triage symptoms. Complex patients needing to speak to a clinician will be identified quickly and receive a clinical assessment following direct "warm" transfer;
- To ensure a more comprehensive 24/7 urgent care access, treatment and clinical advice service, commissioners should also provide access to a wider range of clinical expertise. This will include GPs, pharmacists, mental health workers and dental nurses. Clinical expertise may be available within NHS111 call centres, or accessed by direct transfer to a 'clinical hub'. Patient experience will be enhanced by the early identification of calls that would benefit from access to this level of clinical expertise e.g. dental pain.
- All providers, or combination of providers, must commit to adherence with the Commissioning Standards and contractual framework.
- Special Patient Notes, including End-of-Life Care Plans, will be available at the point in the patient pathway which ensures appropriate care. In addition, patient records including the Summary Care Record will be available to all clinicians.

High quality care for all, now and for future generations

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- Patients who are assessed as needing to see a GP will, in time, be directly booked into the patient's own surgery, or, increasingly as networks and federations of GP practices develop, be offered an alternative practice-based appointment within the GP network. Alternative options include home visit or appointment at an urgent care centre. Clinicians will have access to the Summary Care Record and any Special Patient Notes relating to the patient.
- For other, more minor ailments, patients will be able to be signposted to community pharmacists or optometrists for advice and treatment depending on local commissioning arrangements.
- Red ambulance dispositions will be despatched without re-triage. Green ambulance dispositions will be subject to early clinical assessment within NHS 111 before an ambulance is despatched, but there will be no further re-triage.
- Emergency Department (ED) dispositions will be subject to early clinical assessment within NHS 111. The facilities for NHS 111 to book patients directly into an ED clinic will be a priority enhancement.
- The facility for NHS 111 to book patients directly into a comprehensive range of community services e.g. Urgent Care Centres and Community Services will be a priority enhancement. This should include ability to warm transfer patients who need urgent community nursing support to a 'fast response' multi-professional community team. Patients may also receive visits from community staff e.g. district nurses, falls assessment team and health visitor routinely booked directly by NHS 111.
- It will be an essential requirement that all providers working with NHS 111 demonstrate integration by working jointly to plan and manage patient pathways and capacity. They will also need to show their commitment to integrated clinical governance. Urgent and Emergency Care Networks, working with SRGs and CCGs, will provide assurance that joint planning is effective, and that, for example, there is sufficient GP and primary care service availability and call handling capacity commissioned to meet demand 24/7 and in particular on national bank holidays.
- The Directory of Services will hold accurate information across all acute, primary care and community services and to be expanded to include social care. The functionality to contact social care support through NHS 111 will offer significant benefit, specifically in relation to home support / carers etc.