NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

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Via email to:

7th June 2018

Kate Parker
Senior Commissioning Manager
Unplanned Care
NHS Leeds Clinical Commissioning Groups Partnership

Dear Kate

Senate Review of Leeds CCG Draft Strategy for Urgent Care and Rapid Response

Thank you for the opportunity to review your draft strategy for urgent care and rapid response in Leeds.

The objectives of the clinical review are to inform your further development of the detail of the strategy and we welcome the opportunity to work with you in the earlier stages of its development. The members of the clinical review panel who reviewed the proposals through email and teleconference discussion are listed within the Terms of Reference enclosed with this letter. The Terms of Reference also detail the information we were asked to consider and the process and timeline we followed for the review.

The question you asked us to consider is:

- What issues/problems/considerations can the Senate see in the Urgent Care strategy that we need to address?

I hope this letter provides a constructive summary of our comments and advice.

Overall comments

1. The Senate are agreed that this is a good and ambitious set of proposals which are clearly presented. Overall you have provided a good description of the strategy which ties in all the elements that will come into effect in the next 1-2 years. The drivers both nationally and locally are well identified and we have no disagreement with the citizen and system perspectives outlined and the Leeds Plan Triple Aims.

2. Much more operational detail is needed but the direction of travel is the right one and in line with available evidence and national policy. Our evidence review is available for your

information.

3. The real challenge is in the detail of how this strategy will work and in achieving the high level of collaboration and interdependency between the different providers. One of the first issues which we recommend that the CCG address is the 'system' agreement on what data is used, how it is collected and interpreted to monitor and describe what is happening in the system. We also recommend that you focus on developing a very clear description of how the clinical oversight and governance of the safe care of the patient is provided (and universally understood and agreed) when the patient is moving through the 'system' of partner providers.

4. Our comments on particular issues within the strategy that we recommend that you address are detailed below:

The navigation hub and its relationship with other services.

5. In your description it is evident that you have a good understanding that a protocol driven, non-clinical service is inadequate in identifying and prioritising need unless this is supported by local providers. As described the Hub would provide a timely, accessible, multidisciplinary way of dealing with the recognised shortcomings of 111. The Hub should ensure that the quality of any services booked "directly" would be more appropriate than the current 111 service and in doing so would promote stable and equitable access across the community.

There are a number of challenges however to the Hub proposals:

i. There is work to do in gaining public confidence in the NHS 111 service and the CCG need to give some thought as to how they will do this as if the public don't have confidence, 111 will not be used.

ii. In order to make this hub work effectively for the patient there needs to be good inter -operability of IT to ensure that patient data is shared across all these organisations to achieve seamless care for the patient. Ensuring that there is sufficient IT interoperability will be a key challenge for the CCG which currently does not seem to be acknowledged. This system needs a fully integrated patient record/information data set to pass seamlessly between all elements of the system (NHS111 to Leeds Navigation Hub to GP systems, to GPOOH, to UTC systems through to Hospital Systems and Social Care). We questioned whether there is a clear transfer (and acceptance) method to transfer clinical care through the system flow and to avoid patients being left in the gap between contractual arrangements. We are also not clear how these proposals fit with the Leeds Care Record. One other consideration is if prescriptions can be issued through the telephone call.

iii. Our lay members on the panel advised of their frustrations of being passed through the system and the navigation hub is key to ensuring that this is avoided. To give the patient a good experience, and a better one than the alternatives, the navigation hub needs to be able to book into all associated systems - the GP in hours, the out of hours service and access all practice appointment systems including across dentistry, opticians and community pharmacy. It is also not clear whether there will

be social care support within the Hub for access to community services. The Senate advises that the Hub needs to be responsible for directing the out of hours staff so that there is one point of access for all and we recommend that the out of hours provider relationship needs to be described.

iv. The Senate assumes that you intend for the Hub to be staffed by clinicians and not call handlers. We agree that the much of the success of this strategy hinges on the skills of the Hub staff and the quality of the advice that they provide but the workforce pressures currently mean that this will be very difficult to achieve. Clinicians within our panel have advised that it takes very experienced staff to feel confident in giving telephone advice and GPs do not have the capacity to staff such a service. We note that there is no mention of staff training within your strategy or how you will manage the required cultural and behavioural changes into the new system. You will also be aware of the importance in ensuring that you have an adequate number of call handlers to prevent long wait times for the patient as again this will result in lack of confidence in the system with the consequence of the public choosing the Emergency Department as the alternative.

Equitable Access for Patients

6. You will be aware that telephone access does not suit all members of the public and particular thought needs to be given to those patients with mental health or hearing issues to ensure that they have parity of access into the system. We recommend that commissioners have those discussions about the mental health pathways, if these have not commenced, to ensure that this is woven into the system. This strategy needs to be a health and social care model but there is little reference to social care at present. There is also no mention of paediatrics in this model.

Engagement with GPs and GP extended access and out of hours service

7. There is little detail within the information provided on what engagement you have had with GPs in these proposals. We recommend that you talk to the GP federations and discuss the expectations of this service if you have not already done so. There are details here to be worked through and significant discussions needed on the staffing of services.

8. The operational detail is unclear around the arrangements for the use of the UTC's and how the practices will signpost patients to them. We are also not clear on the relationship between the Hub, GP extended access and Out of Hours services and we recommend that you give this further consideration. The strategy doesn't express what all these parts of the service offer but in reality the boundaries are becoming less clear. When patients are unclear which service to access the default is to attend ED. We are also not clear how the extended access services and out of hours services will be aligned with the UTCs and whether there will there be an overlap in their operation and how will this be explained to the patient. A single point of access can simplify the model for the patient and avoid confusion.

9. We recommend that you give further consideration to the Hub's working relationship with the GPOOH Service and how these proposals fit with your strategy regarding the longer-term

procurement of GPOOH Services. We presume that the out of hours provider can prescribe and dispense.

Urgent Treatment Centres proposals.

10. The CCG will be aware that urgent treatment centres (UTCs) which are inappropriately located, inappropriately staffed and who do not communicate with the wider health community can cause more problems than they solve. The UTCs in this model need to have the capability to "complete" health episodes rather than just add to the steps in a patient pathway. To allow them to function effectively they ideally need to be able to view GP systems in order to access patient records and also so that any episodes they deal with can be communicated seamlessly to the patient's usual GP. They need access to pathology requests and reports and equal access to diagnostics and specialist advice alongside access to social care, mental health and voluntary sector. They need to be able to offer parity of service across physical and mental health.

11. Co-location within ED as aspired to in the review has many benefits. Co-location allows for true triage at the front door of the hospital and therefore full access to the multi-disciplinary teams, consultant advice and diagnostics which in turn will deliver "Ambulatory care", as well as "Right person at the right time", and avoid unnecessary admissions. People arriving by ambulance should also have the opportunity to be triaged at the front door and co-location allows for ED staff to send a patient away from ED to the UTC without being concerned about risk management. We assume that the current streaming models will be taken up in this element of the service.

12. However, there is not a national requirement to have a UTC co-located with an ED and your streaming services could continue to filter out the primary care element. With the location of other UTCs still to be confirmed the current model places your UTCs only 2 miles apart and we note that LGI has very poor parking facilities. You will need to ensure that there is space in the building and that you have thought through the patient flow. With the co-location patients will assess whether the UTC or the ED has the shortest waiting time and make their choice on that basis.

13. Your plan includes using a pilot approach at St Georges but you will be aware that there is little time to apply the learning from that pilot and mobilise the new UTCs in time to meet the national timeline.

14. We do have concerns with the challenge to filling rotas to staff the UTCs. There should be a GP presence in the service and not an over-reliance on Nurse Practitioners. Similarly, the model describes the presence of Urgent Care Practitioners in the UTC, they also have the skills to see and treat in the home and we suggest that the CCG considers using them for that purpose as another route to treating people closer to home.

15. As we have discussed in earlier sections it is unclear how the Practices will use the UTCs and whether they will they use them as an overflow for on the day demand. There will need to be some form of risk share and local working arrangements to maintain a level of safe working. We also suggest that it would be helpful for the UTCs to have the ability to book into ambulatory care at the hospital.

16. One question that we are not clear on is the facilities that you have at Wharfedale and how they fit into the proposals.

Ambulance pathways

17. We are all aware that patients will often by pass advice services and call 999 and therefore the ambulance pathways need to be integrated into this system with access to advice through the proposed Hub. We suggest that it may be desirable to transfer category 3 or 4 calls to the hub for review before an ambulance is dispatched. This will need detailed discussion with the ambulance service but commissioners may wish to consider this as a potential way forward. If an ambulance arrives at a house and further advice is needed before transferring a person, it may also be worth exploring whether ambulance staff should again seek advice from the Hub. Paramedics often try and talk to GPs before transporting a patient but unfortunately accessing GPs at the surgery is not always timely and causes further delays in the system. There is opportunity for improved integration with ambulance services through the Hub and the Hub needs to have the capability to handle demand for calls from all sources in a very timely way. This ability to call in to the Hub needs to apply to both the low acuity control room and the crew on emergency calls. This will also improve the system with care homes who request an ambulance for the default option of taking the patient to ED. Commissioners will also note that in the future all ambulances in Yorkshire and the Humber will have video connectivity.

18. Clinical governance and accountability needs to be very clear in this system. Paramedics especially need to know who is taking responsibility for a patient if they are not going to convey that patient. If this clear governance is not in place they will convey the patient.

19. There is little information on the conversations being undertaken with ambulance services and we suggest that the CCG take forward these discussions and develop a set of agreed criteria and governance procedures across the ambulance pathways.

20. The Senate also questioned how patients get transferred to the locality hub from the UTC. Ambulance services will not provide this transport and as many patients are unable to drive commissioners need to consider a flexible transfer solution working with the voluntary sector.

Success criteria

21. We agree with the success criteria that you have identified. You may also wish to consider that the Trustworthy Collaboration will require a shared agreement and understanding of the validity, interpretation and required actions that comprise the key success metrics. What happens if one provider in part of the system is under severe pressure of demand (and activity costs) as an unforeseen result of another part of the system failing to meet demand? One example of this could be over winter GP Practices which are unable to cope with demand and signpost people to UTC's. Will the new system be modelled to be able to absorb variation?

Governance and Accountability

22. It is not clear from the strategy who is the organisation or the person with responsibility for the system wide overview. Accountability and clinical responsibility needs to be clear when there are potentially several transitions through the system and each organisation dealing with their one part of the system will not be sufficient.

Other comments

23. Patient level engagement is needed early on in the development of these proposals and we suggest that the CCG commences this engagement soon.

24. There are 2.5 million visitors to Leeds within a year and we questioned how the model can handle the non-registered Leeds population without referring them back to healthcare where they are registered.

Conclusion

25. In summary the Senate is in agreement that this is a very good broad description of the vision of this service. It is short on details currently which make our challenges and endorsements very broad.

26. We recommend that the main issues that you will need to address are the IT interoperability, workforce and rota fill, overall accountability for a patient as they transition through the system and the alignment with GPOOH and its future plans. The scale of the challenge ahead in changing behaviours is not to be underestimated. Finally we recommend that this model needs to demonstrate that there has been a measure of the 'trustworthy collaboration' and actions to facilitate it as the culture and behavioural changes required of this system will not happen without actions to build trusting relationships between partners.

27. We hope that this advice is of assistance in your developing plans and we welcome the opportunity to work with you at a future date when the detail of the strategy is more developed.

Yours sincerely

Chris Welsh
Senate Chair
NHS England – North (Yorkshire and the Humber)

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Urgent and Emergency Care Strategy on behalf of Leeds CCG

Sponsoring Organisation: Leeds CCG

Terms of reference agreed by: Debra Taylor-Tate, Leeds CCG and Joanne Poole, Senate Manager, Yorkshire and the Humber Clinical Senate

Date: 27th March 2018

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Dr Steve Ollerton, GP & Clinical Leader, Greater Huddersfield CCG

Citizen Representatives: Denise White and Margaret Wilkinson

Senate Review Clinical Team Members:

Prof. Graham Venables, Consultant Neurologist, Sheffield Teaching Hospitals NHS Foundation Trust & Clinical Director, Y&H Clinical Networks

Dr Tololupe Olusoga, Consultant Psychiatrist & Interim Deputy Medical Director, Tees, Esk & Wear Valley NHS Foundation Trusts

Dr Rod Kersh, Consultant Physician & Geriatrician, Y&H Clinical Advisor for Dementia, Rotherham General Hospitals NHS Foundation Trust

Dr Louise Merriman, GP Cancer Lead, South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance.

Mark Millins, Associate Director Paramedic Practice, Yorkshire Ambulance Service

Dr Andrew Phillips, Joint Medical Director, Vale of York CCG & member of the Y&H Senate Council

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: What issues/problems/considerations can the Senate see in the Urgent Care strategy that we need to address?

Objectives of the clinical review (from the information provided by the commissioning sponsor):

Feedback from the Senate will allow changes to be made to the strategy and to what transformational work occurs. The advice will mainly be used by the Commissioners, however given the strategy is a system-wide strategy; other partners are also likely to use the advice.

Scope of the review: The Clinical Senate will focus their review on the above question based on the information provided in the documentation. The clinical panel will supplement their understanding of the model through discussion with commissioners.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 22nd March 2018
Agree the Terms of Reference: by first week in May 2018

Receive the evidence and distribute to review team: executive summary and strategy received 4th April 2018 and distributed to the appointed panel on 19th April.
Teleconferences: The Clinical Panel teleconference discussions scheduled for w/c 7th May.
Style of Report: Chair's letter
Draft letter submitted to commissioners: 8th June 2018
Commissioner Comments Received: within 10 working days of the draft letter being received
Senate Council ratification: at the July 2018 Council meeting
Publication of the report on the website: to be agreed with commissioners

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the letter and be accountable for the advice contained in the final report. The letter will be given to the sponsoring commissioner and a process for the handling of the letter and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- The Urgent Care and Rapid Response Strategy V9
- Executive Summary 28th March

The review team will review the evidence within this documentation and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate letter will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The letter will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second letter being published by the Senate rather than the amendment of the original letter.

The draft final letter will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final letter will be disseminated to the commissioning sponsor and NHS England (only if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will:

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

Clinical senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

i. appoint a clinical review team; this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.

iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialising during the review.

END