Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCG Governing Body Meeting

Date: Tuesday 1st September 2020
Time: 1:30pm
The meeting will be accessible to members of the public. Please see our website for more details.

Agenda Number:	6.1
Title:	Think 111 First Programme Overview
Purpose: Discussion and Decision	
Key Points for Discussion:	
This item is to brief Governing Body on the Think NHS 111 programme which is being established in BNSSG. The Think NHS 111 First programme aims to: • Empower patients to access the full range of BNSSG services available to meet their needs in the fastest and most convenient way possible • Improve patient outcomes and safety by ensuring people access the service which matches their needs • Improve patient experience when attending urgent care service by ensuring they are "heralded", meaning they will not have to tell their story twice and the service will honour assessments made by other parts of the system. • Improve patient experience and safety by reducing crowding within EDs and other urgent care facilities. • Enable our EDs to plan and respond through the "heralding" of patients to urgent treatment facilities • Enable our EDs to safely redirect patients who attend ED to more appropriate services to meet their needs • Enable IUC and other health professionals to refer into hot clinics and other hospital services without going through the ED • Enable the sharing of risk across the system instead of it resting disproportionately on a small number of services or individuals	
Recommendations:	To discuss and approve continuation to the implementation phase of the programme: • Receive and support the approach undertaken by the Programme to meet the CCG's commitment to achieve two system goals related to urgent care and to formally mandate the NHS 111 First Programme • Recognise the timeline for implementation/ roll out as set out for the programme and identify GB assurance requirements
Previously Considered By and feedback:	This programme has been discussed and approved at • Capacity and Impact Cell (28/7/20) • Strategic Change Command (28/7/20) • Governing Body (In CE update report 4/8/20) • Commissioning Executive (19/8/20)

	• Finance and Analytics Cell (21/8/20) • Healthier Together Executive Group (24/8/20)
Management of Declared Interest:	No conflicts of interest have arisen. This programme is concerned with routing patients between existing services which retain their respective roles in the system while we divert demand to lower-acuity services
Risk and Assurance:	Risks are details in the main document and the programme will be assured through a full NHSE/I assurance framework
Financial / Resource Implications:	Modelling is underway to assess the impact and figures are not yet available. Impacts and potential additional cost is expected in: • Additional call handling and clinical capacity in the Integrated Urgent Care Service • Additional activity in MIUs and our UTC as a result of minors being diverted from ED • There is a potential impact on General Practice and the Severnside IUC service • There is potential for increased in activity ambulance services, this may be mitigated by revision of clinical pathways
Legal, Policy and Regulatory Requirements:	There are no legal implications of the proposed change. This is a proposal to route appropriate activity to services that are already commissioned to accept it.
How does this reduce Health Inequalities:	This approach supports health literacy in that people who do not know how to navigate the system and who therefore potentially miss out on access to services available to them will be assessed and routed to the best service to meet their needs. However, a full Equalities Impact Assessment will be required to ensure patients whose easiest way of accessing services to attend are not adversely impacted by the change. This will include the consideration of the impact of easy access to language line and translation services.
How does this impact on Equality & diversity	EIA/EISA has not been carried out but will be part of the governance activity of the project
Patient and Public Involvement:	We are engaging with the public through the citizens panel to ensure that we understand how the approaches to communications are likely to impact on the propensity to understand and take up the call to action. In addition the design of the experience for people when they arrive at A&E and MIUs will be tested with people via the BNSSG UX Lab and feedback on actual experience will be collated and used as part of the iterative improvement cycle for the programme
Communications and Engagement:	Extensive stakeholder engagement has taken place in informal and formal forums and the direction of travel is consistent with our Long Term Plan response for urgent care. Communications with the public will be based on

	the learning from our local Pilot site (Cornwall). National communications are planned by NHS England starting on 1st December 2020.
Author(s):	Deborah El Sayed Kate Lavington Mark Bradford Tunde Adewopo
Sponsoring Director	Deborah El Sayed

Agenda item: 6.1
Report title: Think 111 First Programme Overview

1. Background

Think 111 First is designed to reduce activity in high acuity urgent and emergency care services by moving low acuity activity to more appropriate settings. This will reduce the risk of patients needing to wait in crowded facilities for assessment and treatment and maximise the use of all commissioned resources.

The current position of the UEC system in BNSSG is challenging:

- COVID-19 saw a dramatic reduction in urgent care attendances but this is beginning to change
- Our acute bed base is reduced by 300 beds, has reduced flexibility and is unable to rely on escalation beds which are one of the usual ways of managing demand over the winter period
- Social distancing in our A&E departments and MIUs means that waiting space is dramatically reduced
- Ambulance handover time is increasing
- 111/ IUC is an opportunity but needs staffing to be able to respond.
- Demand in primary care is rising
- Capacity constraints in primary care are a challenge in delivering transformed models of care
- Increased demand from COVID-19 patients needing specialist care will exacerbate reductions in winter capacity in secondary care.

BNSSG has committed to achieve two system goals related to urgent care:

- BNSSG will work together as a single System to support our population to access the care they need in the most appropriate and convenient setting possible. For example, For example, community urgent care services will be supported by secondary care to resolve peoples' care needs at the time of presentation and without onward referral unless clinically necessary, leading to a better experience and better outcomes for our patients.
- BNSSG residents will benefit from an integrated approach to help them to access the right treatment option first time. This will help protect them from the risks of COVID-19 by ensuring that Emergency Departments are not crowded and that people can access same-day primary care and community options for treatment reducing the need for specialist emergency support.

Successful delivery of NHS 111 First will be a key contributor to achieving these goals.

2. Objectives. What does success look like?

The Service Change

It is important to understand this is a system wide change and requires all partners to adopt new ways of working. The premise is that by encouraging people to call 111 before attending urgent care services we are able to use NHS 111 as a central routing and triage capability getting people to the right place first time, and reducing the reliance on our emergency services. The current triage and routing will likely need to be amended and endorsed clinically to ensure that the right acuity and case mix is directed to the right services. This connection between triage dispositions and the Directory of Services will need to be closely monitored and have rapid feedback loops to ensure that clinical decision making is driving the right demand. We need to consider the experience of the patient, and as a system we have some decisions to make about how we will implement transfer and booking of patients, and critically how we will respond where people have not called 111 first.

Objectives to Benefits

For **Patients** it will mean faster access to the right service to meet their needs and improve their journey and outcome.

For **Clinicians** and professionals, it will mean they work with the patients appropriate to their skills and environment minimising professional risk and moving to a shared-risk model across the system

For our **Services** it will enable capacity and demand management to enable them to do the best job for their patients while maintaining safety

The development of BNSSG 111 First will create a single, consistent point of access for all of a person's urgent care needs enabling them to access the care they need in the most appropriate setting and timescale. It will enable the following benefits across the system.

Single consistent approach to triage and assessment, connecting and booking patients to the service they need first time - The system is complex and difficult to navigate for patients and we can help them to navigate the system to find the right service for them by assessing their needs in a consistent and safe way before giving them the advice they need to care for themselves; the advice and a prescription they need delivered to the most convenient place for them; or referral to the best service to meet their needs. This is an experience measure that will drive the public propensity to reuse and embed the IUC service. We know from our research that a core factor for using ED for our population is proximity, displacement demand from primary care driven by perception rather than evidence, out of hours access and knowing that you will get the

treatment or reassurance you need by going to one place. A lack of understanding and awareness of what other services also drives ED as the most likely choice. The concept of an appointment slot and certainty of being seen tests favourably as a desirable element across the engagement and insights so far.

Clinical staff in each setting are able to focus on the right case mix for their skills getting more time to spend on appropriate care for people: ensuring that our staff are safe, supported and have a rewarding environment is an aspiration through this programme. This will lead to more patients getting the right treatment first time without onward-referral and enable staff and service development through our understanding of patient satisfaction and outcomes.

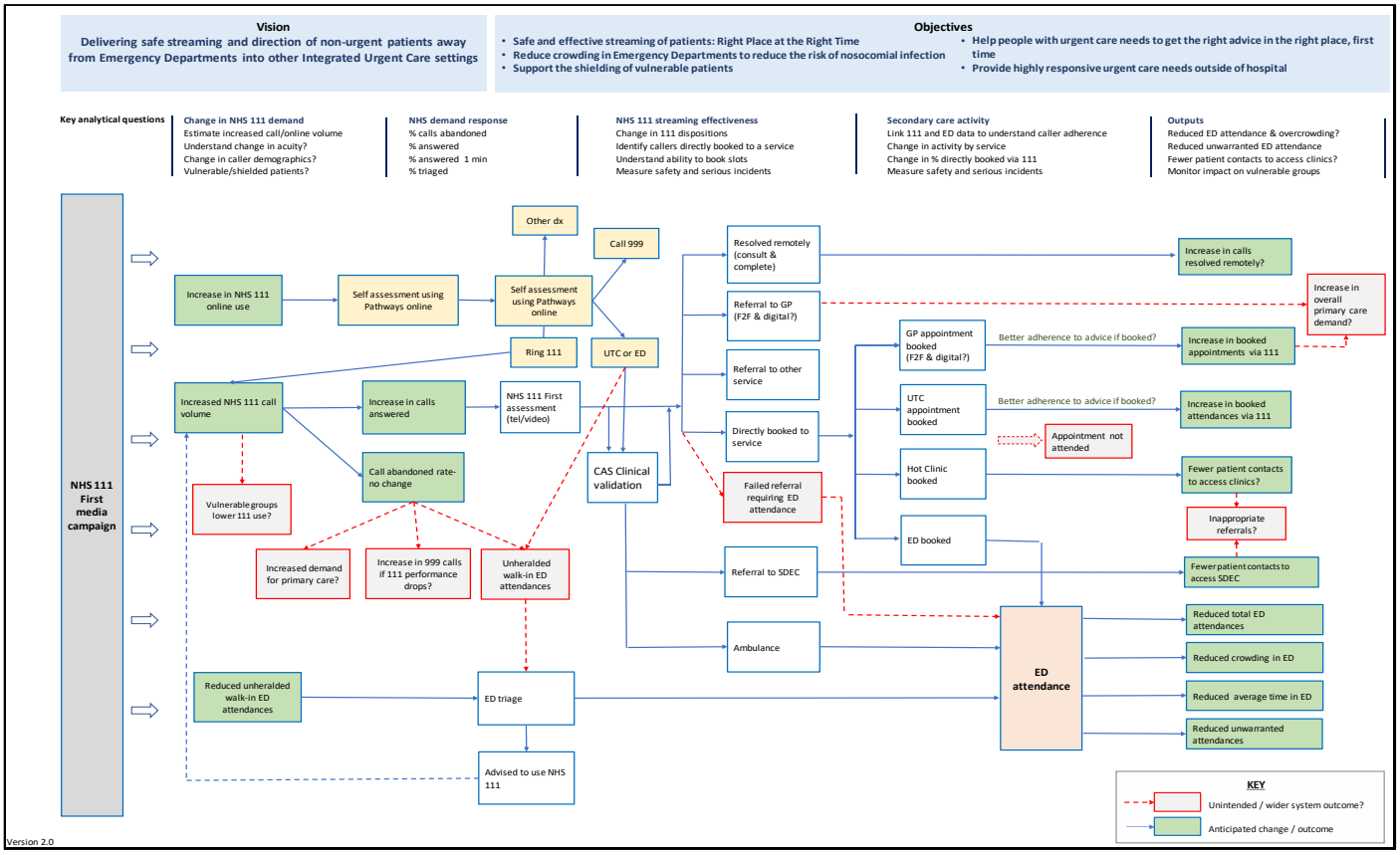
Enabling our system to stay safe over winter - Improved patient safety through reducing crowding in ED departments and other urgent care services achieved through directing people to the right service for their needs including MIU/UTC, primary care and direct admission pathways.

The programme **builds the foundations for development of increased community based same day urgent** care keeping our A&E departments free to focus emergencies where their skills and expertise are most critical.

Think 111 first is envisaged nationally as a way to try to reduce demand in ED departments but in BNSSG we see it as a catalyst for whole-system change that will enable us to meet our goal of every patient being treated by the right clinician every time.

3. Overview of Theory of change

Figure 1 below sets out the nationally-produced overview of how the service might work> BNSSG will expand and tailor this model to our patient needs



The diagram and the national vision is an excellent framework for our own local development, but our approach has been to convene a team of clinicians across the system, chaired by Dr Lesley Ward and including consultants and other specialists from our secondary, primary and community care services, to lead a clinical design of our system. We are considering, among many options:

- whether front-door filtering via 111 and/or redirection to other services from ED is desirable or viable in our EDs
- the role of our locality hubs
- the role of and interface with our new mental health crisis line
- how we can access community and secondary services, clinics and specialities without the need for additional clinical validation or unnecessary steps for our population to take in order to reach the right service for their needs

4. Next steps and outline plan

What we have already done

We have identified six key workstreams for the programme and each has been allocated a project manager. A governance structure is in place clinical and management and technology leads have been recruited from all system partners.

Weekly “clinical huddles” have commenced on a Friday mornings involving clinicians from across the system to oversee the development of the technical model and test the clinical pathways. Cornwall’s biggest learning point was the power of a “clinical huddle” and we will move these to daily following go live.

We have engaged with the Cornwall system to understand their learning and experience and a visit took place on 6th August

Substantial work has already taken place to re-profile the DoS. This directly addresses some of our objectives; notably linking our MIUs to support from our acute hospitals to support a wider case mix being available to our MIUs and changes to our Directory of Services to divert 111 referrals away from ED to our UTC and MIUs.

We have secured a prioritisation of BNSSG support from MiDoS which is widely used by SWAST crews to search for alternatives to ED and for advice/referral to a wide range of community services for patients during see and treat episodes. MiDoS is in use in our GP practices for social prescribers and will be made available to the new AWP Crisis Line to enable referral by clinicians at the end of a therapeutic consultation to identify further support for patients.

The use of MiDoS within ED and other settings is a potential game changer to enable redirection and will be taken forwards as part of the DoS workstream described in the programme.
Our UEC Clinical Lead, Dr Lesley Ward and Dr Leilah Dare, Consultant in Emergency Medicine at NBT are members of the Regional Think 11 First steering group with Dr Dare as the Regional Clinical Lead for the programme.

What we are currently doing
A project plan has been developed for the workstreams which are:

1. Increased IUC Capacity and UEC system modelling to manage and spread demand
2. DoS improvement to extend IUC referral into secondary care (hot clinics) and community services and to enable clinicians and the public to access the DoS through the MiDoS app
3. Referral and booking from IUC and between UEC services including operational processes and electronic enablement
4. Monitoring and evaluation of clinical safety and outcomes, effectiveness of the programme, and to support sustainable change
5. Communications and engagement strategy
6. Clinical risk management

Capacity and demand analysis is underway as the basis for any business cases required for additional capacity, resources, or technical capabilities.

DoS outcomes are being analysed for cohorts of calls that could be directed to a hot clinic or community service (DVT, TIA etc.)

A draft model to assess impact has been completed. This will be used to assess the system resources and costs for a successful programme.

Partner design sessions with all parts of the system to agree the operational pathways have commenced and draft pathways have been developed.

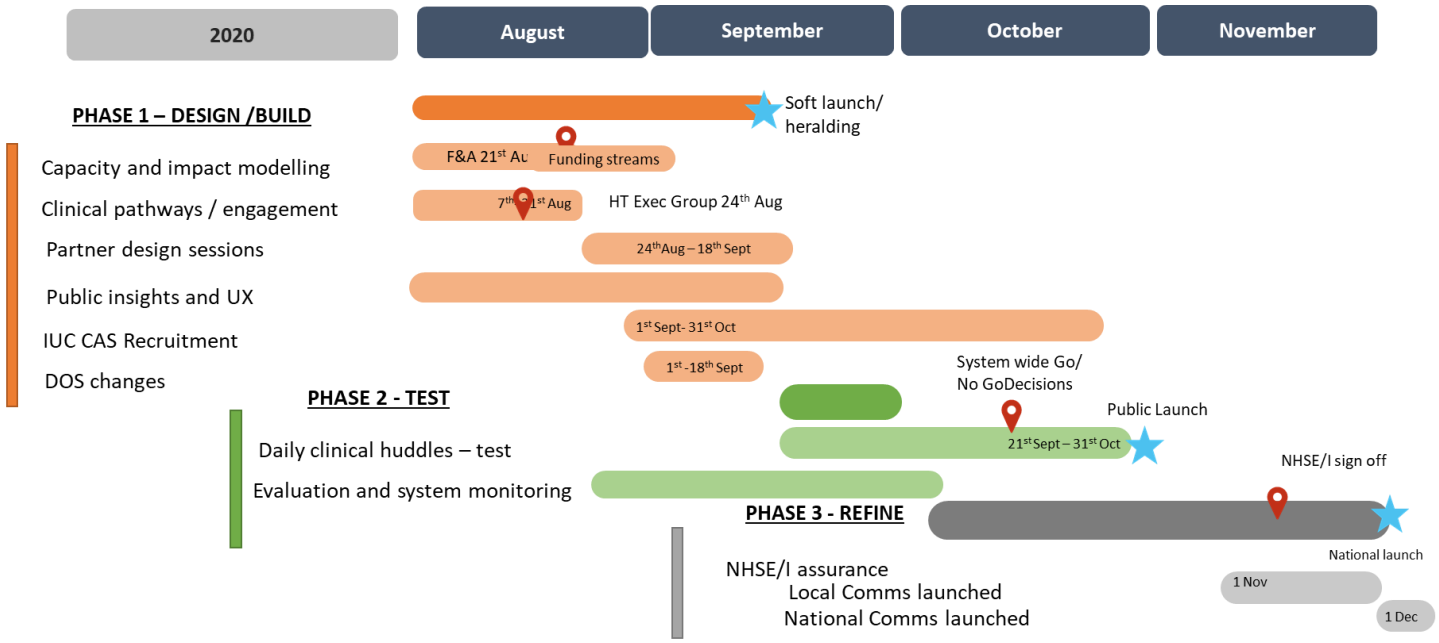
Key engagement messages have been agreed across the system.

What we plan to do now

We are assessing the learning from the Cornwall Pilot and will be adapting some of their excellent Comms and Engagement materials for use in our area.

The Directory of Services is capable of "heralding" patients who access the NHS through the 111 telephone number and this will be enacted via NHSmail with plans to move, where possible and appropriate, to full booking capability in the future.

High Level programme plan



5. Workstreams overview

This section describes the content of the 6 workstreams.

Workstream 1: Increased System Capacity
Finance analytics and modelling, forecast increase in activity in IUC and resulting impact across the system for MIUs/UTC, General Practice, ED, ambulance, mental health and pharmacy services.
Ensure sufficient resource to meet this modelled need:
1) Enhanced capacity within IUC
2) Make recommendations in respect of the walk-in offer (particularly to serve the city centre)
Maximise the capabilities, physical waiting capacity and opening hours of our UTC and MIUs.

Work stream 2: Provider DoS Dispositions (Clinical Pathways)
Connecting the triage with the right clinical service: understanding the efficacy of clinical dispositions, iterative development of clinical pathways and DOS ranking, underpinning governance framework in place.
1) Extend DoS to include referral-only services in secondary care such as hot clinics
2) Extend DoS to include community services such as the community DVT service
3) Extend DoS to include 3rd sector services for Social Prescribers and MH practitioners
4) Extend MiDoS taxonomy/tagging to enable HCPs to search and refer by condition
5) Extend MiDoS taxonomy/tagging to support public use of the app to find non-acute services
6) Investigate capacity management capabilities to smooth the flow of professional referrals and help patients using the app make better decisions about the times they access services

Workstream 3: Referral and booking (Operational processes)
Developing a target operating model.
Scope will encompass enabling other parts of the system to cross book – e.g. primary care to book into ED and vice versa.
Sub streams:
1) Increase booking options for patients who access the NHS through the 111 phone number
2) Emergency Departments
    a) Managing heralded activity alongside unheralded walk-in activity
    b) Flexing dispositions/timescales from IUC, GPs and other referrals to meet availability of appointments and avoid “hot” time slots where possible
    c) Enable safe booking and referral of unheralded patients to alternative services
    d) Understand the impact on the 4 hour standard
3) MIU/UTC
    a) Managing heralded activity alongside unheralded walk-in activity
    b) Flexing dispositions/timescales from IUC, GPs and other referrals to meet availability of appointments and avoid “hot” time slots where possible

   c) Balancing clinical profiles between the UTC (which includes illness and injury) and MIUs (currently injury only)
4) Primary Care
   a) Capacity management and prioritising of the most urgent cases to same-day appointments
   b) Timescales and process for releasing unused appointments back to the practice
5) Digital enablers
   a) GP Connect – Linking IUC to EMIS
   b) 111 Online
   c) GP eConsultations
   d) MiDoS

Workstream 4: Monitoring and Evaluation

1) Clinical Outcomes
   a) Appropriateness of clinical dispositions and DoS service selection (patient safety)
   b) DoS/Referral effectiveness including, where possible, compliance with referral advice and attendance of appointments
   c) Case reviews comparing front-end disposition with real-world presentation
2) Demand management
   a) 111/IUC demand
   b) Channel shift to digital assessment
   c) Effect on A&E 4 hour standard
   d) Effect on GP appointments including Improved Access slots
   e) Capacity impacts (e.g. do booked appointments meet demand.)
3) Patient behaviour
   a) Heralded vs unheralded attendance at ED
   b) Effectiveness of comms (generally and in specific target and hard to reach groups)
4) Monitor effectiveness of the
   a) comms strategies in driving behaviour change (particularly in target groups)
   b) Redirection processes including referral away from ED
5) Monitoring to ensure the new model does not disadvantage vulnerable groups

Workstream 5: Communication and Engagement Strategy

1) Effective system messaging based on best practice and aligned with national campaign.
2) Substantial stakeholder and staff engagement
3) Targeted communications and engagement with specific patient groups

Workstream 6: Clinical Risk

1) Understand the risk of services that could treat a patient referring to an alternative service
2) Understand the transfer of risk between organisations as patients are referred and booked between services
3) Understand the scope for shared risk across the system as individuals and organisations make decisions in line with the programme but that disproportionately increases their own risk profile

6. Financial resource implications

Modelling is underway to assess the resource and cost implications of the full programme. Modelling in our open access services to determine how we maintain safety in our waiting areas indicates that we should aim to reduce attendances by between 800 and 1,000 per week. This programme will be a significant factor in reducing attendances overall and also spreading attendances throughout the day to reduce peaks that could lead to overcrowding.

The implications on capacity across the system need to be fully modelled but likely impacts are on our IUC service through an increase in activity as walk-ins are converted to calls to the 111 phone number. The initaill approaches are expected to make these changes gradually with a small impact between 8 % and 14% at the start of the service commencement. Our community provider is also likely to see an increase in attendances in our MIUs and UTC as minors are diverted away from our EDs. We are working closely with Sirona as a key partner to ensure that this can be well managed and supported. The implications for reduced costs in Acute Hospitals arising from lower activity levels in ED, less crowding and more efficient throughput to admissions also need to be modelled.

The availability of additional revenue and capital cost funding from NHS England to support this scheme is not yet known, and could pose a significant risk to delivery of the Programme.

The programme financial modelling will also need to consider both the Commissioner funding and Provider funding implications in the context of the temporary NHS financial framework and the block contract arrangements for NHS providers.

There is also a potential impact on all other Primary Care and Community Services that provide same day urgent care.

The programme will flex to take account of the potential impact and each change will be planned and executed through a PDSA cycle to allow us to decelerate or reverse adverse changes or unexpected consequences.

7. Legal implications

There are no legal implications except for potential routine contractual amendments to reflect changes in capacity and demand in some services.

8. Risk implications

	Risk	Mitigation
1	There is a risk that patients who appropriately use services (e.g. use their GP Practice appropriately) will be diverted to IUC.	Effective onward-referral of appropriate cases to GP surgeries including booking to IA and routine slots CAS closure of primary care hear and treat case mix
2	There is a risk that removing minor activity from our Emergency Departments could lead to a higher proportion of cases clinically requiring longer periods to asses, stabilise and treat in the ED leading to an apparent decline in compliance with the 4 hour standard.	Carefully plan how the heralded strand is managed against ambulance and walk-in strands and how appropriate cases can be kept safe outside the ED until appropriate capacity is available. Agree when and how the 4 hour clock starts for people heralded to ED from IUC, Primary Care or any other clinical service.
3	There is a risk that a lack of alternative city centre UEC provision outside the BRI will mean that the ED continues to need to support category minor leading to a possibility that even well-designed pathways and processes to reduce activity will be ineffective.	Ensuring appropriate services with sufficient capacity (including a city centre walk in option for minors) are in scope of this project.
4	There is a risk that implementing Think 111 First and at the same time leaving open access options available will simply enable another access route to high acuity services without reducing unheralded, un-triaged activity	Operational arrangements for unheralded patients in ED are in scope for this project.
5	There is a risk that while the system's overall capacity is compromised by COVID-19 and with the onset of winter a few months away, the necessary transfer of resources around the system to support a new demand profile could destabilise some parts of the system leading to delays, poor patient journeys and outcomes and increased clinical risk.	Funding is expected to be made available nationally to support increased IUC activity and a business case to seek this is in the scope of the project. Funding increased activity in MIU/UTC, primary care and elsewhere is in scope of the project.

	Risk	Mitigation
6	There is a risk that all services will require some change and some services will need to implement significant process, staffing and clinical changes while under pressure from other significant pressures leading to destabilisation of services, poor patient journeys and outcomes and increased clinical risk.	Significant engagement resources are required and included in the scope of this project We have created a Clinical Risk work stream to understand and mitigate clinical risk Changes will be subject to a PDSA cycle to enable impact to be assessed and mitigated. Target operational model signed off across the system to ensure no one provider or clinician is unsupported.
7	There is a risk to delivery of the other urgent care phase 3 plans, and priorities agreed at the UEC clinical workshop due to the importance and scope of this project leading to a conflict for resources and the potential to make other important system changes.	System leaders have agreed a phased approach to delivery of UEC programme of work, with this programme as the first priority.
8	There is a risk that the complexity and reach of the programme could mean we fail to make some of the changes we plan leading to a reduction in the impact of the programme and changes would be less significant than modelled and expected	Iterative improvement through PDSA cycles will enable us to deliver the full breadth of the scope while some activities may lack depth in the early stages. They will be implemented in a way that enables continuous improvement to deliver the full scope of the current ambition.
9	There is a risk that the new care model will have higher revenue costs and new capital costs than existing care model	Awaiting Phase 3 Covid Planning guidance to confirm financial envelope available, expected by end of August

9. How does this reduce health inequalities?

A full assessment will be carried out as part of the programme to assess the full impact and particularly the impact on patients who currently do not or cannot access services other than by walking in or attending in person. We have commenced public engagement in testing key communications and messages. As part of this work, we will be exploring how extending services and encouraging people to call 111 might help address health inequalities. Key areas for consideration how public messages will be considered for key communities; NHS 111 service

already has robust translation services we will be exploring how these can help heralded patients with specific communication need and given early indication so when they get to the MIU or A&E they are afforded a more positive experience. In addition, we will be exploring how heralding may help to provide people with LD and autism the ability to make a fast connection with the LD liaison nursing capacity that has been introduced across the system.

We hope that by ensuring people get to the right place first time and by connecting the triage and risk management processes across our system that there will be a reduction in the risk of people falling between the gaps in services and missing the treatment and support they need. We know that it is often people in deprived communities or who do not understand how to navigate the NHS who are most at risk of missing the support they need.

10. How does this impact on Equality and Diversity?

Our comms and engagement strategy will target specific groups and communities across our area to ensure they understand the service and what it can offer to support them. This will enable greater access to the full range of BNSSG services by linking patients to the electronic Directory of Services either through contact with a service or professional or, in the later phases of the project, directly via an app.

11. Consultation and Communication including Public Involvement

NHS England is planning a national campaign as part of its winter pressures communications programme which is due to start on 1st December 2020. We have a dedicated comms and engagement work stream as a key part of the programme and will be working on extensive local communications and capitalising on work already done in the pilot site in Cornwall.

This is a mandated system change by NHSE/I in response to the impact of COVID-19 on our capacity and demand, and the potential for this to be more significant as winter approaches and as such there has been little time to engage with the public.

While it is driven from the centre, it does, nonetheless, match BNSSG ambitions to enable our patients to access the whole range of services we commission on their behalf and to enable them to access the most appropriate service at the most appropriate time and

Extensive stakeholder engagement continues, and this is a clinically led programme to benefit patients and the system rather than to save money or reduce provision.

Appendices

Glossary of terms and abbreviations

Please explain all initials, technical terms and abbreviations. .

Disposition	In this context this is the outcome of a triage through the Integrated Urgent Care service and refers to the facility and timescale recommended for the patient to follow
DoS	Directory of Services. An electronic database of clinical profiles intended to match the outcomes from a triage in the Integrated Urgent Care Service
DVT	Deep vein thrombosis. A blood clot usually in the leg.
ED	Emergency Department
Herald(ed/ing) **Unherald(ed)**	Notifying a service that a patient has been referred to it, or a patient being booked into an appointment. Unheralded patients are those that have either not previously been triaged and referred to a service, or who have not had their details passed to a service
IUC	Integrated Urgent Care (Service). IUC is a combined service that integrates a telephone triage service through the 111 telephone line or website with the out of hours GP service
KPI	Key Performance Indicator. A key measure of the effectiveness and/or efficiency of a service
MiDoS	(See DoS). MiDoS is a third-party application that enables clinicians and the public to search for services based on classifications (taxonomy) or key words (tags) instead of by carrying out a traige through the IUC Service.
Minors	A generic term for patients who are appropriate for assessment and treatment in an Emergency Department but could safely be managed in a lower-acuity service such as an MIU, UTC or a Primary care service
MIU	Minor Injury Unit. A facility with diagnostic and treatment options not usually found in Primary care but that cannot see the most serious cases and is not usually attached to an acute hospital

PDSA	Plan-Do-Study-Act is an iterative change method that allows change to be planned, made and assessed for its impact before the results are used to plan and execute the next iteration.
TIA	Transient Ischemic Attack. This is sometimes a pre-cursor to a stroke or may be referred to as a "mini-stroke"
UEC	Urgent and Emergency Care