Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	28 April 2021
Executive Member:	Councillor Wills – Executive Member (Adult Social Care and Health)
Clinical Lead:	Ashwin Ramachandra Co-Chair Tameside and Glossop CCG Naveed Riyaz Tameside & Glossop Urgent care Lead
Reporting Officer:	Jessica Williams Director of Commissioning Tameside and Glossop CCG
Subject:	**URGENT AND EMERGENCY CARE BY APPOINTMENT- NHS 111 FIRST**
Report Summary:	This report provides an update on the development of Urgent and Emergency Care by Appointment in Tameside and Glossop
Recommendations:	Note the contents of the report

Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	£487k, based on the non-recurrent phase 3 allocation.
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – s75, Aligned, In-Collaboration	S75
Decision Body – SCB Executive Cabinet, CCG Governing Body	SCB
Value For money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark	
The phase 3 CCG budget, which formed the basis of allocations for the second half of 2020/21 included an assumption of spend for UEC. This was based on a combination of regional and GM level costs, plus a locally calculated cost of implementation in Tameside & Glossop. On the basis that phase 3 budgets will be rolled forward into Q1 of 2021/22, we know that funding will remain available for UEC in the immediate future. Longer term funding arrangements for the CCG, or how UEC will be funded following the NHS re-structure are currently unclear. Further work will be required to determine the recurrent cost of UEC, as the service evolves to ensure resilient and efficient post pandemic provision. But based on the foundation already laid by our Care Together programme, the Finance Economy Workstream have already discussed a reduced investment requirement relative to the GM benchmark.	

Legal Implications: (Authorised by the Borough Solicitor)	The Board needs to be content that the service represents good value for money.
How do proposals align with Health & Wellbeing Strategy?	The services within the update are designed to support people in the most appropriate place and ensure that only people who need emergency care are directed to ED and so can be treated more efficiently.
How do proposals align with Locality Plan?	The services described in the update were primarily developed locally in response to Care Together.
How do proposals align with the Commissioning Strategy?	The update shows how we are endeavouring to deliver our commitments of improved Urgent and Emergency care.
Recommendations / views of the Health and Care Advisory Group:	The original plans were endorsed by HCAG before they were implemented.
Public and Patient Implications:	The overall plans for Urgent and Emergency care are national. The services described that have been developed locally have gone through local processes of engagement including a formal 12-week consultation on Effective Urgent Care. The services are all designed to reduce the need for people to attend unnecessary appointments and to receive the right care first time. Access remains through telephone, online and direct walk in.
Quality Implications:	The services are designed to improve experience and clinical outcomes by ensuring effective pathways to care.
How do the proposals help to reduce health inequalities?	The proposals support more care closer to home and reduce the need for the time and expense of travel where possible.
What are the Equality and Diversity implications?	There are no specific implications but the improved patient experience, reduced travel and increased opportunities for care through known professional may have a greater positive impact on some protected groups. The EIA is attached in appendix 1.
What are the safeguarding implications?	There are no specific safeguarding implications the duties for all providers remain and clinical governance processes are in place to look at the system as a whole.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The appropriate MOUs and data sharing agreements exist between providers to ensure compliance with national standards.
Risk Management:	The update does not highlight any risks in services but the affordability of services designed to reduce demand in EDs is always challenging as the nature of EDs means they have to be funded at a safe and appropriate level 24/7 regardless of demand.

Access to Information:	The background reports relating to this report can be inspected by contacting the report writer
	 Telephone: 07855469931
	 e-mail: Elaine.richardson@nhs.net

1. INTRODUCTION

1.1 The term 'Urgent and Emergency Care (UEC) by appointment' is the term used to describe a system that ensures people who need Urgent or Emergency care are able to receive it from the most appropriate professional in the most appropriate timeframe and at a place that makes best use of our facilities and in a way that reduces any impact of overcrowding.

1.2 For some the idea that you can make an appointment for an Emergency has been difficult but the aim is more to ensure people get the right treatment when and where they arrive without having to wait for an unknown time in a waiting room. People with Urgent needs, which will not deteriorate by waiting, will be booked into an appointment so they will be able plan their visit knowing they will be seen at or near that time. In addition, people whose needs will not benefit from passing through the Emergency Department (ED) will receive their care directly in the place that can best assess and address those needs. E.g. on the Early Pregnancy Unit, the Same Day Emergency Care Unit or in the Urgent Treatment Centre (UTC).

1.3 Some people will not even need to travel to the hospital, as the best place for their care could be through a local GP or Pharmacy or for some at home with wrap around health and social care that prevents an admission and reduces the risk of a long stay in hospital.

1.4 This report describes the services in Tameside and Glossop that support the national expectation around UEC by Appointment.

2. NATIONAL BACKGROUND

2.1 The Five Year Forward View in 2014 recognised that urgent and emergency services needed to integrate more, '*Across the NHS, urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services.*'[1] The Next Steps on the Five Year Forward view[2] in 2017 then described the achievements delivered so far and those expected for 2017/18 and 2018/19.' These changes were the basis for a seamless transfer of care for individuals from their point of entry to their treatment.

2.2 The Next Steps also set out the expectations that every hospital must have comprehensive front-door clinical streaming by October 2017 and that systems would implement standardised new Urgent Treatment Centres (UTC). These two elements working together would ensure ED/A&E departments were free to care for the sickest patients, and other people would receive care in a more appropriate place with advance booking in UTCs.

2.3 A starting point for many people seeking urgent care is NHS 111 and the future for this was set out in the Next Steps document. Two developments were key to the further development of UEC by Appointment; Enhancing the access to clinical assessment, so that only patients who genuinely need to attend ED or use the ambulance service are advised to do this and enabling NHS 111 to able to book people into urgent face to face appointments where needed.

2.4 The Covid-19 pandemic brought about a change in the way that people accessed healthcare with fewer people self-presenting at EDs and more people utilising NHS 111. Whilst there were some concerns that people who needed help may not be seeking it, there were also benefits as more people could be supported without the need to attend ED or an UTC and those that did need to attend could be managed more safely with reduced congestion in waiting rooms.

---

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

2.5 The Royal College of Emergency Medicine released a position statement on 6th May 2020 asking for 5 fundamental aims to be supported:

- EDs must not become reservoirs of nosocomial infection for patients
- EDs must not become overcrowded ever again
- Hospitals must not become overcrowded again
- Emergency care must be designed to look after vulnerable patients safely
- EDs must be safe workplaces for staff

2.6 The national 'NHS 111 First' programme aimed to capitalise on the change in how people were accessing services and embed the 'Call before you Go' ethos before people reverted to self-presenting at ED. It aimed to offer people a different way of accessing and receiving healthcare, including a new way to access Emergency Care. The National campaign for NHS 111 started on 1st December 2020. It asked people to contact NHS 111 first, whether online or by phone, if they have an urgent – but not life-threatening – medical need, as an alternative to self-presenting to the UTC or ED.

2.7 The aim is to have fewer patients in ED waiting rooms to reduce the risk of nosocomial (hospital-acquired) infection. Key to achieving this is utilising remote clinical assessment, which enables the caller to be assessed and give advice on self-care or directed to/booked into the service that can most appropriately meet their need. It was hoped that 25% of self-presenters would utilise NHS 111 First and these would follow pathways such as below:

- People who need Primary Care will be booked into their practice or locality based Primary Care such as an UTC or OOH service or directed to the appropriate Primary Care service such as a Dentist, Pharmacy or Optician.
- People who need to access hospital services go directly to the appropriate department in the hospital, and not via ED e.g. a Same Day Emergency Service or direct to a clinic/ward.
- For people that do need to attend an ED, those who can wait for a few hours before attending are booked into timed slots, to smooth the number of people attending and reduce time waiting at the ED.
- For people who would be better receiving care in their own homes Crisis Response Teams or Community Teams will attend them.

3. GREATER MANCHESTER BACKGROUND

3.1 In January 2020, prior to the current COVID 19 Crisis, the GM UEC Improvement & Transformation Board approved a high-level Urgent Care by Appointment model as a refreshed priority for UEC integration. The aim was that by April 2022 the model would reduce across GM: Ambulance attendances by 100 per day and ED walk in attendances by 300 per day.

3.2 The GM model had four key elements that would work together to deliver the reduction.

- 'Call before you go to ED' or 111 First
- Acute-based pre-ED triage and streaming
- Clinical Assessment Service (GM and locality-level)
- Locally agreed referral pathways (community-based and acute-based)

3.3 It was recognised that whilst consistent standards and outcomes were needed across GM that locality level design and planning would ensure that local needs could be met and that some systems already had mature services that delivered some of the elements.

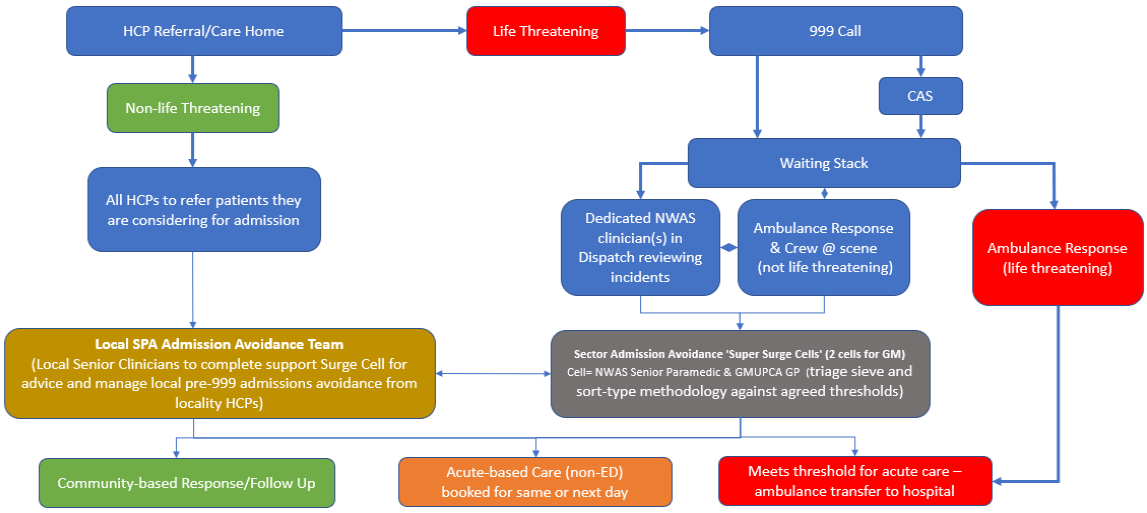
3.4 All GM localities, though the GM Urgent Primary Care Alliance (providers of GP Out of Hours cover), had been working together for several years to provide clinical assessment support to NWAS to ensure people who did not need to attend ED were managed elsewhere. Initially with the APAS supporting NHS 111 calls and since 2019 with the GM Clinical Assessment

Service (GM CAS) supporting first 999 and latterly both 111 and 999 calls. A decision to extend the arrangement throughout 20/21 ensured availability during the Covid-19 pandemic.

3.5 The GM CAS was commissioned to:

- Ensure early patient access to a senior clinical assessment enabling navigation to a more appropriate local service.
- Ensure admission and conveyance avoidance (based on defined codesets) prior to an ambulance being dispatched.
- Receive patients from both the 111 and 999 (cat 3 & 4) services, to avoid escalation through the urgent care pathway and stream as many patients as possible away from an emergency ambulance response and ED attendance.
- Support the pressures on Urgent Care throughout the Covid-19 pandemic.
- Improve the patient journey and minimise any delays in them receiving the most appropriate care.
- Provide a consistent offer to patients across Greater Manchester.
- Provide a consistent approach for GM in achieving the goal of the national 111 First agenda.

3.6 During Covid-19 wave 2, between 29/01/2021 and 08/02/2021, the GM CAS was enhanced to deliver a Super Surge Admission Avoidance Escalation Process. This process as shown below was set up in conjunction with NWAS and Locality based services to safely reduce ambulance conveyance through enhanced clinical assessment and community response in the context of GM having Critical care bed occupancy at 85% and G&A bed occupancy at 90%.



3.7 To support delivery of the 'Locally agreed referral pathways' element GM focused on the availability of community services that could accept urgent transfers and in September 2020 developed the Community Rapid Response Standards set out below:

3.7.1 **Single point of single point of access:** each locality will require a SPA by Q3 2020 which will receive urgent health and social care requests from professionals and the public (generally people already known to services). The SPA must interface with 111, GM CAS and locality Clinical Assessment Service (CAS).

3.7.2 As a minimum, the SPA should operate between 0800-2200hrs every day of the year and be able to provide call handling and clinical triage functions. This increase incrementally towards 24/7 provision, by no later than March 2023.

3.7.3 **Referrals should be triaged within 30 minutes:** requests from ambulance crews should be triaged within a maximum of 20 minutes.

3.7.4 **Where clinically indicated assessment by the** r**eceiving community service will need to be within 2 hours** of the original triage (or earlier if indicated). A home/care home assessment should be provided unless a virtual/telephone consultation is appropriate.

3.7.5 **CRR will operate for a minimum of 14 hours per day** (0800-2200), 7 days per week and support health and social care provision for up to 2 days (where required), including home-based rehabilitation, home care, reablement, or intermediate care .

3.7.6 The SPA will provide access to support from **specialty and associate physicians.**

3.7.7 **Urgent community rapid response should provide support where possible for discharge to assess pathways,** enabling a person to remain in their own home and to maximise independence.

3.7.8 **Data collection: Community Services Data Set 67 - TBC across GM.**

3.7.9 **CRR services should have access to the GM shared care record (Graphnet) and to** personalised care plans to support decision making.

3.8 Through the above services and Locality arrangements in ED GM went live with NHS 111 First in October 2020.

4. TAMESIDE AND GLOSSOP POSITION

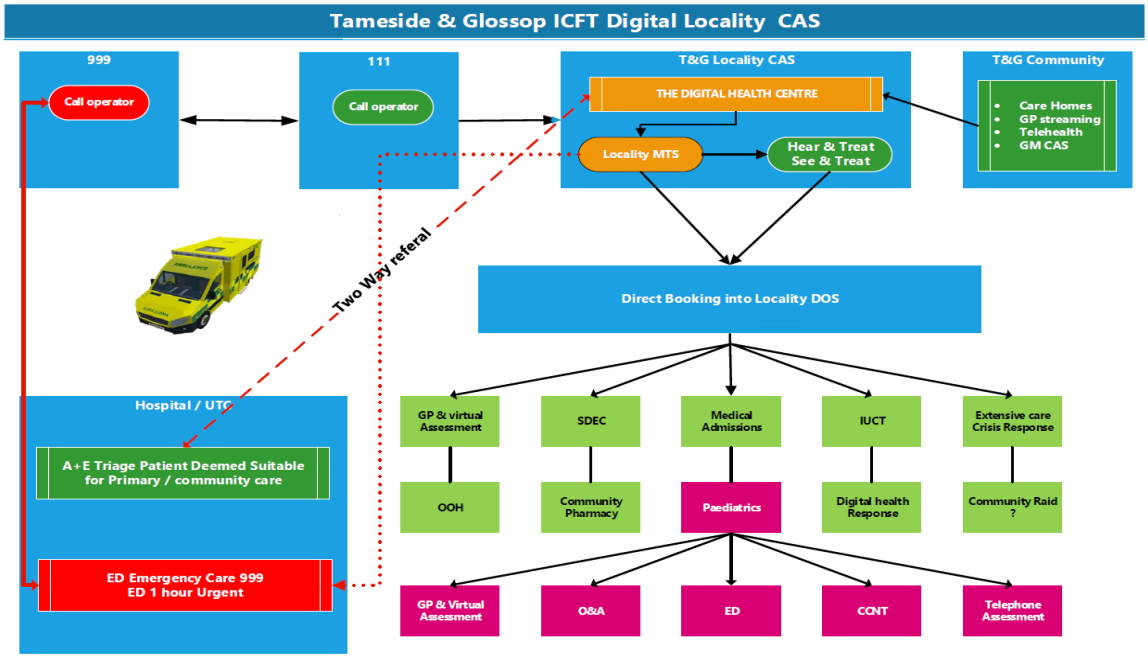
4.1 Tameside and Glossop recognised the opportunity to reduce attendances at ED and admissions in 2015 and developed several services as part of the Care Together programme that would not only reduce illness but also manage urgent care out of hospital, in particular Digital Health and the Integrated Urgent Care Team (IUCT). The Tameside and Glossop Locality plan, 'A Place-Based Approach to Better Prosperity, Health and Wellbeing' set out our vision for people who need urgent care. With a key expectation by 2022 that the most appropriate person within primary care (whether this is registered GP practice, dentist, pharmacy or optician or through a Locality-wide service) will assess people with an urgent care need on the same day. With either, a treatment plan agreed to manage the immediate need within that service or a safe transfer made to the care of another neighbourhood-based service.

4.2 Following a public consultation a more integrated Urgent Care Service was commissioned in 2018 that comprised the Primary Care Access Service (PCAS) and the UTC and that together delivered improved access to Primary Care based Urgent Care enabling people to book appointments for same day care as well as retaining the ability to 'walk in'.

4.3 These services along with existing ED front door streaming, Ambulatory Care (Same Day Emergency Care) and the developing Acute Frailty Services positioned Tameside and Glossop strongly when the Covid-19 pandemic focused attention on how systems mange Urgent and Emergency Care.

4.4 During 2020/21 local services have developed and Digital Health is the service that delivers clinical assessment for NHS 111 First between 08:00 and 22:00 seven days a week transferring to the GM CAS outside of these hours (calls in transfer at 21:00). The rationale for this being this role was already being undertaken by Digital Health for Health Care Professionals and Care Homes and the 999 stack was already being monitored and calls responded to as an alternative to an ambulance transfer when appropriate. This along with the local knowledge and situational awareness the team utilise was considered more beneficial than transferring responsibility to a GM CAS. A previous pilot to establish the benefit of extending Digital Health to 24/7 concluded it was not cost effective for the level of demand and there was no significant improvement in outcomes for individuals so it was therefore more effective to utilise the GM CAS overnight. Together these form the Locality CAS (LCAS)

4.5 The LCAS takes calls from NHS 111 and 999 where an Urgent but not Emergency response is seen as the likely outcome. Notification of the call is sent by NWAS and the LCAS aims to ring the patient back within 20 minutes to carry out a clinical assessment of their condition. From that assessment, it will be clearer which service can best meet the need and LCAS team will then give advice, signpost/refer or directly book the person in to an appropriate primary, community or hospital service as shown below. For some this may be booking an appointment with their own GP, PCAS or the UTC or it could be booking into a virtual appointment with an online GP.



4.6 For people identified as an Emergency either when they ring 111/999 or on assessment in the LCAS the details of the assessment will be sent direct to the ED informing the ED team that the patient is on route to them, so teams can prepare for their arrival. Where possible people will be booked into arrival slots as this helps support demand, it improves social distancing in the waiting areas and provides a much better experience for patients and staff. This 'heralding' also allows a safety net as people who are expected at ED but do not attend are known about so are contacted to understand why they have not attended and ensure their health is not at risk. Previously people were advised to attend ED but no one ever knew they were due so could not check on their health if they did not turn up.

4.7 IUCT already provided a community rapid response, in line with the GM standards, to support people in their own homes and along with the Digital Health/Community Response Service are able to assess people in their own homes with access to more specialist clinical expertise via a digital device. This is especially beneficial to people whom fall as they can be safely lifted with specialist equipment and their health needs assessed there and then avoiding any unnecessary journeys to hospital.

4.8 A new e-Triage area has now been fully implemented within T&GICFT ED with two 'islands' of iPads within the ED waiting room, each with four iPads, two of which are accessible for wheelchair users. These support the identification of people who could be seen in the UTC or SDEC rather than wait in ED.

4.9 When a person arrives at ED, they still go to the reception to book in and are then directed to complete the e-Triage (volunteers are available to help when needed). If the triage categorises them as a four or five, they are sent to the Blue Zone in order to be seen by an emergency nurse practitioner or the UTC. People categorised as three or below will be seen by a triage nurse who will check their condition and advise them of the best pathway to follow next (re-

direct to UTC/ Medical Same Day Emergency Care (SDEC)/Surgical SDEC/ or remain in the ED. This enable better utilisation of nursing staff and ensures people do not have unnecessary waits.

4.10 Some other systems may be triaging prior to booking into ED but the decision was taken locally to retain the booking process at the front door to minimise the risk that people may get missed either by not following processes as expected or by leaving without anyone knowing they attended. This decision was based on assessment around clinical safety and will mean that if the numbers booked into ED are used to evaluate effectiveness this may be a higher number than are actually treated in ED.

5. IMPACT OF UEC BY APPOINTMENT

5.1 The outcomes expected from UEC by Appointment included:

5.1.1 25% of self-presenter to ED utilise NHS 111 before attending

5.1.2 Increased number of people being directed to alternatives to ED

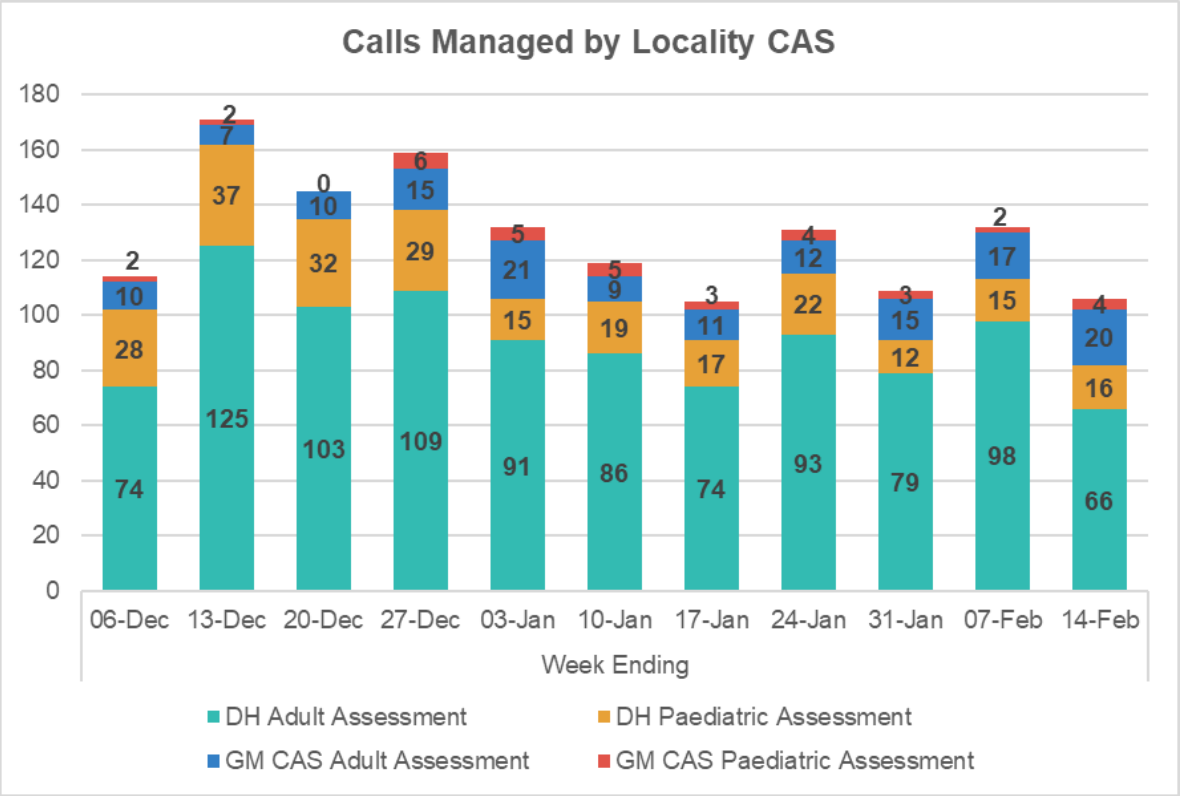
5.1.3 Fewer people within ED at any one time

5.2 It is still early days and the lack of availability of comprehensive and comparable datasets means it is difficult to demonstrate that the UEC by Appointment is delivering the above outcomes.

5.3 Whilst comparing Feb 20 with Feb 21 there has been an increase in calls with 725 more calls (3591 calls compared to 4316) it is not possible to be clear whether this was due to Covid or to NHS 111 First. We do know that in Feb-21 over 300 calls were for potential COVID-19 symptoms so Covid symptoms does not account for the total increase. However if 25% of ED self presenters were ringing 111 we would have expected an increase of around 1200 calls in Feb 21.

5.4 There has not been a significant change in where people who ring 111 are directed to with 11% recommended to attend A&E in Feb 21 compared to 9% in Feb 20 and 52% recommended to attend Primary/Community care in Feb 21 compared to 57% in Feb 20. The recording for those sent to the CAS is not clear and so further work is needed to be clear on the pathways all calls follow.

5.5 The level of calls managed by the Locality CAS has averaged at around 130 a week with GM CAS managing around 17 overnight (21:00 to 08:00) and Digital Health around 113.



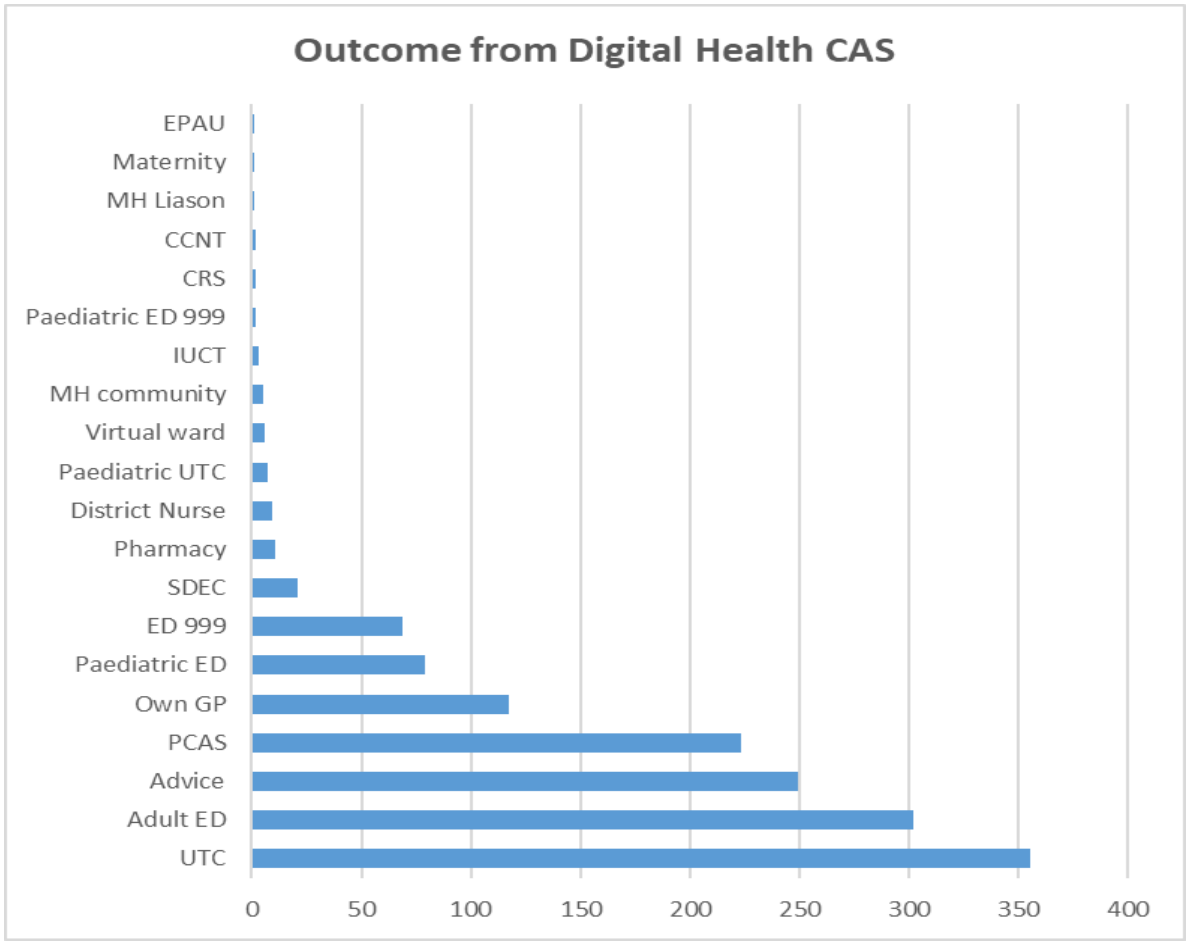
5.6 For the Digital Health time period the average number of calls increase as general practices close in the evenings and at weekend which is as expected. The transfer of call taking at 21:00 to GM CAS may explain the reduction at the end of the day.

Average Calls per Hour and Day	8	9	10	11	12	13	14	15	16	17	18	19	20	21	Grand Total
Monday	0	0	0	1	1	1	1	1	1	0	1	2	1	0	**9**
Tuesday	0	1	1	0	1	1	1	1	1	1	2	2	1	0	**12**
Wednesday	0	1	1	1	1	0	1	1	1	1	2	2	1	0	**11**
Thursday	0	1	0	0	0	1	1	1	1	1	2	2	1	0	**10**
Friday	0	0	0	0	0	0	0	0	1	1	2	1	1	0	**7**
Saturday	1	2	3	3	2	2	2	2	3	2	2	2	1	1	**28**
Sunday	1	2	3	3	2	3	3	2	2	2	2	2	1	0	**28**
Grand Total	**4**	**6**	**8**	**9**	**7**	**8**	**9**	**7**	**8**	**7**	**11**	**12**	**7**	**2**	**105**

5.7 The number of calls handled by GM CAS is much smaller but when considering the total number most happen before 02:00. There are some calls being incorrectly passed through to GM 08:00 to 20:59 and work is ongoing to ensure 111 utilise the correct service.

Total Cases	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Grand Total
Monday	2	7	2	2	2		3	3	2	1	1	1	1	1	1	2		2	2	1	1	2	4	3	46
Tuesday	1	6	1	2	1	2	2	3		1		1		1	1		1	1				6	3	1	34
Wednesday	3		4	1	1	3	2	2		1	1		2	1	2				3	1	1	6	6	4	44
Thursday	1	2		4	1	2	2	2		1		1	1					1	1			3	4		26
Friday	2	2	1	1		1	1				1		1	1	1	1			1	1	1	7	4	5	32
Saturday	7	1		2	2	2	2	3		2	1						1					3	8	7	41
Sunday	3	2	2		1		2	2				1		1								6	7	4	31
Grand Total	19	20	10	12	8	10	14	15	2	6	4	4	5	5	5	3	2	4	7	3	3	33	36	24	254

5.8 The outcome of the calls suggests that a significant number of people are supported without the need to attend the hospital and many do not need to attend any service.



6. CONCLUSION

6.1 Tameside and Glossop have been able to respond to the national and GM expectation around UEC by Appointment by building on the services already in place.

6.2 Whilst too early to be assured that there is a positive impact on ED there is evidence that people are able to be supported without the need to attend any service and it is possible to direct people to services that better meet their needs.

6.3 It is expected that over time the services and pathways will develop further to increase the opportunities to ensure people receive prompt and effective Urgent and Emergency Care as close to home as possible.

7. RECOMMENDATIONS

7.1 As set out at the front of the report.