NHS
South West
Clinical Senate

The South West Clinical Senate met on the 17th September 2015 at Taunton Rugby Football Club.

The question:

Giving due attention to issues of local clinical engagement and ownership whilst retaining focus on economies of scale, how will all health and social care communities move from their current provision of urgent and emergency care to meet the emergent national service standard?

1. *What services need to be co-located, consolidated or decommissioned?*
2. *Which sectors need strengthening and investment?*
3. *What is the workforce redesign required to support the national guidance?*

The Advice

The South West Clinical Senate met on **17th September 2015** to consider the local implications of the emerging consensus and guidance regarding the provision of **Urgent and Emergency Care** (UEC) following a national review, its recommendations and service specifications.

It is entirely supportive of the main thrusts of its outputs; namely:

1. Increased support and provision of information tools for self-help;
2. Sufficient skilled multi-professional resource in the community to minimise hospital attendance and admission;
3. Streamlined portals of entry to the UEC system that are: Simplified and readily comprehensible; Rationalised in their approach to assessment and available treatments; clearly publicised;
4. Clear expectations and ubiquitous minimum standards for Urgent Care Centres, Emergency Centres (ECs) with Emergency Departments (EDs) or Emergency Centres with Specialised Services (ECSSs) also with EDs;
5. Reformulation of the role of the Ambulance Service, strengthening its links with GP 'in-hours', 'out-of-hours' and other community admission avoidance services.
6. The concept of a well-functioning and intelligent clinical portal linked to NHS 111 implies better triage and disposition of patients and is critical to reducing duplication, preventing supply-induced-demand the overall function of the system.

The South West Clinical Senate makes the following comments and recommendations:

1. Whilst the configuration of the ECSSs is clear, there is considerable uncertainty about the location and co-dependencies of ECs and Urgent Care Centres (UCCs). Given that the new

system has to be delivered by 2017, it recommends that the two UEC networks covering the South West should complete the full stock take of existing facilities by the end of 2015 so that plans can be drawn up to meet the requirements to be in place by the required date;

2. Any commissioning organisation should consider not only the needs of its own geographical footprint but also the implications of its plans on contiguous areas and ensure optimisation of service provision from the end user's perspective;

3. The Clinical Hub and professional support provided by that hub needs sufficient expertise and detailed knowledge of the Directory of Services (DoS) to be able to sensitively select the most appropriate source of help for the patient. This requirement should have a higher priority than the shared business consideration of economies of scale as it is likely to lead to more appropriate and acceptable patient care and greater efficiency in the use of NHS and taxpayer resources than intervention from larger more remote call-centres. The importance of clinical adjacencies should not be underestimated (clinical specialties where support from related clinical disciplines is more likely).

4. Further to the above in point 3, this implies that NHS 111 should not be provided at a scale greater than that of a single UEC network and may well benefit from covering a smaller population that is coterminous with GP OOH units (supporting 1 to 1.5 million population). If coterminosity with GP Out of Hours (OOH) is not selected there should, as a minimum requirement, be direct links with senior professional support from GP OOH units ensuring that patients experience an integrated service with minimum 'hand-offs' between providers. As a principle, any patient's management plan should avoid onward referral unless clinical safely necessitates it – patients should not be required to have to attend facilities primarily due to insufficiently precise clinical risk assessment processes within a provider;

5. Although some triage can be done in isolation using various virtual technologies, there is a good deal of learning and peer support to be gained by working in actual multi-professional premises. The practical wider benefit is additional multi-professional clinical risk management gained from the physical presence of other professionals which has the potential of maintaining the care of a specific patient in a lower acuity setting and avoiding referrals. The implications for developing these 'Clinical hubs' relate to the physical facilities and their locations; the workforce redesign requirements; and future training of and support for these multi-professional teams;

6. Self-help needs to recognise the interplay of psychosocial factors such as isolation, social fragmentation and stress masquerading as 'physical' symptoms on presentations to UEC facilities. A range of easily accessible support needs to be available locally and perhaps virtually if this need is to be met more appropriately and we are to avoid medicalising patients psychologically generated symptoms. In addition, any net change on the burden of

responsibilities on carers should be considered when shifting care and services closer to home and their resultant needs should be addressed;

7. There will be a tension in more rural areas between the number of facilities and meeting the national specifications of an UCC. We welcome the clear rationalisation of terminology and standards of what constitutes an UCC. Whilst adherence to national service specifications is expected the overriding consideration should be the quality of service to populations of patients which may require some flexibility to meet the access needs of those local populations. This should not be taken to suggest that commissioners can avoid difficult decisions regarding inadequate or piecemeal services that do not meet national specifications which should either be decommissioned or upgraded to comply. It is imperative for commissioners to assure *inter alia* the provision of tele-medical services in remote locations; and ensure robust patient and user engagement processes in dealing with this and other controversial issues.