West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups
Meeting in public, Tuesday 5 June 2018
Response to questions

Question area : Elective care and standardisation

Question 1: **Changes in the commissioning of cataract surgery are reducing the opportunity to train the eye surgeons of the future. Ophthalmic surgeons develop the skills for microsurgery largely through cataract surgery, because it is the most common surgical procedure. The techniques can be extended to less frequently performed operations. How much consideration have the CCGs given to the effects that denial of training opportunities will have on the future quality of ophthalmologists? What monitoring is taking place?**

Response: Across the West Yorkshire and Harrogate (WY&H) Health and Care Partnership (HCP) there are a number of private providers of NHS eye care services as part of the Any Qualified Provider (AQP) Initiative. This is part of a Government commitment to increase choice and personalisation in NHS funded services. As part of the WYH HCP Elective Care Programme, we are working with all six NHS providers to optimise capacity and productivity. One effect of this is that the volume of NHS activity that is currently subcontracted from NHS providers to private providers will be reduced.

We recognise that the workforce issues are considerable in the programme of work to improve eye care services across WY&H. There is a national shortage of Ophthalmologists, and as demand for their services increases the workforce gap will grow. The NHS in WY&H, and indeed nationally, does not have the capacity currently to meet the needs of all people who require eye care and we are working with NHS England and NHS Improvement to address the challenges this currently poses. We understand the impact on workforce development of using private providers through the AQP initiative, and are well aware of the additional responsibilities that NHS providers have for training and development of the workforce. We will be taking this into consideration in the development of our plans as it has fundamental importance to the future sustainability of eye care services across WY&H.

Question 2: Is the Committee aware of criticisms of the Rightcare methodology, and if so, how is it taking account of them?

Response: Rightcare does not provide 'perfect solutions', but is a tool to support improvement. It highlights variation, and the data is then used with localities to explore whether the variation is warranted. There is significant challenge of the data locally. Rightcare is used as a basis for discussion.

Question area: Urgent and emergency care

Question 3: How will 111 services link with Clinical Advisory Services in the new Integrated Urgent Care service? What route would patient calls to 111 take? Would this involve a tele or face to face consultation? How realistic is the requirement that the CAS team will complete the consultation without referring the patient to A&E or elsewhere?

Response: NHS England have produced a detailed service specification. It is a very complex area, and we have chosen a dialogue with providers to ensure that our response is the right one.

A patient or their carer would have the choice to call NHS111 or access NHS111 Online. A call is handled in conjunction with an initial assessment decision support tool known as NHS Pathways which allows the call-handler to identify the most appropriate next course of action (referred to a 'disposition'). If NHS111 Online is used then the questions asked within the application take the user to a similar point in identifying a disposition. In both cases where it is appropriate the caller/user will be connected to a Clinical Advisor who will further establish what the clinical need of the caller/user is. The target for the number of contacts that would then have access to this clinical advice is 50% of all calls made to NHS111. Dependent on the disposition the outcome could result in a further telephone conversation or a face to face consultation with a clinician.

It is anticipated that a high proportion of calls will be 'completed' without the requirement of referring the patient elsewhere. In 2017/18 of the calls received by NHS111 across Yorkshire & Humber 10.1% resulted in a despatch of an ambulance; 49.2% were passed to primary care of which 37.6% were out of hours; with 16.9% being completed with a self-care disposition.

Question 4: How are Attain involved in the procurement process and how much are they being paid?

Response: The procurement of an Integrated Urgent Care service across Yorkshire and the Humber, including 3 STP areas, is a very complex process. The process involves competitive dialogue with providers through to mobilisation of the new service. An assessment of the resource required to manage and support the process determined that external capacity was needed to work alongside existing NHS staff. An exercise was undertaken to source a partner that could fully provide this support. Attain were identified as the most suitable partner, providing the best value for money when compared to alternative sources of support. The cost of this engagement is £238k.

Question 5: What stage has the procurement process reached?

Response: Expressions of interest have been sought. There were 18 initial expressions. Fewer than 5 selection questionnaires were received, and these were now being evaluated.

Question 6; Why do the WY CCGs not want urgent care services to be part of the Integrated Urgent Care service?

Response: In WY, 111 services have historically been linked to the out of hours service. This is a different service model to that in Yorkshire and Humber. The aim of the IUC procurement process is to connect services, to make it easier for the public to understand and navigate the system and to improve access to services.

Question 7: How can the CCGs consult on the proposals when the procurement process has already started?

Response: Local consultation was not appropriate because all commissioners are being required by NHS England to fulfil the national IUC service specification.

Question 8: How will the impact of patient choice be addressed and how is the learning from the WY Urgent Care Vanguard being used?

Response: The Vanguard learning has underpinned the work in WY and nationally. For example, the approach to clinical advice was based on the Vanguard learning. Learning from 111 referring into GP in-hours services was also being rolled out nationally.

Question area: CVD and diabetes

Question 9: Was the Committee aware of concerns that use of statins may build up problems for the future?

Response: The learning from Bradford Healthy Hearts showed a demonstrable reduction in the number of people suffering heart attacks and strokes. (More detail was provided as part of the item later on the agenda)

Joint Committee governance – risk management

Question 10: Why was the risk relating to cancer so high?

Response: This risk relates to financial penalties relating to the 62 day performance targets. Plans are in place to address this.

Question 11: Why did new stroke models of care create workforce risks?

Response: Workforce is a risk in relation to existing models of care and would continue to be a risk for new models.

Question 12: What did the 50% target refer to in relation to urgent care, and why was it a risk?

Response: This referred to access to clinical advice. This was being addressed through the current procurement process.

Question 13: What were the urgent care risks in relation to system integration and inter-operability?

Response: The current procurement process was designed to ensure that there was inter-operability between all parts of the system, including information technology.

Question 14: Standardisation of commissioning policies – why was public and politician resistance a risk?

Response: The risk relates to change management, and the need to ensure that all parts of the system supported effective prevention.