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ISLINGTON

Governance and Human Resources
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE JOINT OVERVIEW AND SCRUTINY COMMITTEE ON HEALTH

A meeting of the Joint Overview and Scrutiny Committee on Health will be held in on, **11 March 2016 at 10.00 am.**

John Lynch
Head of Democratic Services

Islington Council nominee is **Councillor Martin Klute**

See Agenda Reports Pack for full details

1. Agenda 1 - 84

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 11 MARCH 2016 AT 10.00 AM
COMMITTEE ROOM 4, TOWN HALL, JUDD STREET, LONDON WC1H 9JE

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MEMBERS

Councillor Alison Kelly (LB Camden) (Chair)
Councillor Pippa Connor (LB Haringey) (Vice-Chair)
Councillor Martin Klute (LB Islington) (Vice-Chair)

Councillor Alison Cornelius (LB Barnet)
Councillor Graham Old (LB Barnet)
Councillor Danny Beales (LB Camden)
Councillor Abdul Abdullahi (LB Enfield)
Councillor Anne Marie Pearce (LB Enfield)
Councillor Charles Wright (LB Haringey)
Councillor Jean Kaseki (LB Islington)

Issued on: Thursday, 3rd March 2016

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 11 MARCH 2016

THERE ARE NO PART II REPORTS

AGENDA

Wards

1. APOLOGIES

2. DECLARATIONS OF INTEREST

3. ANNOUNCEMENTS

4. NOTIFICATIONS OF ANY ITEMS OF BUSINESS THE CHAIR DECIDES TO TAKE AS URGENT

5. MINUTES (Pages 5 - 18)

To consider the minutes of the meeting held on 29th January 2016.

6. GPS IN CARE HOMES (Pages 19 - 32)

To consider a report on primary care in care homes.

7. WHITTINGTON HOSPITAL - DEVELOPMENT OF ESTATES STRATEGY (Pages 33 - 38)

To consider a report of the Whittington Health Chief Executive.

This provides a summary of the Whittington Health Estate Strategy, which was approved by the Board in February 2016.

8. PROCUREMENT OF URGENT INTEGRATED CARE SERVICE (111/OUT OF HOURS) (Pages 39 - 82)

To consider a report on the procurement of an urgent integrated care service for North Central London.

9. WORK PROGRAMME

(Pages 83 - 84)

To consider the work programme for North-Central London JHOSC.

10. DATES OF FUTURE MEETINGS

Proposed dates for future meetings:

- Friday, 17th June 2016 @ 10am (Islington)
- Friday, 30th September 2016 @ 10am (Haringey)
- Friday, 25th November 2016 @ 10am (Barnet)
- Friday, 27th January 2017 @ 10am (Enfield)
- Friday, 17th March 2017 @ 10am (Camden)

11. ANY OTHER BUSINESS THE CHAIR CONSIDERS URGENT

AGENDA ENDS

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THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 29TH JANUARY, 2016** at 10.00 am in the Council Chamber, Enfield Civic Centre, Silver Street, Enfield EN1 3XA

MEMBERS OF THE COMMITTEE PRESENT

Councillor Alison Kelly (LB Camden) (Chair)
Councillor Pippa Connor (LB Haringey) (Vice Chair)

Councillor Graham Old (LB Barnet)
Councillor Alison Cornelius (LB Barnet)
Councillor Charles Wright (LB Haringey)
Councillor Jean Kaseki (LB Islington)
Councillor Ann-Marie Pearce (LB Enfield)
Councillor Abdul Abdullahi (LB Enfield)

OTHERS IN ATTENDANCE

Andy Ellis, Scrutiny Officer, LB Enfield
Jane Juby, Scrutiny Officer, LB Enfield
Rob Mack, Principal Scrutiny Support Officer, LB Haringey
Vinothan Sangarapillai, Committee Services LB Camden
Jonathan Hampston, Public Affairs and Consultation Manager, North and East London Commissioning Support Unit
Julie Juliff, Maternity Commissioning Lead, North Central London CCGs
Laura Andrews, Patient and Public Engagement Manager, Enfield CCG
Claire Wright, Enfield CCG
Catherine Swaile, Haringey CCG and LB Haringey
Nicola Wise, Head of Hospital Inspection, CQC

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the. North Central London Joint Health Overview and Scrutiny Committee.

MINUTES

1. APOLOGIES

Apologies for absence were received from Councillor Danny Beales, Councillor Martin Klute and from Cllr Alison Cornelius for lateness.

2. DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

The Declarations of Interest made at previous meetings were **NOTED.** There were no further Declarations of Interest.

3. ANNOUNCEMENTS

The Chair reported that the Chief Executive of the Whittington Hospital had been due to attend the meeting to update on the Lower Urinary Tract Review but, as the review was still in progress, it was felt to be better that he attend at a later date.

Cllrs Beales and Kelly had been due to visit the University College Hospital Stroke Unit but this had been postponed. Thanks were expressed to Cllr Pearce for the recent meeting regarding stroke services which had provided useful information to take back to individual boroughs.

4. NOTIFICATIONS OF ANY ITEMS OF BUSINESS THE CHAIR DECIDES TO TAKE AS URGENT

There were no notifications of items of urgent business.

5. MINUTES

The Minutes of the Meeting held on Friday 27 November 2015 were **AGREED** as a correct record.

6. MATERNITY SERVICES UPDATE

Julie Juliff gave the following update, the key points of which were as follows:

- The purpose of the report was to ensure Value for Money and safe services were the key priorities.
- The birth rate seemed to have levelled off at present; however the Royal Free, Barnet and University College Hospitals were reporting increased activity this year. It was not yet clear why this was the case, whether growth is from our boroughs or that people from outside the NCL boroughs accessing the service may be contributing to the situation.
- JJ's role is to assist the North Central London CCGs (Clinical Commissioning Groups) to commission and monitor outcomes , as well as participate quarterly reviews into maternity for each Trust.
- A maternity dashboard had been implemented this year which indicated Trusts' performance. All outcomes put onto the dashboard were now being reported on.
- Data for the third quarter would shortly be available.
- There would also shortly be enough comparative data to analyse.

- Referring to the recent CQC (Care Quality Commission) Maternity Survey, it was noted that London generally had lower levels of patient satisfaction. A presentation was available which gave further details and could be circulated **ACTION: Rob Mack**
- All Action Plans were being collated at the moment.
- At the time of the CQC Survey, the North Middlesex University Hospital's new Head of Midwifery had not yet been in post and this may have impacted upon results.

The following questions and comments were then taken:

Cllr Kelly, based on a meeting with the Trust, noted that throughput at the Whittington Hospital was a concern as there were a lower number of births at this hospital than at others and so there was concern that not enough experience was being built up there. Councillors questioned whether there was a view that there were too many providers in the North Central London area. Julie did not feel this was a concern currently.

CQC Maternity Survey 2015

Q: Why did the CQC Survey take so long to complete?
A: The CQC would have been responsible for these timescales.

Cllr Old commented that the results of the Survey were disappointing and worrying in respect of the North Middlesex University Hospital, given that he had recently visited the Hospital with Cllr Bull and morale appeared to be high after the recent move of maternity services from Chase Farm.

Julie Juliff replied that the Survey had been undertaken in February of last year and that she expected that the situation had improved since then. However, the intention was to look into this further. It was also important to note that comparisons had been made against national, rather than London, data.

It was also noted that the fabric of a building surveyed may well have affected results on cleanliness; and it was difficult to deep clean an older building.

Maternity Dashboard

Cllr Kelly referred to the maternity dashboard, and asked if any additional indicators should be added.

Julie Juliff replied that the purpose of the dashboard was primarily to monitor clinical outcomes to help clinicians understand their performance.

Antenatal Screening and Caesarean Sections

It was noted that current focus was on ensuring antenatal screens were carried out by 12 weeks of pregnancy; however, it was now recognised that screening should be carried out at 10 weeks for Sickle Cell anaemia and Thalassaemia and 13 weeks for Downs Syndrome.

Monitoring of the Caesarean Section rate needed breaking down further to understand what proportion of them were for first time mothers and how many were planned or emergency procedures. There was potentially too high a proportion of elective C-Sections and these were being checked to ensure all NICE (National Institute of Health and Care Excellence) guidance was being followed in this respect.

A resident commented that it should be recognised that North Middlesex University Hospital was situated in a very diverse community and there were particular pressures on its services that should be taken into account. He also raised the issue of un-booked deliveries which would place extra, unforeseen pressure on maternity services and thought these could be better managed.

It was then asked how the North Central London area compared to other areas in respect of antenatal screening.

Julie Juliff responded that the area compared favourably with the rest of London, especially given the greater mobility of the population. It was not known, however, how it compared with other large cities, such as Manchester as this data is no longer collected nationally. Work was ongoing with GPs to improve referral rates and a research project was also being conducted with East London University to determine what may prevent women from booking screens – cultural issues may be a factor.

Un-booked Deliveries

Cllr Kelly asked whether there was any data on un-booked deliveries, particularly for the North Middlesex University Hospital, to understand better the circumstances around these.

Julie Juliff replied that one factor could be that such mothers did not have a registered GP and this may be because of their residency status. It was important to note however, that maternity care could not be withheld if someone was unable to pay for that care.

Cllr Kelly suggested that there should be further work undertaken with local community groups to reassure and work with such mothers.

Perinatal Mental Health

Julie Juliff reported that important work was ongoing in this area for mothers during and after pregnancy.

It had been recognised that there had not been a fully formed service up until now, and workshops had recently been held with commissioners to develop a strategy.

Implementation of the strategy was now under consideration. It had been agreed that the service at the Whittington Hospital would be the starting point for development going forward and that the aim was to create a single North Central London service with one central referral point and clearer pathways.

Development work would continue through 2016/17; an update was proposed for a future meeting.

Cllr Cornelius commented that she felt there was a particular issue with providing effective perinatal mental health services at the North Middlesex University Hospital. The new service should provide clinical specialities at all hospitals across all Boroughs and should be consistent.

Julie Juliff commented that, in addition, all maternity staff were currently receiving training in order to better identify potential patients in need of the service.

It was asked if anyone identified as needing the service transferred to the Whittington Hospital. Julie Juliff responded that those with severe issues could be referred to the Mother and Baby Unit at the Homerton.

Cllr Cornelius expressed concern at how support would be provided until the full, new service was up and running and asked what 'safety net' was in place during the transition period?

Julie Juliff replied that Haringey CCG had recently released funds to the Barnet, Enfield and Haringey (BEH) Mental Health Trust to increase the level of service it could provide in this regard in the meantime.

The Committee **AGREED** that an update on 'Stop Gap' services be provided to them in 6 months' time **ACTION: Vinothan Sangarapillai**

It was further **NOTED** that as yet, comprehensive figures for perinatal mental health cases were not available; but these would be collected in the near future. It was also acknowledged how significant an impact mental health issues in the mother could be upon a child's psychological health. It was also **NOTED** that 50% of those women who had an existing mental health condition were likely to relapse during pregnancy but this was often difficult to predict.

The issue of specialist units to deal with patients developing psychosis was raised. It was **NOTED** that the Mother and Baby Unit at the Homerton Hospital was the primary service point for this, and this was operated by NHS England (not the CCG). It was **AGREED** that mothers should be referred to this Unit wherever possible, rather than standard adult psychiatric care.

Cllr Kelly then asked how maternity services were co-designed with users. Julie Juliff responded that it had been difficult up to now to find service users willing to participate but that the Maternity Services Liaison Committee did involve them. It was **AGREED** that there was room for improvement in this regard.

Cllr Abdullahi raised the issue of substance misuse among pregnant women and asked how big a problem this was. The figures for this would be obtained **ACTION: Julie Juliff.** More information on how local authorities currently worked with DAATs (Drug and Alcohol Teams) was also requested **ACTION: Julie Juliff.**

Referring to the final pages of the report, the Committee acknowledged that much positive work had been done across both local and London wide networks in reducing the numbers of stillbirth.

Members of the Committee then expressed concern that there may be, in fact, too much provision and that consequently, this may impact on overall safety.

Julie Juliff responded that there was no evidence this was the case and that all services were NICE compliant, with staffing levels as they should be.

Cllr Kelly asked if safety was less of a concern in larger units. Julie Juliff responded that this was debateable and that a unit needed to be of significant size in order to ensure 24 hour cover. In addition, larger units may not be what patients wanted; proximity may be more of a concern. Development of services going forward was essentially about creating the right models, rather than the right buildings.
Cllr Wright asked if Ms Juliff undertook commissioning across the whole sector. Julie Juliff responded that she worked for the Lead CO for maternity, on behalf of all CCGs, and did commission across the whole sector. At present, each CCG commissioned their own services but were looking to increase joint commissioning.

Referring to mortality rates in childbirth, the Committee requested further data in this regard (data was published annually both nationally and by Borough) **ACTION: Julie Juliff.**

Referring to the Appendix provided by Imperial College, London, the Committee expressed concern at the data provided for Great Ormond Street Hospital. Cllr Kelly commented that Imperial College had been invited to the meeting, but were not available.

In conclusion, the three key strategic risks for maternity services across the North Central London area were identified as being:

a) Perinatal mental health;
b) Ensuring value for money whilst maintaining patient safety;
c) Patient experience.

The Committee made the following **RECOMMENDATION:**

1. That further work be undertaken to improve the involvement of local people in co-designing services.

7. CQC INSPECTION PROCESSES

The Chair introduced Nicola Wise, Head of Hospital Inspection and reiterated the wish of the Committee to receive **written** reports in future rather than presentations.

Nicola Wise outlined the CQC inspection process as follows:

- The CQC carried out both inspection programmes and enforcement;
- There had been a significant shift from short, one day inspection visits to comprehensive reviews carried out by a team of inspectors over a number of days.
- Certain experts were sometimes also engaged to support inspections.
- The inspection programme covered three main areas:
    - Hospitals;
    - Mental Health services; and
    - Adult Social Care.
- Primary medical services were also inspected.
- Inspection concentrated on determining if services were:
    - Safe;
    - Effective;
    - Caring;
    - Responsive; and
    - Well led.
- Inspections looked at, for example, fundamental staffing standards, staff interaction with patients, management awareness of issues and how organisations approached learning.
- Inspections did not try to 'catch people out' but helped to identify areas of good practice and aimed to work with organisations.
- There were two further Comprehensive Inspection Reviews planned for University College Hospital, London and the Royal Free Hospital. Camden and Islington Mental Health Trust also had an upcoming inspection.
- In addition to planned inspections, the CQC could also undertake an inspection in response to specific concerns. Follow-up inspections after these ensured appropriate action had been taken.
- Inspections resulted in the following ratings:
    - 1 – Outstanding;
    - 2 – Good
    - 3 – Required Improvement;
    - 4 – Inadequate.

- If an organisation received a 3 or 4 rating, a 'Quality Summit' meeting would be held with that organisation to ensure plans were in place and a warning notice would be issued. A follow-up inspection would also be undertaken after 6 months.
- Nicola Wise expressed the wish of the CQC to work more closely with bodies such as the JHOSC to share information and create a working dialogue.

The following comments and questions were then taken:

Cllr Kelly asked if the CQC had approached the relevant Lead Members for Health regarding the upcoming University College Hospital and Royal Free Hospital inspections. It was felt that there was a lack of clarity as to who was involved with and aware of such inspections.

Cllr Connor commented that the North Middlesex University Hospital, after its inspection, had seemed uncertain as to the time frame for follow-up action. Cllr Connor endorsed Cllr Kelly's view that there should be improved consideration of who should be involved both before and after inspections and there needed to be improved feedback to stakeholders such as the JHOSC.

Cllrs Kelly and Cornelius also commented that there was also a lack of appropriate notification around Quality Summit meetings.

Cllr Pearce enquired as to how many days and how big a team was required to undertake an inspection. Nicola Wise responded that a Comprehensive Inspection usually took 3-4 days with a team of 30-50 people. An analyst was sometimes also engaged to work on the team who may put forward data requests prior to the visit. After the inspection visit was completed, a report would then be drafted and this would usually take up to 2 weeks. If very serious issues of concern were found during the inspection, a follow-up visit would take place at a much sooner date than the usual 6 months.

Cllr Kelly acknowledged that it was a difficult task to remain consistent in approach with all hospitals across the country and recognised the CQC's work in this regard.

A resident attendee asked if hospitals were aware that an inspection was due to take place.

Nicola Wise responded that for a Comprehensive Inspection, hospitals would be notified.

The resident responded that false impressions could be created if a hospital was aware of an inspection and suggested that unannounced inspections, during the day and evening, should be undertaken.

The Committee **RECOMMENDED** that:

1. A letter be sent to the London Scrutiny Network to ascertain if there was a national framework for engagement and public local accountability, especially with regard to Quality Summits;
2. That information be provided on the level of spend per hospital (to include Great Ormond Street and the Camden and Islington Mental Health Trust) in preparing for an inspection.

Nicola Wise would also circulate the presentation for this item **ACTION: Nicola Wise.**

8. NEW MODEL FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

Claire Wright, Enfield CCG and Catherine Swaile, Haringey CCG and Haringey Council, introduced the new model for CAMHS as follows:

- The Government's Autumn Statement had provided new money for CAMHS services, initially to fund a number of pilot projects. Two pilot projects had been successful in obtaining funding in the North Central London area; these aimed to create closer links between schools and statutory services.
- The remaining funding would be disaggregated to Boroughs via CCGs.
- A standard 'blanket' formula for disaggregating funding had been applied which had not recognised Borough profiles.
- Across the North Central London area there were currently a variety of providers of CAMHS which had resulted in a complex overall picture.
- Individual Boroughs were therefore working on Transformation Plans to improve and develop more coherent services.
- Some services operated as shared services across Boroughs, for example, those for Eating Disorders. Boroughs in these cases were therefore working together to ensure the right level and parity of investment.

The following questions and comments were then taken:

Q: Why are CCGs providing services for eating disorders; was this not originally provided by NHS England?
A: Community services are provided by CCGs.

Q: There is a minimum standard for all services but there appears to be different offers in different Boroughs. Does this not lead, in effect, to a 'postcode lottery'?
A: There is an acknowledged lack of parity, where this is the case funding is being targeted locally to ensure improved standards. These are outlined in each borough's Transformation Plan.

Q: How are the funding allocations determined?
A: These are determined by NHS England, devolved to CCGs.

Q: Is it the case that the North Central London area has one of the highest numbers of mental health cases and, consequently, why investment by the corresponding CCGs is quite high?
A: There is a concern that, in some areas, levels of spend are actually lower than they should be; for example, in Haringey.

Members of the Committee expressed a wish to see in further detail how spend was allocated across boroughs and whether there were any historical reasons for this. Cllr Old, however, felt that this may be of limited value and that it may be better to focus more on outcomes.

It was **NOTED** that national minimum data sets would be available from February and outcomes could be determined more clearly from these.

The issue of mental health services within schools was then discussed. It was **NOTED** that spend within schools was not included in current captured data. Ofsted regulations had imposed some duties on schools to offer emotional support; but there was a lack of clarity as to what this should be.

It was suggested that it might be useful to undertake an audit of schools to determine what services they provided and their expenditure. Such information could be obtained from the local authority; or directly from the school if it was not local authority maintained.

Cllr Wright commented that there appeared to be a significant stream of funding and commissioning of CAMHS within schools that were as yet not fully known and that these were likely to be early intervention services that were critical to children's ongoing development.

Cllr Abdullahi asked how the transition from CAMHS to adult mental health services was currently managed and how it would be further developed. Were CCGs confident that transition was happening successfully?

Claire Wright responded that development plans in this respect had been detailed in Enfield's Transformation Plan for next year but that it was in fact the overriding intention to avoid the need for transition completely i.e. that mental health issues were resolved before adulthood. There was no current evidence that where transition was necessary, this was not being managed successfully in Enfield; however, Cllr Abdullahi was invited to report any concerns to them.

Cllr Cornelius commented that she felt Haringey's Transformation Plan appeared to be redeveloping services 'from the beginning' and thought that some of this work should have already taken place.

Catherine Swaile replied that there were overall good services being provided in Haringey but that the Transformation Plan identified gaps. There would be greater focus on using evidence bases nationally to help improve outcomes. This was not to say, however, that outcomes were not already good.

Cllr Kaseki asked what provision was or would be, in place for the most vulnerable patients.

Claire Wright and Catherine Swaile responded that the Future in Mind initiative would cover 5 areas which included care for the most vulnerable (for example, those on the Autistic Spectrum). The 5 year plan had just commenced to establish current provision and performance, and develop on these.

It was then asked whether services were being co-designed with the community.

Claire Wright and Catherine Swaile replied that this was a key tenet of the Transformation Plans and that the Plans had undergone an assurance process to check that community had been appropriately engaged. It was also confirmed that GPs had been engaged in the process.

The Committee made the following **RECOMMENDATIONS:**

1. To keep CAMHS a priority and a partnership;
2. That prevention be looked at as a key element of the service;
3. That each Borough's appropriate Scrutiny Panel see and review their Transformation Plans in more detail.
4. That CAMHS be brought back to the Committee for review of initial outcomes of the Transformation Plans and any learning within the next year.
5. That data on schools be collated to identify the types of services and spend thereon.
6. That the Risk Registers for each Borough be circulated.

9. TERMS OF REFERENCE AND PROCEDURAL ARRANGEMENTS FOR NORTH-CENTRAL LONDON JHOSC

It was proposed that a list of services commissioned by NHS England should be included as a rolling programme for agenda items entitled 'Specialised Commissioning' **ACTION: Rob Mack**

It was **NOTED** that, as the borough which currently provided the Chair, LB Camden was required to provide officer support to the Committee but that it did not have allocated support in additional to general administrative support from Committee Services.

It was **RESOLVED** that LB Camden work with the other participating authorities to ensure an appropriate level of support for the Committee, and that a letter would be drafted for the Chair in this regard **ACTION: Vinothan Sangarapillai**

10. WORK PROGRAMME

11 March 2016

Primary Care Update on the 'Case for Change' – it was **AGREED** that the Islington CCG lead and NHS England representative be invited for this item **ACTION: Rob Mack/Vinothan Sangarapillai**

NHS/111 Out of Hours GP Services – Commissioning – it was **AGREED** that the Islington CCG lead and NHS England representative be invited for this item **ACTION: Rob Mack/Vinothan Sangarapillai**

North Central London CCG Strategic Planning Group – It was **AGREED** that an Enfield CCG representative be invited for this item **ACTION: Rob Mack/Vinothan Sangarapillai**

Potential Future Items

It was **AGREED** that the following be added:

- GP Care for Older People in Care Homes;
- Whittington Hospital – Estate Strategy
- Sexual Health Update

It was **AGREED** that the GP Care for Older People in Care Homes item be brought to a future meeting, that Cllr Abdullahi draft proposed questions for the Committee on this item and that an Enfield CCG representative be invited in this regard **ACTION: Rob Mack/ Vinothan Sangarapillai**

11. DATE OF NEXT MEETING

It was noted that the next meeting would be on 11th March 2016 at Camden Town Hall.

12. ANY OTHER BUSINESS THE CHAIR CONSIDERS URGENT

It was **AGREED** that a meeting on the BEH MHT Quality Accounts should be held. It was **AGREED** that Cllr Cornelius chair this meeting.

The meeting ended at 1pm.

CHAIR

Contact Officer: **Vinothan Sangarapillai**
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MINUTES END

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Joint Health Overview & Scrutiny Committee

Agenda Item:	
Subject:	**Primary Care-Related Support for Residential & Nursing Care Residents**
Date Of Meeting	**11th March 2016**
Report Of:	NCL CCGs
Contact Officer:	Paul Allen, Integrated Care Programme Manager, NHS Enfield CCG
E mail:	Paul.allen@enfieldccg.nhs.uk

1. EXECUTIVE SUMMARY

2. This report summarises how the 5 CCG fulfil their responsibilities in relation to ensuring residents of nursing and residential care homes have access to primary, community, secondary and other health services as all citizens have.

3. As each of the CCGs has a different population and care home market in its borough, the discussion below indicates the different ways each of the CCGs, working with partners such as relevant Councils and/or community health services, currently fulfils or plans to fulfil their responsibilities, including the right for patients to be registered with, and have ongoing healthcare management by, a GP practice of their choice. The paper also outlines how each CCG supports GPs and care homes themselves to fulfil their responsibilities to their residents and their families and the degree to which they are successful in doing so.

4. **RECOMMENDATIONS**

5. The Joint Health Overview & Scrutiny Committee is asked to note the contents of this report.

Primary Care Support for Residential & Nursing Care Residents

6. BACKGROUND

7. Residents of nursing and residential care homes are entitled to access to primary, community, secondary and other health services, including the right to be registered with a GP (Department of Health, *NHS-funded Nursing Care Practice Guide July 2013 (Revised)*, 2013).

8. Within the national GP contract with NHS England, practices with open case lists therefore accept new patients who choose to register with them, and this include patients who are in or have recently moved to residential or nursing care homes. This transfer of cases from one practice to another becomes particularly important when the care home is in another part of, or outside, the patient's original Borough. For example, it is estimated around 15% of residents aged 65 and over in Enfield care homes were originally resident in Borough's outside of Enfield, often from inner London areas with no or very limited care home accommodation.

Most of these patients (or their representatives on their behalf) will choose to register to an Enfield practice on moving to a home in that Borough.

9. The patient or their representatives should have a choice over whether to move and onto which practice to register. There are significant personal and logistical advantages to registering with a nearby practice and most care home residents (particularly those originating from another Borough) choose to do so. A number of homes have developed individual working arrangements with one or more nearby practices to manage the health cases of their residents. This includes initial registration and ongoing health management with staff working in the homes.

10. The health management of residents in these care homes can be complex compared to the general population, with a greater number of vulnerable patients with co-morbidities and/or physical frailty. For example, it is estimated two-thirds of people with advanced dementia reside in care homes. Patients who are in or admitted to care homes are therefore likely to need a greater intensity of health management and resources than the general population. Individual CCG areas have evolved strategies for supporting residents and to support care homes and GPs to fulfil their responsibilities (see below).

11. In this context, it should be noted there is a CCG responsibility to ensure community health services available to people at home are available to care home residents. How CCGs comply with this requirement will vary – different models across North Central London CCGs are discussed below.

12. CONTEXT AND SOLUTIONS IN ENFIELD

13. London Borough of Enfield's Market Statement states there are currently 101 residential and nursing care homes (40 older people's care homes) in the Borough registered with the Care Quality Commission, providing a total bed capacity of 2,029, three-quarters of which are for older people. The breakdown by care home type is shown in the figure below. The Care Quality Commission had inspected 56 of Enfield's care homes under its new inspection approach. CQC rated 80% of these homes as "good" with 20% requiring improvement. Along with Barnet, Enfield has a significantly higher number of care homes than the other 3 areas in the North Central London cluster.

14. NHS Enfield CCG recognised there needed to be significant investment in the support available to care homes to manage the health of their residents with the CCG's GPs. Several strategies have developed to do so over the last 3-4 years as outlined below.

15. *Older People's Care Homes*

16. NHS Enfield CCG, London Borough of Enfield and their partners in the Health & Well-Being Board made a decision to invest in a multi-disciplinary, multi-agency Care Homes Assessment Team (CHAT), commissioned and provided by Enfield Community Service from 2013. CHAT is a NHS community nurse-led prescribing team with acute geriatrician input working closely with other professionals to help manage the health of care home residents sustainably. CHAT's objectives are two-fold:
    - Working with GPs and care home staff (including their nurses), to successfully and pro-actively manage the cases of individual residents with complex and progressive needs such as co-morbidities and/or physical frailty. This leads to optimising the quality of life and health and well-being of individual residents and makes better use of direct health care resources (e.g. reducing the need for as intensive GP input and follow-up) and indirect resources (e.g. reducing the risk of hospitalisation of individual residents). It also allows issues such as safety or quality risks to be identified and addressed early in

conjunction with the homes and with the London Borough of Enfield (e.g. provider concerns or safeguarding alerts);

- To provide a lasting legacy in the homes through improving the quality of care and upskilling the care home's staff in a variety of nursing and care duties. This workforce development is accomplished through a mix of multi-disciplinary formal staff training workshops (e.g. fall prevention with therapists or end-of-life care with hospice staff) conducted in the homes and "on-the-job" training and development with CHAT through managing residents' health ("doing with" rather "for" care home staff) to consolidate skills and training.

17. CHAT originally covered 7 older people's care homes in Enfield with the highest level of emergency admissions and/or concerns over the health management of these patients. As a result of its impact and popularity with care homes, residents/carers and GPs, additional CHAT investment means the service now covers 40 care homes with plans to cover all 48 in Enfield by the end of Mar-16. CHAT's success has led to its increased investment over the last 3 years. Some of its key outcomes are:
    - CHAT undertook 4,000 joint health assessments or reviews of residents in the care homes with care home staff, GPs and residents and families in which it covered in 2015 through clinics held regularly in the homes (weekly to monthly depending on the home);
    - One of CHAT's functions is to optimise the care of individuals and this includes advising on better management of multiple medications patients may be receiving. As a result of the CHAT intervention, 25% of residents had reduced numbers of medications in 2015;
    - Of those end-of-life patients in CHAT-covered homes who died, all did so in their preferred place of death (primarily the care home rather than in hospital) in 2015 as a result of CHAT and GPs working with individuals (and their families) to develop End of Life Advanced Care Plans. By comparison, the corresponding position in Enfield for all older people living in the community was 37% for 2013/14;
    - There was a sustained reduction in the levels of hospitalisation as a result of CHAT's involvement. For example, there was a 17% reduction in the number of emergency hospital admissions from care homes between Apr-Oct-14 and Apr-Oct-15 (the latest period for which figures are available) which became covered by CHAT in 2014/15;
    - CHAT is highly popular with GPs, care homes and with their residents and families:
      "*I wanted to thank for your time and effort with Dad over. It is hugely appreciated myself, my family and Dad. I would say that you have been by far the most helpful, transparent, honest and knowledgeable health professional I have come into contact with." – Relative of home resident*

      "I avoided a hospital admission and instead got to see a consultant in my care home…I am thankful they supported me to have a voice" – Care home resident

      "CHAT is an integral part of the Provider Concerns Core Group which works with providers who are failing to provide safe care. We have received positive feedback from relatives and carers and providers about the work and partnership approach that CHAT takes" – Designated Safeguarding Adults Manager, London Borough of Enfield

      "Training for staff is helping us to keep up good practice...For me a manager and Registered General Nurse I no longer feel alone and there is always one of the matrons at the end of the phone. [Care of the elderly NMUH] doctors who visit the home with CHAT are excellent." – Care Home Manager

      "I have complete admiration for CHAT…I have used them on a weekly basis to make holistic management plans for my [care home] patients. They are constantly educating nursing staff and GPs – in particular, they have assisted me in making advanced end of

life care plans which have made a real positive impact on the patient, carers and families." – Enfield GP

18. CHAT is a key element of Enfield's integrated care network for older people built around individual patients and their GPs. In particular, its model closely fulfils the requirements for Enhanced Support for Care Homes, one of the new models of care included in the *NHS Five Year Forward View*. As a result of its success, Enfield partners are committed to its funding for 2016/17 and beyond.

19. CHAT also liaises with the Quality Checker scheme operating in care homes in Enfield. This scheme, supported by the Council, is a group of trained former users of social care services or their carers who visit <65 and 65+ homes in Enfield to provide an independent assessment of residents' experiences in these homes through discussions with residents and families and their own observations, from which an improvement plan is developed for the home who can then liaise with CHAT to fulfil relevant actions.

20. As part of its integrated care network, NHS Enfield CCG also introduced a GP Local Incentive Scheme with NHS England to enhance the support offered to all practices to enable GPs to identify their more complex patients and attend multi-disciplinary case conferences, including those residing in care homes, in 2015/16. This additional resource has enabled GPs to better manage their caseloads to work more closely with CHAT and care homes more generally. Given the vulnerability of these patients, the CCG intends to continue this scheme in 2016/17.

21. *Primary Care Arrangements for Under 65 Homes*

22. There are fewer working age adults who are residents in such care homes. These residents' health needs are often different to those who are older who tend to have conditions chiefly associated with frailty. More usually, the <65 care home population are accommodated due to profound learning and/or physical disabilities or severe functional mental health disorders and because they cannot otherwise be accommodated in the community or suitable alternative provision, such as supported living options.

23. The complexity of many of these cases means their health needs are managed on a multi-disciplinary basis often through a lead specialist model. This approach includes primary care for general health issues but it is more likely that most of the health needs of this younger care home population will be met through specialist medical and nursing care staff working on a routine basis with these residents who will coordinate the healthcare of the individual with their GP.

24. CONTEXT AND SOLUTIONS IN BARNET

25. Barnet has one of the largest numbers of care homes in Greater London (79 residential and 23 nursing homes: CQC June 2015) as well as a handful of care homes for Physical and learning disabilities. This means that there is a significant net import of residents with complex health needs move into Barnet from other areas. The total population registered with GPs and residing in Barnet care homes is circa 3000.

    Statistics related to Care Homes:

    - The rate of emergency hospital admissions due to respiratory infections, dementia and stroke is significantly higher in Barnet than London or England.

    - Overall rates of individual mental health problems are higher in Barnet than London and England.

- Increasing demand for urgent and emergency care in 14/15 compared to 13/14.

- Increasing levels of delayed discharges in 2014/15 placing added pressure on bed capacity and emergency admissions.

- An insufficient level of capacity outside of acute hospitals resulting in some service users having extended hospital stays.

- A pilot to enhance GP presence and input in care homes failed to reduce the rate of emergency hospital admissions or London Ambulance conveyances from Care Homes.

26. Barnet CCG - GP Care Homes Pilot

Barnet CCG implemented a GP Care Home Pilot in September 2014 for a period of a year. The aim of the pilot was to provide enhanced primary care support to residents in care homes, by proactively and effectively managing patients with complex needs, to reduce London ambulance callouts, frequent attendances in A&E and emergency admission. GPs provided additional weekly ward rounds in care homes.

Sixteen practices participated with registered patients in 29 care homes. The homes included Residential; Nursing; Learning and Physical Disabilities. A comprehensive evaluation of the pilot was carried out.

Findings from the evaluation:

KPIs not met :

- Overall the A&E attendances were not reduced
- Overall the LAS conveyances were not reduced

A sample of patients that were interviewed had not noticed any improvements in the service and support from their GPs.

The pilot did not achieve any savings.

Duplication of payments to GPs were identified with enhanced services, and retainer payments through private arrangement between the care home and the practices.

The cost of the pilot could not be sustainable without improvements.

Recommendations from the evaluation

- The CCG to discontinue the pilot.
- The CCG should link investment to support the delivery of outcomes identified at the October 2015 Barnet CCG Care Home workshop and the revised Care Home Strategy.

27. Solution

A stakeholder workshop identified a need to develop a high standard integrated out-of-hospital community service, with the appropriate skills mix and 24 hour capacity. The CCG along with the London Borough of Barnet are currently working with relevant stakeholders to explore and develop such services.

The first step was to have a whole system strategy in place: To Improve the Experience, Efficiency and Quality of Care Home services in Barnet. Four key work streams were identified in the stakeholder events during 2015.

1. Workforce, Training and Development
2. Urgent Care and Resilience
3. Primary Care (Including Medicines Management)
4. Quality and Patient safety

28. Gaps

One of the key gaps in developing a whole system plan is the lack of understanding and governance between organisations; lack of understanding of what commissioners; providers; and regulators are currently doing in relation to care homes; lack of cohesive information and data on individual care homes; lack of information on the third sector involvement and capacity.

29. Short term

Therefore, the short term plan moving forward is to implement a coordinated (IQICH & Continuing Health Care) governance structure for implementing agreed vision and work plans.

Barnet CCG are planning to collate current information on the numerous care homes in its borough and are exploring the development of a Dashboard of Barnet care homes.

30. Medium term

Putting into place a programme of training and skills development to ensure a consistent standard of high quality care. There is a recognition that care home staff need ongoing clinical support and facilitation to embed training learnt and to ensure that it is put into practice.

Barnet CCG will be working in partnership with the Community Education Provider Network (CEPN) along with London Borough Barnet's Integrated Quality in Care Home Team (IQICH) and North London Hospice to deliver care home training across the next financial year on the following:

- Dementia
- End of life
- Mental Capacity Act
- Communication
- Significant Seven Training Tool for all staff groups

31. Long term vision

Integrated Care is a strategic change programme deliverable for both Barnet CCG and Barnet Council. The purpose of this program of work is to focus on care home residents who are at higher risk of hospital admission and/or have complex needs, with the aim of delivering improved outcomes; access to more integrated care outside of hospital; a reduction in unnecessary hospital admissions; and enable effective working of professionals across provider boundaries.

The overarching philosophy around the development of the Care Homes Multidisciplinary Support Team is to proactively plan and manage care home residents that are at high risk as well as building on the competency capabilities of the workforce in care homes.

32. Improving access to Urgent Care during out of hours

The introduction of this pilot supports the urgent care system by providing care homes residents with urgent clinical needs to an out of hours GP and also will improve integrated working between Barnet care homes and the provider of Barnet GP OOHs service.

The patient journey will be streamlined with the care home registered nurses able to refer patients directly into the GP OOH service as opposed to accessing the GP via 111, improving the patient journey and enhance patient experience.

33. CONTEXT AND SOLUTIONS IN HARINGEY

34. The London Borough of Haringey currently has 12 care homes for frail older people; 10 residential care homes and 2 nursing homes with a total of 436 beds. The table below sets out the care homes by owner, type of bed offered and the latest CQC rating.

CARE HOME	**BED CAPACITY**	**OWNER**	**Latest CQC rating**
Priscilla Wakefield House Nursing & Residential	112	Magicare Ltd	24 April 2015 - Good
The Meadow Residential	40	Methodist Homes	30 December 2015 - Good
Spring Lane Residential	62	Springdene Nursing & Care Homes	22nd March 2014 – Met standard
Ernest Dene Residential	33	Ventry Residential Care	19th February 2016 - Good
Osborne Grove Nursing Home Nursing	32	Haringey Council	4 January 2016 - Good
Peregrine House Residential	35	Goldcare Homes Ltd	11 March 2015 – Requires improvement
Morris House Residential	25	Abbeyfield Society	4th January 2014 – Met standard
Alexandra park Residential	15	David Weston	6 January 2016 - Good
Brownlow House Residential	24	Ventry Residential Care	20 July 2015 - Good
Stirling Park Care Home Residential	5	Mrs Pauline Hogan	10th September 2013 – Met standard
Mary Fielding Guild Residential	47	Mary Fielding Guild	18th September 2014 – Met standard
The Fer view Residential	6	Soonil Bodoo	August 2013 – Met standard

35. Haringey CCG has a Quality Assurance Team for Care Homes comprising of a Quality Assurance Manager and a Quality Assurance Nurse. The team is responsible to enhance quality and standards within Care Homes by supporting staff and managers to achieve the optimum levels of care delivery. The Quality Assurance team works closely with the Local Authority Commissioning team and the Adult Safeguarding teams as well as the Care Quality Commission to provide quality assurance.

36. Examples of the types of activities which provide additional support are as follows:

a. *Visits and audits* – the Quality Assurance Team regularly visits care homes to review specific metrics and to provide support and advice where necessary.
b. *Care homes forum* – A regular meeting with care homes where information and training is disseminated and care homes network with one another and access peer support.
c. *Care homes clinical services working group* – A group formed to look at the quality of care provided by community services in care homes. The group is working together to produce a directory of clinical services, provide training to care home staff and produce condition specific treatment plans to prevent unnecessary admissions to hospital.
d. *Training*: The quality assurance team represent care homes at the Community Education Provider Network (CEPN). This provides access to specific training. In this year many care homes have been able to access Care Certificate Training for healthcare assistants and healthcare support workers. Dementia training has been made available through UCL. This has included dementia mapping in 5 of the local care homes. End of Life Care training has also been offered to all the care homes.
e. *Harm free care group*: Care Homes participate in this group, which works to monitor and reduce the number of falls, pressure ulcers and urinary tract infections in care homes.

37. *Primary Care Arrangements for Care Homes:* GPs attend as part of their more general responsibilities within their NHS England contracts, whilst other homes also entered into private arrangements with a GP practice to conduct weekly ward rounds. In general most care homes have one or two nearby GP practices that have patients registered at the care home, and this is the model the CCG promotes as it can be difficult logistically for all parties if a large number of practices are involved in residents' care.

38. *A new local incentive scheme:* Haringey CCG is currently evaluating the benefit and practicalities of initiating a local incentive scheme which would support GPs to additional support into care homes through providing a regular ward round. Further discussions are taking place about the scope of the team involved, e.g. whether geriatricians and community nurses are included as part of the new service. The plan is to initiate a pilot in the next financial year, subject to funding approval.

39. *GP out of hours:* Another pilot is currently providing direct access to Barnoc out of hours with Priscilla Wakefield Nursing Home, Haringey's largest care home. The impact of this is currently being reviewed.

40. CONTEXT AND SOLUTIONS IN ISLINGTON

41. Islington has 9 care homes for older people with a total of 505 bed spaces. Joint commissioning arrangements between Islington Council and Islington CCG ensure we have a joined up approach to health and care services. The Council and CCG jointly commissions £80m+ of prioritised care services annually. Islington CCG also works with key partners in the voluntary sector to provide support and advice and have recently commissioned Healthwatch to carry out a resident feedback exercise across all care homes. The Care Quality Commission, as the regulator, has a role in reviewing standards of care and in this role meets regularly with council commissioners.

42. Residents often have complex healthcare needs that require active review and management from a range of professionals. In Islington we have therefore developed a number of services to enhance the support available to both patients and staff in an effort to improve outcomes for residents.

43. *Islington care homes*

44. The table sets out the care homes, the numbers and type of bed offered and the latest CQC rating.

Name of home	Address	Total number of beds	Bed type	CQC rating
Cheverton Lodge	30a Cheverton Road N19 3AY	52	Nursing	Feb 2016 – overall rating good
Lennox House	75 Durham Road, N7 7DS	87	Residential and nursing care dementia	Oct 2015 – overall rating good
Highbury New Park	127 Highbury New Park, N5 2DS	53	Residential and nursing Dementia	June 2015 – overall rating good
Muriel Street	37 Muriel Street, N1 0TH	63	Residential and nursing Dementia	Aug 2015 – overall rating good
St Annes	60 Durham Road, N7 7DL	50	Residential and nursing Dementia	June 2015 – overall rating good
Bridgeside Lodge	61 Wharf Road, N1 7RY	64	Nursing Dementia	Sept 2015 – overall rating outstanding
Highgate	12 Hornsey Lane, N6 5LX	55	Nursing Dementia	June 2015 – overall rating good
Ash Court	Ascham St, NW5 2PD	62	Nursing and residential	Jan 2015 – overall rating good
Stacey Street	1 Stacey St, N7 7JQ	19	Nursing Mental health	Oct 15 – overall rating requires improvement

45. *Care Homes Locally Commissioned Service*

46. Islington CCG understands the important role that general practice plays in delivering care to residents and recognises that to do this properly GPs have to invest additional time into patient care. It has a GP Locally Commissioned Service (LCS) that provides financial remuneration for the enhanced level of service required. 8 Islington practices are signed up to this LCS and cover the 9 homes (in addition the LCS also covers one extra care sheltered scheme).

47. Performance of the LCS is regularly reviewed and commissioners submit a six monthly report to the CCG's Quality and Performance Committee. Care home performance including information about serious incidents and safeguarding issues are also reported to the CCG's Quality and Performance Committee to ensure oversight.

48. The specification for the LCS was reviewed and revised in 2015 in response to findings from a safeguarding review. This had highlighted concerns about record keeping and liaison between those providing care as well as a gap in knowledge around implementing the principles of the Mental Capacity Act, 2005.

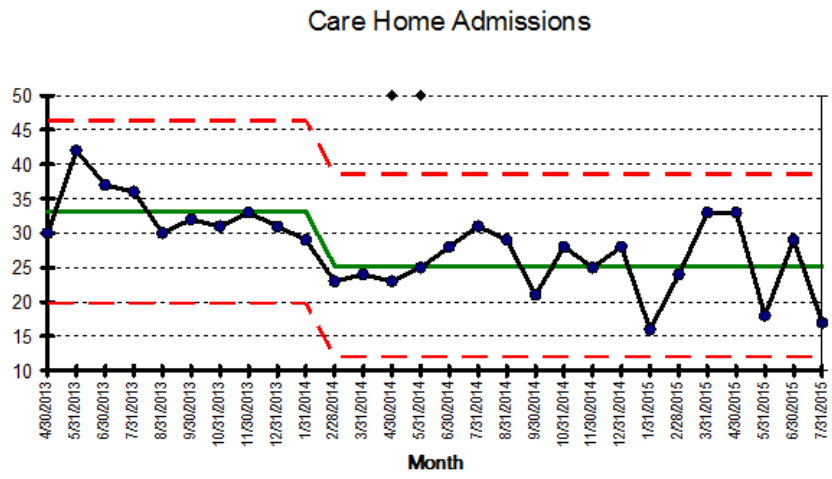
49. Another change that was included in the 2015/16 LCS was a requirement to attend two CCG organised training events and two peer review meetings per year. This is so that relationships can be developed between professionals working in the homes and also provides some opportunity to come together for education and learning. As an example, the next event to be held is in early March and will be led by Dr Sarah Yardley, Consultant in Palliative Medicine at UCH. The session will focus on palliative care in nursing homes.

50. Patient and carer satisfaction surveys are required annually and are carried out in a variety of ways including through Healthwatch Islington and Age UK Islington. Insights from relatives and staff are of particular interest in understanding how the care in the home is perceived (including specific feedback on the GP service).

51. *Integrated Community Ageing Team (ICAT):* Another key service supporting primary care clinicians and care home staff is the Integrated Community Ageing Team (ICAT), commissioned in March 2014. This provides enhanced clinical support into the community in recognition of the increasing complexity for many of those living at home. The service is led by geriatricians from UCH and Whittington Health as well as a local GP with a Special Interest. The team includes pharmacists, therapists and nurses. ICAT activity for 2015/16 indicates that the number of residents that the service has reviewed has increased. Importantly, quarter 2 of 2015/16 has seen a sustained drop in unplanned admissions to hospital from care home residents in Islington (Figure below).

QUARTER	NUMBER OF RESIDENTS REVIEWED
1	130
2	179

Q2 Whittington Activity – sustained drop in unplanned admissions to hospital



52. *Lead nurse for care homes:* This joint funded role sits with the Islington Joint Commissioning Team and has a responsibility for overseeing clinical improvement and quality assurance. Working with care homes, GP's and other providers of care, the lead nurse develops education and learning events that bring professionals together. The post holder holds responsibility for overseeing the quality dashboard that seeks to provide assurance to commissioners for the quality of clinical care being delivered.

53. Islington partners have started to develop a range of activities to support education and learning across health and care settings through working together in an Education Network. This has included the roll out of the Care Certificate which is aimed at Bands 1-4 and provides

a portfolio qualification recognised across the health and care sectors. Islington has seen a significant numbers of staff from care homes attend this training.

54. *Other key services that support care homes*: In addition to Care Homes LCS the CCG has commissioned community services to enhance the care for patients in care homes. Practices and care homes are required to ensure there are appropriate communication systems in place to enhance the roles and responsibilities across the agencies, where appropriate. These include, but are not exclusive:
    - Camden & Islington's Services for Ageing and Mental Health (SAMs)
    - District nurse team for residential care patients
    - End of Life and Palliative Care services (ELIPSE team)
    - Tissue viability nurses
    - Continuing Healthcare Team
    - REACH – OT and PT
    - Dieticians
    - Speech and Language Therapists
    - Podiatrists
    - Community mental health services
    - Clinical Standard, Quality and Assurance Lead Nurse and Team
    - Residential and review team from social care

55. CONTEXT AND SOLUTIONS IN CAMDEN

56. Patients living in residential/nursing care homes or Extra Care or accommodated in residential Intermediate Care beds have a greater degree of need than the general population. To address this, Camden CCG invested in a GP Locally Commissioned Service (LCS) to improve physical, mental and social care of the Borough's care homes residents.

57. *Care Homes GP Locally Commissioned Service*

58. The aims of the GP LCS in Camden are to:
    - Provide an additional level of care over and above those provided by all GPs under the General or Personal Medical Services Contract;
    - Provide a proactive, preventative service;
    - Improve the quality of care to older people's care homes ensuring all patients receive dedicated medical services;
    - Ensure that all patients cared for within the home are registered with the GP provider on a permanent or temporary basis, unless the patient exercises choice in agreement with their existing GP provider;
    - Minimise the risk and complications within this vulnerable group, which includes patients with highly complex needs by providing and monitoring a comprehensive programme of care;
    - Fulfil the minimum requirements set out in the NSF Older People, 2001; End of Life Care Strategy, 2008; End of Life Care LCS; Gold Standards Framework.
    - To provide proactive care in managing chronic disease and medicines including care planning especially around discharge and end of life care.
    - To reduce reliance on Out of Hours for crisis management as well as reduction in inappropriate non-elective admissions and A&E attendances.
    - To reduce inappropriate prescribing and wastage.

59. Currently 6 GP practices are signed up to the Care Homes Locally commissioned service covering the 8 care homes in Camden (see table below).

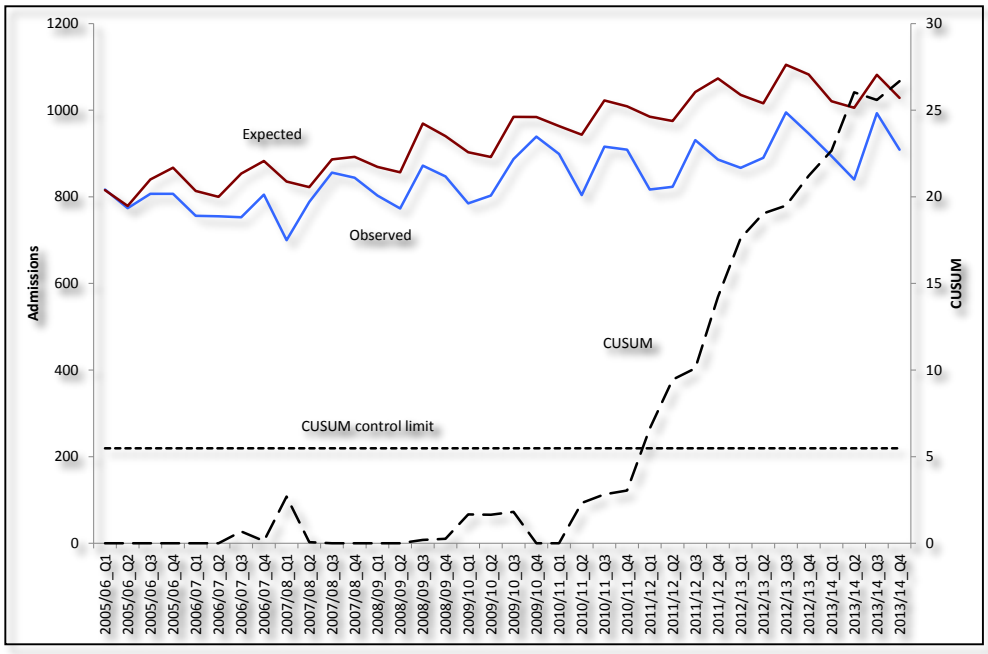
GP practices (6)	Care Homes (8)	Number of beds (375)
Abbey Medical Centre	St. John's Wood CC	100
	Spring Grove	46
Adelaide Road Practice	Compton Lodge	34
	Rathmore House	20
Hampstead Group Practice	Maitland Park	60
	Roseberry Mansion	46
Swiss Cottage Surgery	Mora Burnet	35
Regents Park Practice	Esther Randall Court	34

60. As part of the service, GPs from the practices regularly visit residents in Care Homes and work collaboratively with the management of the homes to ensure that residents get optimal care. They carry out regular medication audits and work with other teams working with the residents to ensure that that care is seamless. In addition to this they meet every 6 months with representatives from the:
    - Medicine Management Team
    - Consultant Geriatrician – Royal Free Hospital
    - End of Life Care Lead
    - Quality assurance contracts manager
    - Strategic Commissioner - Later Life and Dementia at London Borough of Camden

61. *Patient/Carer Involvement:* GPs providing the service have regular care planning meetings which include patients (where appropriate), relatives and staff from the care home, whilst geriatricians will meet with relatives on a monthly basis. These meetings often cover sensitive issues, such as advance care planning with patients and relatives about such issues as resuscitation, where they would like to die and other important choices about end of life.

62. *Outcomes:* Research conducted by the Nuffield Trust (still in draft) shows that there is evidence the number of emergency admissions for the 75+ population (the key group of individuals in older people's homes) is lower than would otherwise be expected without the range of initiatives in Camden CCG, including the GP LCS for Care Homes (Figure 1, in which the predicted and observed number of emergency hospital admissions are charted each month). This trend in admissions is particularly true for certain conditions common in older people in care homes e.g. lower than expected admissions due to fracture neck of femur and Chronic Obstructive Pulmonary Disease (COPD). Though it cannot be directly linked back to GP input to care homes or the other initiatives supporting older patients, it can be assumed that these initiatives has had impact on these figures.

Figure 1: Trends in the observed and expected emergency admissions for those aged 75 years and over in Camden, 2005/06 to 2013/14 (Source HES)



63. Due to the success of the service, Camden CCG plans to continue its LCS funding into 2016/17 and beyond, and will continue to work with Council commissioners to ensure that this vulnerable group of patients continues to be well-supported.

64. *Other key services that support care homes:* In addition to the GP Care Homes LCS, the CCG has commissioned community services that enhance the care for patients in care homes. GP practices and care homes are required to ensure there are appropriate communication systems in place to enhance the roles and responsibilities across the agencies, where appropriate. These include, but are not exclusive:
    - Camden & Islington's Services for Ageing and Mental Health (SAMs)
    - District nurse input to residential care patients
    - Older peoples outreach service
    - End of Life and Palliative Care services (ELIPSE team)
    - Tissue viability nurses
    - Continuing Healthcare Team
    - REACH – OT and PT
    - Dieticians
    - Speech and Language Therapists
    - Podiatrists
    - Community mental health services
    - Residential and review team from social care
    - Camden Active Health Team (Falls advice and prevention)

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Whittington Health NHS

REPORT TITLE: Whittington Health Estates Strategy	
REPORT OF: Whittington Health Chief Executive	
FOR SUBMISSION TO: North Central London Joint Health Overview and Scrutiny Committee	**DATE:** 11th March 2016

SUMMARY OF REPORT

This report provides a summary of the Whittington Health Estates Strategy, which was approved by the Trust Board in February 2016.

The Trust needs a modern estate that is designed to deliver our clinical services and enables us to provide care, where and when people need it. We are committed to providing our patients, staff and communities, with care in buildings that are fit for the provision of modern healthcare services.

To deliver the Trust's plan for a modern estate, the Trust will need:

- To consider entering into partnerships that will allow the Trust to secure the funding needed to improve services, within the current challenging public capital funding environment.
- To investigate the possible release or the redevelopment of under used buildings, to enable the necessary redevelopment for clinical services.
- To explore partnerships with other providers to develop under used buildings, helping to secure future income and sustainability.
- To develop a detailed prioritisation of requirements, scoping of options and preparation of business cases.
- To deliver informed estate efficiencies, as part of good practice and to support the reduction of the operating deficit.
- To invest in information technology (IT) as a key part of changing working practices and helping to reduce occupancy levels.
- To invest in change management to support planned changes in working practices.
- To continue to engage with stakeholders, the public and interest groups, and secure their support.

CONTACT OFFICER:
Philip Lent, Director of Estates and
Facilities Whittington Health

RECOMMENDATION:

The Joint Health Overview and Scrutiny Committee are asked to note the contents of the report.

SIGNED:

Simon Pleydell, Chief Executive, Whittington Health

DATE: 2nd March 2016

Whittington Health

Estates Strategy

1.0 Introduction

The Whittington Health Estates Strategy provides a framework for future decision making on the future development and management of the Trust's estate for the period 2016 to 2021. The Trust has a clear vision for its estate – to support excellent healthcare with high quality, patient focussed environments. The estate strategy sets out the Trust's plan to make sure we have the right facilities to deliver our services, both now, and in the future.

2.0 Where are we now – the challenge?

The Trust needs a modern estate that is designed to deliver our clinical services and enables us to provide care, where and when people need it. We are committed to providing our patients, staff and communities, with care in buildings that are fit for the provision of modern healthcare services.

Our analysis shows that our estate provides a good foundation for meeting our patient's future needs and for developing the opportunities identified in this strategy.

Hospital site: Our hospital site, located in Archway, is the main site for delivery of our acute clinical services. The site is bisected by an access road and the majority of clinical and patient activities take place south of this road. This area will continue to be the focus for our acute clinical services.

The hospital site has a number of clear investment needs, including backlog costs to bring the estate up to national condition B standard of c. £16.4m. An additional investment of c.£40m is needed to deliver a fully sustainable and functional site and enable us to meet national guidelines regarding patient space, privacy and dignity.

The area north of the access road is primarily used for non-clinical services and offers a flexible space that could be redeveloped to improve and enhance the services we offer, without impacting on our existing clinical activities.

Community estate: Our community estate is mainly spread throughout Haringey and Islington. As part of our remit to deliver community services in these areas, we inherited occupancy rights for a number of properties from two Primary Care Trusts (PCTs) in 2013. Our community buildings require an investment of c£6.5m to bring them up to national condition B standard.

As local authorities and clinical commissioning groups (CCGs) begin to look at how health services are delivered locally, there is an opportunity for us to work closer with these partners to reconfigure our services to deliver better care for patients in improved environments.

It is important to note that our community estate is also part of a national review of public sector health and social care assets. The Department of Health (DH) has asked for a CCG led strategic estates plan, and we are working closely with our CCGs to ensure our vision aligns closely.

3.1 Where do we want to be and what is required - building our future together?

To ensure we have the right buildings and estate in place to support our patients, we must understand the demands that will be placed upon our services over the next five years. A number of drivers have been explored and shape the themes around which the strategy is based.

Drivers

- **Clinical strategy**: Our clinical strategy (2015-2020) focuses on our development as an integrated care organisation, with seamless delivery of care across acute and community sites in Islington and Haringey. The Clinical Strategy describes the following mission, vision and strategic goals.

  Our mission: "Helping local people live longer, healthier lives."

  Our vision: "Provide safe, personal, co-ordinated care for the community we serve."

  Our strategic goals:

  1. To secure the best possible health and wellbeing for all our community
  2. To integrate/co-ordinate care in person-centred teams
  3. To deliver consistent high quality, safe services
  4. To support our patients/users in being active partners in their care
  5. To be recognised as a leader in the fields of medical and multi-professional education, and population based clinical research
  6. To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population.

- **Stakeholders:** We want to work with our community and stakeholders at every stage to help us shape and deliver services that are fit for the future. We been working with staff, patients and other key stakeholders to understand their views on the future direction of our estate to help inform our strategy.

  Initial conversations have uncovered a range of views; however, there is universal acknowledgement of the need for investment and change, supported by innovative and creative thinking.

  As an active member of the Haringey and Islington Estates Group, which brings together representatives from CCGs, local authorities and local provider trusts, we are working to develop an integrated approach to the future development of the overall estate. A number of work streams are being considered including: integrated networks/hubs and shared administrative functions and premises

- **National, local and Trust Drivers:** national, local and Trust service drivers are summarised in the table below:

Figure 1.National, local and Trust service drivers

<table>
<tr><td>Quality
Expectations from patients and regulators
Competition for patients
Care close to home
High quality emergency and urgent care
New investigations and treatments</td><td>Financial
Reduce income and expenditure (I&E) deficit
Limited access capital to support investment
Population growth
Need value for money in procurement</td></tr>
<tr><td rowspan="2">Meeting local health needs
Rising activity levels
Health inequalities
Relatively young population
Ethnic diversity
Prevention of ill health</td><td>Staff
Need to attract and retain high quality staff
Need high quality facilities to train & develop staff</td></tr>
<tr><td>Structural
Improve integration in acute & community estates
Working with partners in health & social care</td></tr>
</table>

4.0 Estate strategy principles

Our estate strategy outlines our commitment to providing high quality patient focussed environments, whilst balancing service delivery, affordability and risk. The key principles underpinning our estates strategy are described in Fig 2 below:

Figure 2: Estate strategy principles

Estate Strategy Principles
Patient centred Improve the estate to be patient and client centred with ease of access to care, both physical access and transportation access; supporting the co-location of services to enable integrated care through the development of integrated networks/hubs.
Quality Improve the quality of the estate to meet patient and staff expectations**.**
Effective use of assets Maximise the effective use of the estate to support clinical service delivery.
Design Ensure that our estate has flexible and modern space in all our buildings.
Capacity Ensure that the Trust's estate has the capacity to meet demand for healthcare in the right places.
Statutory and non-statutory compliance Continue to manages estates risks and meet all necessary standards.
Future sustainability Ensure that the delivery of the estate strategy supports the future sustainability of the organisation in terms of quality, financially, effective working and environmental sustainability.
Partnerships and engagement Maximise the opportunity of partnerships and engagement with our local community and ensure Trust plans align with wider health economy plans.

5. What is required and how do we get there?

What is required?

From the analysis of where we are and where we want to be to deliver the best service to patients, there are five key deliverables required:

- Targeted investment in the hospital site is required to ensure the estate supports the delivery of high quality clinical services. Many of the buildings require redevelopment or refurbishment.

- Investment in, and reconfiguration of, the community estate portfolio is required to support the development of integrated networks/hubs; provision of high quality clinical and patient care environments; and more efficient service delivery.
- Investment is required to maintain and develop high quality training and education and research facilities.
- Investment is required to ensure that our staff have access to low cost, high quality staff residences.
- Investment and a change in working practices is required to enable non-clinical support and corporate services accommodation to be reconfigured and used more efficiently.

Our strategy concludes that the current estate offers a number of development opportunities which could be delivered on the hospital site or within the community. These development opportunities would support Whittington Health deliver its mission to 'help local people live longer, healthier lives', and support the investment requirements identified.

6. How do we get there?

To deliver our plan of a modern estate, we need:

- To consider entering into partnerships that will allow us to secure the funding we need to improve services within the current challenging public capital funding environment.
- To investigate the possible release or the redevelopment of under used buildings, to enable the necessary redevelopment for clinical services.
- To explore partnerships with other providers to develop under used buildings, helping to secure future income and sustainability.
- To develop a detailed prioritisation of requirements, scoping of options and preparation of business cases.
- To deliver informed estate efficiencies, as part of good practice and to support the reduction of our operating deficit.
- To invest in information technology (IT) as a key part of changing working practices and helping to reduce occupancy levels.
- To invest in change management to support planned changes in working practices.
- To continue to engage with stakeholders, the public and interest groups, and secure their support.

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Update: Procurement of an Integrated Urgent Care Service for North Central London

Executive Summary

The report below duplicates the paper being submitted to the March 2016 Governing Body meetings of the five north central London CCGs. This covers the background to the programme to commission an integrated urgent care service combining NHS 111 and GP out-of-hours services across north central London (NCL), and includes details of the procurement process.

As we have presented to JHOSC on past occasions, the proposal to commission an integrated urgent care service emerged from local engagement, in particular findings from the Camden and Islington Urgent Care Review, which suggested that the NHS 111 and GP out-of-hours services should work more closely together, and that NCL CCGs should collaborate in commissioning these services.

This approach is closely aligned to NHS England's national strategy for integrated urgent care, which has been subject to substantial national engagement and to which NCL leads have contributed significant feedback and advice. The aim of this strategy is to ensure that all people with urgent care needs get the right advice in the right place, first time, and to enable commissioners to deliver a functionally integrated 24/7 urgent care service that is the 'front door' of the NHS and which provides the public with access to both treatment and clinical advice.

NHS England published national standards for integrated urgent care services in 2015, but NCL CCGs have had the opportunity to tailor the local service specification and the key performance indicators (KPIs) that we apply to the service. We conducted extensive engagement with patients, clinicians and other stakeholders, including this committee, throughout 2015, and received an enormous amount of feedback. Key themes which we have identified and taken forward as requirements (see Appendix) are:-

- The service has an effective and sustainable workforce (clinical and non-clinical)
- The service provides continuity of care, particularly for people with complex or specific care needs.
- The service works collaboratively with the local healthcare economy
- The service is effective at managing callers with mental health needs and utilises local mental health services
- The service is effective at managing risk and diverting activity away from A&E and Acute Hospitals
- The service is easy to access and direct patients to the right place in the fewest possible transactions.
- Users are happy with the service

Appended to this report is a draft list of the local and national KPIs that will apply to this contract. These have been developed by the KPI Working Group based on input from CCG staff, clinicians and lay members from across north central London and after extensive stakeholder engagement during 2015. These KPIs are draft subject to approval by the Urgent Care Programme Board and agreement with the successful bidder.

The procurement process for this new service model began in October 2015, and has had clinical and patient involvement from across north central London throughout, including in the evaluation of the bid documents, interviews with the bidders and simulated clinical situations (see sections 10-13). Throughout the process, evaluation has been weighted 80:20 in favour of quality against price, with factors including clinical quality, workforce planning and stakeholder involvement all separately considered (see section 11).

This procurement process is now nearing completion – the remaining stages are identified below and in section 8 of the paper.

NHS England Check Point 2	29th February to 18th March 2016
Contract Award Approval by CCG Board	29th February to 18th March 2016
Successful and unsuccessful bidder notification	21st March 2016
Standstill Period expires	5th April 2016
Contract Signature	From 6th April 2016
Commence mobilisation	From 6th April 2016

As indicated above, we expect to be able to announce the successful bidder and future provider of this integrated urgent care service in April, and the new service itself should begin in autumn 2016.

Procurement of an Integrated Urgent Care Service for North Central London (paper submitted to NCL CCG governing bodies in March 2016)

1) Background – 2014/2015

In March 2014, the 5 North Central London Clinical Commissioning Groups (NCL CCGs) embarked on a review of unscheduled care services for the residents of NCL and agreed to commission an Integrated Urgent Care NHS 111 and GP Out of Hours Service.

A comprehensive business case was produced, considered and approved by the Urgent Care Programme Board on 2nd March 2015 and by the CCGs [Governing Bodies] during March 2015. The decision was taken to agree the clinical model as set out within the business case for the commissioning of an NCL Integrated Urgent Care 111/OOH service through a lead provider contract for a period of five (5) years plus the option of a two (2) year extension through a competitive procurement process.

The scope of services to be included in the tender process were for all residents and registered patients within Barnet, Enfield, Haringey, Camden and Islington boroughs. NCL Integrated NHS111/GPOOH service, namely NHS 111 and GP OOH services.

2) Procurement Process and Planning

In order to prepare for this complex procurement, an NHS111/OOHs steering group, a procurement sub-group and a clinical sub group comprising of key Clinicians and Commissioning Managers from each of the 5 CCGs was set up to manage the procurement. The project steering group reported regularly to the NCL Urgent Care Programme Board which comprised of the Urgent Care SRO (Enfield CCG Chief Officer), key Directors and senior managers from the 5 CCGs; public representatives and clinical leadership. As part of this process a procurement proposal was approved by the project steering group, in addition a Procurement Strategy was developed and approved (6th May 2015). The Procurement Strategy included details on the procurement options / route, considerations for collaborative arrangements, Subject Matter Experts / local provider requirements, overall evaluation criteria / weighting, payment mechanism and an agreed scoring range of 0 – 4. A programme manager was appointed to lead the project, and the procurement was undertaken as a project with a risks and issues register, communication (internal and external) strategy and lessons learnt report.

To comply with the required rules and regulations the contract for the integrated NHS111 and OOH service would need to be awarded through a competitive tender process to ensure that the provider would be selected following a fair and transparent process.

An options appraisal to justify the procurement approach was conducted and outlined in the Procurement Strategy document. The recommendation to use a 'Restricted tender process' was agreed upon for the following reasons:

- Significant work to define the clinical model, outcomes and financial model as well as extensive engagement with wider stakeholders gave the CCGs confidence that the needs / requirements had been identified and they would be able to clearly define the specification.
- Market research had identified a large number of potential providers in the market who would be interested in bidding for this service. A market information event held with organisations that provide NHS 111 and GP OOHs services in February 2015, generated much interest with over 13 providers in attendance.

The NHS111/OOHs service was considered to be a Part B Service under Public Contracts Regulations and therefore did not require the mandatory publication of an OJEU contract notice. The CCGs agreed to follow best practice and Monitor guidance and place a voluntary contract notice in OJEU.

A 'Restricted Tender process (Pre-Qualification Questionnaire [PQQ] and Invitation to Tender [ITT] requires interested parties to register their interest, submission of a PQQ for shortlisting, submission of an ITT and evaluation, presentation/interview and then contract award. Time is built into the process for clarifications during both the PQQ and ITT stages

NHS England documentation was utilised as a base to develop the PQQ and ITT documentation. The steering group, procurement subgroup and key members of the evaluation panel tailored the documentation to the requirements of this procurement and developed the necessary evaluation criteria, scoring mechanisms and evaluation thresholds against which a fair and objective assessment could be made. As a further assurance process, an external independent review of the ITT documentation was undertaken.

The PQQ stage itself focuses on the potential Bidders. It is about obtaining and interpreting general information about potential Bidders to test their capacity, capability, economic and financial standing, and eligibility to take part in the Procurement and for working with the NLC CCGs. The PQQ stage does not entail any detailed analysis of proposed solutions, nor how arrangement and interactions between potential Bidders and the NCL CCGs should work, or any information regarding pricing. Bidders provide this type of information at the ITT stage of the Procurement.

At PQQ stage, the focus is on evaluating potential Bidders in three main areas:

- Capacity and capability – Assessment of the resources and core competences available to the potential Bidder including, without limitation, clinical, workforce, infrastructure, local knowledge and ability to integrate with the local healthcare community;
- Economic and financial standing – Whether the potential Bidder is in a sound financial position to participate in the Procurement; and
- Eligibility – Whether the potential Bidder, or its Relevant Organisations, satisfy any of the conditions for which they may be deemed ineligible to be awarded a public contract as detailed in Regulation 23 of the Public Contracts Regulations 2006 (SI 2006 No 5).

The main objectives at this stage of the Procurement are to:

- Establish whether any potential Bidders should be excluded from further consideration because they fail to meet minimum criteria and standards;
- Create a list of realistic candidates who meet the threshold for participation and may be recommended to proceed to the next stage; and
- Identify any issues that need addressing prior to future stages of the Procurement.

The decision to shortlist up to five (5) potential bidders from the PQQ stage to the ITT stage was based on the requirements of the Public Contract Regulations (PCR), assessment of the market and the NCL CCGs own Prime Financial Policies (PFP). Under EU procurement rules, no less than five (5) potential bidders are to be invited to tender unless fewer suitable candidates have met the selection criteria and these are sufficient to ensure genuine competition. Although health contracts are usually classified as 'Part B' under the PCR and are not subject to all the EU procurement rules, five (5) is considered to be a reasonable number, and therefore a maximum of five (5) were to be shortlisted to the ITT stage

At ITT stage it was proposed that an 80:20 Quality / Price weighted model would be used to evaluate tenders. This was based on OGC/Cabinet office guidance for complex specifications where failure of the service has an impact on the organisation, for long term contracts and where the provider is motivated to provide quality services. The ratio determines how much quality and price will influence the tender evaluation and should reflect the relative importance of either element to the CCG.

To satisfy the service requirements, the shortlisted Bidders need to demonstrate satisfaction of the service requirements and are formally evaluated against the pre-defined criteria set out within the ITT documentation. These requirements represent the key issues that are important to NCL CCGs.

To satisfy the commercial requirements, Bidders had to complete a Financial Modelling template. The design of the tender evaluation was to allow selection of a Bid that represented best Value for Money (VfM) rather than the lowest priced bid alone. The best VfM (most economically advantageous tender) would be that which was judged to offer the optimum combination of service, capability, quality (including clinical standards, safety, deliverability and other areas as detailed in the ITT) and Bid Price within the stated affordability parameters.

To satisfy the legal requirements, Bidders had to be willing to contract on the terms and conditions set out in the NHS Standard Contract, and acceptance of any mandatory provisions issued with the ITT documents.

All sections of the ITT would be formally evaluated in order to identify those Bidders to be invited to the final presentation stage. This final stage of the ITT was split into two assessment phases and 15% (from the overall 80% for quality) was adopted and split as follows:

- 10% for the Objective Structured Clinical Examination (OSCE) Scenarios.
- 5% for the formal presentation/interview.

The scores would be added to the ITT and finance score to result in an overall final score. Transparent records to explain the rationale behind the selection process and decision making would be maintained throughout the whole procurement process.

Following completion of the ITT evaluation, a Part 2 Contract Award Recommendation report is finalised and co-ordinated by Enfield CCG as lead commissioner, is taken to the five (5) CCG Governing Bodies to obtain approval of the decisions recommended and hence approval to award the contract.

3) Communication and Engagement

Effective engagement with stakeholders is an essential requirement of all NHS Organisations and offers substantial benefits to the generation of outcome-based service specification. The five (5) CCGs engaged with their respective CCG Governing bodies, members, clinicians, service users, stakeholders, external agencies, local media and potential providers at appropriate times during the commissioning and procurement processes in accordance with the principles set out in the CCGs communication and engagement strategies.

Since January 2015, the 5 north central London (NCL) clinical commissioning groups have been engaging extensively with local service users and residents on our proposal to commission an integrated urgent care NHS 111 and GP out-of-hours service.

We engaged with hundreds of people, face to face or through our on-line survey, particularly those who would be most likely to use the proposed service or who we know face particular barriers to accessing services or are vulnerable. We held a number of public meetings as well as arranging targeted events for specific user groups including people with learning disabilities, mental health users, young carers, people affected by HIV, older people and refugee and migrant communities.

In parallel with the engagement programme we established a Patient and Public Reference Group (PPRG) including representatives from Healthwatch organisations across NCL. The PPRG had around 22 members with approximately 4 representatives from each borough. The PPRG met on a monthly basis and had the opportunity to discuss the service specification and make line-by-line comments.

Additionally, the draft specification was published on the websites of all five CCGs from 21st July to 19th August 2015, and circulated to stakeholders, inviting comments. We received 800 comments on the service specification and have reflected these comments within the service specification.

We presented an engagement report to the north central London Health and Wellbeing Boards and have attended a number of meetings of the Joint Health and Overview Scrutiny Committee.

Input from groups and associations across the five London boroughs, as well as the Patient and Public Reference Group, was used to ensure the views of patients were included in the service being commissioned.

4) Evaluation panel membership

An evaluation panel was established at the start of the process prior to the advertisement being issued with roles and responsibilities documented.

Evaluation demands a mix of expertise across a range of specialisms. The panel was organised into work streams for both the PQQ and ITT stages, with each stream headed by a suitably qualified / experienced Subject matter expert (SME) or Leads.

The evaluation panel comprised of an external Chair and a diverse range of representatives from across the five (5) NCL CCGs, NEL CSU and Patient Public reference group. In addition to this, there were non-scoring advisors/subject matter experts from NEL CSU and NHS England to provide additional support as and when required.

The work streams were as follows:

- Chair
- Procurement Leads
- Clinical Leads
- Commissioning Leads
- Quality and Governance Leads
- HR Leads
- Contract Leads
- Patient Representative Leads
- Information Management & Technology Leads
- Information Governance / Risk Leads
- Estates Leads
- Finance Leads
- Independent subject matter experts (non-scoring)

Definition of roles

Various roles are required to carry out the evaluation process at both the PQQ and ITT stages:

- Procurement Lead – to oversee strategic and day-to-day management of the Procurement process ensuring quality and consistency of approach, and managing the moderation process;
- Programme Manager – to oversee the evaluation process and ensure sufficient resources are available to conduct the evaluation;
- Evaluator – to undertake evaluation activity as required and determined and coordinated by the Procurement Lead or Programme Manager;

It is the responsibility of each evaluator to ensure they are available to conduct the evaluation in the timescales required.

General Responsibilities

All members of the evaluation panel were asked to:

- Ensure that they familiarise themselves with the context of the Procurement and have a full understanding of the relevant details at the PQQ and ITT stages;
- Maintain high standards of confidentiality at all times;
- Undertake all activities in a manner consistent with fair competition;
- Declare to the Programme Manager / Procurement Lead any potential conflicts of interest prior to joining an evaluation team;
- Notify the Procurement Lead of any element of any PQQ / ITT submission or dealing with a Provider that gives rise to a suspicion of collusion between potential Bidders, or other practices not consistent with fair competition;
- Not communicate with any potential Bidder other than through the formal process set down in this Plan; and
- Notify the Procurement Lead of any attempt by any potential Bidder to communicate with them outside of the formal process.

All members received evaluation training, guidance and support throughout the process from the Procurement Leads and Programme manager.

5) Evaluation Methodology

The method of evaluation is designed to enable the identification of Potential Bidders / Bidders at each of the PQQ & ITT stages that:

- Comply with the standards required by the Procurement
- Meet with the PQQ and ITT requirements specifically against the pre-defined criteria

Assessment of scored questions was carried out using the grading definitions in table 1 below. Half scores were not permitted.

Table 1: Scoring scheme

GRADE LABEL	GRADE	DEFINITION OF GRADE
GRADE LABEL	**GRADE**	**DEFINITION OF GRADE**

Unacceptable	0	The response has been omitted, or evaluator is confident that the potential Bidder has inadequate (or insufficient) capability / capacity to deliver the required services.
Compliant with shortcomings	1	The evaluator is confident that the potential Bidder has a level of capability and capacity to deliver the required services that is adequate for the purposes of the Procurement although contradictions in the submission are evident, or other doubts exist.
Compliant	2	The evaluator is confident that the potential Bidder has a level of capability and capacity to deliver the required services that is adequate for the purpose of the Procurement.
Compliant with superior capability	3	The evaluator is confident that the potential Bidder has a level of capability and capacity to deliver the required services that is adequate for the purposes of the Procurement (with significant capability evidenced).
Compliant with exceptional capability	4	The evaluator is confident that the potential Bidder has a level of capability and capacity to deliver the required services that is adequate for the purposes of the Procurement (with exceptional capability evidenced).

Assessment results were recorded in the score cards provided by the Procurement Lead with responses scored and comments appended (explaining the basis of this scoring). Evaluators reviewed and scored their relevant sections independently of each other.

6) Moderation

Moderation meetings were held during the PQQ and ITT stages, during which each evaluator was able to discuss their rational for the scores provided and to discuss any differences in views such as; split pass/fail decisions; variances of 2 or more in the scores allocated; any 'fail' or zero' grades .

To ensure consistency of approach and grading, evaluators were given the opportunity to moderate their scores. It was agreed that where any difference in judgement within the panel occurred, the panel would take the average score to the nearest whole number. A final consensus score would be recorded at each moderation meeting with final agreement from the whole panel on the shortlisting of Potential Bidders / Bidders at each stage.

7) Governance arrangements

Access to evaluation information (i.e.: Planning documents, Bid submissions, evaluation results etc.) were not granted until reasonable measures to ensure confidentiality and to secure against conflicts of interest were taken.

Confidentiality and conflict of interest forms were signed by all members of the111/OOH project steering group, procurement sub groups and evaluation panel.

In addition, at key points of the procurement process all members were reminded of the agreements signed to maintain such information as confidential and to guard against any Conflicts of interest.

8) Procurement timetable and further engagement

The original plan to commence the procurement was scheduled for May 2015. It was agreed by the five (5) CCG chief officers to delay and revise the timetable to allow for a period of wider engagement with the public in July 2015.

In addition, NHS England advised all CCGs that new commissioning standards for an Integrated Urgent Care NHS 111 and OOH service was in development and as such, commissioners were asked to suspend procurement of these services until the end of September 2015.

This was already in line with the revised timeline of the NCL CCGs, with the planned procurement to commence on the 1st October 2015 following a further period of engagement and communication with each of the five CCGs local communities.

A draft report on the additional engagement and communication conducted in July was published on the five (5) CCG websites in advance of the report going to September Governing Bodies. Furthermore, engagement on the draft service specification took place in early August with comments received sent to the drafting team. During September 2015 updates were provided to each Health and Wellbeing Board and NCL joint health overview and scrutiny committee. An update was also presented to both the Camden and Islington Health Overview Scrutiny Committees.

In addition to the above, another Market Information sharing Event was held on the 5th August 2015, to re-engage the market by allowing potential bidders to learn more about this potential opportunity. There was a high level of interest in the event with over 35 attendees representing 20 organisations.

An overview of the procurement timetable is outlined in table 2 below

Table 2: Procurement timetable:

Activity	Date
Pre-procurement planning and activities	January to September 2015
NHS England Check point 1a	28th September 2015
Advert Placed on Official Journal of the European Union / Contracts Finder and Supplying2nhs.com	2nd October 2015
MOI, Information & Guidance and PQQ Published on Pro-contract	2nd October 2015
Deadline for PQQ clarification questions	23rd October 2015
Deadline for Expressions of Interest and PQQ submission	2nd November 2015
PQQ Evaluations	3rd to 20th November 2015
NHS England Check point 2	27th November 2015
ITT Issued to successful bidders	30th November 2015

Deadline for ITT clarifications	4th January 2016
Tender submission deadline	11th January 2016
Tender Evaluations	13th January to 1st February 2016
OSCE assessment & /Presentation/interview	11th and 12th February 2016
NSH England Check Point 2	29th February to 18th March 2016
Contract Award Approval by CCG Board	29th February to 18th March 2016
Successful and unsuccessful bidder notification	21st March 2016
Standstill Period expires	5th April 2016
Contract Signature	From 6th April 2016
Commence mobilisation	From 6th April 2016

9) NHSE Assurance Process

The NHSE NHS111 Procurement and Mobilisation Checkpoint Assurance Process consists of three checkpoints covering key phases from development of procurement strategy through to go live.

Checkpoint 1	**Delivery strategy** (Pre-tender up to publication of documents)
Checkpoint 2	**Investment decision** (Post-evaluation and before contract award)
Checkpoint 3	**Operational review** (Before go-live of the new service provision)

Checkpoint 1 takes place from the initial start of developing the local procurement strategy through to publication of tender documentation onto the appropriate procurement portal. The checkpoint sections are designed to enable assurance at critical planning stages before the formal procurement process begins:

- Development and review of high-level strategy and options appraisal, including the geographical footprint of the service
- Procurement specification development and sign-off
- Development of procurement documentation and processes before formal process begins

The Checkpoint 1 assurance process was carried out in week commencing 23rd November 2016. NHS England's recommendation for the "Checkpoint 1" (pre-ITT) gateway for Integrated Urgent Care procurement in NCL is that the CCGs should proceed and publish their tender as planned on 27th November 2015.

NHS England was assured that the NCL CCG's vision, specification and procurement approach are closely aligned to the new commissioning standards for Integrated Urgent Care services.
The Checkpoint 2 assurance process will take place prior to contract award.

10) Pre-qualification stage

Following approval by Enfield CCG on [16th Sep 2015] this restricted tender was advertised on the Official Journal of the European Union / Contracts Finder on the 2nd October 2015 to notify potential Bidders of this procurement and seek formal Expressions of Interest. The PQQ documentation was released on the 2nd October 2015 on the Pro-Contract eprocurement portals (www.supplying2nhs.com). This procurement process was carried out via the Pro-Contract e-procurement system and therefore the expressions of interest and PQQ submissions were received via this e-tendering suite. The deadline for expressions of interest and PQQ submission was at 1000hrs on 2nd November 2015.

There were no late submissions.

Potential Bidders were advised in the PQQ that their submissions would be; checked for compliance with the instructions given; checked that they agreed with the Commercial Terms set out; checked that they had signed the Declaration form; evaluated on the basis that they had to pass all Pass/Fail questions and score above a 50% threshold in order to qualify and be shortlisted to the ITT stage.

The PQQ evaluation criteria and assigned weighting was as follows:

Table 3: PQQ evaluation criteria

Section	Contents and sub-criteria weighting	Overall Weight / Criteria
A	Details of Potential Bidder and its Business Structure	Pass/Fail & For information only
B	Legal and Regulatory	Pass/Fail
C	Economic and Financial Standing	Pass/Fail
D	Business Continuity Planning	10%
E	Workforce, Recruitment & Policy	Pass/Fail
F	Insurance	Pass/Fail
G	Technical and Professional Ability	Pass/fail & scored 60%
H	Equalities	Pass/Fail
I	Health and Safety	Pass/Fail
J	Quality Assurance	Pass/Fail
K	Environmental & Social Management	Pass/fail & scored 10%
L	Information Governance	Pass/Fail
M	Information Management & Technology	Pass/Fail & scored 20%
N	Applicant's Declaration	Pass/Fail / Compliance
	Total	100%

Following the PQQ submission deadline, the Procurement Lead accepted all on time submissions. The evaluation panel members were informed of who the Potential Bidders were and as an additional governance process were asked to confirm if there were any new Conflicts of Interest to Declare. None were raised.

The PQQ evaluation consisted of two parts; an Initial evaluation and Detailed evaluation

The initial evaluation was completed by the following work-streams;

- Procurement – compliance with the instructions and key commercial terms
- Finance - Economic and Financial standing
- Contracting - Eligibility and satisfaction of conditions to be awarded a public contract

Following approval by all three work streams, the Potential Bidder submissions were then released to the wider panel for the Detailed Evaluation (assessment of remaining Pass/Fail questions and scored questions)

Evaluators submitted their individual scores for the sections they reviewed to the Procurement Lead to collate ahead of the moderation meeting which was held on the 20th November 2015.

During the moderation meeting each of the Potential Bidders responses were reviewed in full.

Bidders who failed any of the Pass/Fail questions were excluded from the process and their scoring questions were not evaluated and moderated by the panel any further. For the Scored questions the panel reviewed each response and had the opportunity to discuss any variations of scores in order to reach a consensus score. Where there was a difference in judgment the panel agreed to take the average score to the nearest whole number.

The Procurement leads kept a record of the final consensus scores and presented the results to the panel.

At the end of the Moderation meeting, the Panel concluded by reviewing and confirming the following:

- Was the process compliant and in line with the Procurement Principles?
- Were the evaluation criteria followed?
- Was everyone comfortable with the process followed and in agreement with the decisions made?

All panel members confirmed their agreement that the process was compliant, the criteria were followed and that all were comfortable with the decisions made.

Following this stage, the Procurement Lead completed a PQQ evaluation report which summarised the conclusion of the PQQ evaluation process. This was to assure the NCL CCGs that the process for securing the necessary reassurance about the capacity, capability and eligibility of the applicants to satisfy the minimum requirements of the procurement process was robust. This was submitted to the Enfield Procurement Committee on the 23rd November 2015 and they were specially asked to consider and approve the following recommendations:

- To note the outcome of the PQQ process
- To approve the shortlist based on the outcome of the PQQ evaluations
- To approve issuing the ITT documentation to the shortlisted bidders.

Enfield CCG Procurement Committee approved the recommendation on 25th Nov 2015

11) Invitation To Tender stage

Invitations to Tender were issued on [30th November 2015] to all shortlisted bidders. The deadline for submitting tenders was set as [1700hrs on the 11th January 2016]

Tender responses were received as sealed bids through the Pro-contract e-procurement portal. There were no late submissions.

Potential Bidders were advised in the ITT documentation that the award criteria weighting would be based on 80% quality and 20% price as follows:

- 65% Quality (ITT Bid response document – non financial)
- 20% Price (ITT Bid response document – financial)
- 15% Quality (OSCE/Presentation – non financial)

Bidders were informed that in order to be shortlisted for the OSCE/Presentation stage, their submissions would be checked for compliance with the instructions given, they would have to pass all of the Pass/Fail Questions and also achieve the following minimum scores for Sections 1 to 7.

- Minimum of 60% for Section 1, 2 and 3
- Minimum of 50% for Sections 4, 5, 6,& 7

The right was reserved to vary the minimum score threshold specified above if deemed necessary.

An indication of the contract value was included in the OJEU and Pro-contract e-tendering portal advert and ITT documentation. The right was reserved to not appraise any bids that exceeded the maximum estimate of £50m based over the 5 year term.

As was set out in the tender documentation tender submissions would be assessed on the following evaluation criteria and weights:

Table 4: ITT Evaluation Criteria

	Evaluation Criteria	Overall Weight / Criteria
Bidder ITT Bid Response document		
1	Service Delivery	Pass/Fail & scored 15%
2	Demand & Workforce planning	Pass/Fail & scored15%
3	Clinical	Scored 15%
4	Mobilisation	Scored 5%
5	Stakeholder Involvement and Feedback	Scored 5%
6	Information & Reporting, IM&T / IG	Scored7%

7	Premises and Equipment	Pass/Fail & Scored 3%
8	Cost Bid	20%
Bidder OSCE / Presentation		
9	OSCE	10%
	Presentation / Interview	5%

Procurement removed the seal, verified the submissions and then released them to the evaluators for scoring. There were two stages in the tender evaluation process

- Initial Evaluation - Verification / Pass/Fail stage
- Detailed Evaluation - Scoring stage

Procurement verified the Bidder Submissions to confirm:

- Complete submissions were received (checked for any omissions)
- Bidders adhered to the instructions and word count limits set Bidders cost submissions were within the financial envelope set Bidders passed the Pass/Fail questions set.

Following this Initial Evaluation score sheets were released to the wider evaluation panel to complete the Detailed Evaluation.

As per the PQQ stage, evaluators submitted their individual scores for the sections they reviewed to the Procurement Lead to collate ahead of the moderation meeting which was held on 1st February 2016.

The same process was followed in terms of reviewing each Bidders response in full and discussion and moderation of any scores where appropriate in order to reach a consensus score.

Once the quality section of the moderation meeting had concluded, the Finance Leads presented their assessment of the Cost Bid section.

The financial model contained within the ITT scoring mechanism, was constructed with one Pass/Fail Question and 4 scored questions where the highest weighting applied to the lowest 5 year contractual value.

The Procurement Leads kept a record of the final consensus scores and presented the outcome to the panel members without revealing the actual scores.

At the end of the Moderation meeting, the Panel concluded by reviewing and confirming the following:

- Was the process compliant and in line with the Procurement Principles?
- Were the evaluation criteria followed?
- Was everyone comfortable with the process followed and in agreement with the decisions made?

All panel members confirmed their agreement that the process was compliant, the criteria were followed and that all were comfortable with the decisions made.

Procurement notified the shortlisted bidders of their success in reaching the OSCE/Presentation stage of the ITT.

12) OSCEs, BIDDER PRESENTATIONS AND INTERVIEWS

Bidders were given advanced notice of the assessment process for the Objective Structured Clinical Examination Scenarios and Presentation stage, which was held over two consecutive days

OSCE

The OSCE assessment was held on the 11th February 2016, during which Bidders were given 10 clinical scenarios over the course of the day. The purpose of the day was to test Bidder responses to clinically based scenarios which covered a range of themes such as Safeguarding, Mental Health, pathways and clinical audit.

There were 5 NCL teams responsible for assessing and scoring two clinical scenarios each. The teams were made up of three assessors (Clinical lead, Commissioning lead and Patient representatives)

The ten clinical scenarios were weighted 1% each (total of 10%) and a numerical score of 04 was applied by the assessment panel.

Bidders were allocated to a room, with the assessment panel teams rotating between rooms for each scenario accordingly.

In addition other members of the evaluation panel and external observers were used to support the day as follows:

<u>Team roles and responsibilities</u>

Assessment Panel – There were five teams, made up of a panel which included a clinician, commissioner and patient representative. The assessment panel were responsible for assessing and scoring Bidders responses to two scenarios each.

Facilitators – consisted of commissioner and/or CSU representatives. Each Bidder was assigned a facilitator who remained in the Bidder rooms and co-ordinated each OSCE Session. The facilitator was responsible for time management during the session, issuing the scenario questions, letting the panel members into the room to evaluate and collecting all materials from the Bidders at the end of the day. A separate facilitator also directed each assessment panel to the relevant Bidder rooms.

Calibrators – consisted of Clinical, quality and CSU representatives. The calibrators were there to provide some support and test the reasoning behind the assessment panel's evaluation & scoring. Calibrators were not told which Bidder the assessment panel had reviewed.

Observers – consisted of external personnel from NHS England and the Chair. The Observers sat through 1 or 2 OSCE sessions to ensure uniformity in our process.

Procurement – consisted of CSU representatives. The procurement leads collated all panel member scores and comments.

Confidentiality

The OSCE process was managed strictly in terms of confidentiality. All attendees (Bidders, evaluation members and observers) were asked at the start of the day to declare any conflicts of interest and were informed that all associated materials were to remain confidential due to the potential that this process would be replicated across other London Procurements. All documentation / materials (including any notes) was retained by the Project and Programme leads.

13) Presentation/Interview

The final stage of the assessment was the presentation/interview. Bidders were advised in advance of the questions/themes in order to prepare their final presentation for a select key members of the evaluation panel. The presentation / interview stage was allocated the final 5% of the overall marks reserved for this ITT stage.

Each Bidder was given 30 minutes to present followed by a 30minute Q&A session at the end. The Q&A question was used to clarify any points from the presentation and to ask each Bidders a series of unseen questions.

The evaluation panel comprised of representatives from across the 5 NCL CCGs within the following workstreams: Clinical, Commissioning, Quality, Information Governance and Patient Representatives.

The presentation was facilitated by the Chair, procurement leads, and programme manager and who did not take part in the scoring. There were two senior observers for quality assurance purposes.

After each of the Bidder presentations, the panel members scored individually and then discussed scores as a wider group in order to reach a consensus score.

The procurement leads subsequently recorded these scores to arrive at the final scores.

The panel were not informed of the final scores and the Procurement leads will now complete a Contract Award Recommendation report which will be submitted to the five CCG governing boards for approval.

14) Integrated Urgent Care Service Contract and Contract Monitoring

This contract will be offered on a block basis with the NCL CCGs developing local Key Performance Indictors (KPIs) that will sit alongside the suite of national KPIs. Some of the KPIs will pertain specifically to Quality and Performance and there will be financial sanctions attached to these KPIs for non-delivery. Payment will be monthly at 1/12th of the total contract value. 20% of the total contract value will be split across the aforementioned KPIs. Financial sanctions will be applied on a quarterly basis, following reconciliation where the provider has not achieved the KPI targets. This will be managed through the contract monitoring meetings and the clinical quality review group.

We are very keen to see patients and members of the public involved in monitoring the contract once it has been awarded. There will be an expression of interest exercise to recruit members of the public into this role following the contract award.

15) Conclusion

This paper, presented to Part 1 of Governing Bodies, summarises the very complex procurement process for an Integrated NHS111 and GP OOH service to service the populations of the five NCL CCGs.

Part 2 of Governing Bodies will receive a similar paper with the addition of the outcome of this process with a recommendation for one of the bidders to be awarded the contract. The Governing Bodies will also be asked to approve proceeding to contract discussions on successful completion of the standstill period and award the contract within the terms of the tender as outlined above.

Appendix: Local Key Performance Indicators
DRAFT recommendations to the 111/OOH Steering Group

- **Introduction**

At the end of 2015, the 111/OOH Steering Group compiled a list of Key Performance Indicators (KPIs) for the new Integrated Urgent Care (IUC) service, sourced from a range of stakeholders across north central London during engagement.

A 111/OOH KPI Working Group was formed in January 2016 with the aim of developing this list into a small number of local KPIs that are reasonable and effective at focussing performance management on the things that really matter locally. The local KPIs have been compared against the list of nationally agreed KPIs to ensure there is no duplication, and put into themes that correspond to the key issues identified during the 2015 111/OOH engagement process. The working group agreed seven key themes around which to shape the local KPIs, which were:

- The service has an effective and sustainable workforce (clinical and non-clinical)
- The service provides continuity of care, particularly for people with complex or specific care needs.
- The service works collaboratively with the local healthcare economy
- The service is effective at managing callers with mental health needs and utilises local mental health services
- The service is effective at managing risk and diverting activity away from A&E and Acute Hospitals
- The service is easy to access and direct patients to the right place in the fewest possible transactions.
- Users are happy with the service

This document describes how each of these themes has been considered during the local KPI development process, taking into account any national KPIs.

- **Performance Metrics and Key Performance Indicators**

The following definitions may be useful to meeting participants if they have not had a lot of prior involvement in developing KPIs.

Performance Metrics

A performance metric is an agreed number that denotes the expected level of performance. This could be a quantity or a percentage but the important thing is that it can be measured reliably and relatively easily. For example you might set an expectation that 10% of people using the service every month are asked for feedback. So, if 1000 people use the service, then the metric will only be met if 100 or more people are asked for feedback.

Key Performance Indicators (KPIs)

KPIs are a select group of metrics that allow commissioners to see the whole picture quickly when they are managing performance. They should therefore cover all the most important areas of performance making it quick and easy to identify the parts of the service that are not working effectively. If there are too many KPIs, the importance and impact of each one is

diminished and this can be a major factor in poor performance management. This is why KPIs need to be developed with careful consideration. KPIs usually have a financial penalty attached to them in order that there is a commercial incentive to achieve them. But KPIs can also be used to monitor the effectiveness of a system (rather than the provider specifically). Where this is the case, it is usually unfair to penalise the service for poor performance (unless all organisations operating in the system are signed up to achieving the target) but it may still be useful for commissioners to track.

- **The Local KPI Working Group**

We wanted to develop local KPIs that are reasonable and effective at focussing performance management on the things that really matter to commissioners and stakeholders. The group was designed to include a mixture of people who have a good grasp of the issues that really matter locally, and those who understand what makes a good KPI. The Local KPI Working Group was made up of:

- A GP from the Clinical Reference Group
- Two lay-members from the Patient and Public Reference Group (PPRG)
- Two commissioners from the 111/OOH Steering Group
- A contracts lead from NEL CSU
- A quality lead from NEL CSU

- **Key themes and how they are supported with local and national KPIs**

Effective and sustainable workforce (clinical and non-clinical)

Concerns around the effectiveness and sustainability of the Integrated Urgent Care workforce was a key concern raised during the 2015 engagement process. **Local KPI L9** requires the IUC provider to conduct an annual staff survey and report back to commissioners on how the survey information has been used to improve the working environment.

	Title	Theme	Frequency	Assesses
L9	Staff Feedback	Sustainable Workforce	Annual	Provider
Description	Staff survey to be conducted annually, with report on themes, trends and actions taken to address any issues highlighted to be bought to the contract review meeting.			
Rationale	The quality of the IUC service will benefit from low levels of staff turnover. The longer staff members stay in the organisation, the more they build up experience and local understanding. The provider organisation should be able to affect staff turnover by creating a good working environment.			

Source	Annual report
Standard	An initial baseline survey should be conducted within three months of the service going live. Following this, an annual report on staffing, including findings from the staff survey, should be produced within three months of the end of each contracted year. The report should include: • Staff members leaving and reasons for leaving (themed); • Turnover broken down by staff type and grade; • Sickness absence levels and reasons why (themed); and • Assessment on how absence has been covered.
Issues	None identified
Cost	Obtaining feedback from staff and producing the staff survey report will require some resource but this should be standard practice for any organisation.
Penalty	There will be a penalty attached to this KPI

Many residents felt strongly that they wanted to be able to speak to a local doctor when they used the new service. Recognising this would not be within the gift of any provider to deliver, the focus of the steering group has been on ensuring the clinical workforce is effective and sustainable. **Local KPI L10** will apply a penalty to the IUC provider should they fail to cover clinical shifts adequately.

	Title	Theme	Frequency	Assesses
L10	Sustainable workforce (1)	The service has an effective and sustainable workforce (clinical and non-clinical)	Monthly	Provider
Description	The service must ensure there is a safe level of staffing cover at all times.			
Rationale	The provider must demonstrate that they have clinically safe rota fill covering all shifts. It also relates to all HA rotas. If for example, a GP were to call in sick and the Provider wasn't able to fill their shift with another GP but they were able to fill it with a Nurse, then they would be clinically compliant. However, if there were not enough GPs to cover one shift then they would not be clinically compliant. It is the provider's responsibility to ensure shifts are filled; therefore it is reasonable for the CCG to penalise the provider if capacity is reduced resulting in overspill to other parts of the system. Worst case scenario would result in a divert to other NHS111 providers.			
Denominator				

Numerator	
Source	
Standard	Suggested standard is: <75% Red, 75-95% Amber, Yellow, >95% Green We would expect a minimum of xxxxx GPs and a minimum of xxxxx Nurses covering both the call Clinical Hub and the OOHs provision, i.e. No. of GPs available to see patients whether that be home or base visits. Likewise this KPI will cover the HAs, (call handlers) and Pharmacists. If a minimum number of HAs are not available to take the calls then the service becomes unsafe %ages to be determined (i.e. excellent is 100%, 75% is very bad and this could invoke financial sanctions if not rectified immediately).
Issues	
Cost	
Penalty	There will be a penalty attached to this KPI

During engagement, there were also some concerns expressed about the knowledge, skills and experience of the call handlers and a strong feeling that they needed good and on-going training and support. **Local KPI L16** has been developed to ensure the provider supports continual professional development of Health Advisers.

	Title	Theme	Frequency	Assesses
L16	Sustainable workforce (2)	The service has an effective and sustainable workforce (clinical and non-clinical)	Monthly	Provider
Description	Health Advisers will receive regular training to improve their knowledge, effectiveness and customer service skills			
Rationale	Most people calling NHS 111 will speak to a Health Advisor in the first instance. Effective call handling by this staff group is essential to the overall effectiveness of the service.			
Denominator	Number of Health Advisers employed by the IUC service			
Numerator	Number of Health Advisers compliant with the staff training programme			
Source	Management data			
Standard	Further to the national training programme for Health Advisers, the provider will develop a programme for continual professional development of Health Advisers. This will be in line with the requirements set out in the service specification and include:			

	• Training in customer service/empathy (frequency to be determined) • Annual updates on the Clinical Decision Support tool • Observational training (frequency to be determined) Suggested standard for compliance is: <75% Red, 75-90% Amber, Yellow, >90% Green The service must also have a quality assured audit process in place (as described in the service specification) in order to be compliant with this KPI.
Issues	
Cost	Staff training and development will be a reasonably significant cost to the provider; however the associated costs will have been considered as part of the tender process.
Penalty	There will be a penalty attached to this KPI

The service provides continuity of care, particularly for people with complex or specific care needs.

Providing continuity of care and good management of people with complex or specific healthcare requirements is an essential requirement clearly set out in the service specification (particularly under section 5.2.1 – 'telephone advice', and section 7.1.1 – 'Interoperability within Integrated Urgent Care Services'). In order to re-enforce this, **Local KPI L5** incentivises the UIC service to identify and correctly manage callers with specific care plans in place.

	Title	Theme	Frequency	Assesses
L5	Personalised care (1)	The service provides continuity of care, particularly for people with complex or specific care needs.	Quarterly	Provider
Description	Calls relating to patients with an urgent care record e.g. Coordinate my Care, Special Patient Note and other types of urgent care record that are being developed, such as mental health crisis plans and child protection plans, to be warm transferred to, and handled by, the clinical hub to be handled by an Integrated Urgent Care clinician who has reviewed their urgent care record.			
Rationale	It is not appropriate for callers with complex care requirements to be assessed by a health advisor through the Clinical Decision Support (CDS) system. This KPI will incentivise the provider to put a robust process in place to ensure complex patients are managed appropriately.			

Denominator	Number of calls relating to patients with an urgent care record
Numerator	Number of callers warm transferred to the clinical hub
Source	Audit
Standard	<85% Red, 85% - 95% Amber, >95% Green
Issues	For this to be successful the urgent care records will need to be reliably made available by the organisation(s) or individuals developing the caller's care plan. Health Advisors may also not be able to reliably identify patients with urgent care records.
Cost	Cost of audit
Penalty	There will be a penalty attached to this KPI

Local KPI L6 incentivises providers to ensure that all calls related to people under 5 or over 85 are automatically transferred to a clinician.

	Title	Theme	Frequency	Assesses
L6	Personalised care (2)	The service provides continuity of care, particularly for people with complex or specific care needs.	Monthly	Provider

Description	Calls relating to patients under five years old or over eighty years old to be warm transferred to, and handled by, the clinical hub.
Rationale	Due to the level of clinical risk and potential complexity of cases seen in the very young and very old, it is not appropriate for these callers to be managed by a health adviser through the Clinical Decision Support System (CDSS). This KPI incentivises the provider to put a system in place to ensure these callers are transferred to a clinician as soon as possible.
Denominator	Number of calls from people >80 or <5 years old
Numerator	Number of callers warm-transferred to a clinician
Source	Minimum dataset
Standard	<80% Red, 80 - 90% Amber, >90% Green
Issues	None identified
Cost	Minimal - this information should be easily extracted from the minimum dataset
Penalty	There will be a penalty attached to this KPI

The service works collaboratively with the local healthcare economy

The new service needs to be able to make good links with the local health system in order to be effective. The ability of the IUC service to access relevant patient information, update notes and then feed back appropriately to other organisations was a key area of concern raised during engagement.

Rapid transfer of referral information

National KPI 8 (Electronic transfer of referral information) sets a time standard for relevant patient information to be transferred to any organisation that the IUC service refers into. This is designed to incentivise the provider to develop electronic communication systems involving local health, social care and voluntary sector providers, and will help ensure timely information transfer from the provider to other care organisations.

	Title	Domain	Area	Frequency	Assesses
N8	Electronic transfer of referral information	Effectiveness	Advice	Monthly	System

Rationale	To support strategic intent within Commissioning Standards to improve referral processes from IUC rather than those between call centre / hub. Currently, very few community voluntary or social care providers have capability to receive electronic information transfer. Nevertheless, we will include them in this measure, because this is exactly the arrangement we want to encourage.
Denominator	Count of calls where DoS is opened.
Numerator	Count of calls where DoS is opened and the details obtained during the call are transferred electronically, securely, and so the subsequent service has them available at the time they continue the assessment and treatment. Secure transmission methods include ITK or nhs.net email, and not fax. Merely sending a post-event message to the GP is not enough to count for this KPI.
Source	Management Information; will need to be compiled by IUC providers.
Standard	Will be set once sufficient reliable data are available.
Cost	Difficult to estimate; providers may incur costs to develop information streams that identify which of many subsequent services are able to receive electronic transfer.
Penalty	No penalty will be applied to this KPI

System monitoring

Local KPI L4 (Monitoring the effectiveness of local pathways) has been designed to ensure effective monitoring of referrals from the IUC service and identify areas where collaboration can be improved.

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Commissioners recognise that the effectiveness of a pathway is usually the responsibility of more than one organisation and is something the Integrated Urgent Care service may not be able to affect. For this reason, in most cases, it will be inappropriate for the service to be penalised for failure to, for example, refer to a crisis response service, if that service is unreliable. However the Integrated Urgent Care service will be well-placed to collect and convey essential intelligence, which can be used to determine which pathways are not effective and help identify what the issues are.

	Title	Theme	Frequency	Assesses
L4	Monitoring the effectiveness of local pathways	The service works collaboratively with the local healthcare economy	Monthly	Commissioner/ system

Description	Onward referrals will be monitored, issues reported regularly and recommendations made to commissioners for improving local pathways.
Rationale	The IUC service should endeavour to improve their utilisation of local pathways but it will not necessarily be within their gift to resolve issues that may be routed within other organisations (e.g. long waiting times, unpredictability or inability to accept electronic referrals). The IUC service is therefore required to report on which services they refer to, making it clear where there are barriers preventing referral to particular services.
Source	This data will be included within the minimum dataset
Standard	A monthly report must be produced within 30 days after the end of each month (with a penalty attached for non-completion or if submission is more than three months late) that includes, as a minimum, the data set out below. This data will be broken down by: • Borough of residence; • Age of caller; • Date and time of call; • Whether caller has been processed by a health adviser (via the CDS) or a clinician • The service they were referred to; and • Referral method (e.g. direct booking or recommendation to self-refer). The report should also include analysis/interpretation, identify any barriers preventing referrals and include recommendations for each CCG for improving referral pathways.
Cost	Small resource cost to produce the report
Penalty	No penalty will be applied to this KPI

Exception reporting on Directory of Services use

	Title	Theme	Frequency	Assesses
L15	Directory of Services Exception Reporting	The service works collaboratively with the local healthcare economy	Monthly	System

Description	The provider should be expected to provide quarterly exception reporting on cases where the first choice given by the DoS has not been used. This will be discussed at the CQRG.
Rationale	Understanding of why call handlers decide not to use the first service listed in the DoS will give commissioners a better understanding and awareness of issues with local pathways. This KPI is designed to encourage providers to develop an effective mechanism to capture this information.
Source	DoS Exception Report
Standard	Information should be collected in enough detail for reviewers to understand the reasons why the first choice has not been selected. Reasons for non-selection should be grouped, where possible (i.e. not just free text) to enable quantitative analysis. This standard will be met if the report is presented to commissioners up to 30 days from the end of each year of the contract.
Cost	Producing this report will require a small amount of resource
Penalty	There will be a penalty attached to this KPI

Frequent users

People who call NHS 111 frequently are usually doing so because they are having trouble accessing the support they require. For this reason, the IUC service will be required to flag frequent callers quickly to the appropriate body. **Local KPI L1** requires the IUC service to alert a patient's GP if they have called NHS 111 three times with a non-urgent need, within 96 hours.

	Title	Theme	Frequency	Assesses
L1	Frequent Users (1)		Monthly	Provider

Description	All repeat callers [threshold to be determined – suggestion: who have called the service 3 times within 96 hours, and where an ambulance has not been called], must result in a "warm transfer to a GP" disposition and

	be booked within this timeframe. Patient's registered GP must be specifically alerted to the case in addition to the ITK message.
Rationale	People who call NHS111 frequently within a short period of time may have underlying complex mental or physical healthcare needs and require their local GP, in their role as care co-ordinator, to be involved. The GP will then be able to access local mechanisms (e.g. Local MDT teleconferences) to support on-going management of the caller.
Denominator	Number of callers who call 111 three or more times within 96 hours
Numerator	Number of callers given a “Speak to GP within one hours” disposition on the third call
Source	Frequent User Report
Standard	<90% Red, 90% - 98% Amber, >98% Green
Issues	This does not cover patients who are given a disposition but continue to call.
Cost	Cost implications for the IUC service are expected to be very small
Penalty	There will be a penalty attached to this KPI

Feedback from local health professionals

Local KPI L3 incentivises the IUC provider to consider and respond to feedback and promote continual improvement within the organisation.

	Title	Theme	Frequency	Assesses
L3	Healthcare Professional Feedback		Monthly	Provider
Description	All healthcare professional feedback and patient complaints to be responded to in full within 21 working days. Professional feedback and complaints from each contracted month should be listed for discussion at CQRG meetings.			
Rationale	This KPI will incentivise the IUC provider to consider and respond to feedback and promote continual improvement within the organisation.			
Denominator	Number of items of feedback from healthcare professionals outside the organisation and number of complaints from patients.			
Numerator	Number of items of feedback/complaints responded to in 21 working days.			
Source				
Standard	<80% Red, 80 - 90% Amber, >90% Green			

Cost	Responding to feedback will require a small amount of resource but should be standard practice for any organisation.
Penalty	There will be a penalty attached to this KPI

The service is effective at managing callers with mental health needs and utilises local mental health services

During the engagement process, many people commented that the IUC service needs to be better at helping people with mental health needs.

Local KPI L5 (listed under section 4.2) is designed to encourage the Integrated Urgent Care service to access, record and share information appropriately with other organisations. Local stakeholders, particularly clinicians, expressed concern that relevant information about callers with mental health needs was not shared well enough between professionals involved in their care.

Local KPI L4 (listed under section 2.3) will also enable commissioners to better identify and resolve any issues preventing utilisation of local mental health services.

The service is effective at managing risk and diverting activity away from A&E and Acute Hospitals

Although this was not a key theme brought up during engagement with the public, diverting activity away from A&E and acute services is a key objective IUC services. This theme is well-addressed through national KPIs.

Supporting Self-care

National KPI 4 (self-care) works to incentivise IUC services to manage more callers without onward referral. **NKPI 5 (re-contacts)** is designed to ensure that these calls are managed safely.

	Title	Domain	Area	Frequency	Assesses
N4	Self-care	Effectiveness	Assessment	Monthly	Provider

Rationale	Urgent and Emergency Care Review (UECR) requirement on IUC to manage more callers without onward referral, by solving the problem at the time and not requiring patients to wait and then explain the situation again to another service when that is available.
Denominator	Count of calls triaged.
Numerator	Count of calls triaged and closed on the telephone without any face-to-face assessment. Includes calls closed by the initial call handler, by a clinician after a live transfer, or by a clinician calling back.
Source	Management Information; will need to be compiled by IUC providers.
Standard	Will be set once sufficient reliable data are available from IUC providers.

Issues	Further data will be needed on the point at which calls are closed, to check for perverse incentives.
Cost	Negligible extra cost for providers, data already available in existing dataset.
Penalty	TBC

	Title	Domain	Area	Frequency	Assesses
N5	Re-contacts	Safety	Assessment	Monthly	Provider

Rationale	To assess the success and safety of advice given and in particular to check that the self-care measure (KPI 4) is not achieved through inappropriate call closures. Therefore, re-contacts will only be counted for calls closed with self-care. The standard will not be zero, some re-contacts will always be inevitable; but this measure will identify providers with unusually high proportions of re-contacts. Excludes calls from patients with a frequent caller procedure in place, so that the measure is not mostly determined by avoid a small number of patients.
Denominator	Count of calls closed with self-care (the numerator from KPI 4).
Numerator	Count of calls closed with self-care, with at least one repeat call to 111, for the same condition, for the same patient (even if through a different caller and/or from a different telephone). Will exclude calls from patients where there is an agreed frequent caller procedure in place before the call. When national data allows, numerator will not be limited to re-contact with 111, but will include patients attending A&E, and calls to any existing OOH GP provider service still in place.
Source	Management Information; will need to be compiled by IUC providers and may require software development.
Standard	Will be set once sufficient reliable data are available from IUC providers.
Issues	Some patients know that calling three times automatically increases the priority of response they will receive. However, that can be solved with alternative prioritisation without needing to change this KPI.
Cost	Low, if this can be derived monthly for all provider areas from the Repeat Caller database. If not, may need software development and some staff training to calculate this; unclear whether cost would be borne by providers.
Penalty	TBC

A&E dispositions resulting from gaps in local service provision

National KPI N6 is a system measure that identifies callers that were directed to A&E due to the lack of available local services. This will help commissioners identify gaps in local provision and gage the level of demand for particular services.

	Title	Domain	Area	Frequency	Assesses
N6	Directory of Service catch-all	Effectiveness	Assessment	Monthly	Commissioner / System

Rationale	IUC effectiveness is dependent on commissioning of adequate urgent care services and population of the Directory of Service (DoS) with these services, so that the Emergency Department (ED) catch-all is not needed.
Denominator	Count of calls where the DoS is opened.
Numerator	Count of calls where the DoS only displays two Emergency Departments with the suffix "(catch all)".
Source	NHS Pathways (needs requesting)
Standard	Will be set once sufficient reliable data are available.
Issues	Should DoS data (generally, not just for this KPI 6) be collected direct from NHS Pathways at HSCIC rather than providers? Would be more efficient, but need assurance that NHS Pathways at HSCIC receive all necessary raw data from providers.
Cost	No financial cost. Small analytical time resource required to request and verify data from NHS Pathways.
Penalty	No penalty attached to this KPI

Appropriate call back times

Local KPI L12 is designed to incentivise the service to respond in a timely way appropriate to each caller's requirements. Appropriate call back times will minimise the risk of callers 'giving up' and resorting to A&E/emergency services.

	Title	Theme	Frequency	Assesses
L12	Call backs	The service is effective at managing risk and diverting activity away from A&E and Acute Hospitals	Monthly	Provider

Description	Time taken for call back a. Urgent: 100% in 10 minutes of the call being completed by the health advisor. b. Less Urgent: 100% in 20 minutes of the call being completed by the health advisor.

	c. Other: 100% in 1 hour of the call being completed by the health advisor.
Rationale	This KPI is designed to incentivise the service to respond in a timely way appropriate to each caller's requirements. Appropriate call back times will minimise the risk of callers 'giving up' and resorting to A&E/emergency services.
Denominator	a. Number of callers assessed as 'urgent' and assigned a call-back from the clinical hub b. Number of callers assessed as 'less-urgent' and assigned a call-back from the clinical hub c. Number of callers assessed as 'non-urgent' or 'other' and assigned a call-back from the clinical hub
Numerator	a. Number of callers 'called back' within 10 minutes b. Number of callers 'called back' within 20 minutes c. Number of callers 'called back' within 1 hour
Source	Minimum dataset
Standard	a. <95% Red, 95% - 99% Amber, >99% Green, b. <90% Red, 90% - 98% Amber, >98% Green c. <90% Red, 90% - 98% Amber, >98% Green
Cost	Data should be collected as part of the minimum dataset so monitoring costs will be very low
Penalty	There will be a penalty attached to this KPI

Green Ambulance Dispatches

Local KPI L13 reinforces the requirement, set out in the service specification, for the IUC service to re-assess any calls initially considered to need a 'green' (less urgent) ambulance response. This is expected to result in a 50-70% reduction in ambulance conveyances, with no negative impact on GP OOH or patient experience and safety.

	Title	Theme	Frequency	Assesses

L13	Green ambulance dispatch	The service is effective at managing risk and diverting activity away from A&E and Acute Hospitals	Monthly	Provider CDS system

Description	Calls resulting in green ambulance dispositions are to be warm transferred to the Clinical Hub and clinically assessed, prior to dispatch.
Rationale	Evidence from NHS 111 pilots has shown that, when re-triaged by a clinician, a high proportion of calls resulting in green ambulance dispositions are downgraded. Compliance with this KPI is therefore likely to result in a lower impact on emergency services, particularly ambulance services.
Denominator	Number of calls resulting in green ambulance dispositions
Numerator	Number of calls re-assessed in the clinical hub
Source	Minimum dataset
Standard	<80% Red, 80 - 90% Amber, >90% Green
Issues	Over the lifetime of this contract, the Clinical Decision Support (CDS) system may improve the way it manages this cohort of patients (currently it needs to be relatively risk-averse). In this scenario, it may no longer be efficient to re-triage green ambulance dispositions because they are more likely to be appropriate. It is therefore important to continually monitor all changes in disposition following re-triage.
Cost	Meeting this KPI will require the service to have additional clinical resource in the clinical hub to provide additional assessments. Monitoring the KPI will not be resource intensive as the required information should be recorded as part of the minimum dataset.
Penalty	There will be a penalty attached to this KPI

The service is easy to access and directs patients to the right place quickly, in the fewest possible transactions.

During the engagement period, local residents stressed the importance of being able to speak to the right healthcare professionals as quickly and as early as possible once they called NHS111. This theme will be well-supported through the proposed national KPI framework. This includes **National KPI N9**, which measures how long it takes for callers to get the support, treatment or advice they need.

	Title	Domain	Area	Frequency	Assesses
N9	Average time to definitive clinical encounter	Effectiveness	Advice	Monthly	System

Rationale	Callers to urgent care services want an answer to their concerns as soon as possible – either in the form of advice and reassurance or the commencement of necessary treatment. This mean average time to receiving an 'answer' across the range of presenting symptoms and final diagnoses is particularly valuable in understanding the patient journey when broken down into such groups.
Denominator	Count of calls triaged.
Numerator	The time from call connect until (i) call closed with self-care, for calls that count towards KPI 4; or (ii) subsequent advice or treatment started (whether on telephone or face to face). Providers should supply this time aggregated into a total for all calls triaged each month, to avoid transcription errors due to software and time formats. The mean average can then then calculated by dividing by the numerator.
Source	Management Information; will need to be compiled by IUC providers.
Standard	Will be set once sufficient reliable data are available.
Issues	Requires staged implementation approach and further definition of time stamps and end points. For example: Needs to exclude calls where caller advised to attend A&E, where this measure would depend upon how soon they departed, and how long they waited at A&E. A caller may be completely happy with an appointment made with an appropriate provider many days in advance, but that would skew this average measure. If such appointments are excluded, where should the cut-off be? In practice, this will mainly measure the time until treatment face to face, because those times will be much longer than the times until closure with self-care or treatment on the telephone. Need a way to ensure data supplied covers all applicable episodes, and this KPI doesn't appear low because data are missing for certain types of episode. The terminology "Definitive clinical encounter" is also used as an aspect of NHS Pathways. This KPI will only be a total across all symptoms and diagnoses; however, it will standardise reporting, and be useful as a comparison for commissioners to then request the same measure for specific symptoms and diagnoses.
Cost	Possibly the most expensive indicator. For each caller referred to subsequent services, providers will need time data at individual call level, and/or software development to collate, store and output data, which will require their analytical and possibly financial resources,
Penalty	No penalty attached to this KPI

Accessing the service

During engagement local residents expressed the importance of enabling non-English speakers to access the service easily. Some delay is expected when an interpretation service is required; however any delay increases the likelihood that a caller will revert to A&E and may, in some circumstances, put the caller at risk of harm. **Local KPI L7** is designed to monitor and maintain focus on any delays experienced by non-English speakers.

	Title	Theme	Frequency	Assesses
L7	Meeting individuals' needs	The service is easy to access and direct patients to the right place in the fewest possible transactions.	Six-monthly	Provider

Description	Patients unable to communicate effectively in English are to be provided with an interpretation service within 10 minutes of initial contact. Interpretation service must also make appropriate provision for patients with impaired hearing, learning challenges and other access issues. Of total calls requiring interpretation what is the % figure for those initiating contact within 10 mins.
Rationale	The new service must be able to deal with the communication needs of all community groups (this is set out in the service specification). This includes taking reasonable measures to meet the needs of non-English speakers.
Denominator	Number of callers flagged as requiring an interpretation service
Numerator	Number of callers provided with an interpretation service within 10 minutes of initial contact
Source	Regular report on access
Standard	<85% Red, 85% - 95% Yellow, >95% Green
Issues	Achievement of this standard will be partially contingent upon the effectiveness of the interpretation service used. Currently providers have limited choice over which interpretation services they use.
Cost	This will require the provider to flag callers that are unable to communicate effectively in English and collect data on time waited for interpretation service.
Penalty	There will be a penalty attached to this KPI

Repeat Prescriptions

Local KPI L8 is designed to support the PURM pathway, enabling more urgent repeat prescriptions to be accessed without the need for a GP appointment.

	Title	Theme	Frequency	Assesses

L8	Repeat Prescription requests	The service is easy to access and direct patients to the right place in the fewest possible transactions.	Monthly	Provider

Description	People calling NHS 111 with a repeat prescription request only (who have not expressed the need for another service as well) should be diverted to the PURM service and not require a clinical appointment.
Rationale	Most callers requiring repeat prescriptions will be directed to PURM by the Interactive Voice Recognition (IVR) system before they enter the IUC service. However, a small proportion will be directed to a health adviser in the IUC service.
Denominator	Number of callers requesting a repeat prescription only (excluding callers diverted via IVR. Also excluding any callers requesting restricted drugs not available via PURM)
Numerator	Number of repeat prescription requests (with no expressed need for another service) directed to PURM by a health advisor.
Source	Minimum dataset
Standard	It is unrealistic to expect 100% callers to be re-directed to PURM before being directed to a clinician within the IUC service, as it will not always be easy to differentiate callers that only require repeat medication from callers with more complex needs. Suggested standard is: <80% Red, 80-95% Amber, Yellow, >95% Green In order to establish realistic parameters for this KPI, we need to look at current performance.
Cost	Negligible. This metric should be captured through the minimum dataset.
Penalty	There will be a penalty attached to this KPI

National and Local KPIs indirectly supporting this theme

This theme will also be supported if the measures to improve integration and improve local pathways are successful. **National KPI N4 (described in section 2.5)** is designed to encourage as many callers as possible to be managed within the IUC service and **National KPI 8 (described in section 2.3)** is designed to improve information sharing between organisations and support seamless transfer of care from the IUC service to other organisations.

Users are happy with the service

National KPI N12 and N13 will enable overall satisfaction of the IUC service to be compared against other providers nationally. There will not be any penalties attached to these KPIs.

	Title	Domain	Area	Frequency	Assesses
N12	Helpfulness of advice	Patient Experience	Advice	Twice a year	Provider

Rationale	
Denominator	Count of survey responses where “How helpful was the advice given by the 111 service” was answered “Very helpful”, “Quite helpful”, “Not very helpful”, or “Not helpful at all”.
Numerator	Count who responded “Very helpful” or “Quite helpful”.
Source	NHS 111 patient experience survey.
Standard	No standard, just comparison of improvement over time between providers. Assessment of helpfulness depends upon patient expectations, which are in turn influenced by media and public mood.
Issues	This question appears in the recommended questionnaire in the MDS specification, and most existing 111 providers include it in their own questionnaire. However, it is not in the NHS England data collection specification, so data has not yet been compiled. Partly duplicates KPI 7. Which is better, patients’ reported views on the helpfulness of advice, or patients’ reports of whether they complied with that advice? See more general survey issues in KPI13.
Cost	Perhaps a few thousand pounds per year for some providers; see costs in KPI13.
Penalty	No penalty attached to this KPI

	Title	Domain	Area	Frequency	Assesses
N13	Satisfaction	Patient Experience	Advice / Treatment	Twice a year	Provider

Rationale	
Denominator	Count of survey responses where “Overall, how satisfied or dissatisfied were you with the way the 111 service handled the whole process?” was answered “Very satisfied”, “Fairly satisfied”, “Neither satisfied nor dissatisfied”, “Fairly dissatisfied” or “Very dissatisfied”.
Numerator	Count of survey responses where this question was answered “Very satisfied” or “Fairly satisfied”.
Source	NHS 111 patient experience survey.
Standard	No standard, just comparison of improvement over time between providers. Satisfaction depends upon patient expectations, which are in turn influenced by media and public mood.

Issues	Survey will need to be timely and make clear to patients that this refers to the advice from IUC as a whole, including the clinical hub. A separate project is considering wider Urgent and Emergency Care (UEC) outcome measures. It will consider whether a new survey is needed, but that would be unlikely to be available in 2016/17. Once available, that survey could use existing questions in KPI 7, 12, 13 and 14, or new questions could be asked. New questions could be introduced now to the existing survey, but keeping them unchanged for now will allow us to compare the new IUC service with the existing 111 service. Alternative patient experience data collections can be investigated, for example via text messages.
Cost	Some providers need to increase their sample sizes from the existing survey; cost to them could be a few thousand pounds per year. This would improve data quality for KPI 7, 12, 13 and 14. New patient experience data collection mechanisms other than existing postal surveys would cost many thousands of pounds to develop, although in time such costs may be less than savings to providers from no longer needing postal surveys.
Penalty	No penalty attached to this KPI

Capturing Feedback

Obtaining feedback from people seeking urgent care can be particularly problematic but having a mechanism to capture feedback is essential and will inform continual service improvement. The level of feedback captured for urgent care services is typically very low, so **Local KPI L14** is designed to encourage the UIC service to be flexible in the way it captures feedback and also sets a minimum expectation for number of service users feeding back per month.

	Title	Theme	Frequency	Assesses
L14	Caller feedback	Users are happy with the service	Monthly	Provider
Description	Caller feedback must be obtained from at least [25 patients – suggested quota] per month for each service element: • Callers speaking to a Health Adviser only • Callers receiving a telephone consultation • Callers attending a face-to-face consultation (either base visit or home visit) Feedback must be obtained using more than one method e.g. SMS surveys, telephone surveys, postal surveys, focus groups etc.			

Rationale	Obtaining feedback is an essential part of continual service development. This KPI incentivises providers to develop different ways of getting callers to provide feedback.
Source	The service will need to keep record of the feedback it obtains from callers
Standard	<15 Red, >15 - <25 Amber, 25+ Green
Issues	This is not entirely within the provider's control. However getting 25 callers to feedback per month, for each service element, should be achievable.
Cost	The provider will need to put mechanisms in place (e.g. an SMS feedback system) which will have some cost.
Penalty	There will be a penalty attached to this KPI

- **Quality Reporting**

The KPIs for the IUC service are designed to cover all areas of performance that are considered to be important on a national and local-level, including metrics to cover both performance and quality. This means that National Quality Requirements (NQRs), currently in place for GP Out-of-Hours services, will become obsolete. However, in order to maintain a separate focus on quality, the provider will be obligated to produce an annual quality report for commissioners. The content and format of the report will be designed separately to this process.

	Title	Theme	Frequency	Assesses
L16	Quality Reporting		Annual	Provider
Description	The provider is required to provide an annual quality report for discussion at CQRG.			
Rationale	This KPI will require the provider to demonstrate that the service meets local quality requirements.			
Source	Quality Report			
Standard	This standard will be met if the report is presented to commissioners up to 60 days from the end of each year of the contract.			
Cost	Producing this report will require a small amount of resource			
Penalty	There will be a penalty attached to this KPI			

- **National KPIs that do not report to a local theme**

These have been listed here for completeness.

	Title	Domain	Area	Frequency	Assesses
N1	Calls abandoned after at least 30 seconds	Safety	Access	Monthly	Provider
Rationale	Abandoned calls represent an unquantifiable clinical risk since by definition the needs of the caller are not established.				
Denominator	Count of calls offered, which is equal to calls answered + calls abandoned (whether after more or less than 30 seconds).				
Numerator	Count of calls where the caller waited at least 30 seconds after clock start and then abandoned the call before it was answered. Clock start is the end of any local or national introductory message, which should normally be no more than 30 seconds long. If there is no such message, clock starts at call connect.				
Source	Management Information; will need to be compiled by IUC providers.				
Standard	Can be set now from existing NHS 111 MDS data.				
Issues	Applies to all KPIs where a standard is set, not just KPI 1: Should they be purely based upon existing performance (and perhaps made more challenging over time)? Or should they depend upon clinical evidence of what is required for certain circumstances, or upon patient expectations and/or standards for other health services?				
Cost	No extra cost, data already collected and supplied by providers.				

	Title	Domain	Area	Frequency	Assesses
N2	Average time to call answer	Patient Experience	Access	Monthly	Provider
Rationale	Every call counts equally for the mean average time to call answer, and as a measure, it keeps the incentive to answer a call that has already waited more than 60 seconds. The length of time before a call is answered is an important contributor to the overall patient experience. Prolonged delays in call answer time result in increasing rates of calls abandoned which generates clinical risk as described in KPI 1. Calls answered in 60 seconds is a crude measure, because a provider answering 10% of calls after 2 minutes gets the same performance measure as one answering 10% of calls after 10 minutes; and there is no clinical justification for requiring 95%. That crude measure can still be collected monthly in Tier 2 for comparison against KPI 2.				
Denominator	Count of calls answered.				
Numerator	Time from clock start (same clock start as KPI 1) until the call is put through to a call handler, in seconds.				

	Providers should supply this time aggregated into a total for all calls triaged each month, to avoid transcription errors due to software and time formats. The mean average can then then calculated by dividing by the numerator. All answered calls count; in the extremely unlikely event of a caller genuinely waiting for an hour, for example, that should still contribute to the average time. However, seemingly long wait times that are actually due to data errors, and not genuine, should not be included. Abandoned calls are excluded because otherwise this would overlap with what KPI 1 is designed to measure.
Source	Management Information; will need to be compiled by IUC providers.
Standard	Could be set now, once sufficient historical data requested and received from existing NHS 111 providers.
Issues	Current average answer time calculations will be needed in order that a standard can be set. Some months are more demanding (such as those with five weekends), but providers should plan for this, so patients receive the same levels of service at all times. Longest call time was considered and rejected; one bad call early in a month can determine the measure and remove the incentive to answer subsequent calls quickly.
Cost	Negligible extra cost for providers, who should record the call answer time for each call in order to calculate the numerator and denominator.

	Title	Domain	Area	Frequency	Assesses
N3	Access to assessment within 10 minutes	Patient Experience	Access	Monthly	Provider
Rationale	Requirement to provide timely patient assessment without prolonged call-backs within IUC. Calls closed by the call handler excluded from numerator and denominator. The risk of call handlers unnecessarily transferring calls to clinicians, purely to improve this measure, is low, because of the cost of clinician time.				
Denominator	Count of calls either live transferred to a clinician, or with a request for a call back.				
Numerator	Count of calls either live transferred to a clinician, or followed by a call back from a clinician starting within 10 minutes of the first call ending.				
Source	Management Information; will need to be compiled by IUC providers.				
Standard	Will be set once sufficient reliable data are available from IUC providers.				
Issues	Will require data linkage to Clinical Hub as this is likely to be source of much clinician assessment and advice				
Cost	No extra cost for providers, data items already provided in existing dataset.				

	Title	Domain	Area	Frequency	Assesses
N7	Compliance with advice	Patient Experience / Effectiveness	Advice	Twice a year	System

Rationale	Important to understand compliance with advice given and referrals made, particularly in relation to subsequent unplanned health seeking behaviours.
Denominator	Count of survey responses to “Did you follow the advice given by the 111 service?” answering “yes, all of it”, “yes, some of it” or “No”.
Numerator	Count of survey responses answering “yes, all of it” or “yes, some of it”.
Source	NHS 111 patient experience survey.
Standard	Will be set once sufficient reliable data are available from IUC providers.
Issues	Partly duplicates KPI 12, asking whether patients found the advice helpful. However, there is a difference; if advice was followed, it shows the service is effective and patients have confidence in it. KPI 12 captures a separate aspect: if patients find found advice helpful, it shows patients have the ability to choose care that they feel is best for their circumstances. Longer term, data linking will provide a more reliable measure than surveys of whether patients actually attend / contact the service they were recommended to. See more general survey issues in KPI 13 below.
Cost	Perhaps a few thousand pounds per year for some providers; see costs in KPI13.

	Title	Domain	Area	Frequency	Assesses
N10	Serious Incidents	Safety	Whole journey	Monthly	Provider

Rationale	Oversight of IUC incident reporting and learning. The measure is not a simple numerical count, because that would incentivise non-reporting.
Measure	Confirmation from commissioner that provider has sent qualitative report on SIs. No quantitative measure.
Source	Email notification by commissioners.
Standard	No standard will be set.
Issues	Needs designated NHS England staff to advise whether commissioners’ reports are satisfactory. May need verifying against SIs reported within 48 hours on Strategic Executive Information System (STEIS), or National Reporting and Learning System at www.england.nhs.uk/patientsafety/serious-incident.

Cost	Should be low. Providers are already expected to identify and report SIs. Perhaps a small staff time cost for providers to produce reports acceptable to commissioners on learning resulting from SIs.

	Title	Domain	Area	Frequency	Assesses
N11	End to end reviews	All	Whole journey	Monthly	Provider / Commissioner
Rationale	Important to embed clinical audit of whole patient journey in to IUC system.				
Measure	Confirmation from commissioner that provider has sent qualitative report on end to end reviews. No quantitative measure.				
Source	Email notification by commissioners.				
Standard	No standard will be set.				
Issues	Needs designated NHS England staff to advise whether commissioners' reports are satisfactory.				
Cost	Should be low. Providers are already expected to conduct end to end reviews. Perhaps a small staff time cost for providers to produce reports acceptable to commissioners on learning resulting from such reviews.				

	Title	Domain	Area	Frequency	Assesses
N14	If 111 was not available	Patient Experience / Effectiveness	All	Twice a year	System
Rationale	To understand how IUC influences health seeking behaviour. Shows how successfully IUC diverts away patients who do not need services but would have used a service had 111 not been available.				
Measure	Denominator: count of survey responses with an answer to "If the 111 service had not been available..." Numerator: count of survey responses that answered "I would not have contacted anyone else". Then, subtract the proportion above, from the proportion of calls triaged that were not recommended on to other services.				
Source	NHS 111 patient experience survey.				
Standard	No standard, just comparison of improvement over time between providers. This measure depends upon the categories of patients that choose to call 111.				

Issues	See survey issues in KPI 13. Publicity and signposting may increase calls to 111 from low acuity callers, decreasing this measure; which is why it measures the system, more than individual providers. An improvement in KPI 4 on self-care is likely to also lead to an improvement in this measure; some overlap between these to KPIs, so this could be excluded as a KPI; it would still be collected as an item in Tier 2.
Cost	Some cost to providers – see KPI 13

- **Next Steps**

The recommendations for local KPIs, contained in this paper, will be taken to the 111/OOH Steering Group on 21st March for agreement. They will then be presented to the Urgent Care Steering Group for final approval.

They will also be considered by a technical group for further scrutiny and to develop robust mechanisms for monitoring.

Once the Local KPIs have been approved by the Urgent Care Programme Board, they are still subject to agreement by the winning bidder as part of contract negotiations taking place in Spring 2016.

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Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London

11 March 2016

Future Dates/Work Plan

1. Future Dates

1.1 The following dates for JHOSC Meetings in 2016-17 are proposed:

- 17th June (Islington);
- 30th September (Haringey);
- 25th November (Barnet);
- 27th January 2017 (Enfield); and
- 17th March 2017 (Camden)

2. Potential Future Items

2.1 Members are requested to consider potential items for future meetings of the Committee. Issues already identified as potential future items for meetings are currently as follows:

- Primary Care Update on the "Case for Change"; To include details of local authority involvement in the development of plans and proposals for collaboration as well as measures of success for the Primary Care strategy;
- LUTs Clinic – Outcome of External Review/Update on progress;
- North Central London CCG Strategic Planning Group: Update on Development of Five-Year Strategic Plan;
- LAS – Progress with response to CQC Inspection report;
- Sexual Health;
- Dementia;
- NMUH – Foundation Status;
- Patient safety;
- 7 day NHS;

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- CAMHS - initial outcomes of the Transformation Plans and any learning arising from them (Jan 2017); and

- Stop Gap Services (Maternity)

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