Surrey Heartlands Partnership and East Surrey CCG

Integrated Urgent Care Clinical Assessment Service (including NHS 111 and GP Out-of-Hours)
Pre-market Engagement Event 19th October 2017

Feedback from facilitated table discussions

The following notes represent the discussions that took place at the facilitated table discussions. The commissioner(s) provide these notes in the spirit of open and honest communication and these notes do not represent the commissioner's position on any of the matters represented but rather the feedback and opinion offered by the variety of delegates present.

IM&T

1.	*Question posed by Commissioners:* **How will you connect your network and systems to the Surrey Providers?** ● **By direct connection to the Surrey COIN – we are upgrading now to become a fully HSCN compliant network** ● **If not directly, then how will you ensure HSCN compliance when N3 is decommissioned?**
	Comments from delegates: • The NHS 111 telephony call centre, CAS and GP Out-of-Hours (OOH) services must link. Currently all but a handful of GP practices use EMIS Web and these will be transferred to EMIS by the time of service Go Live. • There are no current links into acute providers. • The current N3 contract with BT is already in extension until the end of 2018. N3 connects to the national database (spine) and allows for the matching/retrieving of NHS numbers. • There have been occurrences when the N3 connection has gone down at which point paper systems have been required. New resilience in the system should alleviate this although contingency planning of service providers will be required • N3 additionally enables access to the Directory of Services (DoS). There is a national move to transfer more of this responsibility to the provider which was welcomed by those present. • It was recognised that the more providers use the DoS the more reliable it will become. • There is now an NHSE requirement to employ a certain number of DoS leads per population density. • The entire system is increasingly using NHS numbers to follow a patient journey through the system in order to learn about activity. • RAIDR is a tool which follows a patient's journey for a 24 hour period by utilising the NHS number. This provides activity information against which to plan for improvement. • NHS Pathways is the tool used by call handlers to assess the risk presented by a patient and to access the DoS. This software will be utilised for the foreseeable future and will undergo updates. • As more clinicians come into the NHS 111 and CAS system they will need less prompting by NHS Pathways, however they must currently use it to access DoS. It is possible to use a Z code to bypass NHS Pathways and access the DoS. It is also possible for senior clinicians to bypass Pathways with indemnification and access free text to allow for onward direction. • It is anticipated there will be less of a reliance on NHS Pathways over the forthcoming years alongside a transition to the senior clinician template.
2.	*Question posed by Commissioners:* **2. Where are you on your journey to implement the national U&EC interoperability architecture standards?**

	Comments from delegates: • Currently systems work discreetly and separately. The intention is to bring these systems and varying versions of systems together for the purpose of interoperability. • The success of interoperability will be outside the control of the service provider and dependent on the clinical systems providers with whom they choose to work. o *Providers wished to understand whether clinical systems providers had been involved in the development of the NHSE specification and bought into providing this functionality?* • Providers know how to integrate but the challenge for the bid is in understanding what the integration platform will be. This is crucial. • London has developed interoperability but communication between providers is difficult. The ICAS system which determines destination can go wrong; the chosen IM&T providers will need to provide for the ability to share patients across the system. • Much will depend on provider relationships with current host systems. • It is important to incorporate and integrate patient information from hospices. • EMIS has full interoperability.
3.	*Question posed by Commissioners:* **Recognising these standards are still developing and some of the national systems have yet to be delivered how will this affect what you propose in your bids?**
	Comments from delegates: • Do not offer remote consultation/video imaging. Skype has been trialled with connectivity and security issues. Not convinced there is a benefit.
4.	*Question posed by Commissioners:* **How will you deliver resilience in you telephony and hosted service infrastructures including how you will provision staff in secondary/backup sites where your primary site fails?**
	Comments from delegates: • What is meant by resilience? Is this the front end telephony and gateway into the system? In which case smaller providers will struggle. Those with more than one call centre will be able to divert resources and are inherently safer. • If the service is provided by a number of contractors providing small elements of the service there will be a loss of economies of scale and a subsequent lack of ability to cope with service failure. • It will be necessary to establish arrangements whereby disparate services can offload e.g. share staff or bypass triage before referring to OOH for example. Interoperability is crucial here. • This is not just about IT resilience but the entire system e.g. to meet surges in demand it must be possible to take clinicians off templates, bring on staff available to work from home, ask GP practices to undertake some triage., swop staff for overflows etc. All providers need to support each other. • Ideally the definition of an IUC Service is single governance across its entirety. In time the system may be extended to a lead governance provider as well as a lead operational provider. • NHSE standards require clinical governance but GPs do not yet have to align with the requirements of all other providers. They do not use CDSS and are subsequently not currently logging all activity. • For the protection of GPs working within the IUC service it is likely they will need to adhere to a checklist of conditions they must confirm as having considered as possible. This is for their protection as well as that of patients. GPs currently following this practice can see the benefit in it as it provides them with indemnity. • It is when GPs have to follow a lengthy process akin to NHS Pathways that they become frustrated by delay.

5.	*Question posed by Commissioners:* **How will the introduction of the General Data Protection Regulations (GDPR) impact your proposal and how will you demonstrate compliance?**
	Comments from delegates: • It was considered harsh that NHSE is instigating fines of 4% which can be huge particularly when the use of provider data will fall outside of provider control. • Providers are nervous at the prospect of other organisations extracting information from their systems and relaying it. This removes the ability to cleanse PID data yet still requires proprietorship as the data owner. • Providers would like NHSE to clarify how their interests will be protected and produce specific guidance for them. • There is concern that information will be extracted from organisations and stored centrally without control – there have been previous examples of inappropriate information being included in DoS extracts e.g. manager's names. • A mechanism for cleansing data needs to be established. • A mechanism for providers to communicate concerns to NHSE is required. • Patients will have provided permission for the establishment of SCRs, ESCRs and National VCRs but how will they provide permission for all possible touch points under GDPR use? This would require an enormous "catch all" question to eliminate risk. • Should it be assumed that all patients are included in permissions unless they opt out? Particularly as the ability to share information across services is key to the success of the urgent care system.
6.	*Question posed by Commissioners:* **What legacy data will need to be transferred from the incumbent supplier to you and how do you expect this be accomplished?**
	Comments from delegates: • Everything.

COMMERCIAL MODEL INCLUDING THE FINANCIAL ENVELOPE

1.	*Question posed by Commissioners:* **Is the financial envelope viable?**
	Comments from delegates: • It is reassuring to see the envelope has increased. The previous sum was concerning. • It is stipulated in the service specification that the Out-of-Hours (OOH) service is to commence from 18:30 across eight locations. Providers were hopeful of future co-location of OOH sites with UTCs and possible changes within GP extended hours over the period of the contract. • The ability to be innovative with OOH locations will save costs. • Evidence from other contracts does not always validate a reduction in the OOH service as a consequence of offering extended hours until 20:00. Often extended hours appointments are taken by practice patients pre-booking in advance. • The call metric used for assessing OOH cost is call volume but this is misleading as calls entering NHS 111 do not relate directly to the volume of calls entering the OOH system. It was noted that the OOH data has been released by commissioners at previous events. • Discussion arose regarding the need for three tariffs across the three service components of NHS 111 telephony, the Clinical Assessment Service (CAS) and OOH. • Discussion arose concerning whether the tariff should be dependent on the number of calls requiring clinical input.

	• It may be considered reasonable to assume OOH face to face appointments will reduce as the CAS offers an enhanced clinical service. However, this will depend on the risk the service is willing to take on. It will still be necessary staff the OOH service whether clinicians are utilised or not. • There is an expectation that the technological element of the service and enhanced access to patient records will influence the ability to make savings. • There will be a specific cost to providers of integrating services; it was not felt that the financial envelope allowed for this. • Discussion arose concerning "value based healthcare" and subsequent savings in other areas of the health system. How will the IUC service provider benefit from savings in A&E as a consequence of managing more calls? Currently the IUC service provider will receive less funding per call if they exceed projected activity levels which seemed unfair. • The financial envelope is better than it was but still not generous for this service. • A financial model offering both a fixed cost and variable cost element was considered preferable.
2.	*Question posed by Commissioners:* **What is the proportion of cost between call handling, clinical assessment and face to face visits?**
	Comments from delegates: • There are two different cost implications – a cost per call into the NHS 111 service regardless of what then transpires or three separate service tariffs for NHS 111 telephony, the Clinical Assessment Service (CAS) and OOH. • Providers indicated they would be modelling the three services separately, regardless of the commercial model in order to understand resilience requirements, before re-combining for a final cost. • • It was agreed that as the service develops there would be an expectation that the numbers hitting the CAS and the OOH face to face elements of the service would change. • The terminology for calls needs to be accurately defined between calls offered, answered or answered and triaged. Providers understand calls to mean all that are offered i.e. calls that hit the switchboard. • There are sensitivities in call volumes. Some providers found appealing a proposal to offer the NHS 111 and CAS call elements on a 70% block arrangement with options for approximately 30% of the volume but there was some preference for the OOH element to be entirely blocked.
3.	*Question posed by Commissioners:* **What is the sensitivity of increased call volumes to cost – where is the step change?**
	Comments from delegates: • If current activity data can be proven reliable then providers will be assured of their ability to assess feasibility and can make the assessment above. However, should there be doubt about data accuracy much contingency will be required in responses and providers will be unable to offer this detail. • There will be two tipping points – one at which an increase in efficiency is required and another at which further cost is incurred. • The model needs to be agile. In this regard providers must know exactly what it is commissioners want to purchase now and in the future, there must be some certainty in income and contract value. • It will be necessary to analyse where elements of the service can be disengaged to identify the most economic approach to call handling and the cost of resourcing the CAS. • This is very much dependent on the ability of the service to load share i.e. swop resources

	between call centres or utilise staff across functions. • Innovation and subsequent step changes are likely to be the result of provider to provider negotiation and any increase in activity/profit must benefit the overall contract. • Contingencies are required to any step change arrangement e.g. other providers failing will increase the activity centrally into the NHS 111 service. • On enquiring whether a 5% increase sounded reasonable providers replied that if the 100% benchmark was set in the mid-range of expected call volume this was acceptable but if it was set at a maximum level and a 105% delivery was expected after marketing, this would be viewed unfavourably.
4.	*Question posed by Commissioners:* **What is the impact of call shift resulting from on-line consultations?**
	Comments from delegates: • The online pilot documentation was made available to potential providers. It demonstrates an anticipated10% uptake. • Providers were keen to impress upon commissioners that an online option is not a free option. • It is not yet possible to understand whether the offering will break even or present a real saving. • It is necessary to factor in the set up and running costs of an online service including governance and reporting. • One provider has seen detail of the 4 x UK trials currently underway. These do not replicate Call Centre questioning. • Providers wanted to understand whether the "calls offered" metric included digital consultation? It was thought this would need to be the case. • Discussion arose regarding how a "digital call offered" tariff would be triggered. It would be necessary to identify a screen which triggered the enquiry as being legitimate. • Key to success will be service provider and online provider relationships. The online providers will have their own cost models potentially based on "per click" activity. • There is a risk of under activity as service providers will not want to alter staffing levels, particularly for trained staff. Over time, should the profile of staffing requirements change, notice periods will remain a cost. • Under performance must be a trigger to discussion with commissioners, particularly the unknown around NHS 111 Online.
5.	*Question posed by Commissioners:* **What are the advantages and disadvantages of each proposed model?**
	Comments from delegates: **Option 1 – Block (Activity Flex)** • The simplicity and straightforwardness of it is appealing but for a contract of £8-9M it is too minimalistic. • LR queried whether commissioners should look at different models over the term of the contract i.e. start simply and move onto a more sophisticated approach once certain parameters are met? This proposal was not overwhelmingly supported. o Calls need to be defined as answered or offered? It was confirmed that current data is provided on offered calls. • There is a need to account for calls which are received from the Care Line and the line for HCPs. • The specification mentions access to the NHS 111 HCP line by ambulance technicians; this could open the floodgates to that line and possibly delay a clinical response leading to conveyance to A&E which could have been avoided. • The principle of a marginal rate for extra activity was accepted.

- Providers welcomed the increase in cost per call when volumes decrease and understood the need to revisit the viability of the commercial model altogether should volumes dip below a specified parameter.

Option 2 – Block/Cost & Volume

- Currently based on a 2% per annum increase. Some providers stated they would expect greater growth once services were integrated. The service will be far more appealing and will therefore attract greater take up than a 2% increase.
- Concerns over the loss of revenue the following year should volumes fall off.
- Some providers felt commissioners should be stretching providers from Day 1. 105% was considered reasonable. Providers in favour of this option felt it to be more of a commissioner/service provider collaborative approach.
- Acceptance that the model could be split out further. Providers preferred that it be established on a base plus annual % increase, not to be reset annually dependent on the previous year's performance. It was recognised however that if activity changed significantly the commissioner would expect to renegotiate the block.

Option 3 – Cost & Volume

- No certainty about minimum income.
- Costs are variable on a price per call basis for the call handling and CAS service; the CAS can be structured appropriately.
- The most significant cost for the service resides in affording GPs in OOH bases. These costs are not variable which was welcomed.
- This option works best for organisations able to implement a load share. For smaller organisations it is less appealing.
- Appealing to some organisations though not others.

Option 4 - Block

- Straightforward block was not preferred by by attendees.
- Blocking the OOH service can be risky for providers who must have utmost confidence in the activity data presented.
- This approach can be prohibitive to a positive provider/commissioner relationship if employees resign; interpreting what is on paper is very different to an established working relationship.
- Other procurements of this nature have been let as Block Lots on different block tariffs or the NHS 111 and CAS elements have been a separate contract to the OOH element.
- LR queried whether separate tariffs made it difficult to report/reconcile activity? This was not considered an issue.
-

In conclusion preference was expressed for:

- Assured/fixed payment elements.
- Separate variable tariffs for service elements