MEETING

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE AND TIME

FRIDAY 25TH SEPTEMBER, 2015

AT 10.00 AM

VENUE

TO: MEMBERS OF JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Quorum 3)

Chairman: Councillor Alison Kelly,
Vice Chairman: Councillor Pippa Connor and Councillor Martin Klute

Councillors

Graham Old	Anne-Marie Pierce	Jean Kaseki
Alison Cornelius	Abdul Abdullahi	
Danny Beales	Charles Wright	

Substitute Members

You are requested to attend the above meeting for which an agenda is attached.

Andrew Charlwood – Head of Governance

Governance Services contact: Anita O'Malley – anita.vukomanovic@barnet.gov.uk 0208 359 7034

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	AGENDA AND REPORT PACK	1 - 106

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AGENDA ITEM 1

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 25 SEPTEMBER 2015 AT 10.00 AM
HARINGEY CIVIC CENTRE, HIGH ROAD, WOOD GREEN, LONDON N22 8LE

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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, 17th September 2015

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 25 SEPTEMBER 2015

THERE ARE NO PART II REPORTS

AGENDA

Wards

1. APOLOGIES

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

3. ANNOUNCEMENTS

4. DEPUTATIONS

5. NOTIFICATIONS OF ANY ITEMS OF BUSINESS THE CHAIR CONSIDERS URGENT

6. MINUTES OF PREVIOUS MEETING

(Pages 5 - 12)

To consider the minutes of the meeting held on 26th June 2015.

7. NORTH CENTRAL LONDON CCG STRATEGIC PLANNING GROUP: ANALYSIS AND RECOMMENDATIONS FOR DEVELOPING A FIVE-YEAR STRATEGIC PLAN

A presentation to update members on the recent work to develop at a strategic level a clinical and financial 'case for change' and transformational programme to address NCL system-wide clinical, quality and financial challenges.

8. JOINT ACTION BY NHS ACUTE TRUSTS, CCGS, LOCAL AUTHORITIES AND OTHER ORGANISATIONS TO REDUCE A&E ATTENDANCE

9. PROCUREMENT OF NHS 111/OUT OF HOURS GP SERVICES

(Pages 13 - 104)

To consider information on the procurement of NHS 111/Out Of Hours GP services.

10. WORK PROGRAMME

(Pages 105 - 106)

To note and comment on the work programme.

11. DATES OF FUTURE MEETINGS

12. ANY OTHER BUSINESS THE CHAIR CONSIDERS URGENT

AGENDA ENDS

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North Central London Joint Health Overview and Scrutiny Committee - Friday, 26 June 2015

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held at Committee Room 4, Town Hall, Upper Street, N1 2UD on Friday, 26 June 2015 at 10.00 am.

Present:	**Councillors:**	Martin Klute – L.B.Islington Jean Roger – Kaseki – L.B.Islington Adbul Abdullahi - London Borough of Enfield Richard Olszewski - London Borough of Camden (substitute) Pippa Connor - London Borough of Haringey Alison Cornelius - London Borough of Barnet Alison Kelly - London Borough of Camden Graham Old - London Borough of Barnet Anne Marie Pearce - London Borough of Enfield Charles Wright - London Borough of Haringey

1 ELECTION OF CHAIR AND VICE CHAIR

After being nominated and duly seconded it was -

RESOLVED:

(a) That Councillor Alison Kelly, L.B.Camden, be elected Chair of the Joint Committee for the remainder of the municipal year 2015/16, or until her successor in office is appointed

(b) That Councillor Martin Klute, L.B.Islington and Councillor Pippa Connor, L.B.Haringey, be elected as Vice Chairs of the Joint Committee for the remainder of the municipal year 2015/16, or until their successors in office are appointed

(c) That further discussions take place as to the support that can be provided for the JHOSC from officers and the CCG

COUNCILLOR ALISON KELLY IN THE CHAIR

2 FILMING AT MEETINGS

The Chair outlined the procedure for dealing with public questions and filming and recording of meetings

3 APOLOGIES FOR ABSENCE

Apologies were received from Councillor Danny Beales – L.B.Camden

4 DECLARATIONS OF INTEREST

Councillor Richard Olszewski stated declared an interest in that he is Camden's representative on the Royal Free Trust.
Councillor Cornelius stated that she was an Assistant Chaplain at Barnet Hospital.

5 MINUTES

RESOLVED:

That the minutes of the meeting of the Joint Committee, held on 20 March be confirmed and the Chair be authorised to sign them

6 MATTERS ARISING FROM THE MINUTES

Accident and Emergency Performance – Minute 6

In response to a question as to how Trusts were working with Local Authorities to reduce A&E admissions it was stated that a report is due to be submitted to the Committee in September on this issue and Acute providers would be requested to ask for Local Authorities, care providers and the Fire Brigade to input to this

7 ACADEMIC HEALTH SCIENCE PARTNERSHIP

David Fish, Managing Director and Hilary Ross, Director of Strategic Development, of UCLPartners were present for discussion of this item and made a presentation to the Committee, copy interleaved.

During consideration of the presentation the following main points were made –

- There was a challenge of fragmentation across the health system and much of the work of UCLPartners was focused on bringing organisations together to work in partnership for the benefit of patients and the population.
- In response to a question, it was stated that UCLPartners would notify the Chair of the two GP surgeries in L.B.Camden that are not taking part in the scheme to identify atrial fibrillation at an early stage
- One of the priority areas being looked at – a new model for child and adolescent mental health services called i-THRIVE - were just being developed and focused on patients rather than institutions and was more community focused. The Chair stated that it would be useful to have a report on progress on the mental health model to a future meeting of the Joint Committee
- In response to a question, it was stated that the Academic Health Science Partnership was working with CCG's and increasingly directly with GPs as primary care began to organise itself into provider organisations or federations
- In relation to the mental health model, a question was raised about the problems experienced by children when transitioning into adult services. The Academic Health Science Partnership agreed that the transition from children's to adult mental health services was a challenge that must be addressed. Cllr Connor highlighted a review of local child and adolescent services that had been undertaken by Haringey. It was felt that the new model should build on existing good practice. It was stated that there was also a level of interest from other service providers - such as those with responsibility for patients with dementia - in adopting elements of this model, which promoted shared decision making with patients and also indicated how well multi disciplinary or multi agency services were integrating from a patient perspective.
- It was noted that the new Haringey Health and Wellbeing strategy aimed to cut stroke by 25%. Reference was also made to the fact that Camden CCG had funded UCLPartners to work in Camden with GP practices on stroke prevention to learn what worked and then to develop partnerships. This had led to a business case for similar work in Enfield. In response to a question, it was stated that an update on work in Haringey could be provided to Members
- A Member enquired who funded the partnership and, in the light of the reorganisation of the NHS and its fragmentation, whether it had or could take a more strategic overview.

- It was stated that the adolescent mental health and cardiovascular models were at an early stage and there was a need to address patient expectations and experiences and what level of care could be delivered across a range of partners working effectively together
- Members were informed that the Academic Health Science Partnership had been established in 2009 and had been funded initially by providers, such as NHS trusts and academia. This has grown from an initial £0.5M to a turnover at present of £15M from a diverse range of income sources in the current year, which showed a willingness of partners to engage the partnership's services. The full range of partners was detailed in the Annual Report on the Academic Science network website http://uclpartners.com/our-work/academic-health-science-network/reporting-our-progress
- There were now 130 staff employed in UCL Partners with the aim to promote partnerships
  In relation to stroke prevention there is a need to look at a number of factors such as hypertension, lifestyle and cardiovascular issues. There was a need to assess all these when developing a pathway. UCLPartners' cardiovascular prevention lead had developed a web tool where people could assess their cardiovascular risk - http://www.jbs3risk.com/JBS3Risk.swf

The Chair thanked David Fish and Hilary Ross for attending and their presentation

RESOLVED:

(a) That the website link for UCLPartners to be circulated to Members - http://uclpartners.com/our-work/academic-health-science-network/reporting-our-progress and details of any work on atrial fibrillation taking place in L.B.Haringey be circulated to Cllr Pippa Connor

(b) That a report on the development of the mental health model referred to above be submitted to a future meeting of the Committee

8 SPECIALIST CANCER AND CARDIOVASCULAR SERVICES - UPDATE ON IMPLEMENTATION OF RECONFIGURATION

Oliver Bailey, Delivery Improvement Consultant, NELCSU, Dr Edward Rowland, Barts Health and Jonathan Gardener UCLH were present for discussion of this item and made a presentation to the Committee.

During consideration of the presentation the following main points were made –

- The reconfiguration of services in North and East London and West Essex was agreed by CCGs in July 2014 and NHS England in October 2014
- Barts Heart Centre opened in Spring 2015 and consolidated services from 3 existing sites (Cardiac services from Heart Hospital, London Chest Hospital and St Bartholomew's Hospital) were expected to see 80,000 patients per year and there were 1200 staff
- UCLPartners were a key part of the process in the changes to specialist cardiovascular and cancer services and this presentation detailed the post implementation stage of the process
- It was expected that the revised arrangements would result in an improved level of care – it is already providing an improved 7 day service and increase in staff specialisation

- The process had started at the beginning of December and UCLH are creating a brand new ward and a great deal of work is taking place on IT systems
- Barts is being supported with the switching of brain trauma services. Consideration was being given as to whether the trauma services at UCLH would be better situated at Barts and Royal Free. An update would be reported to the JHOSC at a later date
- It was noted that bladder cancer and prostate cancer would be moving to UCLH, however pathways were still being developed and there was a need to look at how diagnosis for prostate cancer could be smoother
- Part of the rationale for cardiac reconfiguration was the variable quality of cardiac care across North Central London. The model of care had supported delivering services from the Heart Hospital and London Chest hospitals on a single site at Barts. This merger was completed at the start of May 2015
- A patient support group had been established 3 years previously to find out where the gaps in the service were and UCLPartners were assisting in maintaining an overview and review of best practice in the transfer of services to the larger site and it is essential to link in with other tertiary deliverers
- Another component is the integration of academic work with universities and the creation of joint institutions and patients will have an opportunity to take part in research studies
- The new service was providing 50% more acute angioplasties than in previous years and by merging bigger teams together there was now a 7 day cardiology service on certain sites
- It was stated that the majority of staff had transferred to the new service
- In response to a question, it was agreed that a report should be submitted to a future meeting of the Joint Committee on the work being carried out with North Middlesex Hospital and local GPs
- In response to a question it was stated that patient and family feedback is being investigated, particularly at the primary care end and the findings would be reported back to the Joint Committee at a future date
- Protocols for MRI scans had been standardised across the sector and this enabled diagnosis to be delivered more locally
- Trauma services were crucial to the patient experience and MacMillan cancer services were available at UCLH to support patients through the process and beyond and this is being looked at across the sector
- More patients would be treated this year than previously

The Chair thanked Oliver Bailey, Edward Rowland and Jonathan Gardener for attending

RESOLVED:

That a report be submitted to a future meeting of the Joint Committee detailing progress on developing patient feedback, and the development of trauma services across the sector

9 NHS 111 AND GP OUT OF HOURS SERVICES - RECOMMISSIONING

The Committee received a deputation from representatives of the Keep Our NHS Public group in North London and the Committee received a document in relation to this.

Rob Wells and Janet Shapiro were present and outlined the submission to the Joint Committee.

Dr. Sam Shah, Clinical Lead NHS 111 Governance and Graham MacDougall, Lead Director, Enfield CCG were also present for discussion of this item.

During consideration of this item the following main points were made –

- The Keep Our NHS Public campaign stated that they felt the tendering process and specification documentation details were vague and there was no scoring system defined and that they felt that there was insufficient information for the JHOSC to consider the proposals
- The Keep Our NHS Public campaign were of the view that the JHOSC should engage with CCGs as they felt that small providers may be disadvantaged and this should be addressed
- Dr Shah stated that the proposals had not changed and the proposal was to join up services across north central London. There had been engagement with a number of groups and a draft specification stage had been reached, however the timelines had now been amended
- It was stated that the focus was on a clinical model and elements of the specification; and the engagement with patient and public reference groups would continue. It was added that discussions would continue with Keep Our NHS Public, if required, however it was hoped that the procurement process would begin from October
- Members were informed that a further engagement exercise would be taking place in July to present the case for procuring the service across the 5 CCG's and it was hoped the new service would enhance the clinical triage of the 111 offer and that it was felt best to build upon the existing structure that was already in place
- It was stated that there had been extensive engagement with GPs in the five boroughs involved and Dr Shah informed Members that he had attended GP locality meetings across NCL and had presented the proposals to GPs. In addition, the CCGs had circulated information on the procurement process to GPs and feedback had been taken on board and incorporated
- Dr Shah informed Members that Islington had carried out a survey of GPs in the area and that most individual GP practices were not keen to bid for the delivery of GP OOH services. However, where there had been indications of interest it had been suggested that they should engage with other providers in order to form a consortium to bid. However feedback from many GPs indicated they were already overstretched during the in-hours period.
- It was added that Islington Health and Care Scrutiny Committee had received a deputation from Keep Our NHS Public and there had been a discussion with a Hackney GP and an Islington GP. The Islington GP had confirmed that GPs in Islington were not willing to tender for the service. A further report was requested by the Islington Health and Care Scrutiny Committee at its September meeting to look at the draft specification
- Some members expressed the view that local GPs had a better knowledge of their areas than other providers and that the tendering process should be tailored to favour of local providers as they would provide a better service
- The Chair stated that she did not feel that a one size fits all was necessarily the best approach given the differences between the boroughs concerned
- In response to a question as to whether joining the services would preclude small providers from bidding, Dr Shah stated that no providers were being excluded on the basis of size of provider. This would not be viewed negatively in the tender process and single handed GPs could apply.

- There were existing GP providers who could submit a bid and in other parts of the country GPs had bid for similar services and local knowledge was important. However there was a need to ensure clinical standards were met
- Dr Shah added that it was necessary to ensure the quality of the service and safety of patients to get the best provider and this would include considering past performance
- In response to a statement about a possible conflict of interest if GPs bid for the service and the CCGs, it was stated that there were safeguards put in place and the draft specification was being shared as it evolved
- The Lead Director, who was from Enfield CCG, indicated that it was hoped to make the process as accessible as possible and, whilst national requirements had to be met, it was important to see how local confidence in the service could be maintained. It was added that it was important to find out what patients locally thought about the outcomes that they expected
- In response to a question as to the integration of IT systems, it was stated that historically these were quite poor and this was being considered. However, it would be ensured that the IT platforms were able to share information irrespective of which provider was chosen. This was one of the reasons that a longer term contract was planned so that providers were incentivised to put in investment into acceptable IT systems.
- A Member enquired as to the market for potential providers and the feasibility of consortiums or federations bidding for the contract. It was stated that at present no one provider offered all the services required. However many offered different components of the service and that there could be a collaboration of providers bidding for the contract. There would be another market testing session event being held in the next few months
- It was noted that there had been contact with some GP federations and this was a welcome development
- The view was expressed that all the current providers appeared to be performing well. Dr Shah stated that whilst the current providers were performing satisfactorily, it made sense to have one GP interaction and to have a cross border approach to improve the quality and performance of the service
- A Member of the Public stated that he supported the deputation and that the draft service specification should be submitted to all five borough Scrutiny Committees. In addition it was not felt that all GPs were aware of the proposals to change the 111/Out of Hours service
- The view was also expressed that there should be a punitive element included in the contract if the successful bidder withdrew during the period of the contract and the Chair stated that she felt that this was an issue that could be taken up with NHS England
- In response to a question, it was stated that information regarding potential bidders for the contract could not be submitted before the contract was awarded. However, details of the successful bidder could be made public once this had happened. 3 patients would be on the tender evaluation panel that chose the provider

RESOLVED:

That a report be submitted to the September meeting of the JHOSC with the details of the draft service specification, how the contract would be monitored, the case for change and how quality will be assured

The Chair thanked Dr Shah and Graham MacDougall for attending

10 MEETINGS OF BARNET, ENFIELD AND HARINGEY MEMBERS

RESOLVED:

(a) That the minutes of the meeting of the Committee be noted
(b) That with regard to minute 6 – page 79 – a copy of the letter summarising the comments as requested be circulated to Committee Members

11 FUTURE DATES AND WORK PLAN

Discussion took place as to the future items on the agenda and the following were noted –

Public Health indicators
Overweight children
A&E attendance – action to reduce
Funding for clinical networks
How CCG's ensure patients are maintained safely in institutions
Local health organisations and Councils – are they healthy employers
Single GP provision
7 day NHS
London Ambulance Service
Winter NHS pressures
NHS England
Maternity update – mental health support
NHS 111/Out of Hours service
Stroke
Primary Care update – Case for change
Dementia
NMUH – Foundation status

RESOLVED:

(a) That agenda setting meetings be arranged between the Chair and Vice Chairs and the workplan above be approved

(b) That the next meeting of the JOHSC be held on Friday 25 September 2015 and the following meeting on Friday 27 November, with venues to alternate over the next year between the 5 Boroughs

(c) That a vote of thanks be given to the former Chair of the JOHSC, Councillor Gideon Bull for all his work as Chair over the previous years

(d) That officers be requested to investigate the viability of webcam facilities for future meetings of the Committee

MEETING CLOSED AT 12.30p.m.

Chair

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Barnet Clinical Commissioning Group
Camden Clinical Commissioning Group
Enfield Clinical Commissioning Group
Haringey Clinical Commissioning Group
Islington Clinical Commissioning Group

Commissioning of an integrated NHS 111 and GP out-of-hours service across north central London

September 2015

1. Purpose

This report provides an update to the north central London Joint Health Overview and Scrutiny Committee on the proposed commissioning of the integrated NHS111 and GP out-of-hours (NHS 111/OOH) service across Barnet, Camden, Enfield, Haringey and Islington (the five NCL CCGs).

It has been prepared with input from clinical leads across the five CCGs and with support from the Patient and Public Reference Group.

2. Background

2.1. NHS 111

NHS 111 is a free telephone number to help people who have urgent, but not life-threatening, conditions get advice and access the most appropriate service to meet their needs. Trained advisers use a tool called NHS Pathways[1] to assess patients and direct them to the most appropriate service.

NHS 111 was introduced across the country as a pilot in April 2013 and replaced NHS Direct. It is available 24 hours a day, 365 days a year and calls are free from landlines and mobile phones. The NHS 111 service in NCL is currently provided by a single provider – London Central & West Unscheduled Care Collaborative.

2.2. GP out-of-hours services

Out-of-hours services are available so that people can access primary care, for urgent problems, when their GP surgery is closed, usually at night or over the weekend. GPs and other clinicians offer advice and face-to-face appointments if needed. Patients get access to the out-of-hours service by first calling NHS 111.

The out-of-hours services in NCL are currently provided by two different organisations – Barndoc Healthcare Ltd for Barnet, Enfield and Haringey, and Care UK for Camden and Islington.

2.3. Proposed integrated NHS 111 and GP out-of-hours service

The NCL CCGs are planning to commission NHS 111 and OOH as an integrated service across north central London, and this is expected to begin in October 2016. The core principles of the integrated service, as set out in the draft service specification, are outlined overleaf.

[1] NHS Pathways is a suite of clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call. It has an integrated directory of services, which identifies appropriate services for the patient's care if an ambulance is not required.

Core principles

The NHS 111 and out-of-hours service will need to:

i. Be available 24 hours a day, 365 days a year (366 in a leap year) for telephone advice
ii. Provide consultations with GPs during the out-of-hours period
iii. Be accessible, personalised and based on service users' individual needs
iv. Have knowledge of when service users have previously contacted the service
v. Be able to connect service users to a clinician where indicated
vi. Be able to provide access to health records and notes, shared with patient consent
vii. Book appointments with other providers where available
viii. Dispatch an ambulance without delay where indicated
ix. Be able to receive referrals through digital and online channels
x. Ensure that specific health needs, such as palliative care, mental health and long term conditions are properly catered for.

The integrated NHS 111 and GP out-of-hours service must provide a consistently high quality service irrespective of the geographic area served.

The proposal to commission a single integrated service across the five CCGs was founded on the recommendations of the 2013/14 Camden and Islington Urgent and Emergency Care Review. This review was undertaken in order to revise existing strategies, address the impact of changes to the provider landscape, assess rising demand for care and to incorporate emerging guidance from the NHS England national review of emergency and urgent care services. Following the review and extensive stakeholder engagement, a number of key recommendations were made and approved including the following[2]:

(i) The CCG(s) should commission a combined NHS 111 and GP OOH service that includes GP OOH face-to-face and home visiting service, and that ensures callers only need to give their clinical details once, providing this meets NHS England guidance at the time

(ii) The CCG(s) should work together with other CCGs in north central London to consider jointly commissioning the combined NHS 111/OOH service, as outlined in Recommendation (i).

The model of care for the integrated NHS 111/OOH service has been developed to support outcomes that are most appropriate for patients across the five CCGs and the way they use the services. Lessons learned from NHS England's NHS 111 Learning and Development pilots, the national Keogh Urgent and Emergency Care Review, and recommendations from the Camden and Islington Urgent Care Review, have all been used to inform and enhance the shape of the new service and its objectives and targets. The new service model includes an innovative use of skills mix including nurses, paramedics, mental health trained clinicians and pharmacists as well as GPs to enhance the service.

Key objectives of the service are to:

1. Improve patients' experience of using and accessing urgent care services, making sure they receive the best care, from the most appropriate person, in the right place, at the right time
2. Ensure better integration between NHS 111 and GP OOH services to deliver a more streamlined pathway for patients
3. Improve information-sharing for better safety and outcomes for patients
4. Ensure better use of urgent care services
5. Improve use of resources

[2] Camden CCG and Islington CCG Urgent Care Review – Final Report and Recommendations, May 2014

6. Provide a consistent model of quality care across the five CCGs
7. Streamline contract and performance management across the five CCGs.

A further context to the commissioning of this NHS 111/OOH service is that NHS England have mandated the establishment of Urgent and Emergency Care Networks[3,4]. These networks are intended to ensure that all urgent and emergency care services (including, for example urgent in-hours GP and dental services, urgent care centres and walk-in services) are commissioned to work collaboratively together in future, so that that there is a clearer pathway for patients with urgent care needs. Too many patients are going to A&E with conditions that do not require that level of treatment.

NHS 111 and the GP out-of-hours service are key aspects of urgent care delivery, and integrating these two services is the first stage in a wider process. The new local Urgent and Emergency Care Network encompasses the five CCGs, local urgent care providers and other partners across north central London.

Representatives of NCL CCGs have presented reports outlining these proposals to the JHOSC on three previous occasions – in June 2014, January and June 2015. The proposals have also been discussed at several local health scrutiny committees, and papers have been presented to the health and wellbeing boards of all local authorities. This report includes additional information regarding the recent period of engagement, the planned procurement process and timelines, and current draft of the service specification.

3. Engagement

Wide engagement on the plans for the commissioning of the NHS 111/OOH service across the five CCGs is being led by the NEL Commissioning Support Unit (NEL CSU) on behalf of the five CCGs, with individual CCGs leading their own local engagement.

3.1 Engagement with the local community in Barnet, Camden, Enfield, Haringey and Islington

The CCGs have undertaken a substantial engagement programme across the five CCGs over the past eight months which has included (but is not limited to):

i. Discussions about the proposed NHS 111 and OOH model at local engagement events, including meeting with over 450 individual service users and meetings with targeted groups such as disabled service users, those with learning difficulties, and refugees
ii. Two phases of focused engagement events, held at venues across the five boroughs and advertised through local newspapers and CCG websites, which were attended by hundreds of interested service users and which encouraged in-depth discussion of the proposals
iii. Updates sent to hundreds of local community groups, local councillors, MPs, Healthwatch organisations and other NHS organisations
iv. Dedicated website pages on all five CCG websites – over 3,800 page views in February-June 2015
v. Presentations to this joint health overview and scrutiny committee and local health overview and scrutiny committees

[3] NHS England, Transforming urgent and emergency care services in England – Urgent and Emergency Care Review: End of Phase 1 Report, 2013
[4] NHS London Urgent and Emergency Care Network specification, July 2015

vi. An online survey to find out the views of stakeholders and service users on the proposed model, which received 65 responses

vii. The setting-up of a Patient and Public Reference Group, whose members are service users and Healthwatch representatives from each of the five boroughs. The PPRG was set up to support the procurement process and to ensure that the views and experience of local patients and carers are reflected in the decisions about the NHS 111/OOH service planning and delivery of care by the new service[5]. Members have greatly inputted to the service specification through monthly meetings, had fact-finding visits to the current NHS 111 provider and will be participating in the procurement evaluation panel.

3.2 Engagement with GPs and other providers

It was important to ensure that the widest range of potential providers of the new service were told about, engaged with and able to participate in these proposals. Engagement with providers included:

i. Presentations at GP locality meetings across NCL to ensure local doctors understand what is planned and how they can be involved

ii. Communications through CCGs' GP bulletins/newsletters and intranet sites

iii. Meetings with clinicians and key clinical stakeholder groups to discuss and develop further the clinical case for change

iv. Two market-testing events to ensure potential providers were fully informed of the proposals and to encourage them to collaborate in developing bids. These were advertised through GP newsletters, GP intranet sites, CCG websites and by direct e-mail to local providers, as well as being posted on the NHS contract finder website

v. Meetings with local GPs and existing providers to encourage them to participate in the process, making sure that the scale and structure of the procurement does not discriminate against them (for example LCW and Barndoc have already announced they are partnering together to bid for the new service)[6].

3.3 July engagement

It was clear from what some people told us, through meetings and survey responses, that the CCGs had not yet fully made the case for commissioning NHS 111 and GP out-of-hours as an integrated service across the five boroughs. The CCGs therefore undertook an additional engagement period in July, during which they shared a document setting out the options which have been considered and explaining the reasons for the choices they CCGs have made. They also published the draft service specification and invited comments in July and August.

The engagement document and accompanying survey were distributed very widely to local stakeholders in the five boroughs, including being sent directly to those groups who had previously raised questions about the proposals. Additional communications took place with local councillors, Healthwatch organisations and other NHS bodies.

The internet was also used to help publicise the engagement document and survey, with CCG and other organisations' websites and social media employed to publicise the survey.

[5] Patient and Public Reference Group – Integrated NHS 111/GP Out-of-Hours service procurement in north central London – Terms of Reference

[6] LCW Summer newsletter

An analysis of the number of times the document had been viewed on the five CCGs' websites showed it had been viewed some 2,800 times and the survey had around 1,140 views. Despite this the engagement attracted only a very small number of responses – fewer than 30 in all.

3.3.1 Survey analysis

In developing the proposals the CCGs considered a number of options for the future of NHS 111 and GP OOH services in north central London:

Option 1 Commission one NHS 111 and two GP OOH providers – no change

Option 2 Each CCG to commission its own NHS 111 and GP OOH providers

Option 3 Commission one lead provider for NHS 111 and GP out-of-hours across five boroughs – the preferred option of the five NCL CCGs

The majority of people who responded agreed with the CCGs' proposal to commission these services across five boroughs. A significant minority of respondents wanted both the services to be commissioned separately for each of the five boroughs.

Q: Our preferred option is to commission an integrated NHS 111 and GP out-of-hours service across Barnet, Camden, Enfield, Haringey and Islington. With which options do you agree/disagree?

		Agree	Disagree	Don't know	No answer
Option 1:	**Commission one NHS 111 and two GP OOH providers – No change**	6	**10**	4	6
Option 2:	**Each CCG to commission its own NHS 111 and GP OOH providers**	**9**	7	2	8
Option 3:	**Commission one lead provider for NHS 111 and GP out-of-hours across five boroughs – *CCGs' preferred option***	**15**	8	2	1

The summary report from this engagement is appended. Major themes in responses included:

i. Integrating the services makes sense, so long as patients can still access local services
ii. The economies of scale from integrating the services should allow investment in clinical support
iii. Importance of local knowledge and local clinicians
iv. Access to medical records – some people felt there were considerable benefits to improving access to records; others were concerned about too many people/organisations having access to their records
v. The potential involvement of private companies
vi. Importance of supporting people who need access to mental health services, people with learning disabilities, hearing impairment or other disability, or who do not speak English as a first language.

The CCGs are mindful of the low level of response, and aware that some groups and individuals continue to have questions about our approach. Nonetheless, they take the view that they have

communicated and engaged extensively on these proposals over the past year and that, while many of the comments received have been helpful in refining our approach, overall there is support from local clinicians and the public to proceed with commissioning an integrated service.

4 Procuring the new service

4.1 Public sector procurement

All public sector organisations have a requirement to demonstrate a fair and transparent process with potential providers of services, and to encourage competition and innovation amongst providers to deliver value for money services.The overarching principles of public sector procurement are:

i. Transparency of process and proportionality
ii. Equality of treatment to all providers
iii. Fairness
iv. Managing conflicts of interest.

It is a matter of law that Public Sector Organisations (NHS) need to abide by the regulations that governs the award of contracts that are publicly funded:

i. EU procurement regulations
ii. Public contract regulations (PCR) 2006 and its amendments (2011)
iii. Procurement, patient choice and competition (PPCC) regulations 2013 which support section 75 of the Health and social care act 2012.

The Procurement, patient choice and competition regulations operate in parallel with the Public contract regulations. They are subject to governance by Monitor in order to promote competitive behaviour for the procurement of all healthcare solutions. Section 75 of the Health and social care act 2012 sets the legal framework for NHS competition in commissioning healthcare services to ensure:

i. Adherence to good practice in relation to procurement
ii. Protection and promotion of the right of patients to make choices with respect to treatment or other health care services provided for the purposes of the NHS
iii. Commissioners and providers do not engage in anti-competitive behaviour which is against the interests of people who use such services.

4.2 Procuring the NHS 111/OOH service

To ensure this NHS 111/OOH procurement process adheres to these regulations and principles, the CCGs are not able to give an advantage to any particular supplier, provider or market sector (public, private, voluntary, charities or social enterprise). This includes ensuring that decisions are taken, not with regard to the type of organisation bidding, but rather to how well that organisation meets the evaluation criteria and is able to deliver a service that would benefit the residents of the five boroughs.

The five CCGs agreed that the NHS 111/OOH procurement would be undertaken through a competitive restricted tender process. This is a two stage procurement process whereby potential providers are ‘pre-qualified’ and shortlisted at the Invitation to Tender (ITT) stage.

The five CCGs have set in place governance procedures to mitigate against potential conflicts of interest; all conflicted GP members of the relevant committee meetings and governing bodies must remove themselves from discussions and decision-making for this NHS 111/OOH procurement.

The procurement process is being led by NEL Commissioning Support Unit (NEL CSU) on behalf of the five CCGs. Documentation produced by NHS England will be used to develop the ITT pack and, in addition, the procurement is subject to a number of gateway assurance checks by NHS England prior to award of the contract and throughout the mobilisation process.

The contracting model the five CCGs have agreed upon is a Lead Provider model (not necessarily a single provider), to deliver the service for a term of five years, with an option to extend for two years under the NHS standard contract. In broad terms, a Lead Provider model means service delivery may be by a group of providers but with a single accountable organisation (who may be a provider itself or service aggregator).

The benefits of this model are that the five CCGs are able to hold one organisation to account for delivering the agreed outcomes and performance across the entire care cycle. Therefore, small to medium-sized organisations, such as GP collaboratives or voluntary organisations (including those without a background in NHS 111/OOH but who might have useful skills and resources to offer), have the opportunity to participate by working together with other providers to bid for this service.

Two market information events have been held to encourage initial discussions about the procurement and assist potential collaboration amongst providers from all sectors. The market event on 5 August 2015 was attended by over 20 different providers, including GP collaboratives, NHS Trusts and private providers. The CCGs already know that this approach has been successful in encouraging some providers to work together to develop bids.

4.3 Service specification

There are national quality standards and targets for NHS 111[7] and GP OOH[8] services with which all providers must comply. Current national standards are expected to change when NHS England publishes new commissioning standards for integrated NHS 111/OOH services in September 2015. A greater focus on measures of patient outcomes are expected in the new standards, but many of the key performance indicators (KPIs), measuring aspects such as the speed and quality of responses, are likely to remain broadly similar. The new standards will be incorporated into the NCL CCGs' service specification.

Any future provider would be required to deliver a consistently safe and high quality service across the five boroughs with equitable access, and meet all key performance targets. There is no expectation of borough-specific criteria being set, as the goal is to produce an equitable service – but the future provider/s would need to respond to local needs, such as differences in population, in order to deliver that equitable service – for example flexing the numbers and location of the different types of clinician in response to varying types of need. They would need to demonstrate how they plan to achieve this as part of the procurement process.

To ensure that the population needs of each CCG would be met by the service, a clinical subgroup comprised of GPs from the five CCGs, nurses and pharmacists has been set up to co-produce the NHS 111/OOH service specification. In addition, each of the five CCGs have processes in place to assure their governing bodies that the requirements in the service specification would address the needs of their populations – CCGs are using assurance groups of non-conflicted clinicians to review the specification throughout its development.

[7] NHS England NHS 111 Commissioning Standards – June 2014

[8] National Quality Requirements in the delivery of out-of-hours services – July 2006, Gateway no. 6893

The Patient and Public Reference Group has had the opportunity to discuss the service specification and make line-by-line comments. Members of the PPRG will also be involved in the procurement evaluation panel that chooses the eventual provider/s, helping to ensure continuity between the design of the specification and its implementation.

The specification is deliberately designed not to be overly prescriptive beyond those areas that have a direct bearing on quality and performance. For example, there is no specification of precise ratios for the skills mix of clinicians – potential providers are expected to outline the approaches they would take in these areas and how they would meet the quality standards and KPIs as part of their bid. This approach allows for innovation over the lifetime of the contract, whilst ensuring that commissioners enforce the contract in the best interest of local service users.

Specific information on objectives and targets, including quality objectives and targets are all outlined in the draft service specification which was published on all five CCG websites, with comments invited from all stakeholders – the specification was viewed online over a thousand times. The draft specification is also included as an appendix here. If there are suggestions for improvements to the specification please let them be known at the meeting or in writing to feedback@nelcsu.nhs.uk – these will be collated and added to a further draft if appropriate.

4.4 PQQ and ITT

The Pre-Qualification Questionnaire (PQQ) criteria for bidder selection will be made publicly available once it has been released to potential bidders. The PQQ is designed to evaluate the capacity, capability, experience and eligibility of potential bidders (in particular minimum levels of economic and financial standing and technical or professional ability), to determine whether there are any legal impediments to a potential bidder's further participation in the process.

Following the PQQ stage, as is standard, it is likely that around five bidders would be taken through to the Invitation to Tender (ITT) stage. This will be a fair and transparent process, including patient representation on the PQQ and ITT evaluation panels. Tender quality and cost weightings form part of the evaluation criteria (expected to be in the region of 80% and 20% respectively), and will be made available to providers who have qualified for the ITT stage.

It is important that the NHS 111/OOH procurement process is non-discriminatory and transparent at all times, neither including nor favouring nor excluding any particular provider. This includes documentation and, particularly, some specific criteria and financial information that would be used as part of any evaluation process. There is a very specific procurement process the CCGs have a duty to follow and the bidders must be the first to receive these documents.

The criteria for PQQ and ITT will largely be based upon the service specification, which has already been published and engaged on in draft form, as well as on the national quality standards for NHS 111 and GP OOH services, which are also publicly available. They will also take into account the new NHS England quality standards for a combined NHS 111/OOH service.

The stages in the procurement process are summarised below:

i. Advert and EOI (Expressions of Interest)

- The contract opportunity is advertised and, upon review of the information, the bidder choses whether or not to participate in the tender. There is no commitment by the contracting authority or the bidder/s

ii. PQQ (Pre-qualification Questionnaire)

- This is a shortlisting stage designed to review the bidders as organisations, in particular their experience (of delivering this type, or similar services), capacity and capability. If bidding as a consortium, the lead provider must submit a PQQ on behalf of all the parties in the consortium. Bidders that pass this stage will be invited to tender (ITT)

iii. ITT (Invitation to Tender)

- Bidders deliver proposals on how they would deliver the service as described in the specification (quality response). They will also deliver proposals on how the service would be priced

iv. Bidder interviews

- Following evaluation at ITT stage, the highest ranked bidders will be invited to a presentation/interview stage which is designed to give clarity on the overall bid/proposal. In this instance they will also face scenario-based panels (objective structured clinical examinations – OSCEs) which will examine in more detail their capacity, experience and capability; members of the PPRG will also be on these panels. Questions might focus on specific population groups, management of sub-contracts, or how providers would deploy their resources to deliver an equitable service across the five boroughs

v. Award/Selection

- Governance approval of a fair and open process and the effectiveness of a decision in selecting a preferred bidder/s

vi. Standstill process

- Although health and social care services do not follow the full 'Official Journal of the European Union' (OJEU) process, the 10-day standstill period is followed as best practice

vii. Mobilisation

- This contract will be subject to a six-month mobilisation period. This allows time for the new provider/s to arrange leases, staff contracts, technology and other infrastructure, and to give assurance to the CCGs that they are fully able to meet the requirements of the service from the first day of operation.

4.5 Procurement timeline

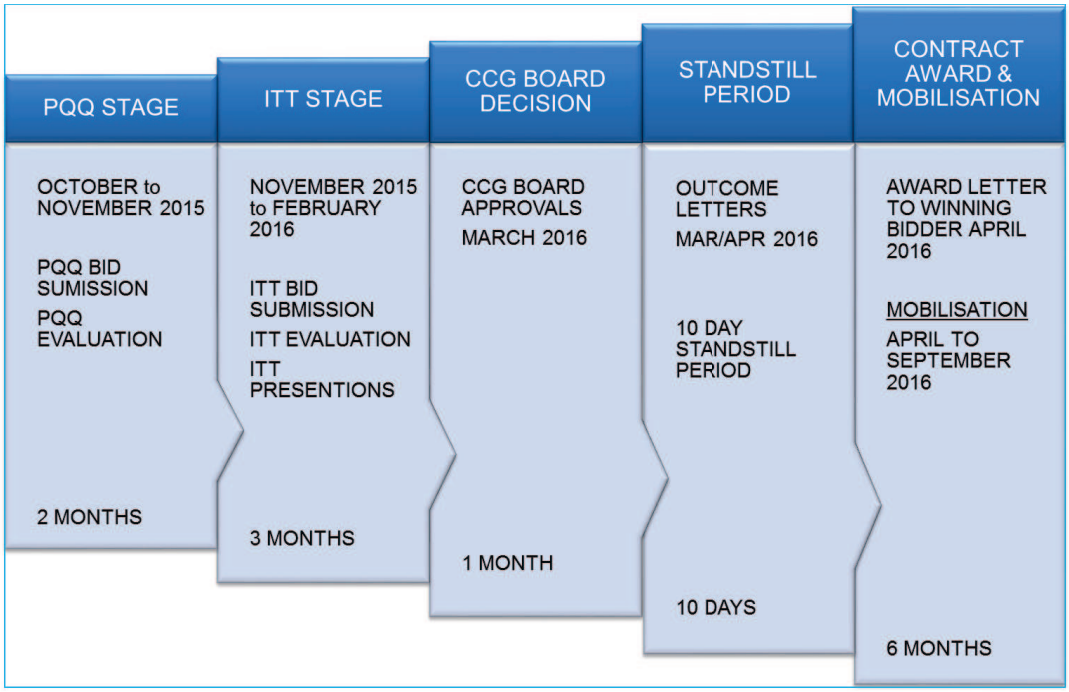
NCL CCGs had originally intended to procure the new service model to start in April 2016. Earlier this summer, the CCGs took the decision to delay the procurement and extend the existing contracts for a further six months, in order to:

a) Allow time for further engagement with local people on commissioning intentions
b) Avoid the need for a mobilisation period taking place over the winter months.

The revised start date for the new service is expected to be 1 October 2016.

In July 2015, all CCGs were advised of NHS England's expectation for the commissioning of NHS 111 and OOH services in a letter from Dame Barbara Hakin, National Director of Commissioning Operations[9]. The recommendation from NHS England was that CCGs should aim to commission a single integrated NHS 111 and OOH service across a number of CCGs and to consider collaboration of providers through a lead provider arrangement. The NHS 111/OOH service model and provider arrangement proposed by the five NCL CCGs conforms to the recommendations from NHS England.

NHS England will be publishing new commissioning standards for an integrated NHS 111 and OOH service in September 2015 and has asked all CCGs to pause procurement work until October 2015 to allow for publication of the new standards. The CCGs anticipate being able to incorporate these new standards and proceed with its procurement in October as planned. The expected timetable for the procurement is set out below:



4.6 Contract management

The procurement process is designed to minimise risks to the future quality of the NHS 111/OOH service by setting rigorous quality standards and ensuring that potential providers are financially stable and able to deliver the highest quality of service.

As commissioners of this service, the five CCGs will hold the future provider/s to account, through regular quality review meetings and ongoing monitoring to ensure all aspects of the service adhere to the highest of standards and meet the needs of service users in each of the five boroughs.

As at present, there would be monthly meetings involving representatives of both providers and commissioners. These involve a Contract Technical Group (looking at financial and similar aspects

[9] NHS England - Commissioning a Functionally Integrated Urgent Care Access, Treatment and Clinical Advice Service July 2015 Gateway No. 03568 http://www.england.nhs.uk/wp-content/uploads/2015/07/nhs-111-bh-letter.pdf

of the provider's performance) and a Contract Quality Review Group (looking at performance data, serious incidents, complaints and service user feedback). The Patient and Public Reference Group is considering how best to involve service users in the contract review process.

Monthly reporting on a detailed set of key performance indicators would provide the CCGs with early notice should the provider struggle to meet the expected standards. The provider/s would be required to have processes in place that allow patients and carers to share experiences and provide feedback about the service on an ongoing basis. This patient feedback would form part of the monthly reporting to CCGs. The provider/s would also be required to meet any changing quality requirements established by NHS England for NHS 111 and OOH services.

There is a well-established procedure for contract enforcement detailed in the standard NHS contract[10]. This sets out the process for remedial action should a provider fail to meet the required quality standards, as well as the mechanisms for enforcing financial penalties and, ultimately, contract termination, should a provider fail to improve its services to the expected standard.

In summary, the stages of this process run as follows:

i. The commissioner identifies a failure on the part of the provider to comply with the contract
ii. The commissioner issues a Contract Performance Notice
iii. Commissioner and provider hold a contract meeting within 10 working days of the Contract Performance Notice, at which they agree whether a review is necessary
iv. Commissioner and provider must then agree a Remedial Action Plan within five working days of the contract meeting, at which they establish:
    a. Milestones for performance issues to be remedied
    b. The date by which each milestone must be completed
    c. Subject to maximum sums identified in the General Conditions, the consequences for failing to meet each milestone by the specified date
v. If the provider fails to meet the Remedial Action Plan, financial penalties will be applied.

There are separate processes which apply in the case of serious untoward incidents, as is the case for all NHS providers – these have to be reported to commissioners within 48 hours; in practice this notification is much sooner.

5 Recommendations

The Committee is asked to note the contents of this report and comment on the commissioning of an integrated NHS 111/OOH service across north central London.

6 Appendices

a. Future model for NHS 111 and GP Out-of-Hours services in north central London – engagement document (July 2015)
b. Report of the outcomes of the July engagement activity on the CCGs' commissioning intentions to procure an integrated NHS 111 and out-of-hours service (August 2015)
c. Integrated NHS 111 and Out-of-Hours draft service specification

[10] NHS Standard Contract 2014/15 General Conditions p9-12 http://www.england.nhs.uk/wp-content/uploads/2013/12/sec-c-gen-cond-1415.pdf

Report of the outcomes of the July engagement activity on the north central London CCGs' commissioning intentions to procure an integrated NHS 111 and out-of-hours service

Since January, the five north central London (NCL) clinical commissioning groups (Barnet, Camden, Enfield, Haringey and Islington CCGs) have been engaging extensively with local service users and residents on a proposal to commission an integrated NHS 111 and GP out-of-hours (OOH) services.

The CCGs engaged with hundreds of people, face to face or through an online survey, particularly with those who would be most likely to use the proposed service, those who face particular barriers to accessing services or are vulnerable.

This NCL-wide engagement has included:

- Discussions about the proposed NHS 111 and OOH model at local engagement events, including meeting with individual service users and with targeted groups such as disabled service users and refugees
- Focused engagement events held at venues across NCL and advertised through local newspapers and CCG websites, which allowed for in-depth discussion of the proposed model
- Presentations at GP locality meetings across NCL to ensure local doctors understand what is planned and how they could be involved
- Presentations to the NCL joint health overview and scrutiny committee and local health overview and scrutiny committees
- Publication of an online survey to find out the views of stakeholders and service users on the proposed model
- The setting-up of a Patient and Public Reference Group (PPRG), involving service users and Healthwatch representation from each of the five boroughs. The PPRG was set up to support the procurement process and to ensure that the views and experience of local patients and carers are reflected in the decisions about the NHS 111/OOH service planning and delivery of care by the new service. Members have greatly inputted to the service specification, had fact-finding visits to the current NHS 111 provider and are participating in the procurement evaluation panel
- Two market-testing events to ensure potential providers are fully informed of the proposals and to encourage them to collaborate in developing bids.

A considerable amount of support has been received for the idea of combining NHS 111 and OOH. However, it became clear that more needed to be done to make the case for commissioning these as an integrated service across NCL.

The decision was therefore taken to undertake a further period of engagement during July 2015, specifically focused on the intention to commission the integrated service across five boroughs. This included:

- Publishing and widely circulating an engagement document, outlining the case for NCL-wide commissioning and encouraging residents and stakeholders to submit their views
- Sharing an online and postal questionnaire - and gathering feedback
- Meeting with clinicians and key stakeholder groups to discuss and develop further the clinical case for change
- Holding an additional 'market-testing' event for providers to ensure that all those who might want to bid for the new service had the fullest possible information about the proposed service.

The engagement document was distributed widely across CCGs through GP practice patient participation groups (PPGs), local patient groups and communities, voluntary organisations, Healthwatch, key stakeholders, providers, local councils, GP practices and staff. It was also emailed, posted and published online on all five CCG websites.

Responses to the engagement

Although the engagement was publicised widely, the level of response has been very low. It is worth noting that this was the final phase of a long period of engagement.

Online questionnaire responses	**21**
Questionnaire responses by post	5
Other responses	2
Total responses	**28**

Who responded to the questionnaire?

As this was not a full public consultation, the survey did not collect a full set of demographic data. However respondents were asked for their age (within a range), gender and the capacity in which they were responding. Specific to this exercise, they were asked which borough they lived in and in which borough they worked.

28 responses to the questionnaire were received, with more responses from women than men (18 of the 22 responses where this was indicated), more from those aged 65+ (14 respondents) or 41-65 (10 respondents) and more responses from people who lived in Camden and Haringey.

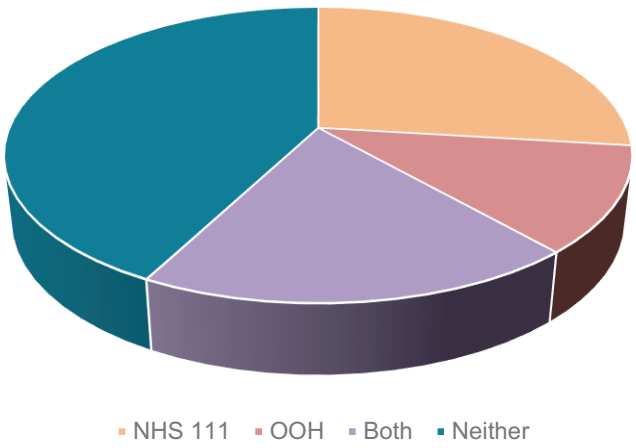
Respondents were invited to leave a comment to clarify or explain the answer which they had given to the question. These comments have been examined in some detail as they provide valuable additional information about the views of patients and public.

Common themes have been identified and are highlighted within the report for each section where qualitative data was collected. A sample selection of quotes from respondents has also been included in order to give some indication of the range and diversity of views. Two responses did not reply to the specific questions but gave a narrative response. These have been included as they provided helpful feedback.

It should also be noted that respondents had the option not to complete some of these questions by either choosing the 'don't know' or 'prefer not to say' categories, or by skipping the question completely. A count of how many respondents answered each question has therefore been included alongside each graph as there are variations in the number of responses to each question. The two narrative responses will not appear in the following analysis.

Analysis of the questions

Q: Have you used NHS 111 or a GP out-of-hours service in the past two years?



NHS 111	7
OOH	3
Both	5
Neither	11
Total responses	**26**

The majority of respondents (15 out of 26) stated that they had used one or both of the NHS 111 and OOH services in the past two years. One of the narrative (non-questionnaire) responses received also alluded to using NHS 111. The question did not ask where they were in the country when they used the service(s), and did not specify whether the respondent had accessed telephone consultation only or an out-of-hours base/home visit.

This indicates quite a large proportion of respondents (close to two-thirds) with experience of the services in question.

Q: We are considering a proposal to commission an integrated NHS 111 and GP out-of-hours service across north central London. What factors are most important for you when using these services? (Please select your top five)

Selected factors	Chosen by	As %age of respondents
Out-of-hours sites being easy to get to by public transport	19	73.1%
Being able to speak with someone with access to your medical records	17	65.4%
Being able to speak to a nurse or other health professional	15	57.7%

Selected factors	Chosen by	As %age of respondents
Getting useful advice about your condition quickly	14	53.8%
Being able to speak to a doctor	14	53.8%
Being able to speak with someone with good knowledge of local services	12	46.2%
Being able to speak with a local doctor	11	42.3%
The service being accessible for people who don't speak English as a first language	5	19.2%
The service being able to book an appointment with your GP practice (inside practice working hours)	4	15.4%
The service being accessible for people with a physical disability	3	11.5%
The service being accessible for people with a hearing or visual disability	2	7.7%
Other	3	11.5%

The most important factors for respondents were:

- **Out-of-hours sites being easy to get to by public transport.** It is important to note that the procurement proposals do not include any plans to reduce or change the locations of the current out-of-hours bases. Further, if the decision is taken to procure these services across all five CCGs, it is hoped that this would improve access to more local services for some patients by **removing artificial service boundaries** within north central London.

> "I wouldn't wish to have to go all the way to Barnet/Haringey/ Enfield. I live south of Euston Road, and I am nearing 80 and don't travel well these days – osteo-arthritis etc."

- **Being able to speak to someone with access to your medical records.** By developing an integrated NHS 111 and out-of-hours service we would **improve record-sharing** between urgent care services.
- **Being able to speak to a nurse or other health professional.** The plans for procuring an integrated NHS 111 and out-of-hours service include **investment to fund additional clinical support** – doctors, nurses and paramedics working closely with the call advisers to make sure that those service users who need clinical advice are put through to the most suitable clinician.

> "Being able to register serious life-threatening conditions so that you are flagged as being a high priority. I have a rare life threatening condition called Addison's disease. If I'm really not feeling well I don't want to have to battle with someone trying to get them to understand I need advice or help quickly."

- **Being able to speak to a doctor**. As above, the proposal is to use a range of clinical support. However, by integrating NHS 111 with the out-of-hours service, we hope also to be able **to increase access to GPs**, where that is the clinician with the right skill-set to give the advice required
- **Getting useful advice about your condition quickly.** NHS 111 is designed to be a **rapid response service**. NHS 111 provider organisations have challenging performance indicators measuring how quickly they answer calls and how quickly they transfer callers to clinicians if clinical advice is required. The NCL CCGs' proposals should increase the access to this clinical support.

The statements relating to localisation – '*Being able to speak to a local doctor'* and '*Being able to speak with someone with good knowledge of local services'* – were selected by 11 and 12 respondents respectively, although a number of these people had not previously used either service.

It may be worth noting that these options were disproportionately selected by respondents who had not used NHS 111 or OOH services recently, as set out below:

	Used NHS 111 or OOH recently (15 in total)		Have not used the services recently (11 in total)	
Being able to speak to a local doctor	4	26.7%	7	63.6%
Being able to speak with someone with good knowledge of local services	4	26.7%	8	72.7%

The NHS 111 service works by giving call advisers access to a comprehensive directory of services, designed to make sure callers who need further support are directed to the most appropriate local service. As such, it doesn't not depend on the local knowledge of the individual, but on their ability to use the system and their communication skills.

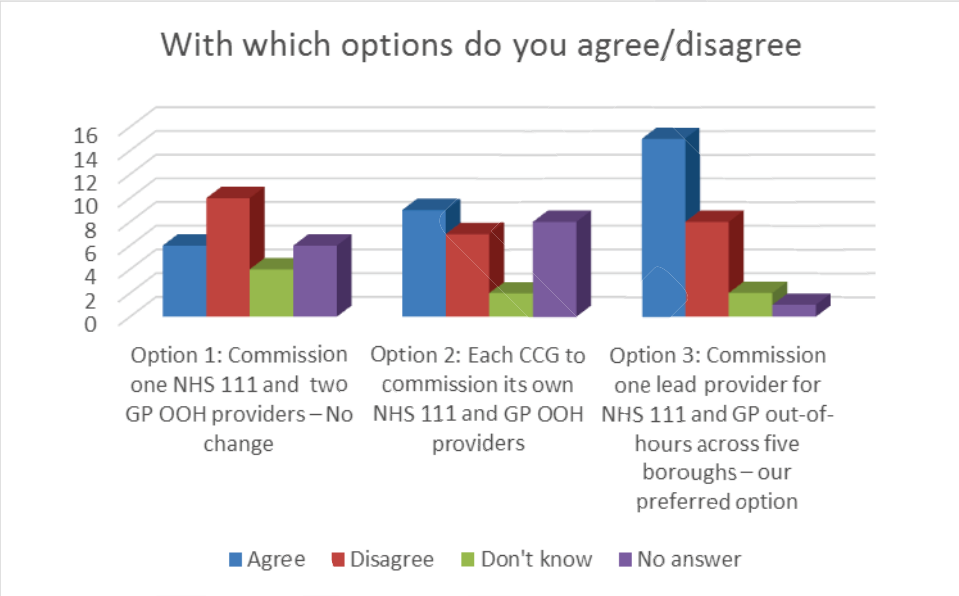
From the evidence above, it suggests that there is work needed to communicate more widely how NHS 111 works, and to give local people the confidence that they would be given access to the right services.

Q: Our preferred option is to commission an integrated NHS 111 and GP out-of-hours service across Barnet, Camden, Enfield, Haringey and Islington. With which options do you agree/disagree?

		Agree	Disagree	Don't know	No answer
Option 1:	Commission one NHS 111 and two GP OOH providers – No change	6	**10**	4	6
Option 2:	Each CCG to commission its own NHS 111 and GP OOH providers	**9**	7	2	8

Option 3:	Commission one lead provider for NHS 111 and GP out-of-hours across five boroughs – *our preferred option*	**15**	8	2	1

As these figures indicate, the overwhelmingly preferred option (selected by 15 out of the 25 people who expressed a preference) is **Option 3: *Commission one lead provider for NHS 111 and GP out-of-hours across five boroughs***. Option 1 – no change: *Commission one NHS 111 and two GP OOH providers* – was the least preferred option, with only six out of 25 selecting this.



Option 1 was also the most disliked option (10 respondents out of 25), though the least disliked option was Option 2: *Each CCG to commission its own NHS 111 and GP OOH providers*.

Option 3 was marginally more popular with those who have used the NHS 111 or OOH service recently, than with those who have not used it recently, as shown below:

	Used NHS 111 or OOH recently (14 in total who expressed a view)		Have not used the services recently (11 in total)	
Agree	9	64.3%	6	54.5%
Disagree	4	28.6%	4	36.4%
Don't know	1	7.1%	1	9.1%

This question invited respondents to give the reasons for their choices. These give considerably more nuance to the choices made – for example, some people chose Option 3 for pragmatic reasons, because they felt it would save money for the NHS.

Comments from people who **agreed** with Option 3 include:

- I would hope that a five borough wide service would mean that users would get the best possible advice and access to services available. However I do also think that we need access to local services and would not support this proposal if I thought that, for example, an out of hours service was not available within the borough where I live
- Economy of scale. Access to the services from a wide area in NCL
- Boundaries between boroughs can be arbitrary from an individual's point of view i.e. you may live in Barnet but it might be easier to get to the Whittington
- Integrating 2 services makes sense across 5 boroughs not a problem as long as the service responds to local need
- Financially a better option; should be more cost effective. Wider range of accessible medical services and health care professionals should be available with this option.

People who **disagreed** with Option 3 gave the following reasons:

- Local knowledge of what services are available is very important
- I think the best option is for each contract to be as small as possible so that there is more of an opportunity for the existing local service providers to be able to bid for the contracts. If the contracts are too large the local service suppliers won't be able to bid because they won't be able to afford it
- I think that the service needs to reflect the local community and therefore having one that is specific to the area you live will be better (Camden and Islington). Camden and Islington have very different needs than Barnet, Enfield and Haringey, and the services should reflect this. People want a local service and having services connected with Barnet, Enfield and Haringey isn't local for Camden and Islington residents
- I think a GP-led consortium is preferable and by keeping to the existing model that is more likely. Bigger integrated contract means private providers are more likely to bid. Private contracts have in the past been harder for CCGs to monitor
- I have concerns about too many people having access to confidential medical records. It sounds unwieldy and I am not confident that I'd be referred to the appropriate service with the necessary clinical skills.

Q: Is there anything particular you would like us to consider in our plans to commission an integrated NHS 111/out-of-hours service?

These can be grouped into themes:

- **The ability to speak to a local doctor when they call the GP out-of-hours service.**
  - Clinicians recruited should ideally be local practitioners. If not possible then they must be assessed on their command of intelligible spoken English, and their comprehension of English spoken by patients with a range of accents.
  - How will non-local clinicians be recruited?
  - OOH based in health centres in Haringey. Could be a split service with some centres having nurses only. This could provide some A+ E services.
- **Access to medical records**
  - I think potentially serious medical conditions should be flagged on any electronic patient record system to help assist triage
  - When I have had a doctor out of hours, they did not bring any notes on my medication and once one doctor asked me what I think I needed!

- **The increased involvement of private companies in delivering these services.**

  - That this service be supplied by a not for profit organisation and not by any part of the private sector
  - Check that the profit level is not more than 5% or use non-profit making organisations. Profits equate to less services
  - I think that the concept of breaking up the National Health Service under public ownership and then reuniting it under a private ownership is one that is politically motivated rather than evidence based.
- **Supporting people who need access to mental health services, with learning disabilities, hearing impairment or other disability, who do not speak English as a first language**
  - Mental health services and emergency care needs to be a highlighted facility to ease pressure on A&E
  - The interface or front of house needs to be more coherent. At the moment it is confusing for patients who have a range of options from walk-in centres, A&E and so-called Urgent Care centres, which give the impression they are not part of A&E when they are and OOH.

Many of these comments reflect views that have been expressed throughout the wide engagement on these proposals.

Conclusion

From the wide engagement undertaken since January (see Appendix 1), very useful feedback from many service users and local campaign groups has been received, with support for joining up NHS 111 with the GP out-of-hours service to improve patients' experience.

That a future service would mean fewer handoffs between services has been particularly welcomed, as have the improvements proposed in the clinical model such as the opportunity to talk to other NHS services (dentists, pharmacists, mental health workers), earlier access to services, eg pharmacy, repeat prescriptions and direct access into GP appointments.

Despite wide communications highlighting the engagement document and its survey, there was a very small response to this phase of the engagement; of those that did respond **Option 3 was the most favoured option, supporting our proposals to integrate the two services.**

In parallel with engagement on the proposal to commission an integrated NHS 111/OOH service, the development of the draft service specification for the proposed integrated service has been taking place, with input from the clinical leads from Barnet, Camden, Enfield, Haringey and Islington CCGs. The Patient and Public Reference Group and Healthwatch organisations across NCL have 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 21 July to 19 August, and circulated to the same stakeholder list as the engagement document, inviting comments which will be fed back to the drafting team before the final specification is produced for discussion by the CCG governing bodies in September.

We will continue to engage, inform and involve service users and residents in the progress and process of the proposed procurement of an integrated NHS 111/out-of-hours service across north central London.

Further information can be found at:

Barnet	www.barnetccg.nhs.uk/nhs-111-out-of-hours-service.htm
Camden	www.camdenccg.nhs.uk/about/nhs-111-and-gp-out-of-hours-services.htm
Enfield	www.enfieldccg.nhs.uk/about-us/nhs-111-and-out-of-hours-gp-services.htm
Haringey	www.haringeyccg.nhs.uk/about-us/nhs-111-and-out-of-hours-gp-services.htm
Islington	www.islingtonccg.nhs.uk/111%20and%20OOH.htm

Via email at feedback@nelcsu.nhs.uk

By phone at 020 3688 1615

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North Central London Clinical Commissioning Groups

Integrated NHS 111 And Out Of Hours Service Specification

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Document control

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Contact details	REMOVED FOR ONLINE VERSION

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GLOSSARY AND DEFINITIONS

Term / Abbreviation	Explanation / Definition
Advisor	The NHS 111 call advisor (non-clinician) who carries out call handling and the initial clinical assessment using the CDSS
Caller	The person calling the NHS 111 service whether they be the patient, a third party, or a health professional
CCG	Clinical Commissioning Group; the statutory commissioning body
CDSS	Clinical Decision Support System; used by Advisors and Clinicians to assess patient's presenting problems, for example NHS Pathways
Clinician	The NHS 111 clinician who receives Warm Transfer calls from Advisors for further assessment and provides advice on calls with home management endpoints
Clinical Lead	CCG or other clinical lead and member of the NHS 111 North Central London CCGs or other Clinical Governance Group
CMC	Communicate My Care – a register of patients with End of Life care records
Commissioner(s)	Clinical Commissioning Group Commissioners within the North Central London CCGs responsible for NHS 111 services
Commissioning Standards	The NHS 111 national Commissioning Standards, published June 2014
CPIS	Child Protection Information System
DDI	Direct Dial Inwards. Calls to different DDI numbers may be treated differently and reported on separately.
DoS	The Directory of Services; an electronic database of services available held with details of their service offer, any access restrictions and profiled against the dispositions arising from the CDSS
DNAS	Dental Nurse Assessment Service
DTS	Data Transfer System
ED	Emergency Department (Accident and Emergency)
GP	General Practitioner
HCP	Registered health care professional
HSCIC	Health and Social Care Information Centre (www.hscic.gov.uk) The national provider of information, data and IT systems for health and social care
IGSoC	NHS Information Governance Statement of Compliance
IM&T	Information Management and Technology
ITK	The Interoperability Toolkit – see HSCIC website
KPI	Key Performance Indicator
Lead Commissioner	One CCG acting as lead on behalf of North Central London CCGs
License	The relevant license and terms and conditions for the product in question, e.g. the CDSS
MIU	A Minor Injuries Unit
NHS	National Health Service
NHS 111 Service	The service to the NCL CCGs as described within this Service Specification
NHS Organisation	NHS Organisation or any company/provider acting on behalf of the NHS
NNG	National Numbering Group

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NPSA	National Patient Safety Agency
NICE	National Institute for Health and Clinical Excellence
OOH	An Out Of Hours service, normally a GP OOH service
PDS	Patient Demographic Service
PEM	Post Event Message
PHE	Public Health England
PURM	Pharmacy Urgent Repeat Medicine
Referral	Transfer of care for a patient between services, where there is an agreed protocol for doing so; and the arrangements for sharing data and transferring responsibility are in place.
Re-triage	Triage is the process of prioritisation. Re-triage is defined as a caller being re-assessed on receipt of the referral by a call adviser or clinician with a view to re-prioritising the patient (see Triage).
SCR	Summary Care Record
Self-care	Actions and attitudes which contribute to the maintenance of well-being and personal health and promote human development. In terms of health maintenance, self-care is any activity of an individual, family or community, with the intention of maintaining health or wellness, improving or restoring health, or treating or preventing disease.
Self-management	Management of a patient's symptoms by themselves, without further contact with the health service unless their condition worsens or their symptoms persist for 3 or more days.
Provider	Provider of the NHS 111 Service
Signpost/signposting	Directing a caller to another service that is outside the scope of NHS 111 and therefore no referral protocol exists.
Specification	This service specification
SPN	Special Patient Notes which are elements of the patient record detailing how an individual's care should be offered or key advisories relating to their care, for example a Care Plan, details of long-term condition management, end-of-life plan, warnings and known risks, safeguarding information, etc.
NCL London CCGs	North Central London Clinical Commissioning Group. There are 6 CCGs in the North Central Region
Triage/Clinical Assessment	A process of prioritisation. When a caller contacts NHS 111 and is triaged/clinically assessed as needing to receive services from a primary care organisation, it is up to that receiving organisation to determine how they provide services to that patient (e.g. GP phone consultation or GP clinic appointment).
UCC	An Urgent Care Centre
Urgent Care Board	Urgent Care Boards or similar arrangements co-ordinated locally to ensure integrated management of the urgent and emergency care system. May also be termed Urgent Care Working Groups, Urgent Care Networks or System Resilience Groups.
Urgent healthcare	The range of healthcare services available to people who require, or who perceive the need for, medical advice, diagnosis and/or treatment quickly and unexpectedly.
Warm Transfer	A call that is transferred from one individual to another (in the context of NHS 111 this usually refers to Advisor to Clinician) while the Caller is still on the line. The Clinician acknowledges the transfer of the Caller prior to the Advisor leaving the call.
WIC	A Walk In Centre
UCC	Urgent Care Centre

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Population needs

Context

The NHS 111 and OOH service is an essential component of the urgent and emergency care system within North Central London. It is critical to help people get the right advice in the right place, first time.

NHS Outcomes Framework Domain & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

Core Principles

The NHS 111 and Out of hours service will need to:

- Be available 24 hours a day, 365 days a year (366 in a leap year) for telephone advice
- Provide consultations with GPs during the out-of-hours period
- Be accessible, personalised and based on their individual needs
- Have knowledge of when they have previously contacted the service
- Be able to connect them to a clinician where indicated
- Be able to provide access to health records and notes (i.e., SPNs, CMC)
- Book appointments with other providers where available
- dispatch an ambulance without delay where indicated
- Be able to receive referrals through digital and online channels
- ensure that specific health needs, such as palliative care, mental health and long term conditions are properly catered for.

The Integrated NHS 111 and GP Out of hours service must provide a consistently high quality service irrespective of the geographic area served.

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The Integrated NHS 111 and Out of hours Service Model

The integrated 111 and out of hours service offers triage; telephone consultations with clinicians; and GP consultations during the out of hours period.

The current times of the service are outlined in Appendix 6 together with outline facility and equipment and technology requirements.

The provider is expected to use of skill mix of healthcare professionals to deliver this service including GPs, Pharmacists, nurses and Paramedics supported by clinical advisors (call handlers).

Any local processes that are developed outside of the NHS England Commissioning Standards will require agreement with the commissioners prior to implementation.

Aims of the Service

- Provide call handling, clinical assessment, telephone advice and appropriate referral to other NHS services in North Central London
- Provide consistent clinical assessment of patient needs at the first point of contact
- To provide face to face consultations and home visiting during the out-of-hours period to meet the urgent health needs of patients that cannot be safely deferred to the in-hours period
- To utilise the locally managed Directory of Services (DoS) which identifies a range of locally available services to enable patients to be directed to the right service to meet their needs

Service description/care pathway

The Provider must adhere to the following requirements arising from the Commissioning Standards further enhanced by the key themes identified by CCGs as part of the development of the specification.

Be a Single Point of Access for all non-emergency NHS healthcare service, accepting calls from the public via any agreed channels, including telephone. For the purposes of this specification, the public is defined as the following:

- Patients, carers, guardians
- Social Carers
- Respite, Residential and Nursing Homes

Excludes Health Care Professionals calling for clinical advice, except in exceptional circumstances

a) Clinical Assessment, diagnosis and advice service

Callers to NHS 111 will receive telephone based advice including a telephone consultation with a clinician; and where required will receive an appointment with an out of hours GP for a base visit or a home visit.

The clinical assessment will be carried out by an appropriately trained and experienced health professional. The telephone assessment will identify the treatment requirements of the patient including whether it is necessary for the patient to:

- Have their condition reprioritised and an ambulance to be called

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- Receive an appointment during the Out of Hours period at a designated treatment centre or at home;
- Be referred back to their registered GP
- Be referred to other appropriate health and social care services
- Receive self-care advice, signposting, reassurance and information over the telephone

The clinical assessment will also assess what level of review and monitoring is necessary in order to manage the risk in relation to the patient's condition.

The Service must deliver easy access for all members of the public, including:

- Patients with specific issues such as hearing impairment, non-English first languages (including 24/7 access to interpreter services), visual impairment, learning disabilities and other access issues
- Applying the principles of Mental Health concordat for crisis management work and Provider must work with Commissioners and patient groups to ensure the most convenient and appropriate access to the OOH service.
- Making the experience as stress free as possible for all patients including those who have mental health issues, patients with learning disabilities and long term conditions. Patients in the mental health category may have illnesses that render them confused or vulnerable and will include those patients with dementia and other severe and enduring mental health problems such depression and schizophrenia.

b) Primary Care Centres: Face-to-Face consultation and treatment

A face-to-face consultationwill be conducted in environment most appropriate to patient need at a designated treatment centre. All face-to-face consultations, where conducted, must meet the performance standards outlined in the contract and the National Quality Requirements. Face-to-face consultations will be booked following initial telephone advice.

For the purposes of this Specification, Commissioners confirm that, for calls passed from NHS 111, definitive clinical assessment (as referenced in National Quality Requirements for OOH) has already taken place in the NHS 111 service. Therefore these standards apply from the point of receipt of an NHS 111 referral into the Provider's system.

Face-to-face consultations must be within the following timescales, after definitive clinical assessment has been completed:

- Emergency: within 1 hour
- Urgent: within 2 hours
- Less urgent: within 6 hours for home visits or base visits

Face-to-face consultations will be provided at locations agreed by the CCGs. The hours that face-to-face consultations are offered will also be determined by the CCGS. The hours and locations of this service may need to be varied in the future depending on patient needs.

Patients requiring face-to-face consultations at the designated treatment centres will

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normally be offered appointments at the nearest/most appropriate treatment centre to them. Patients are to be informed of likely timescales during initial consultation. Patients will always contacted if an agreed appointment time at the treatment centre is delayed, utilising the latest technology, where possible.

All treatments provided at the designated treatment centres will be administered by suitably qualified clinicians with local knowledge of systems and processes. A GP must be on each site during opening hours.

It is the responsibility of the Provider to manage demand safely and effectively.

c) Home Visits

A face-to-face home visit consultation will be conducted in the patient's place of residence. The place of residence is defined as any address specified at the time of visit (e.g. home, nursing home, hospice, hospital or treatment centre). All face-to-face consultations, where conducted, must meet the performance standards outlined in the contract and the National Quality Requirements. The Provider must specify the number of vehicles, type of vehicle and equipment to be used. Vehicles and equipment should not be used for any other purpose other than those services outlined in this specification and under this contract.

Home visits will be made by an appropriately skilled clinician, using a suitably equipped vehicle. The clinician will either treat in-situ or send the patient to an appropriate service for on-going treatment.

The Provider will agree with Commissioners the clinical and non-clinical protocols, with clear reasons and criteria that indicate when a home visit is considered appropriate. This criteria needs to include the mode of transport for staff including: the number of vehicles needed, the bases, drivers and associated assurances. All protocols will have version control and a demonstrable mechanism to show that regular review is undertaken, with upgrading as required.

It is expected that clinical definitive assessment may sometimes result in Home Visits. The Out of Hours service will be configured around local communities and their needs, providing care close to patients' homes, via the telephone, at their home, in residential and nursing homes and/or in other clinical settings. The determination of the locations of where assessment and treatment is conducted will be based on the patient's clinical status and the Provider will be expected to demonstrate how it is able, as an organisation, to adapt as the needs of the population change and develop with time. The Provider must apply clinical judgement during assessment to decide if a patient requires a home visit.

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Callers will be routed to the NHS 111 Service based on the routing area from which they are calling. This applies whether callers use a mobile phone or a landline to access the service. Calls will be received by the Department of Health telephony system (CUCM11), identified and tagged as being from a NCL routing area and then passed to Provider telephony system for distribution to the NHS 111 Service call centre(s).

All front end messages used by Provider must be agreed with the Commissioner prior to recording or with an on call director if urgency dictates.

NHS 111 Call Handling Process

- **Demographics and Anonymous callers**

When a call is answered by an Advisor, a baseline set of demographic data will be captured if the Caller is willing to provide the information, including the name and date of birth of the person the call relates to, phone number and home / current address.

Patient records should be matched to the Patient Demographic Service (PDS) to verify the NHS Number. The NHS Number should be used as the primary patient identifier when transferring data between providers.

Where a Caller wishes to remain anonymous the minimum information required for safe clinical assessment is:

- The age group of patient (adult, child (5-16 years), toddler (1-4 years), infant (<1 year) or neonate (<30 minutes old))
- The gender and ethnicity of the patient
- Whether they are calling about themselves
- Current GP surgery details of the patient.

The NHS 111 Provider must ensure they train staff with regards to anonymous patients and have policies and procedures to support vulnerable individuals where anonymity could cause problems. Where a Caller is happy to be identified, and has called before, existing records should be called up from within the call handling system and the new episode added to the existing record.

- **Out of Area Calls**

Callers who access the NHS 111 Service from outside of the boundary area will be assessed and advised of an appropriate service. Provider will assess any out of area callers in the same way as all in area calls and utilise the DoS to identify appropriate services local to the patient's location to meet their assessed needs and report issues that prevent the passing of information electronically. This will include dispatch of an ambulance.

- **Callers Not Located with the Patient**

Where a caller is calling on behalf of someone else and they are not physically located with that person, the NHS 111 service may only be able to offer a limited service. In these cases the clinical assessment system will include a facility to exit the assessment early and if necessary the call should be escalated to a clinical supervisor, who will use their judgement to meet the caller's needs. The advisors should always ask to speak to the patient where possible but if this is not practical the call should be handled through a third party.

- **Clinical Assessment**

Once the minimum demographic data is captured, the Advisor should move to the approved CDSS. NHS 111 services must use approved clinical assessment tools or clinical content to

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assess the needs of callers. Provider of the NHS 111 service must ensure that they adhere to any licensing conditions that apply to using their system of choice. The clinical assessment system should sit within the call handling system used by the NHS 111 Provider. It should be embedded within this host system, by the host system provider, via a license to embed from the appropriate licensing agency. The process of clinical assessment must follow a defined format:

The Advisor must first determine whether the call is in relation to a symptomatic or non-symptomatic call (e.g. health information, appointment booking, service location etc.). If the Advisor determines the call is a symptomatic call then immediately life-threatening symptoms must first be assessed. All symptomatic calls must undergo a full clinical assessment using the CDSS.

All questions asked and answers given must be recorded within Provider's IT system, and must be capable of extraction for reporting and review purposes. The reason for call, nature of any injury or illness and the outcome of the assessment must be recorded and be clearly identifiable for reporting and review purposes. The outcome should include the recommendation of both the level of care required and the timescale in which the patient needs to be seen.

- **Non-Symptomatic Calls**

Callers may not have current symptoms or injuries, for example requests for a repeat prescription, emergency contraception or general information on health related topics. Front end telephone messaging will give patients the option to be directed to Pan London services. Other calls of these types may be resolved through interrogation of the DoS, for example seeking information on the nearest community pharmacy that is open. Where such calls cannot be resolved by reference to the DoS directory, arrangements must be made by the NHS 111 Provider to provide the caller appropriate health information. Equally, where calls are out of scope but health related, the NHS 111 Provider will have the capability to signpost the patient to the most appropriate alternative service.

At peak times for NHS 111 services, there are significant numbers of calls for urgent repeat medication. This results in booking patients into GP out of hours (GPOOHs) appointments to obtain a prescription and for the out of hours services to then arrange for that prescription to be collected by a patient or carer or faxed to a pharmacy that is open near to the patient. All of this takes up time for the NHS 111 provider and GP OOH service which could be used for patients with higher acuity need.

NHSE have published a guide which provides details on how NHS 111 services can establish a direct referral to a pharmacy that is commissioned to provide urgent repeat medication as a local NHS service. The patient journey ensures the patient is directed to the nearest pharmacy without the need of a GP OOH assessment and the pharmacist ensures the governance of the process is adhered to by informing the patient's GP of any repeat supply (see http://www.england.nhs.uk/ourwork/pe/nhs-111/resources/).

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- **Speaking to a Clinician**

Calls should be handled, and assessed, by the person who initially answers the call. There may be times when a Clinician is required to complete the clinical assessment. In these cases the call should be Warm Transferred from the Advisor to an NHS 111 Clinician, i.e. the Advisor speaks to the Clinician before transferring the call. It is the aspiration that all assessments are completed in the initial call. The initial call, unless green ambulance, however must only be held for a maximum of 30 seconds (unless otherwise agreed with Commissioners) for the Warm Transfer following which the call will be ended and the Caller informed that they will be called back and advised of the expected call back timeframe. In the case of green ambulance further clinical assessment, the maximum wait for warm transfer should be 60 seconds following which auto dispatch to the ambulance should take place.

All calls relating to patients identified as being on the CMC Register or alternative End of Life Registers must be warm transferred to a Clinical Advisor.

In line with the aim of providing referrals to the right place, first time, every time, Provider should consider the potential use of other health care professionals (i.e., GPs, specialist nurses within the 111 operating model). If other HCPs are proposed within operating models clear proposals of the systems, processes, policies and protocols and clinical governance will need to be considered by the Commissioners and agreed through the NCL CG Group prior to any implementation.

- **Call Backs from Clinicians**

The CDSS should support the identification of calls requiring transfer to a clinician and could include:

- Refused dispositions
- Green ambulance dispositions
- Validation of home management / self-care advice
- Complex cases – multiple co-morbidities, no clear symptom
- Multiple symptoms
- Patients with clinical care plans / special patient notes
- Patients on CMC or similar End of Life Care Register

When a call is transferred from an Advisor to a Clinician, the Clinician must have access to the electronic record created by the Advisor and should be able to continue the assessment within the CDSS to prevent the Caller having to repeat details other than for verification / validation purposes.

Clinicians undertaking telephone assessment must work within a clearly defined operating model, which reflects the different elements of the process within NHS 111. Specifically, this includes:

- Handover from Advisor to Clinician – this must be structured and any discussions must take place on recorded telephone lines
- Validation by the Clinician of the Advisor's assessment
- Structured clinical telephone assessment with or without the aid of CDSS

Calls streamed direct to Clinicians (e.g. from health professionals) without assessment by the Advisor must be managed in a similarly structured way.

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Providers are required to set out proposals for the prioritisation of call backs and call back timeframes which are safe and in the best interests of the patient. Any proposals will need to be considered by Commissioners and finally agreed through NCL CG Group prior to implementation.

- **Assessment Outcomes**

On completion of the assessment the CDSS will indicate an outcome that will inform the most appropriate course of action based on the condition and symptoms described. The outcome or disposition will indicate the type of service e.g. self-care, ambulance, primary care, A&E etc. to meet the patient's needs and the timescale or urgency e.g. 1 hour, 2 hours, 6 hours, next working day etc. in which the patient should be seen / access the service.

The IT system should then interrogate the DoS to identify the local service best able to meet the patient's assessed needs and present a list of services to the Advisor / Clinician. The DoS returns will clearly indicate the agreed local referral protocols for each service and the message to relay to the patient regarding the referral e.g. NHS 111 to warm transfer to service, service will call patient back within an agreed timeframe, patient to contact service next working day etc. The aim is to maximise understanding within the receiving service and minimise the need for repetition by the Caller.

Referral protocols will indicate the agreed approach to local clinical assessment i.e. whether the local service accepts the type and timescale of the disposition or accepts the type and continues the assessment locally to agree the timescale and setting for any further patient contact (advice, appointment or visit). This will be clearly displayed in the DoS information presented to the Advisor / Clinician and provides local flexibility to allow the most appropriate integration and configuration of services.

In some instances referral will be by means of requesting the patient to make contact with / attend a service, e.g. A&E. In such cases the patient should be given information, e.g. location, phone number etc., to support this. Referral protocols will include the capability to book appointments with urgent care providers where the patient needs.

Service developments are likely to include enhanced methods of advising patients of appointments and information. Provider must consider options of using modern media channels for providing information to patients.

- **Enhanced Dispositions**

It has been proven that, if NHS Pathways is the chosen CDSS System, ambulance green end points and emergency department end points benefit from enhanced clinical review. Pilots have demonstrated that enhancement clinical assessment significantly reduces referrals from NHS 111 to 999. CCGs wish to send patients to the appropriate place of care.

Reducing unnecessary ambulance dispatches is significant for both the whole system and appropriate targeting of resources.

The principles are:

- All ambulance treatment and transport dispositions generated by health advisors will be referred to a clinician for clinical assessment before the ambulance is dispatched or the patient sent to ED;;
- Clinicians will then undertake further evaluation of the patient's condition
- The caller should NOT be told the ambulance is on the way or be given a time frame for the ambulance response;
- Assessment should be available 24 hours a day.

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- Local KPIs will set out the % of all eligible calls required to be sent for assessment.
- Every call managed through this process must be documented to provide an audit trail and enable a review of the effectiveness to be enhancement, information to include:
  - Date;
  - Time;
  - Adastra log number; and,
  - Final disposition.

National pilots have also identified potential benefit of clinical assessment of ED dispositions. Providers should consider this and other disposition codes that may benefit from enhanced assessment by a clinician or other HCPs that may be proposed in their operating model. Any proposals will need to be considered by Commissioners and finally agreed through NCL CG Group prior to implementation.

- **Discharge processes**

At the end of every call, regardless of the outcome, the Advisor or Clinician should be prompted by the CDSS to provide the Caller with specific advice about what to do if their symptoms worsen, and guidance on particular issues to look out for, which may indicate the development of a more serious condition. All calls must end with advice to call back if anything changes.

In alignment with the National Quality Requirements for delivery of OOH services the NHS 111 Provider must send details of all consultations (including appropriate clinical information) to the practice where the patient is registered by 08.00 the next working day. Where more than one organisation is involved in the provision of services, there must be clearly agreed responsibilities in respect of the transition of patient data. Wherever possible, the sharing of information with GPs regarding any contacts with NHS 111 is achieved by Data Transfer System (DTS) or Interoperable Tool Kit (ITK).

Specific Caller Groups

The following are specific caller groups for whom particular processes must be followed:

Unregistered Patients

Callers who are resident in NCL and are not registered with a GP should be advised, when appropriate, to register and provided with information to enable registration. Patients without a permanent address must also be provided for.

Repeat Callers

The Commissioning Standards require that where a patient (or their carer) calls the NHS 111 service 3 times in 4 days, the 3rd call should only be assessed by the Advisor to determine whether or not an ambulance is required. If the outcome is not to send an ambulance, then the call must result in a “Speak to GP within 1 hour” disposition and the GP must be alerted to the fact that this is the 3rd time in 4 days that the Caller has made contact with the NHS 111 service and they should therefore complete a thorough re-assessment of the patient’s needs. The GP should be sent details of all 3 calls.

The host software system will have to be able to identify where a caller has called twice before within four days, so that it can then flag this third call in such a way that when it is answered by the call adviser, the outcome described above is achieved

Provider is required to have agreements in place to enable them to feed and query the National Repeat Caller Database service that has been commissioned by NHS England for this purpose. Provider should include summary details of the number of records sent,

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number of queries performed and the number of successful returns to/from the national Repeat Caller Database in their monthly reporting.

Frequent Callers

None of the requirements for Repeat Callers above applies to that small minority of people who regularly make repeated calls to the same service, where the service will have made separate arrangements to respond appropriately to those calls, nor should it apply where there is an agreed care plan for the particular patient (e.g. long term conditions, palliative care etc.). The host software system will therefore also need to be able to identify these Callers so that the NHS 111 Service can respond appropriately to their needs.

Provider will be expected to liaise with the patient's registered GP Practice and other health and social care providers as is required to support the development of agreed responses to any identified frequent callers. The definition of this group is defined as a Caller who calls 8 or more times within a calendar month.

Mental health and other vulnerable callers

The Provider must be aware and work to the principles of the Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis (18 February 2014) and work with Commissioners and patient groups to ensure the most convenient and appropriate access to the NHS 111 service.

In accordance with the mental health concordant, Provider will work with local mental health services to ensure 111 intervenes early and identifies appropriate callers to refer to local mental health crisis centres open 24 hours a day. 111 must ensure call handlers manage patients in line with local mental crisis plans when they are available. These areas of work are being developed and therefore, Provider must work in partnership with mental health services in order to:

- Access mental crisis plans
- Agree referral protocols for mental health patients in crisis
- Complete end to end patient pathway reviews to ensure patient pathways continue to improve.
- Identify mental health callers for focused patient experience feedback on access for mental health patients.

Provision of health information to the public

The NHS 111 Service will be able to respond to two types of health information related calls:

- Caller may just want to know something about a health related topic (for example "my friend has been told she has shingles and I am expecting a baby, is it safe for me to visit her?")
- Calls where the Caller wishes to know about the provision of certain health services within their locality, for example, at the end of an assessment resulting in self-care, the caller may wish to know which pharmacies are open to enable them to access any over the counter remedies required

Using the CDSS and the DoS the second type of information should be seamlessly presented to the Advisor to inform the patient at the end of the clinical assessment (subject to suitable population of the DoS) without the need for another call or onward referral for that information.

Where the CDSS clearly identifies a call as a pure information request with no associated clinical symptoms, this should be provided.

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The Provider must state clearly how this health information service will be provided including:

- the operating model
- Any proposed prioritisation systems and criteria.
- Proposals for warm transfer or call backs
- Advice to patients

Health Care Professional Calls

The NCL CCGs' aim is that HCP calls will be managed by other providers during in hours periods. During out of hours periods, HCPs are again expected to use their own organisation's resources to manage clinical advice and if they are unable to do this, access for clinical advice should be made directly via the local GP OOH services.

It is reasonable to expect that HCPs will call 111 for advice on service locations and referral information held on the DoS and on occasions for clinical advice. Providers must demonstrate systems will be in place to manage these calls.

Self-care

Where the patient is identified as requiring home management advice to enable them to self-care, the Advisor will refer the Caller to Clinician via a Warm Transfer unless the CDSS provides for this advice to be given by the Advisor. Where an NHS 111 clinician is not available, a call-back should be made within a timeframe or set of timeframes, based on a local call prioritisation system agreed with the NCL 111 Clinical Governance Group.

The NHS 111 clinician (who must be a health professional) will be able to review and validate the assessment carried out by the advisor. Assuming the situation has not changed, and the NHS 111 clinician agrees with the outcome, the NHS 111 clinician will use the clinical assessment system to deliver evidence based care advice to enable the patient's symptoms to be managed at home.

For advisor calls, the call will be concluded with advice on what to do if symptoms get worse, advice on specific signs to look out for which may indicate deterioration and advice to call back if anything changes.

Clinical Decision Support System (CDSS)

The Provider must use approved clinical assessment tools/clinical content to assess the needs of Callers. Provider must ensure that they adhere to any licensing conditions that apply to using their system of choice. This must include the ability to link with the wider urgent and emergency care system.

The Provider must deploy any relevant CDSS upgrade/version, associated business changes, and training within any specified deployment windows for the chosen CDSS system(s), and support Commissioners in the testing of changes to Directory of Service profiling.

Appropriate Referrals

The CDSS will inform the urgency of clinical response and direct patients to appropriate services to meet their need.

Inevitably a proportion of assessments conducted using CDSS will arrive at a priority level which is later found to differ from the priority judged during the definitive clinical management of the patient. This can be both under and over prioritisation and as such can create clinical

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risk and unnecessary burdens on services.

Commissioners require the 111 provider to develop local mechanisms with key providers (i.e., A&E, GP OOH, Ambulance, Primary and Community services to ensure feedback and learning supports improvements in appropriate referrals.

The Commissioners have set some KPIs as a mechanism to ensure a focus on this important area however, Providers are required to demonstrate how they will approach and achieve this to improve service delivery and support future development of the CDSS and improvements in DoS.

Directory of Services (DoS) & Capacity Management

It is the DoS that will enable patients to be directed to appropriate local services and ensure that NHS 111 'fits' with each CCGs local clinical assessment approach.

Populating and updating the DoS with the skills and capacity within any given area enables the NHS 111 Service to have a clear view of the capacity within the system to provide the appropriate service for each patient. It also gives NHS 111 oversight of services available locally to the patient. It also enables services to register their capacity in real time, in the form of a red, amber and green indicator. This information can be used by NHS 111 to avoid sending patients to services with restricted capacity and direct them instead to services with more capacity.

The DoS is held centrally by HSCIC on a web server. This is a Commissioner owned database that will be available to the Provider. Data within the DoS is subject to robust governance and sign off by Commissioners to ensure that all parties agree that the listed services are commissioned services and that updates to the Red/Amber/Green status are a true reflection of capacity. North Central London CCGs have allocated resources to ensure there is robust management and oversight of the DoS in all areas and that the urgent care service offer for each CCG is accurately reflected in terms of the demographic data, the clinical profiling and the referral instructions.

The Provider will submit management information to Commissioners regarding the demand, usage and performance of services, to enable the commissioning of more effective and productive services that are tuned to meet patient needs. The Provider is also required to establish a process to provide feedback to Commissioners regarding potential DoS errors identified during service operation.

The DoS will contain details of all available services for the NHS 111 Service to refer into. It is the responsibility of the Commissioner working with providers of services to ensure that the DoS is continually updated so that Callers are referred to the appropriate service and that health professionals have access to the most accurate and up to date information relating to services via NHS 111 or via a web link.

The Provider is required to ensure there is a designated DoS lead within the organisation that fully understands the working of the DoS and has responsibility for:

- Liaison with Commissioner DoS lead
- Education and training of staff in the purpose and use of DoS
- Ensuring systems are in place to report errors, omissions or issues to Commissioner and that they are used.
- Produce reports required by the Commissioners

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- Monitoring and reporting DOS rejections
- Urgent amendments to DOS (under agreed arrangements with Commissioner DOS lead)

Data Transfer

All patient related correspondence must include a validated NHS number where this is available.

When a call is transferred electronically (e.g. to Ambulance, GP OOH providers or other Providers) relevant data, including patient details and assessment completed to date, must automatically transfer to the receiving organisation to inform their response and minimise the need for the patient to repeat information, other than to validate their identity / update regarding their condition.

Where systems are available, notes specific to the patient which are relevant to the case must also be transferred electronically together to other providers.

In accordance with the "Primary Medical (Out of Hours) Directions 2006", OOH services should have robust arrangements in place that give all the clinicians working for their service access to all the notes of earlier out-of-hours clinical consultations. This will also apply to the 111 Provider.

Referral to Other services

Specific requirements relating to onward referral of callers to a variety of services:

- **Referrals to Ambulance Services**

NHS 111 must be able to identify potentially life threatening problems and dispatch an ambulance without any delay or need for re-triage, and support the patient prior to the vehicle arriving.

Where a clinical assessment establishes that a patient requires referral to an ambulance service then this referral must be by electronic transfer of data into the dispatch queue of the relevant ambulance service's IT system with appropriate prioritisation of the call, to trigger dispatch of a vehicle to the recorded address within the required timeframe. The message will include the appropriate information required by the ambulance service to determine the case's priority as, for example, a 'Red' or 'Green' response. Where appropriate and directed by the CDSS the Advisor should provide appropriate first aid instructions and advice to support the Caller prior to the emergency vehicle arriving on scene.

This must include the capability to dispatch an ambulance from a provider other than the local ambulance provider – known as 'any to any' to 999 Providers – this will facilitate the rapid dispatch of an ambulance for callers from out of area.

Where clinically appropriate the Advisor taking the NHS 111 call must remain talking to the Caller until the further medical help arrives. Examples of the situations where this may be required are as follows:

- Cardio-pulmonary resuscitation instructions provided until further help arrives
- Drunken minor in a strange environment
- Suspected vulnerable adult
- Hysterical caller
- Child in house with a poorly adult
- Fire – person trapped

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- Choking patient
- Victim of serious crime
- Childbirth

This list is not exhaustive and Provider will be expected to have operational protocols in place, supported by training, that guide NHS 111 staff in determining whether or not they should stay on the line until an ambulance arrives.

Where the clinical assessment of a 111 caller indicates that the dispatch of an ambulance is appropriate, but the caller's location is unknown, the advisor should ask the caller to hang up and redial 999 themselves, thereby ensuring that their call reaches the right ambulance service that will have immediate access to their location information.

- **Referrals to GP OOH**

Referral to GP Out of Hours (OOH) services must include electronic transfer of data into an agreed queue within the relevant provider's IT system with appropriate prioritisation of the call (i.e. emergency, urgent, routine).

The mapping of 111 to Out of Hours Systems will be agreed with the Commissioners. The referral process will be clearly documented on the DoS and will state whether Provider has a local clinical assessment service in place and what handover message to give to the patient.

Providers are required to work with GP OOH providers to ensure, dependent on the local commissioned arrangements that mechanisms of reviewing operating models and appropriateness of referrals and booking are reviewed to enable continuous improvements in ensuring patients re referred to the right place, first time.

Booked patient appointments must be done in accordance with agreed booking protocols. In all cases the patient must be clear on what will happen next in their care and in what timescale.

- **Referrals to Dental Services**

In London NHSE Area Teams have confirmed their intention to continue to commission Dental Access Call Handling services separately to the NHS 111 Service. However the NHS 111 Service receives a considerable volume of calls from Callers assessed as having problems of a dental nature.

The NHS 111 Service will assess these calls using the same CDSS and where the outcome is determined as being of a dental nature, patients will be referred to the appropriate dental service as identified through the DoS. Where technically possible data will be transferred to the selected dental provider with the Caller advised of the outcome and timescale for contact from the dental service.

As stated previously in this document 111 Providers will be required to work with pan London developments related to callers with urgent dental problems.

- **Referrals to other services**

Referral to all other providers should be encouraged to include electronic transfer of data with appropriate prioritisation information as part of the agreed referral protocol to ensure callers do not have to repeat themselves other than to validate who they are / any symptom changes. Where a patient is identified as needing to attend another service, the Advisor may have the ability to book an appointment directly where this is technically possible and has been agreed by the local commissioners.

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Patients referred to their own GP Practice should be advised to contact their GP directly. Patients will also be advised that if their GP is unavailable within the suggested timeframes, they should call NHS 111 again in order that NHS 111 can identify an alternative service to meet their needs. In this event it will be expected that Provider is able to access the recent call information and reconfirm the patient's condition rather than carry out a full clinical assessment. A referral will then be made to an appropriate alternative service and lack of access will be documented to share with Commissioners in the monthly report.

In areas where agreement for direct referral to other services (acute, community, mental health, sexual health, social care etc.) have been established it will be possible for the Advisor answering the NHS 111 call to direct Callers to services via the DoS. The DoS will contain details about the referral process for each service and where possible the NHS 111 assessment information will be sent to the selected service electronically. In all cases the patient must be clear about which service they are being referred to, what the next steps in their care pathway are and in what timescale their next contact will be. Where patients are expected to attend / contact the service they are being referred to Provider will provide contact details to the patient.

Direct Booking

Where system interoperability allows and when local commissioners request it, NHS 111 must be able to directly book patients an appointment at the service that can best deal with their problem, that is as close to their location as possible.

By offering a booked appointment the NHS 111 Service is better positioned to be able to guide the patient to the right point of access, this reduces the risk to the patient and unnecessary costs to the service associated with multiple interactions.

This appointment could include, for example, a booked call back from a GP, a pharmacist review at a local pharmacy, an appointment at an urgent care centre, an appointment with GPOOH or a home visit,

NCL Commissioners will consider with local stakeholders the options for direct booking with a patient's own GP practice.

Where a referral is not made through a direct appointment, detailed arrangements for the referral process must be put in place and agreed by the NHS 111 clinical governance lead. The full referral process must be visible to the NHS 111 Service, including failsafe mechanisms.

Direct appointment booking functionality is currently available for some urgent care services, primarily GP Out of Hours providers. The aim of the Commissioners is to improve accuracy and appropriateness of referrals and increase the range of services in which appointments can be booked and assessment data directly transferred. This will enable better patient experience, improve the efficient use of NHS resources and reduce unnecessary delays and waste.

Provider for the NHS 111 Service will be expected to support this approach through a capability to identify ways of improving appropriate referrals and link to other providers' data systems to facilitate further developments of direct bookings.

HCP Call Handling Process

The Provider must outline the call handling process for health care professionals within the service. The Provider will be expected to provide details of their service model and must report actual performance against NQR call handling standards on a monthly basis.

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Health care professionals e.g. GPs, Community Nurses etc. may dial directly into the OOH service in order to gain access to services for their patients. The Provider will establish systems to appropriately manage calls from health care professionals with regards to the level of assessment required to determine the appropriate service for their patient, and appropriate level of urgency. These systems will ensure appropriate details are available for the receiving service without unnecessary delay in the referral process.

Demographics

When a patient attends, has a home visit or OOH receives a call from an HCP, a baseline set of demographic data must be captured if the patient/HCP is willing to provide the information, including the name and date of birth of the patient, phone number and home / current address.

Patient records should be matched to the Patient Demographic Service (PDS) to verify the NHS Number. The NHS Number should be used as the primary patient identifier when transferring data between providers. It is the responsibility of the Commissioner to ensure pathways are developed and implemented which supports the single triage prior to a face-to-face assessment or treatment of the patient. This requires the development of the urgent care system to ensure patients are treated in the most appropriate location.

Clinical Triage and Assessment

All patients passed to the OOH for a clinical triage or assessment from a HCP including NHS 111 must undergo a clinical assessment.

The Advising Clinician or staff member must first determine whether the visit or call is in relation to a symptomatic or non-symptomatic call or visit (e.g. health information, appointment booking, service location etc.). If the Advisor determines the call or visit is a symptomatic call then immediately life-threatening symptoms must first be assessed.

All questions asked and answers given must be recorded within the Provider's IT system and must be capable of extraction for reporting and review purposes. The reason for the visit or call, nature of any injury or illness and the outcome of the assessment must be recorded and be clearly identifiable for reporting and review purposes. The outcome should include the recommendation of both the level of care required and the timescale in which the patient needs to be seen.

This process will form a full audit trail which (when coupled with the call recording when HCPs call) enables a full reconstruction of the data captured during the conversation with the Caller.

The clinical assessment seeks to identify the precise clinical skills and/or facilities required for the patient and the time frame in which they must be accessed.

Once the minimum demographic data is captured, the Clinician should proceed with a clinical assessment following the Provider's agreed and defined format

OOH Referrals to other services

Referrals made to other services should be encouraged to include electronic transfer of data with appropriate prioritisation information as part of the agreed referral protocol to ensure patients do not have to repeat themselves other than to validate who they are / any symptom changes.

In areas where agreement for direct referral to other services (acute, community, mental health, sexual health, social care, own GP, etc.), the Provider's electronic system will contain details about the referral process for each service and where possible the OOH assessment

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information will be sent to the selected service electronically. In all cases, the patient must be clear about which service they are being referred to, what the next steps in their care pathway are and in what timescale their next contact will be. Where patients are expected to attend / contact the service they are being referred to, the Provider will provide contact details directly to the patient.

Direct Booking (onward booking) from OOH

Where system interoperability allows and when agreed by local commissioners, OOH must be able to directly book patients with other services where available.

Where a referral is not made through a direct appointment, detailed arrangements for the referral process must be put in place and agreed by the OOH clinical governance lead. The full referral process must be visible to Commissioners, including failsafe mechanisms.

Access to records

Advisors and Clinicians within the service must have access to relevant aspects of patients' medical and care information, where the patient has consented to this being available. Provider must have systems in place that enable access to the information contained within any GP practice system, SPNs or similar records held by other providers where these systems are available. These systems must comply with appropriate Information Governance protocols and Caldicott 2 directions.

This must include knowledge about patient's contact history and medical problems; so that the service can help patients make the best decisions. Patients with special notes or a specific care plan including End of Life must be treated according to that plan and, where patients have specific needs they must be transferred to the appropriate professional or specialist service.

Provider should have in place systems and processes to collect, store and record notes that will assist with identifying appropriate referral recommendations for individual patients e.g. end of life patients, patients with long term conditions, patients on a community care plan, patients with an agreed emergency care plan etc. The notes should be accessible to all appropriate Service staff and data sharing arrangements should be in place (both in terms of data collection and sharing with the various providers). The SPNs should be shared with Provider to whom the call is being passed to where clinically appropriate to do so.

Access to important patient information through the existing Summary Care Record (SCR) service must be the minimum standard. Providers must support the development of wider sharing of records across the healthcare system.

Provider will be required to work with CCGs who will work with NHSE London on the Pan London pilots covering resilience and access to records.

The Provider must be compliance to level 2 for the Information Governance Statement of Complaint (IGSoC) toolkit or above to enable record sharing with other IGSoC compliant organisations without the need for a data/record sharing agreement

Post Event Messages (PEM)

Provider will have the capability to send two types of PEM:

- Primary PEM - the message sent to Provider that the patient is being referred to which contains details of the assessment for Provider to use in their continuing assessment and treatment of the patient
- Copy PEM – a message sent to the patient's registered GP practice containing

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summary information relating to the contact with the NHS 111 service

The purpose of PEM is to inform the receiving provider / patient's registered GP practice about the patient contact, the reason for contacting the service and the outcome of the assessment. The PEM must be formatted in such a way as to make this information quickly and clearly discernible. The PEM should be concise and contain only the information necessary for the recipient to review and to support the aim of patients not having to repeat information (other than to verify / validate who they are). The precise content and format of the PEM is to be agreed through the NCL Clinical Lead(s) and the Clinical Quality Assurance Committees during the mobilisation phase.

In alignment with the National Quality Requirements for delivery of OOH services to, Provider must send details of all consultations (including appropriate clinical information) to the GP practice where the patient is registered by 08.00 the next working day, unless the patient requests otherwise (and this must be documented). This will generally be via copy PEM.

There are a number of agreed exceptions regarding copy PEM which are listed in the NHS 111 IM&T Readiness Guide, and for these outcomes a copy PEM is not sent to the patient's registered GP Practice.

Where more than one organisation is involved in the provision of services, there must be clearly agreed responsibilities in respect of the transmission of patient data. Provider's IT system must also be capable of suppressing copy PEM for calls referred to providers who send a post-event message of their own following definitive management, for example GP OOHs providers. As more services develop the ability to send post-event messages and can demonstrate ability to comply with the transmission standards and timescales, copy PEM suppression may be extended and Provider's IT system must be able to support this.

Wherever possible, the sharing of information (copy PEM) with GPs regarding any contacts with NHS 111 should be achieved by electronic data transfer (ITK or email). Faxed reports should only be used in exceptional circumstances and Provider must have agreed protocols that comply with Information Governance requirements, in place for these situations that minimise the risk of misdirected or lost data.

Wherever possible, the sharing of information with GPs regarding any contacts with OOH should be achieved by electronic data transfer. Faxed reports should only be used in exceptional circumstances and the Provider must have agreed protocols that comply with Information Governance requirements, in place for these situations that minimise the risk of misdirected or lost data.

Medicines Management

Provider must be compliant with all current standards, guidelines and legislation relating to the prescribing, dispensing, storage and administration of medicines applicable to Provider for example:

- Delivering the Out of Hours Review: Securing Proper Access to Medicines in the Out of Hours Period; A Practical Guide for PCTs and Organised Providers (includes National Drug Formulary):
- The Safe and Secure Handling of Medicines: A Team Approach, Royal Pharmaceutical Society Great Britain, 2005
- Safer Management of Controlled Drugs: Guidance

See Appendix 2 for Medicines Management requirements.

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Transport

When required and appropriate, transport will be organised and provided by the Provider. The transport should be appropriate for the purpose i.e. transport for health professional to visit the patient at home, delivery of medicines as a consequence of telephone consultation and in exceptional circumstances, transporting patients to the Provider's premises. Assistance for patients must be available (including a vehicle suitable for the transportation of individuals in wheelchairs as necessary).

Although it is expected that transport will be infrequently required for patients it may save time to arrange transport to bring them to the designated treatment centre. Transport for patients should only be ordered subject to all of the following criteria being fulfilled:

- Requires urgent clinical assessment, and;
  - Genuinely has no access to transport or if a taxi/public transport is used would require reimbursement and
  - Is medically fit to travel

Access to the Integrated NHS 111 and GP OOH Service

Callers must, as a minimum, be able to call NHS 111 free of charge from any landline, mobile, internet phone or phone box 24 hours per day.

Callers will be routed to the NHS 111 Service based on the routing area from which they are calling. This applies whether callers use a mobile phone or a landline to access the service. Calls will be received by the Department of Health telephony system (CUCM11), identified and tagged as being from a NCL routing area and then passed to Provider telephony system for distribution to the NHS 111 Service call centre(s).

All front end messages used by Provider must be agreed with the Commissioner prior to recording or with an on call director if urgency dictates

Patients will only access the OOH service via NHS 111 or walk into a PCC directly. Patients, their parents, guardians or carers cannot directly access the service by telephone during hours of operation (see exclusions). Patients will be directed to the Out of Hours service via NHS 111. Healthcare professionals will access the service during hours of operation from a Provider supplied dedicated line.

Days and Hours of Operation

NHS 111 will be provided 24 hours per day inclusive of bank or public holidays, (365 days a year and 366 days in each leap year).

GPOOH will be provided X hours a day, 6.00pm to 8.00am Monday to Friday and 24 hours per day Saturday and Sunday inclusive of bank or public holidays, (365 days a year and 366 days in each leap year).

Population covered

The provider will treat registred and registered patients from Barnet, Camden, Enfield, Haringey and Islington CCGs.

Exclusion Criteria and Thresholds

The North Central London CCGs' NHS 111 Service is not being commissioned to provide the following functions within this specification:

- Call handling for GP Practices for core hours closure e.g. lunch hour, half day

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closure and training events.
- Call handling services for Health, Social or third party callers
- Calls from Health Care Professional for clinical advice. These calls should be directed through their own organisations in hours and to GP Out of Hours services during out of hours periods. Exceptions may occur.
- Business continuity arrangements / cover for local providers', e.g. GP Practices. This could be commissioned separately at a later stage by provider organisations / commissioners.
- Provision of urgent repeat prescriptions. Patients calling requesting a repeat prescription will be referred to the most appropriate local service to manage their enquiry. However, NHS 111 Providers will be expected to work with NCL CCGs and NHSE London on developing and enhancing the Pan London PURM pilot in accordance with the specification in Appendix 3.
- Provision of dental access helplines / dental call handling. NHS England Area Team Commissioning leads have confirmed that they will continue to commission separate dental access helplines / call handling services for their populations. NHS 111 does receive a volume of calls from patients with problems of a dental nature.

The OOH Service is **not being commissioned to provide the following** functions within this specification:

- Business continuity arrangements / cover for local providers', e.g. GP Practice Deputizing Service (including call handling for GP Practices for core hours closure e.g. lunch hour, half day closure etc.)
- OOH visits to prisons, patients being held by police or social services visits
- Calls made directly to the OOH service from patients, social care services, rest homes or nursing homes (unless the call is made by a Health Care Professional).
- Provision of services for or at emergency rest centres
- Provision of services for or at volunteer organisations
- The updating or maintenance of SPN or similar for GP or other organisations

Interdependencies

The Integrated NHS 111 and GP OOH service will have key relationships with a wide range of service providers and other stakeholders across the North Central London CCGs in addition to the Commissioning CCGs. These include, but are not limited to:

- Ambulance Services
- Accident and Emergency Departments
- Hospital Trusts including Foundation Trusts
- Urgent Care Centres
- Minor Injuries Units
- Walk in Centres
- GP practices
- Community nursing teams and other community based services
- Hospices and Specialist on call teams
- Community pharmacies
- Dentists and Emergency Dental Services
- Opticians and Optometrists
- Social care – including Emergency Duty Teams and Safeguarding
- Voluntary sector services
- Other services held within DoS
- Out of area providers, e.g. OOHs, A&E, GP Practices etc.
- DoS maintenance teams, e.g. at CCGs or CSUs
- Urgent Care Groups and Networks / System Resilience Groups

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- Police
- GP Provider Federations

To make this happen, the Provider must develop service protocols and underpin technical functionality that will enable greater integration with all other elements of the urgent and emergency care system. This includes ambulance services, primary care (in hours and out of hours), urgent care centres, emergency departments and both community and hospital based services. This will include non-identifiable patient data sharing in order to improve the end to end patient pathway and continually ensure that patients are being directed to the correct service.

Location of Service Delivery

- **Call Centres**

The commissioners require the call centre(s) to be located in England and that data is not processed outside of England. Provider should determine the quantity and location of sites for delivery of the service.

The CCGs will require solutions which involve multiple sites to demonstrate both the resilience offered by these arrangements and the protection offered to the local NCL services in the event of unexpected demand or events. The CCGs will require 90% of NCL Calls to go to a dedicated centre or resource group and Providers will need to propose how this will be achieved, together with the maintenance of KPIs.

The 111 call centre premises should meet statutory requirements and follow best practice guidance and must be fit for purpose meet National Building Requirements and provide appropriate space to deal with the call volume and growth of the contract over the term of the contract. This may require the use of multiple call centres.

The tenancy arrangements including signed leases will need to be put in place ahead of contract commencement.

- **Locations other than call centres**

All call handlers are required to work from call centres with clinical and management supervision and support.

If Providers proposals include any call handling in premises other than call nominated centres they must detail how this will operate and under what circumstances.

- **General**

North Central London CCGs reserves the right to inspect the NHS 111 service's premises, records or policies at any time

GP OOH Base locations:
Barnet
Camden
Enfield
Haringey
Islington

- **CCTV**

Commissioners are not stipulating that CCTV be used but if the Provider does choose to use it the following applies. When using closed circuit television ("CCTV") equipment and

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handling CCTV footage, the Provider must:

- comply with any request by Commissioner for the release of CCTV footage in a universal format and must ensure the CCTV footage is provided to Commissioner within a reasonable time after the request;
- comply with access request by Commissioner in case of any incident(s);
- perform a risk assessment at each location to determine whether CCTV is appropriate;
- ensure that at all times the CCTV equipment is operated and the CCTV footage is handled in strict compliance with current legislation;
- ensure that images on the CCTV footage are viewed only when strictly necessary by persons authorised by the Provider and such authorised persons must hold a current and approved fully enhanced DBS check; and,
- ensure that the CCTV footage remains available for the duration of the investigation, if requested.

Business Continuity

The ProviderThe will have systems and arrangements in place so that in the event of fluctuations in demand, technical failure or staff shortages they can invoke this contingency and continue to provide an acceptable level of service to the population. In this context 'acceptable' means continued achievement of the agreed Key Performance Indicators. These arrangements must link into any NCL and London escalation and business continuity plans.

The Provider is required to have business continuity and contingency arrangements for use when there is an unexpected problem not related to local surges of demand (which remain the Provider's responsibility to manage and ensure continuity of service). For the purpose of clarity this refers to unforeseeable circumstances that affect the provision of the service. Generally, any such arrangements are used when there is a catastrophic loss of service due to for example, a major technical issue, loss of power or loss of premises. In these situations, the Provider could have a mutual aid arrangement with another Provider which allows services to be diverted until the problem is resolved.

Provider will have a responsibility to support disaster recovery in the event of a "force majeure" situation. Subject to agreement with Commissioners through the appropriate escalation process via NHS England, Public Health England (PHE) or a multiagency gold command structure, all Commissioners and providers will take responsibilities in accordance with agreed escalation in order to maintain patient safety and neither funding nor performance penalties would be applied.

NHS England has also put in place an arrangement where calls may be diverted from an individual provider and streamed proportionally to all other NHS 111 providers. This is the NHS 111 National Business Continuity and Escalation Policy. It will only be invoked in an emergency situation where local resilience arrangements are not adequate or have failed. Any questions regarding NHS 111 contingency arrangements should be directed to **[NHSE Email]**

Provider must be fully conversant with CCG and/or NHS North Central London emergency planning arrangements for major incidents and emergencies and to participate and respond as necessary and appropriate. In addition, Provider will be expected to appropriately liaise with and assist other local providers with capacity management issues as part of the area escalation procedure.

In addition NHSE London are investigating options for a London wide resilience model and

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the Provider will be required to engage and work with CCGs on this project. Awaiting Appendix from NHSE

Response in a Major Incident

NHS 111 and GP OOH has a number of possible roles in response to a major incident. The Provider must be engaged in planning and preparedness for these roles and must take part in the response if required to do so by NHS England, Public Health England (PHE) or a multiagency gold command structure.

In certain major incident situations, such as a major chemical explosion, individuals may contact NHS 111 with concerns or symptoms. Provider will have mechanisms to identify this type of situation and will link with the appropriate commissioner and provider organisations to ensure appropriate business and service continuity arrangements are put into action.

Provider must have mechanisms in place to be informed of a major incident by the NHS and other agencies and to give out the appropriate public health advice as directed by the PHE or the gold command arrangements which may be in place.

If a major outbreak of a serious infectious disease occurs then Provider will be an essential component of the response and may experience very high levels of demand. It is likely that Provider will be part of the NHS command arrangements and will be expected to respond as directed by NHS England.

Therefore, Provider must have:

- Staff trained to respond to a major incident at strategic level
- Major incident plans in place
- A programme of exercising and testing plans
- A plan for implementation of changes to systems to immediately meet the needs of the incident

Provider must include, as part of its Major Incident Plan and Business Continuity Plan, mechanisms, procedures and policies in place on how they will identify any external forces that may affect services and how they plan to handle the matter. These external forces may include, but are not limited to, ambulance service strikes, acute hospital declarations of "black" status, resilience groups deciding issues that may affect service and other issues.

Any notification made to Provider must immediately be notified to the Commissioners within 24 hours along with the plan to tackle these issues.

Intelligent Commissioning

Given that urgent care is provided in so many diverse locations, often as drop-in services ranging from pharmacies to A&E departments, there is poor information about the use of services in general or indeed individual patient journeys which can often encompass a range of different services including some potentially unnecessary steps.

The Integrated NHS 111 and GP OOH serviceservice provides a means of gathering intelligence about urgent care demand and how this maps onto patterns of service use. This can then be used to inform more effective and sensitive commissioning of urgent care, which could, for example, identify the need for different services, locations and opening times. It also helps ensure that Callers are accurately signposted to the most clinically appropriate and cost-effective care options consistently and on a 24/7 basis.

The Provider will provide Commissioners with information about patientspatients, patient

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conditions, assessed outcomes, services referred to and other information as may be requested to support the development of urgent care services across various geographic footprints. Provider will be required to provide the information available in any data download to support this requirement.

Improved patient experience

There is already a large and growing body of feedback from users of the OOH Service to date that this approach offers them a much improved experience, with improved responsiveness, certainty and choice.

It is expected the OOH Service will contribute towards providing information regarding the patient's journey, developing case studies regarding patient experience and patient surveys to ensure patients have been provided with appropriate treatment where recommended. This information will support the future development of the OOH Service. The Provider will be expected to gather appropriate patient experience information and feedback and provide this to Commissioners when requested.

Communication and engagement

Authorised Officers and contact points must be identified in the contract for Commissioners, Provider and at major acute, community, other healthcare sites and the NHS 111 service.

Provider's staff must have a proactive, friendly, solution-focused style of communication. A key principle is to have high-quality communication to discuss flexible and innovative approaches.

Provider must ensure the Commissioners are made aware of any actions that could impact on service delivery or publicity.

Commissioners will ensure Provider is made aware of any actions that could impact on service delivery or publicity.

Provider and Commissioners must jointly establish a proactive communications/customer relations strategy which will embrace latest forms of communication and media use.

Staff and Patient Feedback and Surveys

The views of staff, patients and the public and feedback of patient experience are key to successful delivery of the NHS 111 Services and Commissioners are keen to ensure there are transparent and robust processes to engage, capture, and respond to this feedback and demonstrate actions taken as a result.
Provider will be required enable staff feedback on a continuous basis.
An annual Survey of all staff engaged in taking NCL calls will be required and reported to the NCL CCGs.

Patients and Carers

In addition to mandated surveys the NHS 111 Commissioners will require Providers to develop a joint patient communications and engagement strategy.

Providers will be expected to include:

- Feedback on the experience of the existing service from service users and carers
- Collaborative working with patient populations across NCL

The NHS 111 provider will have a systematic process in place to regularly seek out, listen to

and act on patient feedback on their experience of using the service, ensuring that they deliver a patient centred service.

Provider should be committed to working with the commissioner to engage with patients and carers to test and evaluate the service, not just to capture the experience of patients, but to generate patient aspirations for the service.

Training and education

The provider will operate approved continuing professional training and education for all staff and will be responsible for meeting all statutory and NHS human resources legislation and guidance.

The provider will maintain a record of the dates and training given to all staff working within the service and ensure that training requirements and competencies are monitored through regular assessment and staff appraisal and that staff are enable to progress through supported learning. All such records should be immediately available to the CCGs on request for audit purposes.

Provider will be responsible for, and is required to demonstrate their ability to, recruit, train and manage an effective workforce, including any subcontract and agency arrangements, within a comprehensive workforce plan to meet the changing developments within the service operating models and must demonstrate effective plans to manage sickness levels, retain and develop skilled staff to meet the requirements of this specification.

The following core requirements will apply:

- All staff involved in the delivery of the NHS 111 Service must be able to communicate clearly and effectively with the local population over the telephone. Recruitment of staff should include an assessment of English within the scope of the service as defined in this Specification
- All staff must be trained to an appropriate level in recognising and dealing with vulnerable adults and children and adhere to any and all aspects of mandatory Safeguarding requirements - Provider must have in place approved Safeguarding policies which comply with statutory requirements and work in partnership with other agencies
- All clinical staff must be registered with the appropriate healthcare professional regulatory body
- All clinical staff working in NHS 111 must be trained in line with the CDSS used in the operational service
- Supervisory and clinical staff must be available in line with any CDSS license. The procedures for seeking clinical advice and the handover protocols from Advisor to Clinician must be simple and clear with voice recording of all interactions. This will include the requirement for voice recording of any interactions provided by non pathways trained clinicians
- Providers are expected to demonstrate that staff have been assessed against a set of core competencies relevant to the roles they undertake

All staff involved in the delivery of the NHS 111 Service must undertake training where appropriate that covers the following:

- General NHS 111 principles, culture and values
- Telephony and call management skills
- Delivering excellent customer service including communication , empathy and

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listening skills
- How to interact with urgent care services
- Other corporate processes and principles
- Use of the CDSS and clinical assessment training to ensure compliance with the licence requirements
- Use of the Directory of Services
- Accessing patient records (i.e. SPNs, SCR, CMC, EOL including DNR and other shared records)
- Safeguarding, as described above
- Induction and Regular education and training to enhance their understanding of commissioned services at local level. Correct and sufficient understanding of local services will enable referrals to the right local service first time

Provider will also:

- Perform regular audit of advisors to ensure compliance with the clinical decision support system and appropriate support from clinical supervisors
- Perform regular audit of non pathways trained clinicians operating within the 111 service
- Ensure that any front line staff provided by material sub-contractors and or partners adhere to the requirements of the Specification and/or contract terms when acting as agent and/or provider on behalf of Provider
- Create a Programme whereby staff from other providers are able to attend the call centres to receive briefings on the role and function of 111 and the opportunity to experience the service operation in a live environment. This will form part of an initial plan to enhance integrated working and understanding

Workforce and employment practice information is provided as a supporting document, which must be complied with (see Appendix 4).

Service development & changes

NCL Commissioners will require Providers to work with the local systems and stakeholders to create improvements in service, embed evidenced based national and local learning into local service provision and plan for changes in strategy, technology and demand, to achieve the aims set out in this specification

In order to achieve this, Provider will need to demonstrate how fundamental principles set out below are reflected in their organisational structure and culture.

- Partnership and Integrated Approaches
- Innovative and developmental
- Listening
- Flexible
- Responsive
- Resilient
- Excellent Clinical Governance & Assurance processes
- Robust Policies and Procedures
- Open and Transparent
- Focus on Patient Pathways and outcome
- Delivering value for money

National Learning and Development Pilots

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The Commissioners will work closely with Providers to ensure learning and development from the National pilots is reviewed and opportunities for service improvements are regularly considered. Some key findings from Phase 1 are listed below and this learning has, in some cases, resulted in operational changes with the impact of others being considered:

- Marketing requires careful and co-ordinated planning to be effective
- Additional clinical assessment of "Green Calls" reduces green ambulance referrals by 70%
- GPs can add value but not costed
- Access and sharing of records improves outcomes
- Further understanding of OOH and Community outcomes needed
- Dental and Repeat Prescription cases present challenges for the 111 system
- Phase 2 National Learning to come – Digital, MH, Biometrics etc.

Technological Advances/Changes

Providers will be expected to ensure they are monitoring and developing innovative uses of technical advances and change to continuously improve access and the range of services that could be offered through a 111 service

Marketing

Each CCG will assist with communication, any advertising material bearing the NHS logo, material pertaining to the CCGs should only be used with the expressed written permission of said CCG(s).

Scope for additional services over 24/7

Provider will be expected to be innovative and flexible in their approach to opportunities for additional services to be provided in the future.

Quality assurance

Clinical Governance

Clinical governance arrangements must be in place to ensure the clinical safety of the whole patient pathway, not just the OOHOOH Service. Strong relationships and partnership working should be established between all providers involved in the pathway so that issues can be identified and service improvements made.

Clinical governance must also establish the levels of understanding and trust between the many different providers who meet patients' urgent and emergency care needs that underpin the delivery of high quality, 24/7 integrated urgent and emergency care.

Clinical governance arrangements will include:

- A robust CCGs clinical governance arrangementarrangement, under strong clinical leadership and with clear lines of accountability through the CCGs;
- Clarity about lines of accountability within the OOH/111 Service, from the Senior Responsible OfficersOfficers through to individual members of staff within theService and any partner provider organisations, and about the manner in which the clinical governance of the OOH/111 Service engageengage with and supportsupport the governance arrangements in other provider organisations
- A robust policy setting out the way in which adverse and serious incidents will be identified and managed, ensuring that the clinical leadership of the OOHOOH

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Service plays an appropriate role in understanding, managing and learning from these events, even where they have originated in a partner provider organisation
- Detailed knowledge of the different stages in the patient's journey through the OOH/111 Services111, including an understanding of the way in which potential shortcomings at any stage in that journey will be identified
- Clear and well-publicised routes for both patients and health professionals to feed back their experience of the Service, ensuring prompt and appropriate response to that feedback with shared learning between organisations, including feedback to the individual who was the source of the comment in the first place
- An annual audit plan in place agreed with Commissioners and including, but not limited to, CMC, NICE
- Regular feedback of patient and staff experience (using a range of qualitative and quantitative methods) to provide additional insight into the quality of the OOH Service
- Assurance by the OOHOOH clinical leadership that thethe quality of clinical staffing, support and supervision is in place and proactively managed and evidenced within the monthly clinical governance reports to Commissioners
- Regular review by clinical leadership of the quality of calls, patient attendances and home visitsvisits, especially where their outcomes have proved problematic, with involvement of other providers through the CCG and Local Clinical Leads as may be applicable. This will include end to end case reviews and audits.
- Audits (1%) of all clinical records
- Ensuring that regular staff training, and refreshing where required on updated policies and procedures, to ensure that the quality of service is in place and proactively managed and evidenced within the reporting suite
- Provision of accurate, appropriate, clinically relevant and timely data about the OOHOOH Service to ensure that it is meeting the quality standards set out in this Specification
- Ensure the wider links to the urgent and emergency care system are prioritised, transparent and robust.

Governance arrangements

There are strong individual CCG clinical governance arrangements which will continue until revised NCL arrangements are developed. Joint arrangements are being considered and will be finalised following award of both NHS 111 and OOH contracts.

There is agreement in principle to a Joint Clinical Governance arrangement which will be finalised following the award of the contract which will inform the best arrangements to ensure robust clinical governance across 111 and OOH services and also across the wider Urgent and Emergency Care system. It will oversee delivery and performance of all clinical and quality aspects of the CCGs NHS 111 and 111/OOH service.

The clinical and corporate governance arrangements will remain in place and be continually reviewed to ensure that they take into account any changes in the Commissioning Standards, improvements identified as a consequence of both the internal and external clinical governance processes that identify any potential gaps or opportunities to incorporate learning and/or best practice.

Provider will be required to work with the Commissioner's clinical governance groups and key stakeholders to deliver and improve the OOH service and patient experience. This will include review of the patient journey and appropriateness of referrals through end to end call reviews, case reviews and audits.

Provider will be required to report to, in an agreed format, and attend these meeting which

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are expected to take place on a monthly basis and will incorporate end to end call reviews

Local CCG 111 Clinical Leads

Each CCG will have a nominated OOH Clinical lead who will be the local point of contact for the Provider.

Links to Urgent Care Boards and System Resilience Groups

This will require Provider to work across the health economies of the North Central London CCGs linking to local Groups and Boards as agreed with Commissioners. It will be the responsibility of Commissioners to link into Pan London Groups and Boards.

Provider Clinical Governance

The Provider must establish a robust internal clinical governance structure with an identified senior clinical lead. The clinical lead is responsible for assuring the clinical quality of the service provided through a suite of robust policies and procedures. The policies and procedures (and any subsequent amendments to them) must be submitted to the CCGs Clinical Group for review and approval. A range of metrics will be agreed to monitor service quality and these must be reported to commissioners in a formally at agreed intervals.

The Provider is responsible for the establishment and on-going management of a robust and responsive feedback process which will be agreed by the NCL Clinical Governance Group, to which patients, the public, health professionals and staff within the service can raise matters for review and investigation. The feedback process must respond to each item of feedback in a timely manner to the person who initially raised the feedback and the relevant CCG Clinical Lead. More series matters should also be copied to the CCG and/or NCL Clinical Lead.

All Serious Incidents (SIs) must be notified to the CCG Clinical Lead and Commissioner no later than the next working day after they incident occurred. Provider must report SIs via Serious Incident Management System (formerly STEIS) when it is appropriate to do so, and report according to STEIS processes in line with the NHS England Serious Incident Framework (March 2013).

Provider must establish processes to regularly review and audit the clinical quality of calls and consultants within the OOH service.

Provider will be an integral partner within the clinical governance structures and will actively participate in both NCL and CCG level meetings, providing information and consistent appropriate representation to each meeting.

Complaints

The Provider shall establish and operate a robust complaints procedure in line with CCG agreed guidelines to deal with any complaints in relation to any matter connected with the provision of services under the Contract. This will include informing and involving CCG Clinical Leads at the earliest possible stage and obtaining sign off of responses before sent to Complainants.

It is recognised that some complaint or dissatisfaction may be raised informally. It is the expectation of commissioners that the Provider will establish a system for dealing with these complaints and engage with other providers and patient groups in improving processes and pathway.

All complaints should be monitored, audited and appropriate action taken when required. The Provider shall take reasonable steps to ensure that patients are aware of the complaints procedure.

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The Provider shall take reasonable steps to ensure that the complaints procedure is accessible to all patients, including those with specific issues such as hearing impairment, non-English first languages, visual impairment, learning disabilities and other access issues.

The Provider shall provide a summary of all complaints and recommendations received, progress outcome and actions taken monthly to Commissioner.

The Provider shall ensure that:

1. Compliance with complaints regulations are met
2. Their Complaints Policy is explicit as to Duty of Candour in respect of complaints handling
3. 100% complaints are acknowledged within 2 working days
4. OOH85% Complaints responded to in 25 working days. The response must include an action plan (monthly complaints audit results to detail compliance).
5. Monthly reports include:
    - Number of complaints
    - Complaints rates and timeliness of responses
    - Trend analysis of complaints broken down by operational department and division and theme. The report should contain actions implemented as a result and lessons shared
    - Number of complaints reopened
    - Number of complaints sent to the Health Service Ombudsman and outcome
    - Complainant survey results, detailing 100% complainants surveyed, response rate and survey results

Serious Incidents

Provider will be required to lead Serious Incident investigations where appropriate and must comply with local and Pan London policies

1. Provider reports Serious Incidents including Never Events reported in accordance with National Guidance:
2. Provider ensures Serious Incidents are reported on Serious Incident Management System (formerly known as STEIS) within 2 working days
3. Provider Agrees grading with Commissioner as per guidance within 3 working days
4. Provider completes report and shares initial findings with the patient / family
5. Provider submits report to commissioner for quality assurance review within 45 / 60 days dependant on grade (100% must be completed in time frame)
6. Commissioner will agree that the report is robust and suitable for closure or Commissioner may require the provider to make changes to the investigation report or action plan before closure
7. Provider shares the altered report with patient / family within 10 days
8. Provider provides reports to provide assurance to demonstrate 95% completion of actions within timeframes agreed on the action plan.

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Mobilisation

The safe implementation of OOH services is of paramount importance and bidders must demonstrate through robust planning how they will deliver an operational system for go live date. Commissioners, as part of the lessons learned, will expect the mobilisation of the service to be phased ensuring a seamless transfer from the current provider(s) to the successful Provider, if different. Detailed mobilisation plans will be required and subject to Commissioner and/or any appropriate third party external review at all stages prior to the go live date for service commencement.

The CCGS will lead a mobilisation delivery group that will oversee and monitor mobilisation to enable full assurance and lessons learned. The CCGs will need full access to mobilisation plans and operational delivery access to enable completion of the assurance framework. The CCGs require the chosen provider to support, adhere and deliver the NHS England gateway assurance process as specified in the assurance and mobilisation toolkit

Readiness testing by both the Commissioners and NHS England will be carried out to assure the quality of service prior to launch of the OOH Service. It will incorporate:

- Reviews of plans and progress during service development and implementation against this Specification
- Live simulation of end-to-end 111/OOH processes from call handling through to other Providers to test for operational readiness against the OOH Service Specification
- Review of the clinical governance arrangements against the requirements set out in this Specification

Privacy impact assessment

Provider will provide a Privacy Impact Assessment. Privacy impact assessments should always be carried out for all services and projects and subsequent risks being managed accordingly. The PIA should be appropriate for the scale of the services and demonstrate adequate robustness in line with ICO and NHS guidelines.

If patient identifiable information is being used and shared appropriately, Provider is to ensure that the data is anonymised or pseudonymised information is used wherever possible.

Equality Impact Assessments

The Provider will be expected to meet the full requirements of equality legislation both in relation to the universal service offered to patients but also in how it delivers equality within its organisation and constituent staff. The Provider will be required to complete an Equality Impact Assessment for the OOHOOH service and provide this to CommissionersCommissioners.

Applicable Quality Standards

The Quality Standards and outputs required are those outlined in National Quality Requirements in the Delivery of Out of Hours Services published by the DOH in July 2006. These standards and their achievement are fundamental to the delivery of the service. The Provider will be expected to comply with these standards or demonstrate that they have clear and robust action plans for working towards achieving them.

Additional quality standards and requirements are included within the Key Performance Indicators.

Applicable National Quality Requirements

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Any standards agreed nationally that are relevant to the service provided must be adhered to.
Any changes in service impacting on other care providers and/or patients will only be agreed with appropriate engagement and consultation with Commissioners and relevant care provider(s).

The following NQRs are considered appropriate to OOH services and must be evidenced. These or similar requirements may also appear in other sections of this specification. Provider must comply with any changes or additional National Quality Requirements.

NQR1
Provider must regularly report to CCGs via the Lead Commissioner on their compliance with the Quality Requirements.

NQR2
Provider must send details of all consultations (including appropriate clinical information) to the practice where the patient is registered by 08.00 the next working day. Where more than one organisation is involved in the provision of services, there must be clearly agreed responsibilities in respect of the transition of patient data.

NQR3
Provider must have systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness).

NQR4
Provider must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the Lead Commissioner. The sample must be defined in such a way that it will provide sufficient data to review the clinical performance, including the appropriateness of disposition, of each individual working within the service. This audit must be led by a clinician with suitable experience in providing care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service.

Provider must cooperate fully with CCGs in ensuring that these audits include clinical consultations for those patients whose episode of care involved more than one provider organisation.
All categories of staff to be included in audit (e.g. Advisors and Clinicians).

NQR5
Provider must regularly audit a random sample of patients' experiences (note – experience is different from satisfaction) of the service (for example 1% per quarter) and appropriate action must be taken on the results of these audits and must be made available to the Lead Commissioner. Providers must cooperate fully with CCGs in ensuring that these audits include the experiences of patients whose episode of care involved more than one provider organisation.

NQR6
Provider must operate a complaints procedure that is consistent with the principles of the NHS Complaints Regulation (2009). They will report anonymised details of each complaint and the manner in which it has been dealt with, to the Lead Commissioner. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.

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In addition clear information about the complaints procedure should be made available to patients and carers. It should also be well advertised on the Provider's website and available upon request in writing.

NQR7

Provider must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service. They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.

NQR8

Initial telephone call:

- No more than 0.1% of calls engaged
- No more than 5% of calls abandoned

Definition: A call is engaged if, when a call is passed from the national telephony infrastructure, there are no lines available to handle the call and an "engaged" tone is generated. This is monitored by reporting on the peak of line utilisation at Provider on a regular basis.

A call is abandoned if the Caller hangs up before they are answered, and the call has been queuing for an Advisor for at least 30 seconds. Some Automatic Call Distributors (ACDs) report on abandoned calls including any message played by the ACD, in which case the length of the message can be added to the 30 seconds. This does not include any message being played by the national telephony infrastructure.

Time taken for the call to be answered by a person:

- All calls should be answered within 60 seconds of the end of the introductory message which should normally be no more than 30 seconds long
- Where there is no introductory message, all calls should be answered within 30 seconds

NQR9

Telephone clinical assessment:

- Identification of immediate life threatening conditions

Provider must have a robust system for identifying all immediate life threatening conditions and, once identified, those calls must be passed to the ambulance service within 3 minutes.

The Sheffield University evaluation of the original NHS 111 Pilots established that the assessments carried out within NHS 111 were at least as safe as those completed by GP OOH services, therefore it follows that Provider will be fully compliant with National Quality Requirement (NQR9), provided that there are no call backs during the course of completing the clinical assessment. NQR9 makes reference to the most urgent assessments being started in 20 minutes and, by definition, where there are no call backs, this requirement will be met.

It is critical for Provider to record precisely how many call backs there are and when they take place, so that the commissioner can ensure compliance with NQR9.

Where the outcome of the clinical assessment is that the patient needs to speak to a clinician with a defined period of time, the patient must end the call with a clear understanding of when they will be called back.

NQR10

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Face to Face Clinical Assessment

Identification of immediate life threatening conditions
Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within 3 minutes.

Definitive Clinical Assessment
Providers that can demonstrate that they have a clinically safe and effective system for prioritising patients must meet the following standards:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre

- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre

Providers that do not have such a system must start definitive clinical assessment for all patients within 20 minutes of the patients arriving in the centre.

Outcome
At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the likely timescales within which further action will be taken and the location of any face-to-face consultation. Patients are to always be contacted if an agreed appointment time at the treatment centre is delayed.

NQR11
Providers must ensure that patients are treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence

NQR12
Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

- Emergency: Within 1 hour.
- Urgent: Within 2 hours.
- Less urgent: Within 6 hours.

NQR13
Patients unable to communicate effectively in English will be provided with an interpretation service within 15 minutes of initial contact. The service must also make appropriate provision for patients with impaired hearing or impaired sight.

Data required – confirmation from Provider that interpretation services are available within 15 minutes of initial contact and evidence to support this, confirmation of the provisions for patients with impaired hearing, confirmation of the provisions for patients with impaired vision, monthly, number of patients requiring interpretation service, number of patients receiving interpretation service within 15 minutes of initial contact.

NQR14
Provider must demonstrate the online completion of the annual assessment of the IG Toolkit

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at level 2 (satisfactory) or above and that this is audited on an annual basis by Internal Auditors using the national framework.

NQR15

Provider must demonstrate that they are complying with the NHS England HSCIC Information Governance Toolkit (IGT) and Serious Incident Framework (SIF) Guidance on reporting of IG and Serious Incidents (SI) appropriately.

The on-going arrangements for quality assurance are still to be agreed and are expected to be based on the minimum dataset and requirements of this Service Specification.

Performance management

Principles of Performance management

Compliance with the requirements (and standards) can only be demonstrated through the production of appropriate evidence. In many cases, such evidence can be submitted in writing or electronically, but there are many other areas which cannot be adequately tested in this way. Periodic face-to-face meetings with Provider and its staff, provide the only sure way of making a comprehensive and accurate assessment of the quality of the service that is being provided.

Regular Reporting

The NCL CCGs require Provider to be able to collect data and report activity, SITREPs, Quality and KPI requirements for any individual CCG or combination of CCGs within the NCL area.

Providers must state the methods and methodology by which call volumes will be allocated and reported to ensure accurate reporting and charging of activity to individual CCGs.

The nature of the demands that arise in urgent care are such that regular reporting on a number of key standards is necessary to ensure the on-going safety of the NHS 111 Service. In this regular reporting, it is critically important that the data is disaggregated in such a way as to reveal the manner in which the service performs at different times of the day and days of the week, notably at peak times such as Saturday mornings and the third day of a Bank Holiday weekend.

Data

NHS 111 Minimum dataset

Provider minimum dataset must be submitted via Unify so that information and intelligence is provided to NHS England and Commissioners to inform the on-going design and place of NHS 111 in their urgent care services. The dataset will also be used to monitor and report on the performance of the NHS 111 Service.

The minimum dataset will collect the following information:

- NHS 111 Provider/process including volume, access, dispositions
- Patient experience including satisfaction, compliance, health outcomes, services used
- System impact/volume changes including A&E, WiCs, MIUs, UCCs, GP, Ambulance

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The detailed content of the datasets are set out in the document NHS 111 Minimum Dataset — Providers Version 0_9 (http://www.england.nhs.uk/statistics/2014/09/05/nhs-NHS 111-statistics-july-2014/)

OOH Minimum dataset (MDS)

Nationally, the MDS must be the minimum data required to report on NQRs and must be submitted via an agreed method so that information and intelligence is provided to Commissioners to inform the on-going design and place of OOH in their urgent care services. The dataset will also be used to monitor and report on the performance of the OOH Service.

Data Downloads

Provider will be required to provide data downloads from both their telephony, host, CDSS systems and clinical assessment systems to the required specifications of theCCGs.
A data specification will be developed following award of contract including data field requirements which may not be covered in this Specification.

General Reporting Requirements

The Provider must provide clinical and quality performance reports that details performance against:

- Key Performance Indicators (KPI)
- Clinical Governance Board Reports
- Clinical Quality Review Group Reports
- Activity and rota cover planning and performance (to 15 minute intervals)
- Others as may be specified

All reports will be required at agreed intervals, with a narrative explanation for any area where the Provider has not achieved the performance target.

The Provider is expected to develop, with the CCGs, a suite of reporting that can be distributed at required intervals to the CCGs and that provides information at individual CCG level relating to each of the data items below covering time periods and reporting frequency as required by the Commissioners.

The Provider must also develop Clinical Quality reports at agreed levels and frequencies that summarises performance and reports on all aspects of Clinical Quality including a summary of all feedback, incidents raised, SIs, complaints and compliments. The exact content of the Clinical Quality report is to be agreed with the CCGs.

- Weekly Reporting items are required within 3 working days of the week end
- Monthly reporting items are required within 10 working days of month end
- Reporting in excess of Monthly are to be agreed.

Daily Situation Reports (Sitreps)

Provider must report against an agreed range of performance measures on a daily basis. This will be daily weekday reporting with Friday, Saturday and Sunday reports being due on the following Mondays. The daily information will also need to be aggregated to provide a weekly performance view. This information must be provided in a format that is suitable for use by a NCL and NHSE London.

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Feedback on CDSS systems and training

Provider has a responsibility to ensure feedback on any issues that arise related to the CDSS system and associated staff training to ensure the improvements can be made.

Providers will follow procedures set down in licence agreements with the system suppliers however Providers must also report to NCL clinical commissioning group any recommendations for improvements.

Ad-hoc reporting

Provider must be able to respond to ad hoc requests for information including any of the below data items from the Commissioners. These requests will be channelled through the Lead Commissioner and timescales for response will be agreed on an individual basis.

Activity, Staff and Rota Planning

Provider will be required to model demand to deliver the Key Performance Indicators as set out in his Specification and to demonstrate how they will use the information as a basis to convert demand into rota cover and capacity planning. Commissioners will expect that the modelling is to a recognised industry standard stating all assumptions and evidence used to inform calculations for each key metric.

As part of the performance framework described above Provider must have the capability to report on the following items for both employed, sub contract and agency staff, which is not an exhaustive list.
The provider is expected to comply with all national workforce requirments as well as those outlined in Appendix 8.

- Total headcount available to roster
- Total staff hours required by week
- Utilisation percentage (excluding shrinkage) for each workforce skill group
- Sickness/absentee rate per individual month for each workforce skill group
- Staff Turnover by skill group
- Shrinkage rates per month including breakdown of shrinkage rate calculation
- Attrition rate per month per workforce skill group
- Specific staff incentives and assumptions planned to fill bank holiday periods e.g. reduction in shrinkage rate and how this will be achieved.
- Expected weekly overtime hours by clinicians & Health Advisors, for each centre to fill the rota
- The staff available by grade, by day of week and time of day

Calls

- Where calls come from – either direct dial or switch through and to be able to distinguish between those switched through by intended number;
- Which kind of phone was used – mobile, landline, Voice Over Internet Protocol (VOIP), other;
- When calls arrive – by date, day of week and time of day;
- The number of abandoned calls by time of day and day of week, by source and the duration between call connect and abandoned;
- The number of calls delivered to the DDI numbers, and;
- Total percentage of calls referred to a clinician
- Total call handling time for each specific workforce skill group
- Average call handling time for each specific workforce skill group
- The number of and nature of calls where the content of the clinical assessment system did not record the type of call including:
    - Follow up calls

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- Service information calls – clinician
- Service information calls – general public
- Out of area calls
- Out of scope calls that result in signposting to other services
- Test calls
- Silent calls
- Complaints
- Compliments
- Administrative enquiries
- Call screen opened for demonstration or in error
- Follow up calls

- How long the call lasted and the duration of call connect to call answered, call answered to action begun (e.g. information supply or assessment), and action begun to action completed, action completed to end of call);
- The number of calls that are transferred
- The number of call backs
- The time to call back form transfer from Advisor, individual calls and average across daily and other time periods and exceptions over agreed call back standards
- Variances from plans in call patterns during to 15 minute intervals for any time period.

Patient assessment and dispositions

Again, as part of the performance framework described above, as a minimum, Provider is required to have the ability to report on:

- Dispositions reached by each staff type
- Frequency and reasons for overriding the assessment system
- Frequency and reasons for non-selection of First DoS Service (Categorisation must inform Commissioners in such a way to improve DoS entries and/or patient access to services)
- Data and reporting appropriate to any agreed call or clinical prioritisation systems

Referrals and feedback from the Provider

Provider must have the ability to report activity by the service referred to (i.e. service selected from the DoS) as well as by disposition. This is key to understanding the impact that NHS 111 is having on urgent and emergency care systems and providers.

Provider should seek regular structured feedback from the range of stakeholder organisations around the appropriateness of the referrals made and suggestions as to improvements in the assessment.

Staff and Patient Feedback and Surveys

The views of staff, patients and the public and feedback of patient experience are key to successful delivery of the OOH Services and Commissioners are keen to ensure there are transparent and robust processes to engage, capture, and respond to this feedback and demonstrate actions taken as a result.

Staff

The Provider will be required enable staff feedback on a continuous basis

An annual Survey of all staff engaged in the OOH service will be required and reported to the CCGs.

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Patients and Carers

Provider will develop a joint patient communications and engagement strategy with Commissioners.

Provider will be expected to include:

- Feedback on the experience of the existing service from service users and carers
- Collaborative working with patient populations

Provider will have a systematic process in place to regularly seek out, listen to and act on patient feedback on their experience of using the service, ensuring that they deliver a patient centred service.

The Provider should be committed to working with the commissioner to engage with patients and carers to test and evaluate the service, not just to capture the experience of patients, but to generate patient aspirations for the service.

Technical Information

Provider must provide monthly IT & telephony system service management reports containing the following as a minimum:

- System Availability reports
- System Capacity reports
- Planned system maintenance (including software / CDSS updates)
- System Incident reports
- System Change Control reports
- System Failure Test reports

Service information

Provider must capture the following information for each call received:

- NHS number
- NHS number status indicator
- Postcode
- CCG of residence
- Patient's birth date
- Patient's gender code
- Patient's ethnic category code
- Patient's registered GP
- GP practice code
- Call category
- Call disposal
- Source of referral
- Activity date
- Activity time (first contact)
- Initial assessment time
- Activity conclusion time
- Staff member code(s)
- Call outcome (answered / abandoned)
- Reason for call / presenting complaint
- Primary diagnosis

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- Secondary diagnoses
- Service referred to / DoS service selected

North Central London CCGs Key Performance Indicators

The National Contract sets out the mechanism under which Provider will receive performance payment in relation to the identified Key Performance Indicators.

Data sharing with Public Health England

Public Health England's (PHE) aim is to protect the public from threats to their health from infectious diseases and environmental hazards. It identifies and responds to health hazards and emergencies caused by infectious disease, hazardous chemicals, poisons or radiation.

PHE uses sophisticated syndromic surveillance systems to monitor seasonal outbreaks of community-based infections (e.g. influenza and norovirus) and major public health incidents. These have proved their worth in monitoring such incidents as influenza A H1N1 in 2009. The agency's systems provide data in near real-time relating to the health outcomes of an incident. This is used to inform both policy makers at national and local level, and front line healthcare workers involved in providing clinical data.

The syndromic surveillance systems rely on the automated supply of specified anonymised data from clinical information systems whose specification, transfer and use is governed by a Caldicott-compliant information sharing agreement between PHE and the data supplier. This includes the NHS 111 Service.

Provider will be required to:

- Enter into an information sharing agreement with PHE for the secure supply of specified anonymised real-time data for public health surveillance purposes (This data capture process is part of the Repeat Caller Database data exchange and the Information Sharing Agreement is covered under the HSCIC Repeat Caller Service Information Processing Agreement). Appropriate governance arrangements should be in place to ensure that all NHS, third sector or commercial organisations participating in the NHS 111 service are committed to supplying a near real-time specified data-set to PHE.
- Ensure that a data sharing agreement is included within contracts with all organisations involved in the delivery of the NHS 111 Service
- Ensure that appropriate Information Governance arrangements are in place such that all NHS, third sector or commercial organisations participating in the delivery of the NHS 111 Service are enjoined in the commitment to supply the real-time specified data-set to PHE
- Ensure PHE is alerted if any concerns about general communicable diseases which would support any case finding required and,
- Support PHE in access to pharmacy via the Directory of Services if prophylaxis treatments are required.

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Information management and technology (IM&T)

Interoperability

The vision for Urgent Care is of a system with an effective and efficient level of integration between services, such as ensuring a smooth hand-off between services, ensuring information for patient notes (e.g. special patient notes, care plans, CMC or other End of Life records) are effectively used, and a seamless transfer of information and referrals for the whole journey from the start of the NHS 111 call to the conclusion of that episode of care in whichever provider is ultimately involved. This will be supported by an appropriately accredited Clinical Decision Support System, meeting national requirements, which will be used within the NHS 111 service, and interaction with the Directory of Services.

Commissioners are seeking innovation in the introduction of new technologies and/or ways of working that may enhance the NHS 111 Service over the term of the contract to enhance patient experience which will support the wider urgent care system.
Interoperability within the NHS 111 environment is detailed in the NHS 111 Interoperability Standards (formerly specification). The specification defines the technical standards that must be used for the transfer of data where applicable, to and from NHS 111 application systems and the applications that integrate with NHS 111 Providers.

The following outcomes are required for all NHS 111 services:

- All NHS 111 applications must connect directly with the SPINE to enable access to the Personal Demographics Service (PDS)and have followed the HSCIC Common Assurance Process (CAP)
- All NHS 111 applications must connect with the Summary Care Record (SCR)to ensure access to patient records is achieved as a minimum
- NHS 111 services must submit and retrieve data from the National Repeat Caller Service
- NHS 111 services must follow the NHS 111 IM and T assurance toolkit
- Commissioners must ensure that providers use NHS 111 accredited software systems with accredited NHS 111 systems functionality

The following outcomes have flexibility in the approaches to how they are commissioned from a technical perspective:

- All serviceAll must be able to book in either an integrated manner, or using Interoperability Standards into OOH services
- All serviceAll must be able to dispatch ambulances in either an integrated manner locally, or using Interoperability Standards when dispatching to a separate application or Out of Area 999 service
- service must be able to determine where patients are being referred/transferred to and transmit the data for all OOH services and all 999 services
- serviceservice must have access to Special Patient Notes (SPN) including the capability to access SPN for Out of Area patients as and when they are made available
- serviceservice must connect to a single common DoS data layer but may use its own middleware application layer
- services must follow the latest IM&T assurance guidance and regulation
- T service must be able to accept direct bookings

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Technical Infrastructure requirements

- Provider must have a fully resilient technical infrastructure with multiple data centres and multiple data connections to the N3 NHS National IT network
- Provider must have in place technical architecture topology diagrams for the application of the IMT system
- Provider must have a technical solution which is able to meet peak service demands, to ensure bandwidth and capacity of at least 1.5Mb of unutilised bandwidth per 10 members of staff
- Provider must have a technical solution which has the ability to scale with increased demand beyond predicted call volumes
- Provider must have robust security architecture in place for the application
- Provider should have arrangements in place for the issue and management of HSCIC Smartcards for access to SPINE services (PDS & SCR)
- Provider must comply with the Information Commissioner's guidance on the Data Protection Act 1998 and the latest NHS Caldicott guidance for information governance and data security. All staff must receive regular training on all aspect of data security and Information Governance
- Provider is expected to have a nominated Confidentiality or Information Sharing Lead Officer, policies relating to information governance, security and confidentiality of service user information and robust Information Sharing Protocols
- The Provider must have data migration support from the existing systems to ensure a seamless transfer of data, as well as allowing for migration of data to future systems, should this become necessary. This should preferably include the ability to proof the data migration process via test or trial loads. The Provider is required to ensure that all data has been correctly migrated before the service commencement date.
- The Provider must provide storage of all paper and electronic records and aim to minimise paper use. Provider will be required to store any physical and electronic files received from existing provider until destruction date required under National standards.

IT Service Management

- Provider must have a Disaster Recovery Procedure (DRP) in place that contains robust, detailed methods and procedures that will be followed in the event of service failure / disaster. The DRP should be tested on a regular basis to ensure it remains current and robust, results of testing to be shared with Lead Commissioners on request
- Provider must have robust failure monitoring processes in place
- Provider must have robust and tested backup procedures in place
- Provider must demonstrate IT Infrastructure Library (ITIL) maturity levels or equivalent and must have robust systems in place to monitor the application and to ensure that they can maintain full operations should an outage of the system occur
- Provider must have the ability to produce detailed service management reports in accordance with ITIL (or equivalent) best practice
- Provider must provide monthly service management reports containing the following as a minimum:
    - Availability reports
    - Capacity reports
    - Planned maintenance
    - Incident reports
    - Change Control reports
    - Failure Test reports

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IT Functional Requirements

Provider must supply a full data extract of all data items for commissioning systems. Provider must also provide real-time access to information to support clinical, commissioning and GP dashboard development. Therefore:

- Provider must provide a mechanism for all data to be exported regularly from the system and transferred to any specified destination
- Provider must provide a data dictionary of all fields within the application
- Provider provide clinical content that has been signed off by the Emergency Call Prioritisation Advisory Group (ECPAG) for ambulance dispatch
- Provider must ensure that any gazetteer to be used to deliver the service has address field compatibility with other organisations delivering the service e.g. to ambulance dispatch systems
- Provider must deliver a geographical / mapping tool for call handlers to reference distance of selected service from DOS to call handler, to provide a quality service

Telephony requirements

Callers in a given Routing Area (a Routing Area includes calls from landline phones and mobile phones within a given area) are processed in a defined way. They will be directed to the NHS 111 Service on a dedicated direct dial in (DDI) number that is devoted to NHS 111.

As well as the main (primary) destination number Provider will also require a secondary (back up) number. This secondary number will be used if the primary number fails for any reason. Ideally the secondary number will use a different exchange/provider/route into the building. Many providers use tertiary routing to add an additional layer of resilience but this is optional.

Other DDI numbers may be required for other purposes.

Calls are played a message when they arrive on the provider's telephony infrastructure. The announcement should be agreed with commissioners. This announcement should start playing within 5 seconds of the beginning of the call.

Telephony Guide

The overall requirements for telephony are contained in the telephony guide (a copy of which is attached). This is updated from time to time. Providers must continue to comply with the guidance contained in the guide.

Reliability

The telephony infrastructure must be extremely reliable. It must be possible to perform maintenance without the provider being unable to handle calls.

At least 2 weeks' notice must be given of any change to the national routing plan that is required for software or hardware upgrade.

Call routing

NHS 111 uses the location of the Caller to identify where a call should be routed on the basis of Routing Areas. For landlines these are based on the National Number Group (NNG) including for calls where the Calling Line Identity (CLI) is "withheld". The NHS 111 national routing plan is updated as and when changes are notified, Provider must maintain their telephony infrastructure in accordance with the national routing plan.

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For mobile phones, the mast location or the Emergency Area is used.

In special cases the NHS 111 infrastructure is capable of routing on the entire telephone number so that specific telephone numbers can be routed to special DDI numbers (known as "Tagging").

Tagging calls from specific groups

It is possible within an NHS 111 Service to create specific groups of Callers whose calls will be treated differently. This is done by creating a list of the telephone numbers to be "Tagged" and passing it to the NHS England Telephony Team who will pass the list on to the NHS 111 telephony provider.

Each group would have a specific DDI allocated to it.

Groups that may be included are:

- The mobile phone numbers of GPs
- Nursing homes
- End of life patients
- Landline phone numbers where the Caller is likely to want to speak in another language
- Persistent Callers (e.g. Frequent Callers)
- Mental health patients, patients with learning disabilities and patients who are visually or hearing impaired

It should be noted that telephone numbers can only be tagged by the consent of the owner of the telephone number and Provider will develop processes to ensure that that happens.

Calls in other languages

NHS 111 Advisors must have a translation service available 24/7/365 to translate calls made in other languages, meeting the requirements of this specification. Provider for the NHS 111 service must have arrangements in place to access interpreting services to ensure equitable access for all patients.

Text relay/Calls from people with hearing impairments/Calls via BSL

The NHS 111 service must be able to deliver a good quality service and adapt its model to include patients with hearing impairments. Advisors need to understand that such calls exist and how to handle them. No special equipment or services are required. In the future it may be a requirement that these calls will be tagged following first call and consent to improve the response for these patients will be sought.
Calls from this group may be routed to a specific DDI and have a higher priority than other calls.

999 escalation

If a call to NHS 111 needs to be escalated to the 999 service (i.e. an ambulance needs to be dispatched) then that will done electronically using a message, not by transferring the call. In mitigation of a potential messaging problem, Provider must have in place a clinically safe workaround which does not involve re-triage. Ambulance Trusts will deal with border issues using the usual procedures.

Resilience of the service

NHS 111 services must have reliable telephony provision that allows calls to be networked across their call centres. In the event of the loss of call answering at any one location, it must be possible to send calls to other centres without modifying the national routing plan.

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Provider must:

- Have a secondary DDI number to connect their Automatic Call Distributor (ACD) to NHS 111 which as far possible uses a separate location, telephony supplier and route into the building
- Have contingency / business continuity plans in place to cope with a fire or other incident at their main call handling location. It is recommended that a charged mobile phone, with an “Emergency Procedures” document is available close to a fire exit
- Have procedures in place so that if visitors to A&E say that they were unable to access NHS 111 the call centre is informed
- Have a procedure in place on how to contact the NHS111 telephony supplier (currently Vodafone) to report any suspected problem with the NHS 111 network. In addition the NHS111 Telephony team should be informed.
- Have an Uninterrupted Power Supply (UPS) available so that a power failure to the main call centre does not close the centre
- Have plans to increase the number of Advisors rapidly in case of a local emergency that increases the number of calls. This could be through a bilateral arrangement with another NHS 111 call handling organisation and should be capable of being implemented within 24 hours
- Provider must have in place robust systems and process such that in the event of a catastrophic event calls can be routed to the contingency site
- Have the ability to implement a local message or split of calls (separating calls from a specified location to a specific group of staff) on their ACD in case of a specific local event. This must be capable of being implemented within an hour, 24/7/365; this is described in diagram A below:

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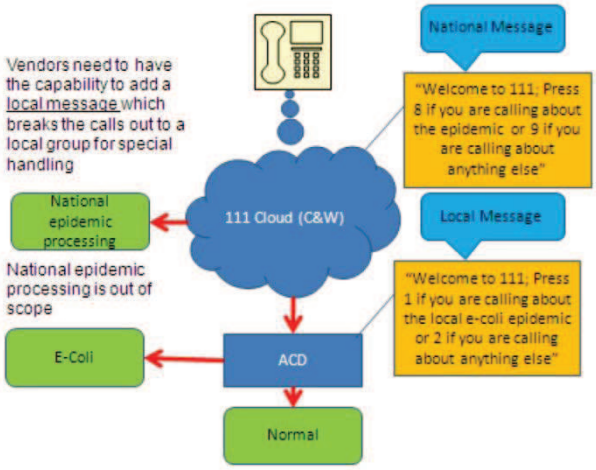
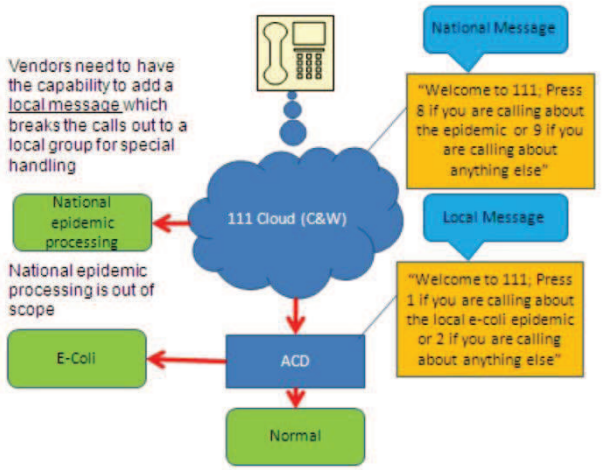


Diagram A



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Direct Dial in (DDI) numbers

Calls to NHS 111 must be received on a specific DDI number that is devoted to NHS 111, enabling calls directly to NHS 111 to be counted. Calls to the NHS 111 centre which are redirected from other numbers (e.g. GPs or existing OOH numbers) must be sent to a different DDI. (It should be noted that this call forwarding is not now a recommended process).

Calls to both DDI numbers can be treated the same and dealt with by the same staff using the same process and sit in a common queue. DDI numbers cannot be 'non-geographic' numbers such as 0300, they must be a landline, unless specific agreement is reached with the telephony team.

Incoming lines

In order to cope with the very high level of demand that appears on a very limited number of days (such as Boxing Day) there should be three times the number of lines available compared to the maximum number of Advisors. If the NHS 111 Service runs out of lines then a "technical error" message is played by the system.

This message is also played if calls do not go "off hook" within a short period (currently 10 seconds). For a call to go off hook a message needs to play. There must be enough IVR ports to start playing the message.

Catastrophic failure

In the event that there is a catastrophic failure and that it is unsafe for calls to be sent to Provider (for example if the ACD fails), then it is possible to divert calls away from Provider

to all other providers. It is essential that such a failure is reported to Commissioners and the NHS 111 telephony team as soon as possible so that such a divert take place.

In the event that another provider becomes unsafe, a proportion of that provider's calls will be routed to all other providers.

Provider must ensure that appropriate email contact details are stored with the NHS 111 telephony team (the Operational Contact List) so that they can be contacted in the event of any unexpected event, including the re-routing of calls.

Telephony reporting & data recording

Provider's telephony system must have the following capabilities:

- Ability to provide management information as defined in the NHS 111 Minimum Data Set and the performance reporting requirements and capable of providing call logs that identify individual call details including the CLI and the agent handling the call.
- Recorded announcements must be compliant with the NHS 111 Brand Guidelines
- All inbound and outbound calls to NHS 111 must be recorded. Calls must be retained in line with the Department of Health Records Management NHS Code of Practice (June 2009)
- NHS 111 providers are required to ensure that systems are in place to comply with regulation concerning child protection and vulnerable adults
- All calls (inbound and outbound) must be recorded for the entire duration of the call (including warm transfer handover) and the recording must be accessible for review immediately the call has been completed

GP OOH Telephony reporting & data recording

The Provider's telephony system must have the following capabilities:

- Ability to provide management information to be defined in the OOH Minimum Data Set and the performance reporting requirements and capable of providing call logs that identify individual call details and the agent handling the call.
- Recorded announcements must be agreed with Commissioner
- All inbound and outbound calls to OOH must be recorded. Calls must be retained in line with the Department of Health Records Management NHS Code of Practice (June 2009)
- The Provider is required to ensure that systems are in place to comply with regulation concerning child protection and vulnerable adults including recording of Serious Incidents during phone calls.
- Provider must have access to Serious Incident Management System (formerly STEIS) and relevant systems.

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Statutory duties

Introduction
Key statutory requirements that Provider will need to comply with.

Protection and retention of information
All NHS organisations have a duty under the Public Records Act to make arrangements for the safe keeping and eventual disposal of all types of their records. In addition, NHS organisations are required to have robust records management procedures in place to meet the requirements set out under the Data Protection Act 1998 and the Freedom of Information Act 2000 (Detailed guidance on all aspects of record keeping and protection of information can be found in Records Management: Code of Practice available at (www.gov.uk). All records, whether electronic or physical, must be managed, maintained, stored and disposed of in England.

Safeguarding and promoting the welfare of children
Section 11 of the Children Act 2004 places a duty on NHS bodies to safeguard and promote the welfare of children. Statutory guidance on this duty is available at www.legislation.gov.uk.

Provider must comply with all guidance and legislation and have procedures in place to safeguard and promote the welfare of children.

Provider will be required to have representation on the relevant Local Safeguarding Children Board(s) as requested.

For further requirements refer to Appendix 6.

Safeguarding vulnerable adults
Provider has a responsibility to safeguard adults. Provider must comply fully with the Department of Health "No Secrets" guidance (March 2000) on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse and also the Care Act 2014.

Provider must comply with all guidance and legislation and have procedures in place to safeguard and promote the welfare of vulnerable adults.

For further requirements, refer to Appendix 9.

Care Quality Commission
Provider must be registered with the Care Quality Commission and comply with the requirements of registration and notify commissioners of any statutory and legal requirements, enforcements or improvement notices.

The Provider is required to meet all appropriate recommendations made by the CQC into the NHS 111 and GP OOH services, including the Consultation on the Approach to Regulating NHS 111 Services and Appendices issued February 2015.

The Provider is required to meet all appropriate recommendations that were made by the CQC interim report into GP Out of Hours services published in the autumn of 2009, the Department of Health report into GP Out of Hours services published in January 2010 and the latest CQC approach to inspect commencing from October 2014.

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Record keeping

The Provider must comply with all legislation and best practice concerning record keeping. All callsmust to be recorded. Calls from adults and calls from or about children will be retained in line with Department of Heath guidance on records retention schedules.

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Future model for NHS 111 and GP out-of-hours services in north central London

Proposal to commission an integrated NHS 111 and out-of-hours service across Barnet, Camden, Enfield, Haringey and Islington

All comments and feedback must be received by **31 July 2015**

1. Foreword

From feedback, both nationally and locally, we understand that people find it difficult to know where they should go when they have an urgent healthcare need.

This often results in people being seen in the wrong place and by the wrong professional; meaning that people may not always get the most appropriate care, and can lead to a poor experience for patients.

It is for this reason that NHS 111 was developed as a single point of access to help people get to the right health care service as soon as possible.

Since its launch in 2013, NHS 111 as a first point of contact has been developed nationally with significant benefits for patients, supporting a coordinated approach to patient care which is fit for the future.

GPs in north central London (NCL) – that's Barnet, Camden, Enfield, Haringey and Islington – are considering a proposal to commission (buy) an integrated NHS 111 and out-of-hours service across all five boroughs. This document explains in more detail why this is considered the preferred option.

We believe the evidence is clear that this is the best match for how patients actually use NHS 111 and out-of-hours services, and that commissioning in this way would provide the most effective way of delivering these services. It would also enable us to develop and improve the services over the next five years.

Many other areas of England are also developing similar services over far larger areas, but we think that NCL is the right size to retain the local perspective and local control.

NHS 111 is a free telephone number to help people who have urgent, but not life-threatening, conditions get advice and access the most appropriate service to meet their needs. Trained advisers use a tool called NHS Pathways to assess patients and direct them to the most appropriate service.

NHS 111 was introduced across the country in 2013 and replaced NHS Direct. It is available 24 hours a day, 365 days a year and calls are free from landlines and mobile phones.

Out-of-hours services are available so that people can still access primary care, for urgent problems, when their GP surgery is closed, usually at night or over the weekend. GPs and other clinicians are able to offer advice and face-to-face appointments if needed. Patients get access to the out-of-hours service by calling NHS 111 first.

The contracts for both of these services were set to expire in March 2015, but these have been extended to allow the Clinical Commissioning groups (CCGs) to refresh and improve the service and consider commissioning a combined NHS 111 and out-of-hours (OOH) service across the five boroughs. This follows discussions by the CCGs at their governing body meetings which were held in public, and other discussions which have been taking place across the patch since 2013.

NHS 111 and the out-of-hours services work very closely together, with OOH seeing by far the majority of referrals from NHS 111. It is vital to make sure they work in a co-ordinated way to support the patient's journey and deliver high quality, safe patient care.

We think it therefore makes sense to commission NHS 111 and OOH as a single contract, with a single specification, so that patients would receive a more joined-up service with fewer transfers between medical staff and better information-sharing.

This would not mean that only a single provider or organisation would be commissioned to do this work – a group of providers working through a single contract could also be an option. They would need to demonstrate how they plan to work together, and would be held accountable by the CCGs for delivering a high quality service.

We have spoken to many residents and service users over the past six months about these proposals. There's a lot of support for the idea of combining NHS 111 and OOH – but it's clear that we need to do more to make the case for

commissioning these as an integrated service across NCL. That's why we are setting out the proposal here and seeking your views about it.

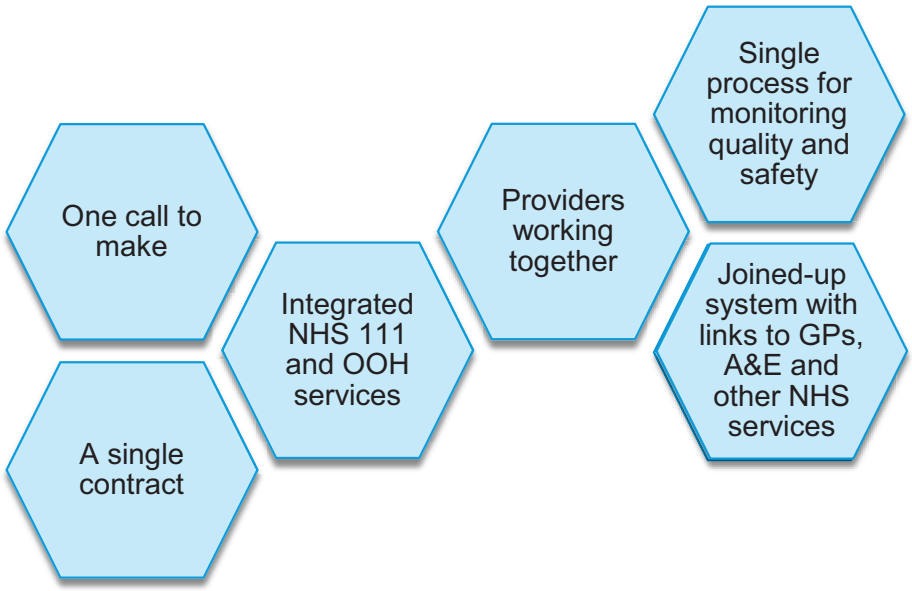
During July, we are undertaking a further period of engagement, specifically focused on the proposal to commission an integrated service across five boroughs. We will:

- Publish and circulate widely this engagement document, outlining the case for NCL-wide commissioning and encouraging residents and stakeholders to submit their views
- Share an online and postal questionnaire
- Meet with clinicians and key stakeholder groups to discuss and develop the clinical case for change further.
- Hold an additional 'market-testing' event, to ensure that all potential providers have the fullest possible information about the proposed service and opportunities to participate.

We are seeking your views and contributions on how the NHS could commission the best joined-up NHS 111/out-of-hours service for the residents of Barnet, Camden, Enfield, Haringey and Islington.

Please take a look at the information in this document and send us your thoughts. We look forward to hearing your views.

Proposed model



2. Current service

Currently the CCGs in north central London commission three different organisations to deliver separate NHS 111 and out-of-hours services to patients in north central London.

- The NHS 111 service is provided by one provider for all five CCGs in North Central London – *London Central and West Unscheduled Care Collaborative* (LCW), a GP-led not for profit organisation.
- The out-of-hours service for Camden and Islington is provided by *Care UK*, and the service for Barnet, Enfield and Haringey is provided by *Barndoc Healthcare*.

These organisations have all demonstrated excellent performance over the years of their current contracts – north central London residents have access to NHS 111 and out-of-hours services that are as good as, or better than, any in London.

We know this from the evidence we see at the monthly clinical quality review meetings. Also, evidence published on the NHS England website[1] shows that 86% of our patients said they were fairly or very satisfied with their NHS 111 experience.

However, we also know from complaints, incidents and feedback that some patients have had a poor experience, and this needs to be improved.

The current contracts for these services are all drawing to an end, which means north central London (NCL) CCGs are legally required to undertake a procurement process.

While the existing contracts were set to expire in March 2015, the contracts have been extended to allow CCGs time to refresh and improve the service specification and procure the best possible service for the population.

3. Case for Change

We now have two years of feedback on the NHS 111 service, and an opportunity to develop the way it works.

Evidence shows that the NHS 111 and out-of-hours services work very closely together, with OOH seeing by far the majority of referrals from NHS 111.

We think it therefore makes sense to commission NHS 111 and OOH as a single contract, with a single specification, ensuring patients would receive a more joined-up service with fewer transfers between medical staff and better information sharing – currently patients often have to be assessed twice, giving their information to both NHS 111 and the out-of-hours provider, and we want to make this simpler and safer.

The five NCL CCGs believe that a single service across the five NCL boroughs would deliver the best service for patients.

Our proposal is to develop a single contract, where a lead provider(s) would coordinate the work with all the local providers (which could include NHS trusts, GP collaboratives or private and voluntary sector providers), making sure they are working together to deliver the best possible outcomes and care for patients – they would be held accountable by CCGs for delivering those outcomes and care, with a detailed and clear specification for the service. We believe this would be the right model because it matches how patients actually access these services.

[1] http://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/

How do patients use NHS 111?

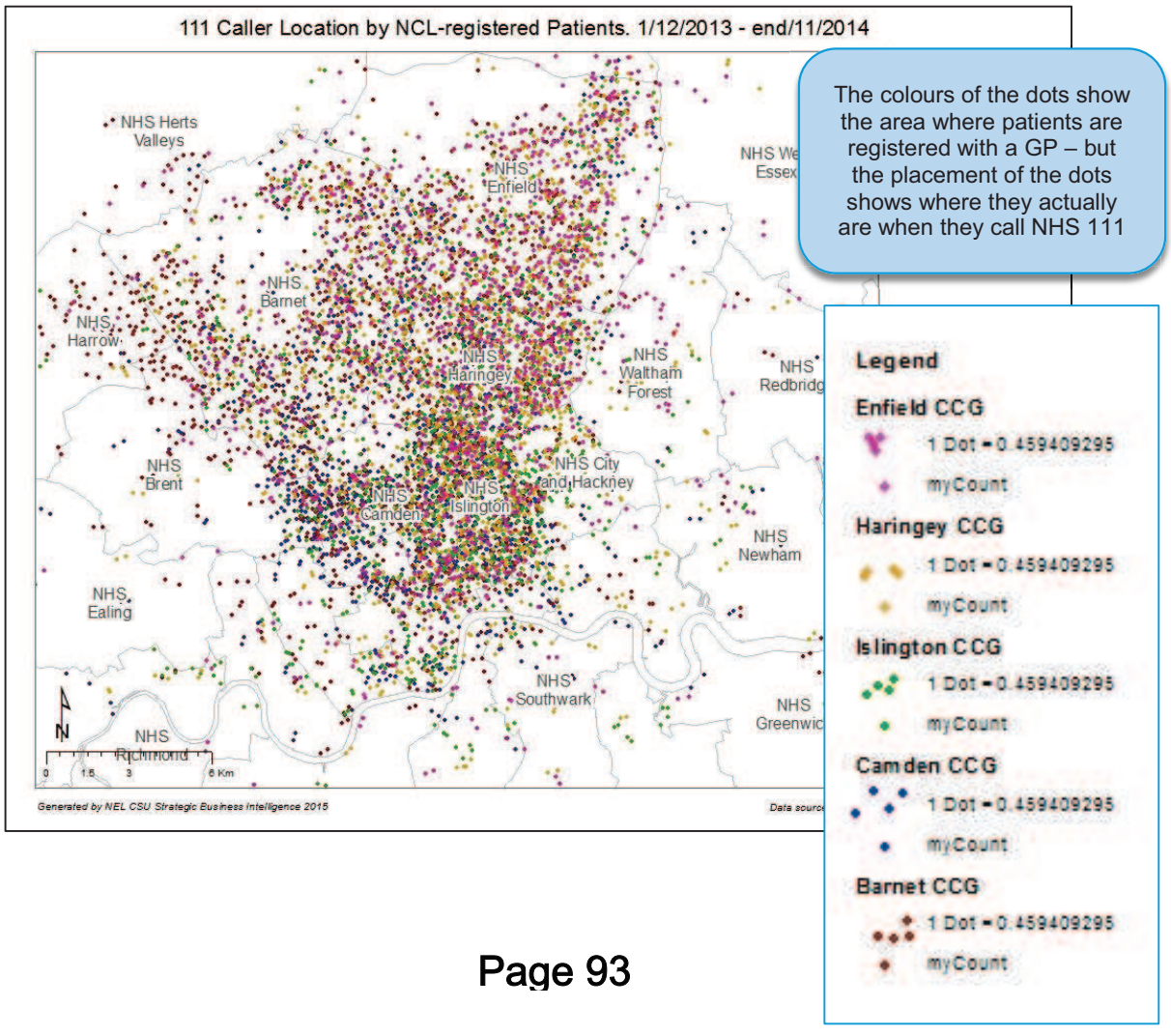
Callers to NHS 111 are often not near their registered GP practice when they call, but are usually somewhere within the NCL area, so it makes sense for NHS 111 to be able to refer them to healthcare services near to where they actually are at the time of their call. Combining the two services would make this easier.

By commissioning a service across NCL, doctors believe it would mean the NHS could develop better systems and infrastructure which would be more flexible and reactive to patients' needs; for example, we want the service to employ a skills-mix of health professionals – including pharmacists and paramedics as well as GPs and nurses – so that patients have access to health advice and treatment that matches their needs, all from a single point of contact via NHS 111 – and this would be the same for our patients, wherever they live.

Deaf service users also sometimes experience a poor service, and we want to develop systems to improve this. This is achievable if we commission at a five borough scale, and would be much less viable if we commissioned separate services.

This is also an opportunity to redevelop the NHS 111 and OOH service as an integral part of the health system across north central London, and ensure that it works intuitively with other aspects of primary care and emergency care.

A single contract, does not, however, mean that a single provider would be commissioned to provide the service. It is anticipated that a number of providers may commit to working together to provide a single integrated service. As part of the bidding process, potential providers would have to demonstrate how they plan to work with other providers, including local clinicians.



	Current model	Proposed model
Contract	One organisation providing NHS 111 for all of north central London (Barnet, Camden, Enfield, Haringey and Islington). Two organisations providing OOH services for north central London (one in Barnet, Enfield and Haringey; one in Camden and Islington)	A single contract with responsibility for all NHS 111 and OOH services in north central London. This may be delivered by a single organisation or (more likely) by a group of organisations working together. A single contract, with a clearly designed specification, would make it easier for CCGs to hold providers to account for delivering the right outcomes and care for patients.
Clinical support	Heavily reliant on GPs for clinical support. Recruitment of GPs is increasingly difficult as there is a shortage of GPs nationally.	A range of clinical skills is available (nurses, paramedics, pharmacists and GPs) who could be used flexibly to provide clinical support. This means callers would be directed to the most appropriate clinician for what they need.
Assessment	People who require a GP urgently have to speak to at least two people (typically more) before they can get definitive clinical advice or an appointment.	People would be directed to the most appropriate service; usually by the first person they speak to.
Appointments	Some direct bookings – but patients usually need to hang up and call a different number to make an appointment with the appropriate service	Direct bookings for OOH appointments, including home visits. Direct bookings available for most other services.
Medical history	Services have limited access to special patient notes for people with complex health and/or social care needs, and no access to routine medical history for NHS 111 or OOH	Those involved directly in patient care would have consistent access to special patient notes and routine medical history for patients using the service
Equity of access	Access to OOH services is different depending on where people live in north central London	Access to OOH services would be the same, regardless of where people live in north central London – and patients would have more choice

4. Benefits for patients

The CCGs believe that investing in an integrated NHS 111/out-of-hours service would provide numerous benefits for patients and residents of north central London.

- Patients would be more likely to be seen by the **right clinician**, **earlier in the process**
- There would be **fewer transfers** as the patient progresses through the system – you should **only have to give your information once**
- Patients would **no longer be bound by administrative barriers** (eg residents in West Haringey could be directed to the OOH base at the urgent care centre at the Whittington hospital, rather than travel across the borough to the North Middlesex hospital) – you would be **able to choose the services most convenient to you**
- The skills mix model, combined with more timely access to a GP, would help support the urgent care system – you would be **directed to the most appropriate service that meets your medical needs** and this should mean you are **less likely to have to wait around at a busy A&E**
- The integrated service would have **flexibility to redeploy staff to where they are most needed** to meet changes in patient use throughout the day and year
- Clinicians would be **able to prescribe without the need for duplication** or unnecessary referral
- **All contracts would be rigorously monitored**, as is the case today, so you can be assured the service is safe and of a high quality. **Providers would be accountable for delivering the outcomes and care that patients need**
- NHS 111 call advisers would be **able to book patients directly to appointments with OOH** and other services, so you **won't need to make an extra phone call**
- Commissioning at this scale would allow the **development of systems and infrastructure** that are **more flexible and reactive to patients' needs** – for example online tools to enable you to assess your own health needs, and systems for deaf service users

Our analysis so far, based on considerable engagement with clinicians and members of the public, suggests there are no significant drawbacks to the proposed model – but we welcome your views on this.

5. Our proposals

In developing our proposals we have considered a number of options for the future of NHS 111 and OOH services in north central London. These options include commissioning the services in the same way as at the moment, or commissioning the services separately for each individual borough. Our preferred option is to commission an integrated service across all five boroughs – there would be a lead provider, but services might be delivered by a combination of providers.

The advantages of each option are summarised below:

✓ = the option partially offers this advantage ✓✓ = the option fully offers this advantage

	Patients get clinical advice quickly from the right person, without calling a different number	Reduces pressure on A&E by making sure patients get treatment early on	Equal access to services wherever you live in north central London	Fewer transfers from one adviser to another	Can adapt to deal with pressure at peak times	Service provided by local clinicians	Contracts can be rigorously monitored	Could develop new systems – e.g. for deaf service users – that are better at meeting patients' needs
Option 1 – Commission one NHS 111 and two GP OOH providers – No change	✓	✓			✓	✓*	✓✓	✓
Option 2 – Each CCG to commission its own NHS 111 and GP OOH providers	✓	✓				✓*	✓✓	
Option 3 – Commission one lead provider for NHS 111 and GP out-of-hours across five boroughs – our preferred option	✓✓	✓✓	✓✓	✓✓	✓✓	✓*	✓✓	✓✓

* The current national shortage of GPs means it can be difficult for OOH services to recruit local doctors. We couldn't guarantee, regardless of how we commission these services, that they would employ local doctors – but we do want to make sure that the local service is an attractive career option that good local clinicians would want to take part in.

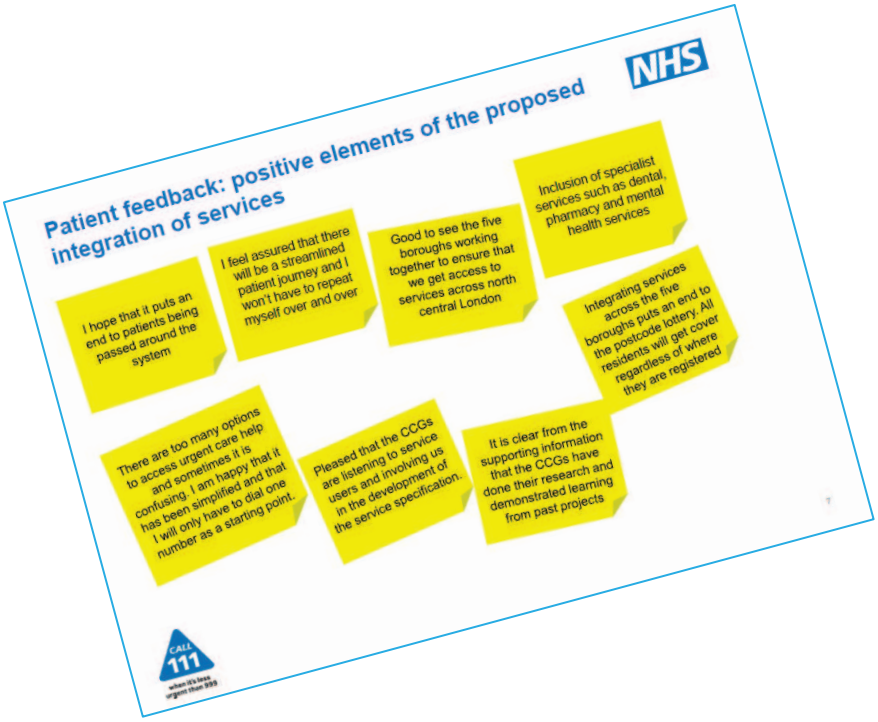
6. How we have engaged with service users and clinicians

The initial idea to commission NHS 111 and OOH services as a single service across NCL was developed based on extensive feedback from service users and clinicians. In particular, the Review of Urgent Care carried out in Camden and Islington in 2013/4, in which we spoke to hundreds of patients, recommended a more joined-up approach to commissioning urgent care services and specifically NHS 111 and OOH services.

There was also an independent review by the Primary Care Foundation which showed how reducing transfers between NHS 111 and OOH would speed up the clinical care patients received and improve their experience.

The CCGs have undertaken a substantial engagement programme over the past six months, which has included:

- Individual CCGs discussing NHS 111 and OOH proposals at local events, including discussions with hundreds of individual service users and meetings with targeted groups such as disabled service users and refugees
- Presentations at the regular meetings with GPs across NCL to ensure local doctors understand what is proposed and how they could be involved
- Two phases of focused engagement events held at venues across NCL and advertised through local newspapers and CCG websites, which were attended by hundreds of interested service users and encouraged in-depth discussion of the proposals.
- An online survey to find out the views of stakeholders and service users on our commissioning proposals.
- The setting-up of a Patient and Public Reference Group, involving service users from all five boroughs and Healthwatch representation – this is looking in detail at the proposed service specification and has had a fact-finding visit to the current NHS 111 provider. Members who have expressed an interest are being invited to participate in the Procurement Panel when it goes ahead.
- Market events with local and national providers, letting them know what we are proposing so they can decide whether to bid for the new contract.
- Presentations to local councillors through their health overview and scrutiny committees.



7. Frequently asked questions

Why would this make things better?

The biggest difference would be the integration of the clinical workforce and the supporting IT systems for NHS 111 and the out-of-hours GP service. This means that when patients are referred, the clinician would have access to clinical information that would support their ability to provide advice; and would also avoid patients having to repeat their symptoms at multiple stages. We also want the NHS 111 service to be able to make appointments with the GP out-of-hours service on that initial phone call – something which is not currently possible. This should result in a much better and quicker experience for patients. Patients would also have a larger choice of OOH bases when they need a face-to-face appointment.

When would the new service start?

We would like the new integrated service to start next year. This would ensure that there is enough time for a full and proper procurement process. Local clinicians are very involved in developing the service specification for this procurement. We know that we need to make sure we communicate what is happening with people in all five boroughs and we will continue to communicate and engage with residents in north central London.

Would there be more clinical involvement in delivering the NHS 111 service.

The NHS 111 call handlers already have access to clinical advice when they need it, but under the new proposals this would include a mix of health professionals, including pharmacists and paramedics as well as GPs and nurses, all operating within the same service, so fewer delays for callers.

Would the new service be provided by local clinicians who have access to local knowledge?

While we cannot instruct the new service only to recruit local staff, we can specify that staff must have excellent knowledge of local services. It is also our intention that the new service would offer more attractive career options and make OOH work a positive choice for staff. Local GP federations are currently developing in several areas, and we envisage these playing a role in the delivery of OOH care in the future.

Isn't it true that only big, private companies would be able to bid for the contract?

We are required to treat different types of provider fairly in any procurement process. The contract must be awarded based on the ability to deliver a high quality service at an appropriate cost. However we are working very hard to ensure that a range of types of provider, including NHS organisations, GPs and voluntary sector organisations are able to participate, and it is anticipated that the eventual service would be delivered by a number of providers working together. As part of the procurement process, potential lead providers would have to demonstrate how they would work with other providers.

Would the new service be more accessible for patients with sensory impairments, learning disabilities or language barriers?

We agree that these are all areas for improvement. There are plans in place and technological solutions being developed at a London and at a national level to respond to the access challenges faced by different groups within the population. Commissioning the service at a five borough scale would make it much easier for us to implement effective solutions to improve access for all.

8. What do you think?

We want to hear about your experiences of the current services, and your views and contributions on the proposals and how we can commission the best NHS 111/OOH service for the residents of Barnet, Camden, Enfield, Haringey and Islington.

Whether you are a patient, carer, staff member, representative group, community organisation or local resident, you can write to us or fill in the questionnaire at the back of this document and post it to:

NHS 111/out-of-hours
Communications Department
NEL Commissioning Support Unit
75 Worship Street
London
EC2A 2DU

Alternatively, you can email your comments to feedback@nelcsu.nhs.uk or call us at 020 3688 1615.

You could also fill in our questionnaire online at http://www.camdenccg.nhs.uk/about/questionnaire.htm.

For further information about the procurement process or to read the background documents, please take a look at our websites at:

Barnet CCG	www.barnetccg.nhs.uk
Camden CCG	www.camdenccg.nhs.uk
Enfield CCG	www.enfieldccg.nhs.uk
Haringey CCG	www.haringeyccg.nhs.uk
Islington CCG	www.islingtonccg.nhs.uk

Questionnaire

We welcome any feedback or ideas you have, but we are particularly interested in your answers to the following questions. You do NOT have to answer all the questions and please use extra paper if necessary.

Confidentiality

If you are responding **on behalf of an organisation or you are representative** of service users/the public e.g. an MP or councillor, your response may be made available for public scrutiny.

If you are responding in a **personal capacity**:

- and you would like to be kept informed of our work then please insert your name and address on the questionnaire
- your response (but not your personal details) will be shared with decision-makers to enable them to consider your views fully
- whether or not you provide your name and contact details, your response will not be published but unidentifiable quotes may be used to illustrate comments made.

Question 1. **Are you providing this response** (please tick):

☐ In a personal capacity

☐ As a representative of a group. Please state which group you are representing

_____

Question 2. **Which borough do you live in?** (please tick):

☐ Barnet

☐ Camden

☐ Enfield

☐ Haringey

☐ Islington

☐ Other (please tell us which one)

_____

Question 3. **Which borough do you work in?** (please tick)

- ☐ Barnet
- ☐ Camden
- ☐ Enfield
- ☐ Haringey
- ☐ Islington
- ☐ Other (please tell us which one)

_____

Question 4. **Have you used NHS 111 or a GP out-of-hours service in the past two years?** (select all that apply)

- ☐ NHS 111
- ☐ GP out-of-hours
- ☐ Neither

Question 5. **We are considering a proposal to commission an integrated NHS 111 and GP out-of-hours service across north central London. What factors are most important for you when using these services? (**please select your top five**)**

- ☐ Out-of-hours' sites being easy to get to by public transport
- ☐ The service being accessible for people who don't speak English as a first language
- ☐ Getting useful advice about your condition quickly
- ☐ Getting useful advice from the first person you speak to, without being referred
- ☐ Being able to speak to a nurse or other health professional
- ☐ The service being accessible for people with a physical disability
- ☐ Being able to speak with someone with good knowledge of local services
- ☐ The service being accessible for people with a hearing or visual disability
- ☐ The service being able to book an appointment with your GP practice (inside practice working hours)
- ☐ Being able to speak to a doctor
- ☐ Being able to speak with a local doctor
- ☐ Being able to speak with someone with access to your medical records
- ☐ Other _____

Question 6. Our preferred option is to commission an integrated NHS 111 and GP out-of-hours service across Barnet, Camden, Enfield, Haringey and Islington. With which option do you agree/disagree? (Please circle)			
Option 1 – Commission one NHS 111 and two GP OOH services (one in Camden and Islington, one in Barnet, Enfield and Haringey) – No change	Agree	Disagree	Don't know
Option 2 – Each CCG to commission its own NHS 111 and GP OOH services	Agree	Disagree	Don't know
Option 3 – Commission an integrated NHS 111 and GP out-of-hours service across five boroughs – our preferred option	Agree	Disagree	Don't know
Please explain why: _____			

Question 7 Is there anything particular you would like us to consider in our proposal to commission an integrated NHS 111/Out-of-hours service?

_____

_____

_____

Please tell us a little about yourself (**this section is NOT compulsory**). If you wish to remain anonymous, your views will still be taken into account, however we would be grateful if you would fill in other data so that we can assess how representative respondents are and whether there are differences to the answers given by different groups of people.

a) Name

b) Would you like to be kept up to date with information about the NHS (including this programme) Yes No

If so, please give us your email or postal address .....

c) Are you…(Circle all that apply)

- Male/Female/Prefer not to say
- Responding as a Service user/Carer/Local resident/Other/Prefer not to say
- Employed by the NHS? Yes/No/Prefer not to say

- Aged….Under 16 16-25 26-40 41-65 65+ Prefer not to say

d) Ethnic background (please tick all boxes that refer to you)

White
- ☐ British
- ☐ Irish
- ☐ Any other White background

Black
- ☐ Black British
- ☐ Black Caribbean
- ☐ Black African
- ☐ Any other Black background

Asian
- ☐ Asian British
- ☐ Indian
- ☐ Bangladeshi
- ☐ Pakistani
- ☐ Chinese
- ☐ Any other Asian background

Mixed
- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other ethnic group
- ☐ Prefer not to say

e) Which belief or religion, if any, do you most identify with?

☐ Agnostic ☐ Atheism ☐ Buddhism ☐ Christianity ☐ Hinduism
☐ Islam ☐ Judaism ☐ Sikhism ☐ Other ☐ Prefer not to say

f) Do you consider yourself to have a disability?

☐ Yes ☐ No ☐ Prefer not to say

Please send your questionnaire to us either by email to feedback@nelcsu.nhs.uk or send it back by post to:

NHS 111/out-of-hours
Communications Department
NEL Commissioning Support Unit
75 Worship Street
London
EC2A 2DU

All comments must be received by 31 July 2015

If you need this document in large print, in Braille or you need it in a different language, please contact us using the details above or call 020 3688 1615.

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

25 September 2015

Future Dates/Work Plan

1. Work Plan

27 November 2015 (Barnet)

The proposed agenda items for the meeting on 27 November are as follows:

1. LAS Update;

2. Stroke Pathways;

3. Primary Care Update on the "Case for Change";

Potential Future Items

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:

- Dementia;
- NMUH – Foundation Status;
- Whittington Hospital – further development;
- Public Health indicators;
- Child obesity;
- Patient safety;
- 7 day NHS;
- Maternity update – mental health support; and
- New model for child and adolescent mental health services.

2. Future Dates

2.1 There are currently no further meetings of the Committee scheduled after the meeting on 27 November. Committee Members may therefore wish to consider setting some additional dates, possibly in January and March 2016.

This would reflect the numbers of JHOSC meetings that have taken place in previous years. The venues for the next two meetings will be Enfield and Camden respectively.

3. Webcasting Facilities

3.1 At the last meeting of the JHOSC, Committee Members requested that officers investigate the feasibility of webcasting future meetings.

3.2 There is currently limited scope for the webcasting of meetings. Barnet, Enfield and Islington do not currently have in-house webcasting facilities. Haringey has webcasting facilities within its Council Chamber but the room is currently used for citizenship ceremonies on Friday mornings, which is when the JHOSC normally meets. Should a day be chosen for JHOSC meetings when the Council Chamber is available, it may be possible to use the webcasting facilities in the future.

3.3 It is possible to webcast meetings at Camden and this is done for its Full Council, Cabinet and Development Control Committee. However, in order for meetings to be webcast, they would have to be held in the Council Chamber, which might constrain when they could be held as the Chamber is regularly in use for a range of meetings. There are also cost and staffing implications to Camden in extending webcasting to cover this body.