ENCLOSURE: F

Agenda Item: 124/14

NHS Bexley Clinical Commissioning Group

Governing Body (public) meeting

DATE: 27 November 2014

Title	South East London 111 Procurement Strategy
Recommended action for the Governing Body	That the Governing Body: **Discuss** and **agre**e the approach to re-procurement of NHS 111 proposed in this paper, particularly agreeing the recommendations in section 2 of this paper.
Executive summary	In 2012/13, the new NHS 111 service was launched in London, where it was agreed to pilot it for two years. The new service was specified by the Department of Health and commissioned locally through a tender process. SEL now needs to re-procure 111, and there is an opportunity to re-commission 111 as an enabler for SEL's five-year strategy to improve urgent care pathways. The SEL NHS 111 Programme Board plans to: • Develop the local service specification including developing controls for quality and improved patient outcomes. Two workshop events have been set for October 2014. • Consult with the market in November 2014 and publish an invitation to tender early in 2015. • Review the options of developing outcome-based commissioning for the new service specification. This will require resources and a timeline to allow the necessary analyses and clinical engagement. • Provide assurance to SEL CCGs and NHS England. To support CCGs, NHS England has developed a 'NHS111 Procurement Guidance' document and checkpoints assurance process (created by SLCSU) to support CCGs and NHS England assure the process. Bromley CCG, lead commissioner for NHS 111 in South East London will undertake a mini procurement to appoint the most appropriate service to undertake 111 procurement. The new procurement service will work very closely with the programme team to ensure that good models of practice are in place.

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Which objective does this paper support?	**Patients:** Improve the health and wellbeing of people in Bexley in partnership with our key stakeholders		✓
	People: Empower our staff to make NHS Bexley CCG the most successful CCG in (south) London		✓
	Pounds: Delivering on all of our statutory duties and become an effective, efficient and economical organisation		✓
	Process: Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience		✓
Organisational implications	Key risks (corporate and/or clinical)	See section 9 – 111 Procurement Risks	
	Equality and diversity	See section 6.4 – Equal Access to 111 Services	
	Patient impact	See sections: 5.3 – Commissioning for Patient Outcomes 5.4 – Reducing the number of patient interactions / triage points in the patient journey 5.6 – Increase digital access to 111 and utilise technology to improve the patient experience and improve access for self-management 6.3 – Increased access to patient records	
	Financial	Strategy to be agreed fist. No financial implications at this point.	
	Legal issues	See section 4.4 – Re Procurement Process	
	NHS constitution		
Consultation (public, member or other)	SEL 111 Clinical Governance Group is attended by patient representatives who also sit on the SEL 111 Patient Engagement Group.		
Audit (considered/approved by other committees/groups)	• SEL 111 Clinical Governance Group • SEL 111 Programme Board • SEL Clinical Scrutiny Committee • SEL CCG's Governing Bodies		
Communications plan	SEL commissioners need to consider local targeted marketing initiatives in conjunction with new ways to access 111, to support the promotion of 111.		

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Date	24 October 2014	

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1. SEL vision for 111

Commissioners in south east London, in partnership with key stakeholders, have been developing plans for urgent and unscheduled care. Their vision for the future 111 service is:

1.1 NHS 111 is the key enabler to ensure that people with urgent care needs are given the right advice first time, to ensure they then seek care in the setting most appropriate for their needs.

1.2 NHS 111 is at the centre of an integrated care network and should be enhanced for patients as the 'smart call to make,' creating a 24-hour personalised priority contact point with access to patient records.

2. Recommendations for the CCG Governing Body

The CCG Governing Body is asked to agree the key points and principles listed below, that will underpin the 111 procurement strategy for South East London (SEL) for 2014/15.

2.1 South East London CCG 111 Programme Board will oversee the re-commissioning of NHS 111 within the timescales outlined. The SEL CCG 111 Programme Board will be accountable for overseeing the projects/work streams to deliver SEL procurement for 111.

2.2 The recommendations in section 5 that will shape patient outcomes will form the basis for commissioning a new 111 service. These recommendations will provide the market with an opportunity to propose service models that will improve patient outcomes in line with SEL's five-year commissioning strategy.

2.3 The new specification will include the recommendations in section 6 to improve access and capacity in 111 receiver services for unscheduled care (Directory of Services capacity).

3. Purpose

3.1 The purpose of this document is to summarise the outputs of the South East London commissioner workshop on the 13th May 2014 and subsequent discussions and detail the key elements and process for the re-procurement of 111. A draft timeline for procurement is given in section 8. This paper has already been presented to the CSC and agreed by that committee.

4. Background and current position

4.1 Strategic fit for NHS 111

One of the key recommendations in the Emergency and Urgent Care Review is to ensure that people with urgent care needs are given the right advice in the right place, first time, to ensure they then seek care in the setting most appropriate for their needs, rather than defaulting to A&E. In order to achieve this, it is recommended that CCGs use NHS 111 as a key enabler for their urgent and unscheduled care strategies. It is also possible to enhance NHS 111 services, for example, advertising the service as the 'smart call to make,' and creating a 24-hour personalised priority contact point with access to patient records. The report also notes the benefits of NHS 111 being at the heart of an integrated care network.

http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

As part of the South East London five-year strategy, CCGs in South East London and the Clinical Leadership Group (CLG) for Urgent and Emergency Care has included the NHS 111 service as an essential part of urgent and out-of-hours access for patients in the future.

This multi-professional group, which includes members of the public, regards NHS 111 as the potential 'glue' between the different services and also as a mechanism to better develop self-management and access to community services for the population. Having better access to special patient notes (e.g. for Co-ordinate My Care) and a fuller and more thorough Directory of Services should help the population get the right care in the right setting.

As detailed below, making fuller use of NHS 111 and advertising it to the population of South East London is a key element of urgent and emergency care.

4.2 Implementation of NHS 111 so far

In 2012/13, the new NHS 111 service was launched in London, where it was agreed to pilot it for two years. The new service was specified by the Department of Health and commissioned locally through a tender process. Nationally almost a million calls were answered by NHS 111 providers in June 2014 and latest NHS 111 providers' service satisfaction survey data show that almost 90% of users of NHS 111 are satisfied with the service they received.

NHS Direct was successful in tendering for the joint SEL contract that went live in March 2013 from a location in Beckenham in South East London. (This service was also successful in bidding for NHS 111 services to Merton and Sutton and part of East London). However, in June 2013 NHS Direct indicated that they would exit the

market following significant service and financial failure nationally, caused by the lack of viability of their business model.

In line with other parts of the country that also used NHS Direct to deliver NHS 111 services, urgent arrangements were made for a step-in provider to take over the service. In November 2013, London Ambulance Service (LAS) went live as the South East London 111 provider, following a restricted procurement process involving local London 111 providers as potential emergency step-in providers. At the time of this emergency re-procurement, many national and local NHS 111 providers were subject to rectification plans and were having difficulty in delivering 111 services to nationally specified standards.

SEL now needs to re-procure 111, and there is an opportunity to re-commission 111 as an enabler for SEL's five-year strategy to improve urgent care pathways.

4.3 Strategic context SEL five-year commissioning strategy

Urgent and emergency care has been selected as a priority work stream of South East London's five-year commissioning strategy. It is proposed to develop and use NHS 111 as a single point of access to direct patients to the right place, first time across the urgent care system by providing:

- access to relevant patient information at the right time.
- advice on the appropriate service for patient symptoms, or if appropriate, advice on self-care.
- an up-to-date Directory of Services to enable 111 call handlers to direct or book patients in to the right service for their symptoms.

In terms of the SEL vision to improve patient care, 111 will support joined-up care and rapid access to ensure patients consistently gain early access to the right care and appropriate self-care advice. This will be achieved by commissioning the right patient outcomes to ensure that a quality service is provided for patients. This approach will support smooth integration across the urgent care providers, including a reduction in the number of stages in the patient journey (otherwise known as patient 'handoffs'). The 111 and out of hours services will increase the number of 'right place, first time' episodes.

111 is a young service which is likely to develop as a result of NHS England pilots and in learning from feedback and incidents. This means the future service needs to be adaptable and amenable to change with appropriate interfaces built into the 111 programme delivery to ensure that the new 111 has the capacity to adapt to an environment that will be changing over the next five years. We will need to consider:

1. Recommendations from the NHS 111 London Learning Programme and also the outputs from the current 111 pilot funded by NHS England will inform the next version of the NHS 111 commissioning standards due to be published in the autumn of 2014.

2. Clinical leadership groups have set the vision for the next five years. The business cases are in development and SEL is in consultation with stakeholders.

3. Local implementation of new models of primary care

4.4 Re-procurement process

The SEL NHS 111 Programme Board plans to

- develop the local service specification including developing controls for quality and improved patient outcomes. Two workshop events have been set for October 2014
- consult with the market in November 2014 and publish an invitation to tender early in 2015.
- Review the options of developing outcome-based commissioning for the new service specification. This will require resources and a timeline to allow the necessary analyses and clinical engagement.
- Provide assurance to SEL CCGs and NHS England

To support CCGs, NHS England has developed a 'NHS111 Procurement Guidance' document and checkpoints assurance process (created by SLCSU) to support CCGs and NHS England assure the process. The first assurance checkpoint will include evidence of:

- local service specification includes all key elements from the NHS 111 Commissioning Standards and embedding NHS111 into the local urgent care strategy;
- appropriate procurement process and documentation used;
- assurance of appropriate skills and 111 experience has been appointed to undertake the procurement process from commencement to pre-contract award and mobilisation.

Bromley CCG, lead commissioner for NHS 111 in South East London will undertake a mini procurement to appoint the most appropriate service to undertake 111 procurement. The new procurement service will work very closely with the programme team to ensure that good models of practice are in place.

5. Achieving the procurement strategy – recommendations for commissioning 111

5.1. This section lists the priority areas to develop the 111 service to support delivery of SEL's urgent care strategy.

5.2. Section 6 lists areas outside the scope of 111 that commissioners need to take the lead on to ensure NHS 111 is effective as the 'front end' of urgent care and run parallel to ensure development of the 111 service:

- developing the capacity of other services in the unscheduled care system to take direct 111 referrals;
- providing 111 with access to patient records to support patient urgent care pathways.

5.3. Commissioning for patient outcomes

SEL would like to develop a set of patient outcomes and invite providers to propose options for service models that will improve patient outcomes. This approach will encourage providers to develop partnerships and innovate to deliver an integrated urgent care experience.

This approach will require significant GP resource and stakeholder engagement across a wider urgent care system to develop the specification for procurement that will incentivise the right behaviours and monitor for unintended consequences. SEL will commission a 111 provider that can demonstrate a robust system of continuous monitoring and service improvement in order to improve patient experience and ensure that we achieve value for money. This will be demonstrated by staff education and support, patient engagement, patient outcomes and clinical audits.

Some examples are listed below where commissioning outcomes for patients could deliver a better patient experience and improve efficiency in the urgent care system by increasing the number of patients directed to the right place, first time.

5.3.1. Reduce referrals to acute services to avoid hospital admissions - an audit of 111 referrals to LAS showed that around half were not clinically appropriate. SEL referrals to LAS are low compared to other 111 providers, but there may be scope to reduce these further.

A recommendation from the London Learning Programme suggested increased access to patient records and special patient notes (SPNs) may reduce referrals to ED.

Commissioners can use 111 to ensure utility of new services in line with commissioners' strategy, for example, 24-hour access to home wards and

sub-acute rapid access response services or direct all non-blue light flow to urgent care centres rather than EDs.

5.3.2. Increase self-care advice - the future procurement specification should include incentives to increase the number of patients with a 'self-care disposition' that is handled within the 111 service. Currently, in SEL 6% of 111 callers reach a self-care disposition, and this is 11% in south west London. The impact of setting a stretch target of 20% to 25% should be explored to reduce onward referrals when it is clinically appropriate.

5.3.3. Ensure patients referred to GP out-of-hours services (OOH) for a face-to-face or telephone assessment are appropriate to facilitate direct booking into OOH for face-to-face visits.

5.3.4. The service will be commissioned to ensure 111 call handlers and clinicians use the Directory of Services (DoS) and service access instructions to direct patients to an appropriate service in line with local commissioning intentions. This will ensure 111 is responsive to changes in local service provision where urgent care pathways are changed. For example, patients should be encouraged to visit pharmacies for repeat prescriptions in line with changes in commissioning.

5.4. Reducing the number of patient interactions/triage points in the patient journey

Review of the current 111 service data highlights opportunities to scale down the triage from three to two points to improve the patient experience. For example, 50% of patients currently speaking to a 111 clinician are then passed on to a GP. These calls could be directed straight to a GP provider or a GP within the 111 service.

SEL would to like to commission a service that encourages providers to reduce inefficiencies where a patient may wait for a clinical call back only to be told they need to wait for a GP to call back. Another option requiring further analysis is the clinical assessment of GP dispositions from 111 by OOH providers. In SEL OOH services are triaging calls from 111 to validate the see or speak to disposition; is this good use of GP time?

5.5. Extending the use of 111 infrastructure

CCGs have already invested in sophisticated infrastructure for 111 and could utilise the resources to increase the scope of 111 to increase value for money. For example, 111 could:

- provide an access point for extended hours for GP services;
- a single point of access for a patient to access community services or mental health services;
- co-location of Single Points of Access under one location, where appropriate and possible.

5.6. Increase digital access to 111 and utilise technology to improve the patient experience and improve access for self-management

5.6.1. Increase access to 111 and OOH through advancing the digital agenda with apps, use of web-based conference apps and symptom checker, enabling direct referral into 111 and OOH services, particularly engaging the younger age groups of patients using A & E.

5.6.2. Explore options for web-based requests for call backs for advice from 111.

5.6.3. Direct access to dental services is limited to a telephone call or fax from 111, resulting in the patient waiting up to 10 minutes to be transferred for an appointment. Trial direct bookings from 111 into dental services.

5.6.4. On line/text cancellation of appointments by patients given by 111, if no longer required, to reduce the number of Did Not Attends (DNAs) in OOH and Urgent Care.

6. Achieving the overall urgent and emergency care strategy – recommendations for commissioners to improve efficiency and effectiveness of 111

In order to optimise 111 as an enabler to transform urgent care pathways, work will need to continue in parallel on commissioning other services in SEL to improve capacity and access for 111 receiver services.

6.1. Review access and capacity of other services for unscheduled referrals from 111

Optimising the services that can take direct referrals from 111 may reduce inappropriate referrals to acute services, for example, chronic asthma and blocked catheters referred to ED. All options to re-direct 111 callers into primary care services will need to be explored, especially current and planned services for chronic disease management, in order to deliver the benefits of 111. The services below have been highlighted through the SEL clinical governance forum as requiring more work to increase 111 referrals.

1. Community – in SEL only 1% of calls are being referred to community services. It is expected that the rapid response teams, joint social care teams and others should receive a direct referral from 111 as appropriate, and any capacity issues should be resolved at the CCG level.

2. Mental Health – use of mental health specialist services within the 111 service or through a joint approach with other areas to enable 24-hour support.

3. Pharmacies – working with pharmacies to support future enhancements to provide primary care for seven days from eight am to eight pm on weekdays and eight am to six pm on weekends.

4. Dental – CCGs need to work with NHS England to resolve the OOH's dental service gap that has been increased since the decommissioning of the NHS Direct nurse-led dental service.

6.2. Integration of patient pathways and commissioning across 111, 999, UCC and OOH

1. CCGs to lead on bringing data together from different providers to enable a comprehensive picture of a patient journey from accessing urgent care in 111 through to the service they are referred to. This will provide transparency on the full impact of commissioning decisions in terms of outcomes and cost.

2. Review patient pathways and outcomes from 111 referrals to urgent care providers to improve the Directory of Services and identify gaps in provision.

3. Improve integration between 111, 999 and urgent care contract management and clinical governance through joint meetings and steering groups.

6.3. Increased access to patient records

The NHS 111 Commissioning Standards of June 2014 state that access to the existing summary care records must be the minimum standard. Commissioners should encourage providers to develop wider sharing of records across the health system.

Patient experience will be greatly improved when NHS 111, 999 and providers delivering services in the OOH period have access to GP records and care plans to enable appropriate advice and organisation of appropriate support to complement current treatment advice.

The current landscape with the Coordinate My Care's end-of-life register (CMC), Special Patient Notes (SPNs) and other emergency care records is challenging because it is not always clear who is responsible for updating records, and the burden falls to GPs. Exploring access to the GP clinical record system and reviewing current adherence to policies for end-of-life records and special patient notes to improve compliance will need to be addressed as part of this programme of work.

6.4. Equal access to 111 services

The SEL clinical governance forum has reviewed the ethnicity and age breakdown of 111 callers, and this has illustrated that more vulnerable patient groups are not accessing 111. A review of the SEL service specification will also be an opportunity to review equality of access and work with 111 providers to improve access for the elderly, disabled and local ethnic minorities.

SEL commissioners need to consider local targeted marketing initiatives in conjunction with new ways to access 111, to support the promotion of 111.

7. Recommendations

The CCG Governing Body is requested to:

Discuss and agree the approach to re-procurement of NHS 111 proposed in this paper, particularly agreeing the recommendations in section 2 of this paper.

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8. Procurement timescales

The proposed timescale has allowed time for the work required to develop the service specification and explore the recommendations listed in section 4.

111 Procurement Key Milestones

	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Pre-tender	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Select procurement partner and agree procurement process (2 to 4 months)															
SEL clinical strategy group to sign off 111 procurement strategy															
SEL governing bodies to sign off 111 procurement strategy															
Pre-market engagement event with providers															
Define TUPE requirements															
Develop local specification/KPIs and local documentation															
Stakeholder engagement															
Develop call volumes analysis for tender documentation															
Agree contract and supporting schedules															
Agree SEL procurement governance															
Agree project plan															
Checkpoint -1 Delivery strategy pre tender assurance up to publication of docs															

Tender stage															
Checkpoint - 2 Checkpoint 2 investment decision (before contract award)															
Mobilisation of provider															
Checkpoint - 3 Operational review (before go-live)															

9. 111 Procurement risks

No	Risk:	Mitigation:
1	Beckenham 111 centre lease expires in June 2016, and landlord will not renew. Start-up costs in year for a new location and accommodation fit are likely to be significant	• Identify TUPE and premises issue early in engagement with potential providers • Include premises questions and mobilization of new premises within ITT
2	Contract variations to support changes to local strategies affecting call volumes and service developments	• A strong contract detailing process for local variation to support changes expected • Current 111 Commissioning Standards will be updated at least once a year in the future and may result in contract variations during the term of the contract to meet new requirements.
3	Risk of perverse incentives: Around 111 streamlining to OOH due to a difference in tariff where 111 and OOH is provided by the same provider.	• The contract model and KPIs will be required to mitigate for this scenario including call audits. • Clinical outcomes are based on specific responses from patients, and it would be difficult for a provider to manipulate the patient flow at scale.
4	Lambeth, Lewisham and Southwark GPs Opt-in for OOH provision.	• Engage with the GP practice consortium and commissioners in June to discuss procurement and requirements • Include GP membership on steering group
5	Impact of primary care strategy. Extension of GP hours could reduce the 111 call volume.	• 111 call demand modelling needs to include the trajectory for the impact of extended GP hours. • Where there is a risk of business viability, other options should be explored, e.g., 111 to provide a call handling service for extended GP hours.
6	Outcome-based commissioning is a risk for providers and may reduce the market.	• Engage with the market and negotiate risk share in contract model

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