

### 1.16.2 Delivery Model (Outcome Measures)

Please provide details on how you will translate the business intelligence gathered from patients and carers into outcome measures that are person centred and which involve putting patients and their families and carers at the heart of their care?

(Maximum Word Count 1500)

Words used = 1496

Vocare uses its business intelligence to monitor that our GP-OOH service in Staffordshire delivers care that put patients, families and carers at the centre. We are aware that person-centred care and co-creation have been associated positively with satisfaction with care and the physical/social wellbeing of patients in primary-care settings<sup>1</sup>.

We gather a wide range of business intelligence that we review and report as outcome measures that map to the 5 domains in the NHS Outcomes Framework and the contract's KPIs (covering national/local quality requirements); e.g. identification of immediate life-threatening conditions maps to Domain 1. Outcome measures evidencing person-centred care include positive patient-satisfaction surveys, numbers/types of incidents and complaints/compliments.

*Our strength and skill is in how we analyse regularly collated data & intelligence to provide assurances around ability to provide safe, high-quality, evidence-based services to patients.*

At contract/area/regional/divisional and organisational level (Vocare is part of Totally plc's urgent-care division), we will use outcome measures to confirm that our service meets/exceeds the specification and the range of patients, families and carers needs through person-centric services.

Where outcomes measures show good levels of person-centred care, we will disseminate that good practice across the contract team and to (and from) other contracts. Where measures indicate improvement is needed, we will work with our teams, local patients, patient/community groups and other system partners to identify and implement ways to make our services more person-centred.

#### 1.16.2.1-Gathering business intelligence

Sources of business intelligence on person-centred care include:

- Our clinical record systems, e.g. recording where patients have communication needs as per the accessible information standard.
- Quarterly audits of clinicians using a standardised 'reflect tool' that detects issues relating to e.g. information gathering, clinical-thought process, dangerous diagnoses, safeguarding/child-protection issues, safety and written records. An example is insufficient documentation to evidence the patient's voice during a consultation.

<sup>1</sup> BMC Health Serv Res 19, 13 (2019)

- Monthly audits of 'comfort calls' by Home-Visit Despatchers to patients awaiting clinician attendance. Our audit tool measures e.g. whether we asked about change in patient symptoms, data-protection checks and if safety-netting advice was given for worsening conditions.
- Monthly 'comfort call' audits for Centre Receptionists, who call booked patients when unexpected developments affect Centre schedules to avoid them waiting longer onsite e.g. 2 recent emergencies in one shift in a centre that involved resuscitation and ambulance transfer impacted scheduling for that shift.
- Prescription audits (part of our antibiotic-stewardship programme).
- Safeguarding audits.
- Breach reviews.
- System-partner feedback, e.g. NHS-111 provider WMAS, local EDs and in the South Lot from the prison teams and the prison healthcare providers e.g. Practice Plus Group, Midlands Partnership NHSFT (Inclusion), South Staffordshire & Shropshire NHSFT and Northamptonshire Healthcare NHSFT.

#### **a)-Intelligence from patients/carers – PROMS**

Intelligence directly from patients/families/carers is our litmus test that we have both listened and acted on meeting local demographic needs. Sources include:

- Surveys e.g. FFT and service surveys, which are accessible via QR codes on posters and our website. FFT provides a net-promoter score, however, the free text feedback can inform us about whether patients perceive our care to be person centred. We are in contact with NHSE Health in Justice regarding a version for use in the South Lot's prisons. For our surveys, options for the new contract include a PROM often used in our Urgent-Treatment Centres that asks patients if, following care, they are better prepared if the circumstances happen again.
- Comments during consultations (which we encourage clinicians to feed into analysis).
- Feedback on websites/social media, including NHS Choices/Care Opinion. While most is not about our Staffordshire GP-OOH service, it provides intelligence that will can use to make delivery more person centred.
- Complaints/compliments are excellent sources of intelligence on how person-centred our care is. In the past 18 months, we have received almost as many compliments as complaints (13 versus 15 in 206,223 patient contacts). Complaints regarding staff attitude/behaviour are particularly useful measures.

*Examples of compliments that help assess patient 'centredness' include:*  
*"He [receptionist] was always welcoming & friendly, very professional & always kept the patients up to date by explaining if & why there were delays, providing updates & apologising for this."*  
*"He [GP] examined me and listened to how I was feeling with compassion and understanding. I really felt that I had been given time from a professional Doctor who cared".*

On the new contract, the contract leads (Operations Manager, Medical Lead and Clinical Services Manager) will build on existing stakeholder relationships e.g. local community services (MPFT) and

hospices (e.g. Katharine House) that support access to intelligence that enhances our ability to deliver person-centred care.

Associated outcomes measures will be agreed during mobilisation but are likely to include e.g. numbers of contacts with patient/community groups to gather intelligence on GP-OOH services; that patients are involved in and have access to their care plans and that patient views/feedback are regularly obtained with comments reflected in continuous service improvement.

We will establish measures such as numbers of patient stories collected and patient/clinician Centre walk-throughs e.g. using the NHS 15-step challenge tool (also for home visits). Using the contract stakeholder map with local community and condition-related groups, we will recruit people to participate e.g. those with learning disabilities, veterans, homeless, sex workers and other 'easy-to-ignore' groups. Such activity will help us make services more cognisant of their needs and what matters to them.

*Pre-pandemic, our Staffordshire team collaborated with the charity dDeaflinks to understand the experience of deaf service users & any access issues using patient stories. This led to a shared learning event where we invited dDeaflinks to present at our workshop giving insight to staff on the disability & how best to communicate.*



### 1.16.2.2-Translating business intelligence into outcome measures

#### a)-Establishing outcome measures

During mobilisation, we will establish outcome measures related to person-centred care as this service will differ from the existing service with the move of NHS-111 to WMAS.

The contract leads and the Staffordshire Operational Director (point of contract accountability) will work with our Patient-Engagement Lead and Business Intelligence team to compile relevant outcome measures. They will align to the NHS Outcomes Framework domains and the contract's national/local KPIs. Measures that are the KPIs will use the specified target e.g. IUC KPI 14, Meeting individual's needs, however, others will be specific to our audit tools and patient-

engagement activities e.g. recording communication needs, longer appointments for those with learning disabilities, collection of patient stories and interaction sessions community groups.

As an urgent-care provider, we believe various service elements positively contribute to the NHS Outcomes Framework e.g. Proportion of people feeling supported to manage their condition (2.1). Our assessments involve patient empowerment with clinicians ensuring patients are at the centre of the decision-making process. Our regional medical team feels strongly about 'No decision about me, without me' and actively promotes empowering patients to know how to manage their diagnosis/chronic condition. Indicators 2.4 and 4.4i (Health-related quality of life for carers and Access to GP services) will be outcome measures.

**Prisons:** Outcomes measures for person-centred care will also include the prisons if we win the South Lot. In line with the 2020 Primary care service – Medical & Nursing for Prisons in England specification, we will include outcomes for:

- PROMs: Patient-Reported Outcome Measures.
- PREMs: Patient-Reported Experience Measures.
- CROMs: Clinical-Reported Outcome Measures.
- PATOMs: Partnership-Reported Outcome Measures.

Examples include evidence in notes and discharge summaries that the patient has been involved in care planning, evidence of patient-feedback mechanisms and service-design involvement, implementation of the Dying Well in Custody Charter and action plans to implement recommendations.

#### **b)-How outcome measures will put patients/families/carers at the heart of care**

Personalising care will ensure patients remains at the centre of decisions. Our outcome measures will assess personalisation aspects and provide quality assurances. Unless services cater for needs of Staffordshire patients/carers, they are unlikely to achieve the outcomes designed to assess quality of this service.

#### **c)-Reviewing/actioning measure results**

Analysis of the outcome measures will be reviewed/actioned in monthly contract performance/governance meetings led by the Staffordshire Operational Director and attended by the contract leads. It will be reviewed as part of service improvement and quality/governance at area/regional level.

Where outcomes do not meet contract targets, we will develop action plans to address the issue at contract level or higher should data suggest we need to look more widely. For example, our comfort call audits identified downward trends in providing safety-netting advice and checking of worsening symptoms. Discussion with staff identified the issue affected calls regarding prescriptions and involved lack of understanding of why these aspects were so important. Reaudit then showed compliance at 100% for our Despatchers in Q1 2021.

Actions following outcome measures on complaints have included delivering shared learning sessions on staff attitude/behaviour using anonymised cases that focusing on non-verbal/verbal communication, customer-service skills and intent and impact. Although complaint investigations usually show no intent by staff, they highlight the impact on person-centred care e.g. wearing PPE (obscuring facial expressions), speaking to patients first before parents, how service delays can contribute to patients' concerns. Such use of outcomes measures emphasises the importance of our telephone and consultation training sessions that include non-verbal/verbal communication.