Clarifying Questions & Answers

Evaluation partner for accelerating prediction and prevention of urgent and emergency care in the NHS programme, North London's national demonstrator of AI-guided clinical coaching (AICC)

Updated on 30th July 2024

Application Details

Q: Can a timetable and risks table be included in the section covering project management? And if so, would this count towards the word count? Or alternatively, would it need to be included in the Appendix?

A: The proposed timetable and risks can be added to project management. We would recommend the detailed timetable (e.g. Gantt chart or similar) to go into an appendix and the risk table to be part of the main body of text. The content of the risk table would not be included in the word count, but should not be used as a vehicle for lengthy explanations.

Q: Can you confirm whether text contained within images included in the bid should be counted in the word-count?

A: Text contained within images will not be included in the word count. Diagrams should be clearly legible and not a vehicle for lengthy explanations.

Q: Can you advise whether invoicing and payment for delivery is expected to be at regular intervals or whether there will be a particular schedule of payments related to delivery of key milestones (and if so can you advise what these will be)?

A: Payments can be at regular intervals, likely quarterly in arrears for a set proportion of the total budget, to support cash flow and enabling the work to begin. In addition, there will be delivery-based payments linked to performance/milestones (e.g. delivery of relevant reporting, completions of RECs, finalising the protocol).

Q: Who holds the contract with Health Navigator?

A: The work is funded by NHS England and there are a number of contracts and subcontracts in place to ensure the funding flow and delivery. The main call-off contract outlining the programme delivery is between UCL Hospitals FT and Health Navigator. UCLPartners holds the contract with HN, and will directly sub-contract the Evaluation supplier.

Q: AICC and AI for UEC appear to be used interchangeably within the tender, can you confirm these are referring to the same intervention?

A: AI for UEC refers to the name of the programme, within which AICC is the intervention itself. The AI for UEC programme provides a wraparound support to ensure AICC intervention is delivered at scale and as intended. Evaluation will help us learn from this process.

Q: The ITT asks for "At least two relevant client references accessible to UCLP". Could you clarify what is required, i.e. do we need to provide side letters from previous clients, or are contact details sufficient?

A: It would be beneficial if the evaluator is able to provide letters from previous clients as part of the bid. However, we will accept contact details of two relevant clients that we might be able to contact following the interviews.

Q: The final assessment criterion is "Commitment to accessibility". Could you clarify what is meant here?

A: 'Commitment to accessibility' includes examples such as, interviews with patients that are accessible to the widest possible community, data collection mechanisms that are accessible to all and outputs that are presented in a plain English version. Assessing the accessibility of the intervention itself is part of the evaluation.

Q: Please can you confirm the dates in Appendix 1?

A: May '24 is classed as Month One, Year One; May '25 as Month One, Year Two etc. For awareness, timeline dates are contingent on implementation dates.

Evaluation

Q: Could you please clarify Objective 1?

A: For this objective we were envisioning primarily assessing the impact of using the tool on UEC service utilisation with and without health coaching.

Data Access

Q: Can the evaluation partner expect to access research-ready datasets, or would the data be directly extracted from clinical systems and still need preprocessing?

A: NEL data will be provided by HN to the evaluator. Regarding NCL, access of data will depend on agreements with NCL which is currently under discussion. There will likely be two streams of data, data from HN and data from NCL. Data from HN should be research ready. If data needs to be accessed from clinical systems i.e. from NCL, we

cannot guarantee the quality. The London Data Service already does a lot to prepare data and improve quality, but this will be outside of the control of HN or UCLPartners.

Q: Will the external evaluator have access to the record-level data, or will findings be supplied in summary form?

A: This will be dependent on what is agreed in the protocol, the legal justifications for being able to access such data and the capability of the ICB for anonymising or pseudonymising data for processing. It is unlikely that the evaluator will have full access to patient record data.

Q: Is there the potential to acquire or access pseudonymised Primary Care Data?

A: There is potential although this would need to be defined in the protocol. If accessing the data directly, the evaluator would need to be responsible for applicable DPIAs and contracts required for this access where appropriate.

Q: Is there an Integrated Population Health intelligence data platform or Secure Data Environment through which to acquire or interrogate data?

A: This will need to be discussed with ICBs as to what access is best for the data we want to access and process.

Q: Is the OneLondon integrated care record a potential source of data to support the evaluation?

A: Yes potentially, depending on what is defined in the protocol.

Data Collection

Q: What data and metrics (including patient activation and quality of life) are HN intending to collect and will this data be made available to the evaluator? Will there be an opportunity to collect similar data from the comparator group (NCL ICS)?

A: HN are intending to collect patient experience and outcome data. They are in the process of reevaluating which tools they will use based on the scale of this programme and building upon learnings from previous work. This data can be made available to the evaluator.
Regarding the collection of similar data from the comparator group, it is unlikely that this will be possible as this group will not receive contact and care from Nurse Coaches. However, there are ongoing conversations with NCL and their IG team regarding the exposure of patient identifiable information this service will be allowed to access, so collecting similar data from this group could be discussed.

Q: What consent processes do HN have in place, or plan to have in place, for collecting evaluation data from patients? Is there the opportunity for HN to approach patients to recruit them and gain their consent to be interviewed/participate in focus groups, and for their details to then be shared with the evaluator to then carry these out?

A: We will work with the evaluator to gain ethical approval to collect data from patients directly that covers the whole programme and will therefore include the evaluator as well as UCLPartners and HN. The details regarding exactly what data should be collected, processes for recruitment and consenting are being discussed based on HN's previous experience in implementing the intervention as well as UCLPartners' understanding and experience in this area. Wherever possible, existing patient contact points will be used as an opportunity to recruit and consent patients for evaluation purposes.

Q: Is it anticipated that s. 251 support will need to be in place in addition to ethical approval from HRA?

A: For patients within NEL, HN are in the process of pursuing section 251. For patients within NCL, we are exploring this option as a risk stratification supplier, although this would be for evaluative purposes. We will need to confirm the best route to information governance clearance with the evaluator once they are in place.

Q: Are the acute organisations appraised of the potential need to design, collect and generate data for regular learnings and insights to improve impact and effectiveness of the AI for UEC programme?

A: Acute organisations will have received high-level engagement to create awareness of the programme and the requirement for their involvement in ethics approval processes and, potentially, data sharing. However, the design and collection of data will be primarily led by the evaluator/UCLPartners/HN as the intervention is intentionally low impact on existing services and resources.

Algorithm

Q: Is the algorithm run on the current patient cohort (at the point of the staggered start) or from the start of the programme? What types of data are used in the predictive model?

A: The target population for the intervention is transient. Therefore, HN use the most current information available to feed into the algorithm to identify new patients. The predictive model will be using both primary and secondary data including inpatient, outpatient and admission data.

Q: Do you have baseline modelling about the impact on unplanned care?

A: HN do not have baseline modelling at this moment in time and plan to extract data before and after the intervention to understand the impact on unplanned care. Previous research conducted by HN (attached in the appendix) provides a guide as to the anticipated impact.

Q: What level of data will be available from the algorithm? Does it create a risk score for each patient?

A: The algorithm creates a risk score as a primary output. There may be the option to pull out feature importance as to what contributed to that score if this is deemed useful.

Q: Are you re-calibrating the algorithm for this population group and will it be the same model for NCL and NEL in terms of the algorithm?

A: The algorithm will not be the same as the populations, behaviours and NHS structures are different between NCL and NEL. However, HN will be patient matching to show equivalency.

Q: Is the algorithm registered with MHRA?

A: The algorithm is not registered with MHRA. After seeking external legal counsel, it was concluded that the algorithm was not a medical device and therefore it has been deemed not necessary to register with the MHRA.

Q: Within the tender specification it is noted that the AI algorithm will find and directly support 11,228 patients at high and rising risk of accessing unplanned care. How did you arrive at this number?

A: 11,228 is HN's target number for patients as committed in the contract but real numbers will vary depending on algorithm sensitivity, appropriateness of patients for coaching and the number of patients who are willing to be involved in coaching. These numbers were generated using estimates on drop offs based on HN’s previous experience.

Q: Will primary care clinicians in general practices in NCL and NEL be aware of who is identified as At Risk by the HN AI algorithm?

A: There are ongoing discussions as to the best approach to developing and managing NCL data flows and ensuring patient data protection overall. We will expect for the selected evaluator to contribute to these conversations once onboarded. As the NCL patients identified by the AI algorithm will not be contacted or receive the clinical coaching, the current plan is that NCL GP practices will not be informed.
In NEL, GP practices will be informed if patients sign up to the Clinical Coaching service but not if they decline/do not respond to the offered service from HN.

Learning Health Systems

Q: What ongoing direct feedback will be sought from patients and in what way (or does this simply refer to an expectation that this will form part of the evaluation)?

A: There are two elements to the evaluation, the evaluation of the intervention itself (led by an external evaluator) and evaluation of the implementation of the intervention using a Learning Health System approach. The expectation is that patient and public input will form part of the evaluation of the intervention as well as the Learning Health System.
The Learning Health System will be led by UCLPartners, but closely working with HN and the external evaluator. There are two types of datasets anticipated for this element; one is a regular report on the key monitoring measures (this will be aggregate data) and a second will be more qualitative in nature, recordings, action logs, records and notes from the regular meetings. This data will be used to monitor the implementation and include metrics which give insight into this such as; number of patients dropping out of the intervention, number of patients who were invited to undertake nurse coaching, but chose not to and duration of the intervention.
There will also be feedback and contact with patients and nurses to get an in depth understanding of their experience. This information will be fed back into the implementation and, wherever possible, used as a means to improve the implementation approach and ensure high quality delivery of service.
Regarding the setup of a PPIE group, this will be undertaken by UCLPartners with the aim of the group being representative of the population of NEL (as much as is possible). This group will provide oversight, input into any patient materials as well as provide ongoing guidance to the programme.

Clinical Coaching

Q: What is the (expected) monthly volume of new patients that will be onboarded to the coaching programme? And how long does the coaching programme last (for an individual patient), e.g. how many sessions over how many weeks?

A: The monthly volume of the patients will fluctuate as the progress is made with rolling out the intervention across the NEL localities. Total number of patients estimated to benefit from the intervention is 11200. Each patient will receive an hour-long assessment and then a number of follow up calls over 4 – 6 months period. The frequency of the follow up calls will be determined by the patient's needs, as appropriate and agreed with the patient. All efforts will be made to ensure the continuity of the contact with the same clinical coach. Coaching is a clinical and psychosocial intervention that promotes health literacy, empowerment, and care

coordination and can include motivational coaching to support self-care, linking with relatives, social services, GPs and 3rd sector.

Appendix: Index of HN published evidence

Academic Papers

- Bull LM, Arendarczyk B, Reis S, et al. **Impact on all-cause mortality of a case prediction and prevention intervention designed to reduce secondary care utilisation: findings from a randomised controlled trial** Emergency Medicine Journal Published Online First: 12 October 2023. doi: 10.1136/emermed-2022-212908
- Cohen, J N. Nguyen, A. Rafiq, M Taylor, P. **Impact of a case-management intervention for reducing emergency attendance on primary care**: randomised control trial British Journal of General Practice 2022; 72 (723): e755-e763. DOI: 10.3399/BJGP.2021.0545
- Wieske, M. Poduval, S. Hamilton, F. Kirby, B. Werr, J. **Artificial intelligence enabled clinical coaching impact on patient health outcomes**: A prospective cohort study (2019) available here. Edgren, G., Anderson, J., Dolk, A., Torgerson, J., Nyberg, S., Skau, T., Forsberg, B. C., Werr, J., & Ohlen, G. (2016).
- Edgren, G., Anderson, J., Dolk, A., Torgerson, J., Nyberg, S., Skau, T., Forsberg, B. C., Werr, J., & Ohlen, G. (2016). **A case management intervention targeted to reduce healthcare consumption for frequent Emergency Department visitors: results from an adaptive randomized trial**. European Journal of Emergency Medicine, 23(5), 344–350.
- Reinius, P., Fjellner A., Johansson, M., Werr, J., Ohlén, G., & Edgren, G. (2013). **A telephone-based case-management intervention reduces healthcare utilization for frequent emergency department visitors**. European Journal of Emergency Medicine, 20(5), 327–334.
- Laher, S., Brackstone, C., Reis, S., Nguyen, A., White, S., & Habli, I. (2022). **Review of the AMLAS Methodology for Application in Healthcare**. arXiv preprint arXiv:2209.00421.

Wider Evidence

- East Kent Poster, 2019 Poster produced by East Kent NHS analytics team – winners of Association of Healthcare Analysts' Team of the Year award.
- HETT Slides, 2019 Healthcare Excellence Through Technology (HETT) 2019 – presentation of HN's RCT results.
- Sara Reis, 2020 Ensuring fairness and inclusion in AI-guided patient screening
- Prof. Matthew Cooke, 2021 – Reducing the high healthcare demand of a few individuals
- NHSE Case Study, 2020 A case study of our York deployment, written by the NHS England Personalised Care Group.
- Policy paper, 2020 produced to explain the benefits of clinical health coaching.
- Videos Interviews with HN, our NHS partners, and patients.