MANCHESTER CITY COUNCIL
REPORT FOR RESOLUTION

COMMITTEE:	**HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE**
DATE:	**5 February 2009**
SUBJECT:	**NHS MANCHESTER UPDATE - PRIMARY MEDICAL SERVICES OUT OF HOURS**
REPORT OF:	**NHS MANCHESTER**

PURPOSE OF REPORT:

To inform the Committee of the procurement of the primary medical service out of hours service from 1 April 2009.

RECOMMENDATIONS:

1. Note the contents of the report

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BACKGROUND DOCUMENTS

National Out of Hours Quality Standards

PRIMARY MEDICAL SERVICES OUT OF HOURS

1. BACKGROUND

Following the implementation in 2004 of the new contractual arrangements for primary medical services, practices became eligible to opt-out of providing out of hours (OOHs) services to their registered patients. As a result the PCT became responsible for commissioning these services.

NHS Manchester currently commissions OOH medical services with two providers. In the central and south localities OOH services are provided by Mastercall. The current commissioning arrangements with Mastercall are managed collaboratively through a consortium agreement with Manchester, Stockport and Trafford PCT's, with Stockport as the lead PCT. In north Manchester, Primecare is the provider for the majority of practices and the commissioning arrangements with Primecare are managed independently by NHS Manchester.

Both contracts were due for re-tendering during 2008/09 (for the service provided from April 2009). NHS Manchester concluded that it should undertake this as a single commissioner with a city-wide approach. This will:

- ensure future service models are sensitive to local requirements by focusing on the Manchester footprint;
- take account of particular needs including provision related to Manchester Airport and the large unregistered population, which may not otherwise be duly reflected where services are commissioned jointly with other PCTs; and
- allow greater flexibility in the links between Out of Hours provision and the NHS Manchester's emerging work on urgent care, particularly in central Manchester.

The purpose of the OOHs service, as per the Primary Medical (Out of Hours Services) Directions 2006 (and any subsequent amendments), is to provide a comprehensive urgent, primary care service for NHS Manchester's relevant population, i.e.:

- patients registered with practices opting out of OOH cover under the new General Medical Services and Personal Medical Services contract regulations; and
- people not registered with a primary medical service provider but residing in the geographical boundary of Manchester, including transient populations.

2. PROCUREMENT

2.1 The Vision for the Service

The vision is to deliver a fully integrated service, accessible via one telephone call by the patient, that provides the most effective and appropriate intervention locally. In reality this encompasses a diverse range of statutory, voluntary and private sector services in a coordinated network of care.

The service provided will need to be sustainable, integrated and of high quality, and have the following features (listed in no particular order):

- A single point of contact with competent/effective and clinically safe triage to the OOH service at the first point of contact;
- Integrated service partnership working (including all health partners, Social Services and voluntary agencies, where appropriate);
- The provision of a team that has strong clinical/professional leadership and that values the individual roles within a team;
- Open to being part of an evolutionary process, balancing the need to work collaboratively with the need to be locally sensitive and innovative;
- Service improvements developed following the involvement of patients;
- Flexible resources and capacity to manage peaks and troughs in demand;
- Good, effective communication and co-ordination supported through robust use of information, management and technology;
- Clinically effective, evidence based and value for money service provision;
- Clear patient pathways developed and used within the service and for making referrals to mainstream in hours services;
- Education to inform patient expectations of the service; and
- Robust performance management principles that can demonstrate efforts towards continuous improvement.

The service has been commissioned to ensure equity of access to services for all patients including:

- traditionally hard to reach groups (including those who do not understand written or spoken English, providing access at all times to a professional translation service for consultations and translation of materials);
- those who cannot hear or see, or have other disabilities;
- asylum seekers or refugees;

- those who have no permanent address, including travelling communities; and
- black or minority ethnic communities.

Services provided will also need to be sensitive to culture, sexuality, age, religion and language around the needs of individual patients. This will include ensuring that appropriate training is provided to maintain the knowledge of its workforce and ensure implementation of relevant policies and procedures.

All patients will be valued as individuals, with respect for their privacy and dignity and confidentiality (which may mean ensuring that patients are able to access a clinician of the same gender).

2.2 Developing the Specification

A local service specification was developed following discussions with a primary medical service provider from each locality: central, north and south Manchester. All medical input was provided from primary medical service providers who are unaffiliated with a current or future OOHs provider.

This specification clarified the core requirements and standards to be delivered, and additional aspects to cover local requirements including:

- having a primary care centre accessible during all out of hours periods, i.e. 18:30 to 08:00 Monday to Friday and all day at weekends and bank holidays, within each locality (north, central and south Manchester) - the sites where current services are provided from were considered suitable;
- ensuring that patients who are not registered when accessing out of hours receive their care and are encouraged to register with a primary medical service provider;
- ensuring that the out of hours service provides coverage of patients within Manchester Prison (that are different to core out of hours provision) are clearly specified and understood.
- ensuring that the service supports medical training as a minimum, with provision for ad hoc training for nurses and allied health professionals if required;
- meeting national quality standards (attached at appendix A) as a minimum; and
- contributing to reducing health inequalities, e.g. opportunistic health promotion and referrals onto other services such as smoking cessation, mainstream primary care services.

Patients will be seen either at one of the primary care centres either following a telephone call and triage or as a ‘walk in’ patient, or, if

required, at home. In addition, the OOHs service will link into the medical centre at HM Prison to provide medical input as required out of hours.

Protocols will be in place with North West Ambulance Service for consistent prioritisation and transfer of calls to 999 for life threatening/appropriate conditions and ensure that patients do not have to make another call.

Primary medical service OOHs is a key component of managing care in the community, and as such there need to be links to other developments relating to urgent care, including:

- preventing people attending A&E departments unnecessarily where there are suitable community based alternatives, such as walk in centres and rapid access district nursing; and
- avoiding the need to admit people to hospital as emergencies where community alternatives may be utilised, such as intermediate care.

The OOHs service will integrate with any developments that impact on delivery of the above bullets to support of the wider service aims, and the Recommended Bidder will be expected to participate in future service redesign/development.

2.3 The Procurement Process

Following local development of the service specification a robust procurement exercise began seeking expressions of interest from potential providers in June 2008. A total of six potential providers were invited to tender for the service with completed tenders required in September 2008. The tender documentation was split into sections (see paragraph 2.3).

Two opportunities were provided for potential bidders to ask questions:

1) prior to the pre-qualification stage at a market type event, and
2) specific sessions prior to the submission date for tender documentation - a session was held for each provider to answer their specific questions and then all questions were collected and presented anonymously to all of the providers to ensure openness and transparency.

Following a pre qualification questionnaire phase six potential bidders were invited to tender. The key success factors were identified as being:

- *Access* – The services procured must be provided in locations and facilities that meet local patient access preferences (e.g. opening hours, specific locations);
- *Capacity* – The aim of the procurement was to provide primary medical care capacity in locations accessible by populations (taking

into account transport links as well as physical access). Potential capacity issues should be local and geographical rather than specialty related. The procurement will adopt a policy of local nil detriment which will focus on service delivery and not how or which people are employed;

- *Quality* – Patient-centred services will be delivered in a safe and effective manner and delivered through a learning environment that incorporates good performance management principles and includes the training of doctors and other healthcare professionals;
- *Value for Money and Affordable* – The services to be procured via the procurement must be affordable and demonstrate value for money; and
- *Integration* – Providers will be expected to integrate with, and positively contribute to, the local healthcare community to support local demand management initiatives and personalised care management.

2.4 Evaluation the Tenders

NHS Manchester established a multi directorate evaluation panel each reviewing particular sections of the tenders appropriate dependent on their levels of expertise, e.g. performance management. For each section there were at least two reviewers. This was completed in mid October and four of the potential bidders were then invited to present their tenders to a panel. A patient representative was involved in reviewing the patient and public engagement section and a primary medical service provider from outside Manchester was part of the team of people

At this stage two of the original bidders were not invited to the next stage and each received debriefs. The remaining four bidders were invited to present their proposals at the end of October 2008 to a small representative panel of NHS Manchester and this was used as an opportunity to clarify any concerns identified through the tender review.

Responses from the short listed bidders were evaluated based on the requirements as stated in the Invitation to Tender (ITT) documentation. These were weighted to produce a 'whole of bid' grading for each bidders' submission. The requirements represent the key issues that are important to NHS Manchester when determining the attractiveness, robustness and acceptability of bidders' proposals.

The apportionment of weighting amongst the different sections of the ITT is as below:

ITT Section	Evaluation Weighting
Scheme Overview	5%

Clinical	20%
Workforce	10%
IM&T	10%
Estates	5%
Commercial & Financial	20%
Transition Management	10%
Equality, Diversity & Access, Patient & Public Engagement and Sustainable Development	10%
Performance Management	10%

NHS Manchester's requirements sought to provide safe, patient-centred and high quality primary medical care services that are effective and flexible through robust staffing solutions and clean environments in the context of local delivery.

Following a review of responses to questions at the presentations a decision was made to identify the Recommended Bidder. Debriefs were offered to the unsuccessful bidders and two sessions were held (NHS Manchester was not asked for a session by one of the unsuccessful bidders).

The Recommended Bidder was GTD Harmoni - a limited liability partnership comprising a partnership of Go to Doc, an out of hours provider in Tameside, Glossop and Oldham, and Harmoni who provide primary care services nationally (including the provision of out of hours and urgent care services to 5 million people).

NHS Manchester has established a project team to work with GTD Harmoni to ensure the transition required from now until the service becomes operational on 1 April 2009.

A summary of the procurement process is identified in the table below:

Stage	Date
ITT issued to Short Listed Bidders	28/07/08
ITT Short Listed Bidder questions and clarification period	From 28/07/08 to 02/09/08
Deadline for receipt of bid submissions	09/09/08
ITT bid evaluation stage	From Sep to Oct 08
Selection of a Recommended Bidder and notification to all suppliers	Oct 08
Recommended bidder stage and contract signature	Dec 08
Service implementation stage	From Jan 09 to Mar 09
Contract go live	Apr 09

3. CONCLUSION

GTD Harmoni are currently working with NHS Manchester to:

- finalise the terms of the contract
- clarify and, where appropriate, revise the precise details of their bid.

GTD Harmoni will work together with NHS Manchester to prepare for the start of the Contract on 1 April 2009, the launch of the services and the agreement of ongoing performance management arrangements.

Appendix A

National Quality Requirements in the Delivery of Out-of-Hours Services

July 2006
Gateway no. 6893

Introduction

1. From 1st January 2005, all providers of out-of-hours (OOH) services have been required to comply with the national OOH Quality Requirements, first published in October 2004. The recent report by the National Audit Office[1] (NAO - The Provision of Out-of-Hours Services in England, London, 2006) identified a number of problematic aspects of the current Requirements and, since then, the Department has worked with the Royal College of General Practitioners (RCGP) to review the Quality Requirements in the light of these observations.

2. While the NAO Report identified some areas of misunderstanding or misinterpretation of the current Requirements and demonstrated further that some particular Quality Requirements remain challenging (particularly at periods of peak demand), none of its discussions with providers or commissioners revealed any sense that the Quality Requirements were either inappropriate or unachievable. The Department will not therefore be making any changes to the Quality Requirements that were published in October 2004; for ease of reference, they are reproduced below.

3. On the other hand, there is a need to clarify a number of aspects of particular Quality Requirements (including some important confusion about compliance). A number of these issues were addressed in the Commentary that was published at the same time as the Quality Requirements, and while this Introduction provides additional clarification, it should still be read in conjunction with that Commentary (The Commentary is available at : click on 'Out-of-Hours' in the menu on the left-hand side of the page and, in the new page that opens, click on 'Key Policy Documents' – scroll down to 'New quality requirements for out-of-hours services' http://www.dh.gov.uk/Urgentcare).

4. Consolidated guidance drawing together this Introduction with a revised and updated version of the Commentary will be published later in the summer.

Compliance

5. In a number of areas, providers have to demonstrate 100% compliance (see in particular Quality Requirements 8, 9, 10 and 12). In many circumstances, achieving compliance at all times would require a disproportionate provision of resources and, for that reason, compliance with these standards is defined as follows:

   5.1 **Full Compliance:** Normally, a provider would be deemed to be fully compliant where average performance was within 5% of the Requirement.

Thus, where the Requirement is 100%, average performance of 95% and above would be deemed to be fully compliant.

5.2. **Partial compliance:** Where average performance was between 5% and 10% below the Requirement, a provider would be deemed to be partially compliant and the commissioner would explore the situation with the provider and identify ways of improving performance. Thus where the Requirement is 100%, average performance of between 90% and 94.9% would be deemed to be partially compliant.

5.3. **Non-compliance:** Where the average performance was more than 10% below the Requirement, the provider would be deemed to be non-compliant and the commissioner would specify the timescale within which the provider would be required to achieve compliance. Thus, where the Requirement is 100%, average performance of 89.9% and below would be deemed to be non-compliant.

6. All the above measures record average performance and this can conceal wide variations in practice from day to day, and at different times within the day. It is therefore important that commissioners look behind the averages to see whether there is any recurring pattern which reveals a more serious situation. Where further analysis reveals an inability to put in place sufficient resources on a particular day or a particular time of the week or both, the provider could be deemed to be partially or non-compliant. Thus, for example:

6.1. A provider might achieve an average of 96% (where the Requirement is 100%), and thus be deemed to be fully compliant. But closer inspection would reveal that on a Sunday this might regularly drop to around 85% and, in such circumstances, it could be deemed to be partially compliant.

6.2. A provider might achieve an average of 91% (where the Requirement is 100%), and thus be deemed to be partially compliant. But closer inspection would reveal that on a Saturday morning this might regularly drop to around 75%. In such circumstances it could be deemed to be non-compliant.

7. Furthermore, wherever a provider is not in full compliance with a particular Requirement, the commissioner will want to be clear that performance has not reached a plateau from which no further improvement is taking place. Thus, in this circumstance, the commissioner would be looking for evidence of ongoing improvement over time and, in the absence of such evidence, would downgrade its assessment of compliance accordingly.

8. Where a provider is commissioned to deliver services for a number of different PCTs, it is important that its compliance data is disaggregated by PCT area. Data averaged across the PCTs could conceal wide variations in the quality of service provided in each locality, and it is only by reporting performance for each separate PCT population that commissioners will be able to assess the quality of the service that is being provided to their patients.

9. Those responsible for writing a service specification and the resulting contract need to ensure that both these documents include the detailed approach to compliance set out in paragraphs 4 through 8 above.

10. The Quality Requirements provide a clear and consistent way of assessing performance. Regular and accurate reporting of the precise levels of compliance with each Requirement will enable the commissioner and the provider together to identify what action is needed in those areas where performance falls short of the standard that service users should expect.

Definitive Clinical Assessment

11. This term is used in Quality Requirements 9 and 10 and there appears to be some confusion as to its meaning. Definitive clinical assessment is an assessment carried out by an appropriately trained and experienced clinician (not a call-handler) on the telephone or face-to-face.

    The adjective ‘definitive’ has its normal English usage, i.e. ‘having the function of finally deciding or settling; decisive, determinative or conclusive, final’ (Oxford English Dictionary, Second Edition¸ Oxford, 1989.). In practice, it is the assessment which will result either in reassurance and advice, or in a face-to-face consultation (either in a centre or in the patient’s own home).

Focusing more clearly on quality and patient experience

12. Quality Requirement 4 requires providers regularly to audit the clinical quality of the service they provide by auditing the work of each and every individual working within the organisation who contributes to clinical care. The Department is aware that some providers have had difficulties in delivering effective clinical audit and has commissioned the Royal College of General Practitioners to develop a new toolkit to support this particular Requirement. The toolkit will be published in the autumn of 2006.

13. Quality Requirement 5 requires providers to audit patients’ experience of the service and the Commentary that was published alongside the Quality Requirements made it clear that this is very different from traditional tools for measuring patient satisfaction. Thus, an effective questionnaire designed to explore the patient experience of the service will range much more widely than satisfaction, looking at patients’ access to the service (including the timeliness with which the service responded to their needs), the character and quality of their telephone encounters with the service, the character and quality of any face-to-face consultation, the environment within which face-to-face consultations take place and so on.

14. As the original Commentary emphasised, however, patient questionnaires are only one of a variety of tools which providers could employ better to understand the quality of the service they provide. While public and patient involvement has become increasingly common in other NHS organisations, it has (as yet) played little role in OOH organisations. Useful as questionnaires and focus groups and other methods of sampling experience may be for exploring patients’ firsthand

experience of the services they have used, none create the transformational opportunities presented by involving members of the public directly in the decision-making processes at the heart of the service. Effective public and patient involvement, coupled with regular audits of the patient experience could constitute a particularly powerful way of giving reality to Quality Requirement 5.

Matching capacity to demand

15. The NAO data showed that the overwhelming majority of PCTs reported very high levels of compliance with Quality Requirement 7 (the obligation to plan capacity to meet predictable fluctuations in demand), while at the same time reporting very low levels of compliance with those Quality Requirements that are designed to measure the match between capacity and demand (Quality Requirements 8, 9, 10, 11 and 12).

16. Both commissioners and providers will want to reflect on this mismatch in the data. Evidence from individual services suggests that it is at periods of peak demands that providers struggle to achieve compliance with the access Requirements, and yet Quality Requirement 7 explicitly sets out an obligation to plan effectively to meet those peaks in demand.

Conclusion

Nothing in the work that the NAO did in its review of OOH services suggested that the Quality Requirements were either inappropriate or unachievable. Regular and accurate reporting of performance against the Quality Requirements will ensure that the ongoing dialogue between commissioners and providers will be meaningful and well-informed, but its primary purpose is to give the service provider regular, accurate data about the quality of that service and thus provide a firm foundation on which to deliver further improvements in the quality of the service in future.

The National Quality Requirements

1. Providers (a provider is any organisation providing OOH services under GMS, PMS, APMS or PCTMS) must report regularly to PCTs on their compliance with the Quality Requirements.

2. Providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00 a.m. the next working day. Where more than one organisation is involved in the provision of OOH services, there must be clearly agreed responsibilities in respect of the transmission of patient data.

3. Providers 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).

4. Providers 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 contracting PCT. The sample must be defined in such a way that it will provide sufficient data to review the clinical performance of each individual working within the service. This audit must be led by a clinician with suitable experience in providing OOH care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service. Providers must cooperate fully with PCTs in ensuring that these audits include clinical consultations for those patients whose episode of care involved more than one provider organisation.

5. Providers must regularly audit a random sample of patients' experiences of the service (for example 1% per quarter) and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the contracting PCT. Providers must cooperate fully with PCTs in ensuring that these audits include the experiences of patients whose episode of care involved more than one provider organisation.

6. Providers must operate a complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the contracting PCT. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.

7. Providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as Saturday and Sunday mornings, and the third day of a Bank Holiday weekend. They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.

8. **Initial Telephone Call:**

Engaged and abandoned calls:
- No more than 0.1% of calls engaged
- No more than 5% calls abandoned.

Time taken for the call to be answered by a person:
- All calls must 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 must be answered within 30 seconds.

9. **Telephone 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 calls must be passed to the ambulance service within 3 minutes.

Definitive Clinical Assessment

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

- Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person
- Start definitive clinical assessment for all other calls within 60 minutes of the call being answered by a person

Providers that do not have such a system must start definitive clinical assessment for all calls within 20 minutes of the call being answered by a person.

Outcome
At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

10. **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 timescale within which further action will be taken and the location of any face-to-face consultation.

11. 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

12. **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.

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