

**URGENT
CARE**



at the
CROSSROADS

chaos or creativity?

nhsalliance

annual urgent care conference

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Urgent care at the crossroads: chaos or creativity?

Introduction

To borrow a phrase from this event's title, *chaos or creativity* could be the north and south poles of the NHS world. And the global policy development that everybody is trying to get right (if not right now) is commissioning – the iterative analysis of a population's health needs, and the redesign of services (some added, some changed and some ceased) to meet those needs.

Commissioning has long been a stated goal of parts of the NHS – indeed it was what primary care trusts (PCTs) were created to do. However, NHS commissioning has by and large been anaemic in the face of the long-established, money-magnetic power of the acute sector.

Clinical engagement in commissioning has been slow, and often hindered by poor data and hidebound attitudes. The realisation of these problems has led to the movement to develop 'world-class' commissioning now being pursued by the Department of Health.

Yet perhaps the one example where commissioning has shown tangible success and real promise has been the provision market for urgent and unscheduled out-of-hours (OOH) care.

The NHS Alliance's provider network has now reached its third annual conference: 2008's event was as lively as ever, offering useful lessons and pointers to a system which is trying to redesign its services and improve care.

The NHS is as ever, changing, in the face of Lord Darzi's next-stage review's focus on better clinical quality and more patient-centred care - while also facing the end of eight years of annual real-terms above-inflation budget growth (and indeed the certain effects of an economic slowdown as the country moves into recession).

In such times, establishing and improving quality of services is more important than ever.

Rick Stern, NHS Alliance provider network national lead

Welcoming delegates to the third annual conference, network lead Rick Stern suggested that the event's title referring to 'Crossroads, chaos and creativity' could be read as a prescient reference to the global financial system's chaos. In fact, it had been chosen more to reflect the urgent care market's development over the past four years.

Urgent care remains crucial across the NHS, he said: "Our focus is on two main themes – commissioning, which four years ago was little discussed; and the impact of the Darzi Review."

There are signs of intelligent commissioning, driven by clinical intelligence, starting to come through the system, and of an emerging recognition of the importance of moving from a competitive tendering attitude towards every contract to one based around partnership and co-operation.

The new NHS Alliance Providers' Network's out of hours leadership group provides an effective new conduit for the opinions of this sector, and is now extended to the commercial sector and to PCTs.

A vision for urgent care

Chris Dowse, Head of Urgent Care, Department of Health

This is a timely moment to discuss urgent care and world-class commissioning (WCC), Ms Dowse said, since the Darzi report is all about integrated, convenient care, accessible 24/7. We need to focus on world-class commissioning of a diverse range of services – unplanned care, available in and out of hours.

There is a debate on how to join up in-hours and out-of-hours care so they are seamless for patients:

- General Practice
- Local out-of-hours (OOH) primary care services
- Community services
- A & E
- NHS Direct
- Walk-in-Centres, Minor Injuries Units, Urgent Care Centres
- Pharmacists (often over-looked)
- Ambulance services
- Community social services (where these are needed urgently)
- Crisis resolution teams (for mental health)
- New workforce - ECPs, PwSI, Physicians Assistants

The issues emerging from Darzi Review are not new ones for the NHS:

- Service users not happy:
 - confusion about service availability;
 - delays and duplication;
 - multiple handovers;

- repetition of details in a disjointed journey to definitive care;
- **OOHs' poor reputation**
 - taking flack for gaps in other services
- **Commissioners**
 - buy services not pathways
 - contract management variable

Urgent care services take a lot of flak for gaps in other NHS services: patients are unhappy about duplication, hand-offs and constantly repeating their details.

Reputation issues have come to the fore. The new Primary Care Foundation benchmarking tool shows great variation in the cost and quality of services. So we have to deal with how we commission care pathways (not just services); and decide what is the outcome we're looking for (not a series of services, but very much how to join them up); and how to do good contract management – all of which are of course elements of world-class commissioning (WCC).

The Darzi report defined good urgent care thus:

“Every member of the public should be able to expect integrated local services that provide access to urgent care, 24 hours a day and 365 days a year. PCTs should ensure that local communities know what services are available, where and when.”

The Healthcare Commission's forthcoming report reviews urgent and emergency care services, and will drive PCTs to consider what they are commissioning for patients in future.

Arming the public and patients with information about what is going on in urgent care is crucial. The Darzi report gave the vision statement, and from 2009, there will be a new Vital Sign focusing on patient experience of OOH services.

PCTs will tell population what services are available and how to access them.

DH support will come under strengthening commissioning, delivery and compliance. The DH are looking at tools to help commissioners, and talking to stakeholders about development networks (and already support the Alliance's OOH leadership group), and are also exploring a role working with SHAs. By assessing provider performance, raising public expectations and listening to their experiences (especially through robust contract management), we believe the system will respond with more integrated care.

Compliance will be helped by the Healthcare Commission's report. We (the Department of Health) are also supporting the new OOH benchmarking toolkit by the Primary Care Foundation: it is giving very valuable information. With the Primary Care Foundation, we are also supporting work around effective general practice. Currently, we don't know how much urgent care is managed in-hours at all, and we need to understand what that means, and any implications –

especially with the arrival of new GP-led centres with extended access 8am-8pm centres on top of existing services.

The Royal College of Paediatrics are looking at best practice with children's urgent care needs. WCC aims to engage and inform local communities and the public. Increasingly commissioners will ask providers about service users' experiences, so patient experience information will become important. The new commissioning tool on access to medicines in urgent care systems will also need to be included in future commissioning and delivery plans.

Eventually, we will look for commissioning of outcomes, not just commissioning of services, and to see an end of distinction between in-hours and out-of-hours. We want properly-commissioned OOH care, 24/7, 365 days a year – it's what patients expect. Patients' experience should be one of a seamless, relevant care pathway with no visible handoffs along the way.

Ministers are keen to explore the feasibility of a new three-digit phone number (similar to 999) as a front end into urgent care 24/7, 365 days a year providing callers with initial response, health advice, triage, information about and access to local services. This is not a new idea, but for first time, there's a great drive to make it happen. However, it will need a robust and integrated service response 24/7, 365 days sitting behind the new three-digit number convenient accessible integrated care services, or it will simply increase patient frustration.

The DH recognise that clinical engagement is key to WCC, and practice-based commissioning (PBC) can be a strong vehicle for this. But it's fraught with difficulties, and one size does not fit all, especially with PCTs in very different places, progress-wise.

The DH is rethinking how to redefine and reinvigorate PBC – it's here to stay; the question is how to re-launch it. I want to know what PBC consortia have done in urgent care services, NHS Alliance have been doing a piece of work on how PBC consortia are already contributing to the delivery of integrated, accessible, convenient urgent care services vision. We hope to deliver product later this year to share round with rest of NHS.

The challenges are not to be underestimated: delivering this is not easy. The components of WCC are vital, but in reality, are also nothing new (using data intelligently, good contracting arrangements) – PCTs still don't know how much or what they're buying in urgent care, we lack data.

If you are a commissioner, here are some important questions:

- What are the public saying about your services and about their community engagement?
- Are your existing bought pathways the ones patient want?
- Do you use data intelligently, to understand public behaviours?

- Should you move services out of A&E into urgent care centres, or do it all in A&E? There are interesting social marketing techniques to segment populations, but data says that there is almost always a group who will go to A&E regardless – you need to think how to manage services for those who won't go elsewhere.

Integration between providers often breaks down, and people get 'handed off'. We must secure these critical interfaces.

Some of this is about technology, and some is about collaboration with partners: it's not all about competition, it's also about collaboration. That is what 24/7, 365-day-a-year urgent care will mean in future, considering the impact on other urgent care services in the system.

Comments and questions for Chris Dowse

Commissioner: People do present to our nearest A&E, which the local foundation trust (FT) owns, and when we debate redesign with them, the question arises of the freedom of who owns the site (i.e. the FT). This is a common issue, and affects true competition of providers. I'm not clear about the best way to crack this.

CD: I'm not clear either. It's something about ensuring you bring providers into a discussion at an early stage, so they support the vision - early engagement of providers so they can buy in. It's tough, as it's asking acute services to change the way they operate over time. But it's not impossible, it's about collaboration – there's always the threat you can buy services elsewhere, but that has to be final stage. We want to explore such negotiations in the national debate.

GP: This is about the practicalities of working across boundaries. What's the DH view on funding a pathway? We potentially want the same service in- and out-of-hours, but the funding streams are different. Should there be a patient budget?

CD: That won't change where money sits: with commissioners in PCTs. We're doing some work about getting cost, pricing and tariff right for walk-ins and A&Es around pricing. The new HRG4 for A&E aims to be more granular. What do you want to change? I will have a look at this.

GP: We're meant to be rationing demand, but there's a perverse incentive of A&E payments for admission to the acute trust, while GPs doesn't want to over-use hospital care because it's expensive.

CD: I'm not sure DH can tell you what to do about that.

GP: This is a national issue – we have to make decisions how to ration care in the NHS. If a patient wants a coil fitted at 2 am, is that a good spend of NHS funding?

CD: I'm not sure patients are always that unreasonable if they know what is available and the best way to access it. Then they can be encouraged to access

services in the right time and place. The problem now is that many patients say they don't know where to go when with urgent care needs.

GP, North London: You've mentioned 'world-class commissioners', but really the phrase means nothing. People who go to supermarkets can choose Waitrose or Lidl, but the Government is encouraging the public to think they can make any choice about health. The real world-class commissioners are patients. Let them vote with their feet and wallets - services would respond to patient choice if you give them a budget. But doing that means the Government and the DH need to give up control to patients.

CD: We've done some work around individual budgets, and devolving control over patient pathway. It's an early stage, but we know there's a desire for this. There are questions about how much control devolves to the patient and how that fits with an overall commissioning and a finite pot of money.

PCT urgent care programme manager: How would you define the difference between an urgent care centre co-located at A&E and a polyclinic?

CD: We've backed off defining what should be in an urgent care centre, that should be for local commissioners, with the public - to decide what needs to come out of A&E and be in the community. What you call it is up to you, but it must have the basics including diagnostics. Strategic commissioners will take the new primary care centres and urgent care centres, and try to combine them to offer value for money and 24/7 access. Do you need me to define this? The more we tie you up from the centre, the less flexibility you have locally to manage.

OOH organisation delegate: The key to all this is the integrated healthcare record, how fast is progress with that? Ambulance services have no link to primary care.

CD: The summary care record has been piloted, I don't know when it's to be rolled out. Technology and Connecting For Health have important roles, but even using old-school phone and fax across the interface shouldn't prevent us trying to join up services better now.

GP co-operative delegate: Urgent care centres could be a huge financial threat to some acute trusts. FTs also face conflicts of interest if they also run a good urgent care centre. How will SHAs manage FTs who win the right to have urgent care centres? Will they force them to come to the table and talk with local commissioners and providers? A potential patient shift to urgent care centres could take 10-20% of business from a smaller FT's A&E and destabilise it.

CD: I think we need local debate about how to keep local systems flowing and working i.e. sometimes, the answer may be not go to tender, but to go with the flow of an incumbent provider and work collaboratively with them. In cases of a big conflict of interest, the SHA should be mediating.

GP: Why are patients confused now? This was not problem 4-5 years ago. Out-of-hours was with GPs for 2 years, then we had walk-in centres, then NHS

Direct, then people just gave up and went straight to A&E. The sane answer is to get GPs to re-take over the gatekeeping.

GP: The perception of Government is that this confusion has been answered by new layers of urgent care. The single three-digit number idea is another unnecessary half-baked triage. Why do you persist with the notion that single number access will work?

CD: We're not making assumptions about what will work. We're not going back to where patients were before - confused. Ministers are very keen on the three-digit number, but I'm keen to see that ministers announce something that it is possible to do. So we're researching views, options, and feasibilities.

OOH provider: If you want no distinction between in-hours and out-of-hours, why don't you spread the existing national quality standards from out-of-hours to in-hours?

CD: Do you want us to do that?

All delegates: **YES!**

CD: We should begin to think about that, I'll make no promises, but we do need consistent quality standards.

The tender trap! Benchmarking quality David Carson, Primary Care Foundation

Most access to urgent care is through general practice in-hours. So there is a desire to see the standards from out-of-hours (OOH) applied to in-hours. What we've seen in the Primary Care Foundation's new quality benchmarking tool is substantial variability in OOH.

We were selected through open tender and commissioned by DH to develop this benchmark toolkit, and it's now ready to go. The aim is to offer clear and consistent comparisons, based on common information. We're keen to develop openness and transparency but acknowledge concerns of providers about commercial sensitivities.

We need to strike a different balance between commissioner and provider:

- the PCT owns the benchmark
- the provider and PCT supply appropriate information
- both work together to make sense of results

Learning and service improvement is central – there are regular seminars to look jointly at how PCTs and providers can improve services. A new component testing patient experience has also been added.

We found that looking at the NAO and Healthcare Commission reports on out-of-hours, both rely on NHS-provided data. The NAO report data was miles off. So we've tried to ensure data is genuinely comparable, and gone to much effort. This is not about beating people with a stick, it's about learning from information.

The tool is clearly pitched to PCTs as the owner of information and by using it they can have positive discussion with providers and support aspects of commissioning.

Commissioning still puts much emphasis on cost – I think many decisions in some places are based on bias and prejudice and are reverse-engineered. We must get beyond this, so it's about good data and comparable information, so we can work out who is cost-effective.

We need to shift the focus from:

- Cost to quality
- Anecdote to fact
- Competitive tendering to long-term partnerships

It's an opportunity to:

- Place OOH at the leading edge of evidence based service development in the NHS
- Counter scare stories about OOH care
- Place patient experience right at the heart of benchmarking

The tool uses the following 12 headline indicators:

Cost

1. Cost per head
2. Cost per case

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Productivity

3. Number of cases per clinician per hour

Outcomes

4. Referrals to hospital (if possible, sub-divided between referrals to A&E and referral to a hospital bed)
5. Overall breakdown of dispositions (advice / send to primary care centre / home visit)

6. Percentage of calls classified 'Urgent' on receipt

Process

7. The quality of clinical governance systems and processes

Performance

8. Time to clinical assessment for all calls as a percentage

9. Time to face to face consultations for urgent calls (including percentage of urgent after assessment)

Patient experience

10. Patient experience of receiving telephone advice

11. Patient experience of treatment at a centre

12. Patient experience of home visits

In our pilots across Northern Ireland, North-East SHA, and other UK providers, the cost per head data shows a variance of 100% on recent data of what was paid across the country. Cost per head vs. cost per case found the demand-side very high, with some providers delivering twice as much activity at £10 a head. So we need to examine demand too.

In the percentage of cases assessed as urgent on receipt, one provider classified 70% as urgent – that's a big outlier.

In the cases per clinician at peak times, we found a range from 9 per hour to 1 per hour. This obviously depends on workload, efficiency and how many people are employed. Providers would want to know about this, as that range is significant.

As commissioner, you should want to know what's happening in the system. This benchmark will include an accurate patient's survey, and will also give you:

- High-quality comparative data to support world-class commissioning
- A comparison of the cost and performance of your OOH providers at PCT level
- No "surprises" in this area of service
- A comparable patient survey measuring a 'vital sign' working in partnership with CFEP
- Developing indicators to measure the impact of OOH services on other aspects of urgent and primary care

Talking about the benchmark, the national director for primary care David Colin-Thomé told *HSJ*:

"Robust information is needed to raise service quality. What we want is to be continually updating so the PCT and its provider can look at their performance. It is about sustainable improvement rather than one-off checking. We are saying, 'what you need to do is to assess yourself against other services. It's up to you how you get there but, by implication, the easiest way is to buy this tool which is already up and running'. Otherwise, you have got to demonstrate some other way of measuring your quality against others and I would argue that would be more expensive."

Comments and questions for David Carson

GP and PCT clinical lead: do your benchmarking surveys have outcomes comparisons? We have 7% OOH referral to secondary care – but what happens there? Are 'rubbish' referrals being admitted to turn profit?

DC: As a commissioner, you've got to measure the performance of A&Es as well if you want to integrate services. You need to know if an acute trust admits twice as many as a neighbouring one. It's the same with OOH providers – you need to know about variation.

Director of OOH clinical services: Isn't there a problem of measuring apples and pears with different OOH services using different criteria?

GP co-op: Only three indicators have £ signs directly against them. As a rural provider, we should come out badly, and pound signs draw commissioner's eyes! Is there anything in your benchmark that can allow providers with similar demographics to compare directly?

DC: We've been very careful to not use providers' normal reports. We go back to direct system information and we're careful to map the process of care delivery, so we can compare similar events, so we can be confident of comparing like with like. You're right – it can be much more effective to deliver from one OOH centre with a few vehicles in urban settings than in rural ones, where it's intrinsically harder. As this rolls out, we will have data on other rural services like yours. The more commissioners and providers who use the benchmark, the more valuable it becomes. Once we get up to a much bigger list, then we probably will divide into rural/urban. But there's already a rurality element built into the national funding allocation. Without the information, you can't make the case as provider or commissioner.

PCT commissioner: This tool looks good in cost and activity, but what about quality of care and experience, and anecdotal feedback on the performance of local or non-local doctors'?

DC: Looking at category 7, the measures in clinical governance, at the process level of providers' individual clinicians performance, there's clearly great variability. Once you look at performance of individuals, more of this data

becomes facilitative, and it gets easier to run systems. Quality and outcomes and cost are all driven by individual staff decisions. The benchmark can also help you to tell if providers have the right systems in place, and it can also measure what do, but it's always up to providers to manage their own clinicians.

Presentation of the Excellence in Service Awards by Dr Michael Dixon, NHS Alliance chairman

Ray Montague of BrisDoc described the awards' categories:

❖ **Best Practice** ❖ **Clinical Quality** ❖ **Beyond Out of Hours**

Dr Dixon said that all three winners had demonstrated the best in urgent care – and the best in using resources wisely too. They have shown that front line innovative thinking, hard work and collaboration across the board can solve problems and provide realistic, high quality alternatives to admission.

The winners were:

Sunderland tPCT Minor Injuries Unit: *Best practice and innovation*

There is no national model for the development of MIUs and walk-in centres, so Sunderland 's nurse led team, which deals with around 80,000 patients each year, decided to carry out a benchmarking exercise involving all their frontline staff. They have demonstrated that Patient Group Directions are more effective than nurse prescribing for this type of unit, and that triage does improve patient safety rather than being just an unnecessary process that delays treatment. Their work was facilitated by the Institute for Innovation and Improvement and is being used to develop the Productive Community Hospital toolkit, which will be available nationally later in the year.

Mastercall: *Clinical quality – can we do it better?*

Reducing A&E referrals by 35% is a success story by any standards. That is what Mastercall has achieved through its excellent clinical governance. Mastercall Out of Hours Services is a GP led provider of urgent unscheduled care to Stockport, Manchester and Trafford patients. Their clinical governance framework is based on progressive learning through auditing and analysis, with effective and timely internal communications. Driven by their commitment to patient-centred care and their roots in local communities, this is a positive and tangible outcome in terms of best practice and best value – but more so for patients who avoid the stresses and time pressures of attending A&E.

Shropshire Doctors Care Co-ordination Centre: *Beyond out of hours*

Shropshire Doctors are a not-for-profit, OOH GP co-operative that has set up an in-hours, single point of access service for GPs and their patients with urgent healthcare needs. Led by experienced nurse practitioners, the service provides an essential co-ordinating role for urgent hospital admissions, rapid access to clinical pathways and signposting to other services for 600,000 patients in

Shropshire County and Telford & Wrekin PCTs and North Powys LHB. It has been involved in developing patient pathways – co-ordinating with primary and secondary care clinicians – has successfully diverted one in five urgent care referrals and believes more would be possible with service re-design.

Innovations in commissioning and collaboration in urgent care: experiences from the field

The providers and commissioners of a service discuss the process and learning

Nigel Wylie, Chief Executive, Urgent Care 24 and **Ian Davies**, Director of Strategy and Programme Co-ordination, Knowsley PCT, with **Eddie Jahn**, Chief Executive, Harmoni and West Sussex PCT and **Liz Tayler**, Director of Quality, West Sussex PCT

Ian Davies, Knowsley PCT

First, from the commissioner perspective: we were one of the first PCTs to go to the OOH market in mid-2004, and let our original contract that November. That three PCT consortia deal was worth c. £14 million.

There's been much media and political interest in our current provider. We had significant issues about media and political animosity hurting public confidence, and so decided to re-tender, also partly as the 2006 PCT merger changed boundaries. Board level support across all three PCTs for this decision was vital, as any transition might not be smooth.

It needed high-level executive support, leadership and accountability, making this clear to GP and PBC colleagues and the public. We were specific about local needs with what we took to the market, especially on which were core and non-core services. Core was the OOH provision; and non-core included things like prison services, and asylum seeker support. We were clear about that separation to avoid cross-subsidy or good performance in one part masking poor performance in another.

We've been very cautious around procurement best practice and employment law: media interest ensured the public and political gaze. This is new territory for us as commissioners, and we had to be as professional as possible, to avoid exposing ourselves or our provider to legal challenge.

We also spent time trying to understand the market. In 2004, there were two bidders. There are many more now, and so we wanted to understand what we were putting out, what was out there already and how the market might respond.

In the broad specification content of our tender, we had to look at key areas like traditional national requirements, to equality, governance, infrastructure,

contract management, and branding. We wanted this promoted and branded as an NHS service, no matter who provided it: that was critical to public confidence, and also to integration. Getting the specification (spec) right helps the process a lot.

Criteria varied, but we involved patients at the start of the process. We wanted to ensure that the new service was (and was seen as) a new start. We wanted to make sure involvement in commissioning was a positive experience for residents, and national quality requirements (NQRs) were a non-negotiable minimum. We also had to look at governance, urgent care centres and Healthcare Commission standards, for providers to meet and exceed.

We were concerned about transition, whether to a new or to the previous provider. We extended the timescale by six months as I think we'd underestimated the required procurement / transition time, even if the incumbent got the contract, it was still going to be a big change, and we needed to see that sensibly managed.

What were the lessons learned?

- Prepare, prepare, prepare. Takes lot of time, PQQ, tender submissions, etc. Clinicians managers and IT experts need quality time
- Don't under-estimate the money, people, time and technical expertise resources involved. You really can't read 12-15 technical tenders in a weekend, and your technical colleagues must have their input.
- Local Authorities have more experiences of procurement, and may be able to help you
- Prepare for media and freedom of information (FOI) interest – we felt under siege at times, regionally and locally, had to be scrupulously fair to incumbent and to all involved in the procurement process.
- Don't underestimate the process challenge
- Don't underestimate the implementation challenge – hard work doubles at preferred bidder appointment, partnership responsibility
- IT and data – remember supply chain capacity, capability, data access and ownership issues. We had to take out one PCT's IT and data who'd chosen a different provider, where previously, we had always done this as a group of three.
- The project management requirement goes on 6-12 months beyond the award of the contract
- Communicate, internally and externally, with clear and concise messages to the politicians

Nigel Wylie, Urgent Care 24

The 16-page spec we faced was exacting. As stated, the NQRs were a minimum for us, meeting the spirit and letter of the DH June 2006 guidance. We liked the strong HR element, and the mandated use of the RCGP toolkit, and we very much see ourselves as part of the NHS family.

All this focuses the mind of the provider! A provider must focus on their strengths and weaknesses, which is all-consuming. All senior management time gets spent on the bid – so all service developments went on hold.

Renewing leases and contracts to third-party contractors was an issue –we had to be acting legally (because we're regulated by the FSA, like Northern Rock ...). It also puts a big responsibility on the board. If the contract was not re-awarded, we knew there would be no more Urgent Care 24.

It had an unsettling impact on staff, with the media onslaught, much of what was written was untrue, but we don't respond as that let us hold the moral high ground. We knew we were clinically safe, and chose not to engage in a cheap debate. Paradoxically, that brought us more together – much cheaper than management teambuilding, though planning blight was an issue. Rumour and speculation become rife, and that was just among the executive team!

The tender trap – done in-house or outsourced? We did it in-house, but bought in some consultancy skill sets and extra time. If you outsource, you need control or things will unravel at interview if you don't know all about the tender and service. We faced a panel of 30, no pressure!

Don't assume – we assembled a 4-page bid, but for the parts that we farmed out to specialists (IT finance, clinical specialists, etc), we emphasised that if you've said something once, it doesn't mean that we don't have to put it elsewhere. In other words, repeat, repeat, repeat.

Be tactical as the incumbent provider, Use your local intelligence to avoid asking further questions, or all bidders will get the answers, which may help them.

Remember to assign time for printing.

We estimate the cost of the re-tender to us as £100,000, it took staff 7 days a week, 12 hours / day. That's a real issue of capacity and capability, because we were still operating and we can't let high-quality clinically safe OOH care down.

We ended up being re-commissioned by two of the three PCTs, and had a bi-weekly mobilisation and decommissioning agenda with the other PCT. We now carry the NHS badge with pride, delivering high-quality cost-effective OOH care. We were also awarded an equitable access procurement for Knowsley. We're still here.

Eddie Jahn, Chief Executive, Harmoni and West Sussex PCT and Liz Tayler, Director of Quality, West Sussex PCT

Liz Taylor

Why did we bother re-tendering? Was it worth it?

The answer is yes, but don't under-estimate the hassle. The West Sussex context was that until 2006, we had five different PCTs, within which much variation: Gatwick and Crawley are like London boroughs, but the coastal strip has 10% of the population over 85; 500 nursing homes; and is really a shire area. The five legacy PCTs had three OOH providers: one major provider covering three PCTs, and two providers whose main focus was in the adjacent PCT over the border. The main provider was closely linked to PCT personally, and the leaders were linked closely.

That meant three different contracts; three sets of meetings, metrics, contact numbers, opening hours and vision. Which was not great, and inconvenient for us and for the providers. Patients said what they wanted was one contract and one point of access to a similar service across the patch - and to ensure quality.

We not convinced of the existing providers' value for money, and business continuity. We also needed scope for future flexible working

For 6-8 months, it was difficult. We had to focus on softer relationship stuff, and risks of conflicts of interests (COI). There was COI and multiple hat-wearing, so we needed clarity on which hat a participant was wearing at any time in any discussion.

It was hard to develop the service specification. Those whom we wanted to work with us as commissioners were almost all involved in providers. We had to separate development of the service spec from the, intellectually impersonally. It needs the local context, and a merge between national best practice and the authentic local flavour.

There's a real difference between the ability to write a good bid and to deliver a good service. From A to B, procurement can get tick-box-y. It's difficult - more art than science.

The service started in April 2008, with a budget of £10 million and we didn't pick the cheapest. We chose on credibility, responsiveness, and the bidder in whom we felt best confidence going forwards in developing new innovative services.

Was it worth it? Yes. It's working well, and they're meeting national standards, as well as being responsive to our needs.

Eddie Jahn

The tender is not just about measuring, benchmarking and hard clinical evidence. It's also about relationships, and we always ask, 'can we work with the commissioner'?

Measurement is necessarily retrospective. Successful tendering is also about vision and about the provider's capability of delivering on vision.

Harmoni arose from a West London GP co-op, started in 1996. Initially 50% GP-owned, we're now a commercial business. We've bid for 10 major tenders in

2007-8 and won five (two partnering; and three alone including one where we were the incumbent) and lost five. These are really important maths - and high risks. I think a bid costs us £100,000, but in reality, that's £200,000 if we win one and lose one.

The Harmoni approach is that on service quality, cost reduction, service design and innovation and sales, if we're not going forwards, we're going backwards.

We couldn't do tenders on our own, and we had to realise this as the old GP co-op from which we grew struggled to to retain, let alone grow, the business.

I concur with Liz's reasons for taking the West Sussex business to tender: providers must realise as organisations that however well they're providing and respected, there will always be a reason for which services can go tender, however good relationships like Urgent Care 24's may be. No-one can relax and sit back any more. Some of West Sussex was about incumbent under-performance, and some was about the local PCT commissioners' structural reorganisation whether we – or the commissioners – like it or not.

So you need capability around the sales side of tenders. Tenders involve a competitive sales and bidding team, but alternatively, a provider can partner for this. Sometimes we do when we feel we wouldn't win a bid on our own, or lack capacity. You have to match strengths and weaknesses: if your bid leaves gaps, you'll lose the tender.

West Sussex experienced three provider incumbents competing against each other (giving an advantage to outside bidder; from the inside, the three providers should have resolved a unified bid as part of their going forward to tender strategy). Appropriateness of bid and record of service development was a key differentiator for Harmoni.

The process involved Primary Care Foundation validation of our quality.

In short, we won. That meant loads of work when the contract was awarded to us, and massive relationship-building, which involved going to every GP practice on patch. It's laborious and time-consuming, but using our rigorous but evidence-based data gives a launch pad for a robust relationship.

Tenders will happen, and provider organisations must have capability to deal with it. You've got to listen to your PCT customers.

Never just rely on one or two contracts: this is not a science, and you will lose them as well as win them.

What's happening in practice-based commissioning?

Dr David Jenner, NHS Alliance national lead for PBC

What's happening in practice-based commissioning (PBC)? Not very much, it would seem. I notice that there's not one single PBC person in the entire delegate list.

And what's the definition of urgent care or out-of-hours care? Practice-based commissioners clearly cannot commission themselves, and urgent care includes in-hours primary care provision. Out-of-hours (OOH) care lies outside the core GMS contracts. There's nothing to stop PBC consortia commissioning OOH care, as long as it's not provided by themselves. But few PBC consortia are invited to commissioning and procurement for OOH tenders.

You must be aware that you get the same busy people doing PBC, PEC and provider. So you've got to explicitly name and be aware of the conflicts of interest, because there's a big risk that you can upset bigger providers if you don't award them the contact – they'll look closely at who wins it.

For urgent care, providers can still inform commissioning. Providers do know how to provide. At some stage, you need to talk to providers, but PCTs are reluctant to do so. PCTs must ensure that the framework and the law are followed for contestability and fair procurement, because PCTs remain legally accountable for the work of their providers.

The big challenge to PCTs and the world-class commissioning (WCC) agenda is how to get that clinical involvement, to engage and involve PBCers while ensuring probity (but avoiding too difficult a cap, or you will leave PBC and clinicians out of the process or have the 'poodle on the PEC'.)

But why do PBCers want to commission urgent care? Because in-hours covers only 1/3 of the week, OOH 2/3. Also:

- Urgent care accounts for c. 66% of PBC budget (excluding prescribing)
- Often, 75% of admissions and A&E attendances are not initiated by practices
- The 50% risk reduction on tariff for excess non-elective admissions may end in 2009
- It's vital for patients

Urgent care overlaps into in-hours GMS care, and much in-hours care is routine. There are elective and non-elective aspects of in-hours. There are now schemes to augment GMS provision, but none that I know have taken core funding from GMS. It's not something I particularly support, but there's a question about whether we redefine GMS / PMS as non-urgent care?

Real PBC would need to put in quality standards and audit processes and processes into the pathways it commissions. So we must specify and cost audit requirements, so that provider can publish health quality accounts, giving the PCT evidence of quality for its WCC assurance.

Real PBC would involve tighter service clinical specification, which are still not quite tight enough, but better than most. Clinicians must invest in education and audit. This would mean:

- Clinical service specifications
- Contractual requirement to participate in pathway audit
- Investment in education and audit
- Published pathways with clear contractual requirements to follow them
- Ongoing dialogue with providers
- Contracts based on quality and not just price and access (the 2003-4 round of OOH contracts were done on the cheap and based on minimum national standards, so it's not unfair to respectively re-tender). What WCC is all about.

In Devon, our PBC consortia have been trying to put primary care on the front of an A&E. With the PCT, we've identified a project lead and funds to effect this, and let a contract with the local OOH provider to provide the GP staff. There are ongoing negotiations with the acute trust still to make it work fully, because the acute trust is worried about governance. But there's an issue here, because although the acute trust is on piece rate per visit (or even better, admission), OOH is a block contract.

Do we need to re-tender? It's hard for passionate primary care providers, some of whom regret giving up OOH as they lost control over specifying quality.

Do we re-tender if all quality requirements are being met and PCT benchmark audit prove value for money? If the service spec is right, and quality requirements are met?

Short-term contracts don't encourage organisational investment in quality - unless quality becomes more important than price. The NHS still tends to buy on price. Moreover, provider trusts are not tendered ...

The real opportunity costs of re-tendering could be invested elsewhere.

In future, we will see:

- PBC consortia specifying wider roles for OOH providers
- Home visiting service in-hours for acute problems
- More quality clauses in contracts
- More primary care 'front door of A&E' schemes
- More nurse / paramedic services

But by 2011, PCTs must shed their provider roles. So what will happen when PCTs shed their provider arms?

- Will OOH providers bid for these?
- Will new providers emerge, who then bid for OOH contracts?
- Will OOH providers move wholesale into APMS / PMS provision?
- Will PBC Provider Consortia merge with OOH providers?

Commissioners will see a certain attraction in having joined-up primary and community care provided round the clock by one organisation. PBC will be critical in looking at these issues. This conference's title is exactly right: it's about urgent care not just out-of-hours care.

Into the commissioners' den – approaches to achieving innovation and integration in urgent care

The Dragons:

- **Dr David Jenner, NHS Alliance**
- **Kaye McIntosh, Journalist**
- **Chris Dowse, Head of Urgent Care, Department of Health**

The Pitchers:

- **Shikha Pitalia, GP, St Helens**
- **Rick Strang, Lead for Unscheduled Care and GP Access, Hammersmith & Fulham PCT**
- **Mo Girach, Special Advisor, Social Enterprise, NHS Alliance**

Shikha Pitalia, GP, St Helens

My proposal is for an acute visiting scheme based in primary care. The acute sector costs the NHS £13 billion a year, 30% of those transferred to acute care spend only 24 hours in, so that's £400 million a year.

Our acute visiting scheme is simple and revolutionary: our PCT has the second-highest emergency admission rate in our SHA and 43% of admissions would be avoidable if better services in the community were available.

The idea was deemed maverick at the time. We reduced acute admissions by 30% in our PCT and saved £1 million. It's an in-hours rapid access home visiting scheme. The GP surgery gets a call from Mr Smith, who requests home visit. He lives alone, is 67, and has COPD. He's had a bad night, and doesn't really want to go to hospital, so waited till surgery hours to avoid it: "now I feel really bad, and can't come out to the surgery". 30 minutes later, our system phones him

back and offers a home appointment with a colleague (a recruited dedicated GP, familiar with the area and services) within the next hour.

Mr Smith doesn't need a visit, there's an avoided admission, no ambulance is needed, that patient is happy at home, and the carer is happy with a dealt-with incident.

There are three critical success factors – intelligent first contact, using patient's confidence in own doctor and practice so if they recommend a course of action, the patient is more likely to receive positively. Second is response time, when people request an urgent home visit, they want to know what's going on and need reassurance. A normal GP takes two hours on average to arrive for an urgent home visit; we get there within 70 minutes. Third, it's about face-to-face time with a doctor if we decide someone does need a home visit. The average GP consultation at home lasts eight minutes, our scheme gives them 20 minutes, allowing a detailed discussion of options including acute admission, but also a thorough examination, as opposed to cursory heart and lungs.

It's well-accepted, with over 90% patients expressing satisfaction at how they were handled by phone. It helps with clinical engagement for the PCT and makes an impact on 18 weeks, HAI and cost savings. GPs are happy as they save 30 minutes / appointment, which means they can see an extra 3 patients / day, helping meet access targets.

The cost for a year is £80,000 for the GP and £20,000 for their driver. Admin costs take the total to £150,000.

Rick Strang, Lead for Unscheduled Care and GP Access, Hammersmith & Fulham PCT

The Government give us £30 million a year for unscheduled care, but say they don't like what I buy and don't like the way I'm doing it. I tell my hospital, for every unscheduled admission you don't see in A&E, I'll pay them £100.

If we give A&E a primary care front end costing £12 million, and cost every admission at £400 (4 x tariff), then every time your patient is diverted, you pay £100 to A&E and the rest is a bonus, as well as periodic £500 bonuses from avoiding 4-hour breaches. It has a key performance indicator (KPI) system, so if we over-perform and do loads of good stuff, there's money to rewards that.

This would cost about £100,000 a year.

Mo Girach, Special Advisor, Social Enterprise, NHS Alliance

The organisation is not fully formulated yet, but our aim is to integrate urgent care services in front of A&E. It will be a social enterprise provider organisation, with GPs nurses, mental health workers. It will have a GP co-operative constitution, and we will run A&E, but not the ambulance service, which will be handled by experienced A&E staff.

The annual cost is not known.

Results

All three 'Dragons' voted for the acute visiting scheme. The audience went mainly for the acute visiting scheme, with some for the Fulham unscheduled care prevention scheme.

The vision for urgent care

Dr Michael Dixon, Chair, NHS Alliance

I like the idea of patient as world-class commissioner. I do have concerns about the degree to which tendering is about selling and provision and what happens afterwards.

I'm not entirely convinced (looking at the rail and TV industries) that tendering holds answer very often – but this is my personal opinion, not NHS Alliance policy.

We do need greater integration, and maybe that is the end point of merging OOH providers with PBC consortium – which is an interesting and topical idea with the Darzi integrated care pilots coming on line this autumn. Maybe we'll see provider and commissioner in one organisation, offering mutuality as the way forwards.