NHS Haringey

Commissioning Out of Hours Services in North London

Progress Report for Overview and Scrutiny Committee

February 2010

Introduction

Camden Primary Care Trust leads a consortium of Primary Care Trusts (PCTs) in North London, who jointly commission the primary care Out-of-hours service (The Service). The consortium includes NHS Camden, NHS Haringey, NHS Islington and NHS City and Hackney.

Background

Following the introduction of the new General Medical Services (GMS) contract in 2004 most GP Practices took the opportunity to opt out from the provision of Out of hours services to their patients. Under the new arrangements PCTs took up responsibility for the delivery of Out of hours services to these patients.

In North London the Camden, Islington, Haringey and City & Hackney Primary Care Trusts commissioned this service from the local provider CAMIDOC. As the contract is coming to an end in June 2010 the commissioners have decided to take this opportunity to review the original assumptions about the purpose and structure of the service, incorporate new requirements and to improve quality standards. It is considered that a competitive tendering process is the most effective way of achieving this.

Tendering Process

All potential providers have gone through the same process namely:-

- Expression of interest
- Pre-Qualification Questionnaire
- Invitation to Tender

NHS Camden has accepted bids for its revised £15million three-year "out of hours" contract from five private firms and the current provider, Camidoc. The deadline closed on 19th February and the winning bidder is expected to be revealed by beginning March 2010.. Following this a new APMS contract will be developed and the recommendations from the Report will be incorporated into the contract.

- Evaluation has been undertaken over February using, all-PCT approach (meaning we have evaluation teams comprising clinical, workforce/HR, LINks/patient involvement and IM&T, the members of which are drawn from all 4 PCTs);
- We have a 65% quality threshold for each section of questions with bidders needing meet 65% in order to proceed to the next stage;
- The next stage is an interview which will be assessed by a panel of evaluators where bidders meet at least 65% at interview, the lowest cost bid will be selected as the preferred bidder;

- All PCTs will adopt the recommendation of the preferred bidder on or by 16th March;
- The aim is to have a contract closed and signed by the end of March;
- Mobilisation will commence thereafter with a target start date of mid June.
- LINks from all 4 PCTs have been involved in evaluating the bids in the areas of patient involvement and patient access. One LINks nominee sits on the decision-making panel. The evaluation report will be prepared once the evaluation process has concluded (still ongoing).

The contract and specification are compliant to the latest CQC/DH report on out of hours services (resulting from the Urbani case). The paper from the NHS Chief Executive sets out 24 recommendations under three headings:

- Commissioning and Performance management
- Selection, induction Training and use of clinicians including Locums
- Management and operation of Medical performers lists

It also has provision for incentives and deductions for over and under performance. There are strong contractual / performance levers within the contract. The service specification also includes all aspects raised in the recent guidance. **(Appendix 1)**

Monitoring arrangements

The consortium has a Steering Group which oversees the contract management for Camidoc; this role will be maintained with any new provider. Each PCT has a seat on the Steering Group and feedback can be provided through this route. NHS Haringey's representative is David Lyons.

Mechanisms for feedback from the Steering Group to NHS Haringey need to be formalised. The Whole Systems Quality Committee (WSQC) will receive exception reporting from providers and should also receive exception reporting from the OOH provider in the same way.

The new contract will be performance managed by a dedicated officer on behalf of the consortium by City and Hackney who will shortly be taking over the lead commissioner role. and will report to the Steering Group, through which decisions are made. Each PCT in the consortium has a seat on the Steering Group, and via our representative we will be able to feed in views from Haringey through the Steering Group for consideration in the new contract, including suggestions for KPIs and responses to the recommendations in the Report.

Next Steps

1. Further clarification of financial and service quality issues
2. Panel to assess clarifications and recommend preferred provider
3. Risk and mitigation of risks clarified

RECOMMENDATIONS:

1. The Overview and Scrutiny Committee notes the progress to date
2. The decision for recommending a preferred provider will be decided by beginning March 2010.

Appendix 1

No	Recommendation	Current contract position	New contract position
Commissioning and Performance management			
1	PCTs should review the performance management arrangements in place for their out-of-hours services and ensure they are robust and fit for purpose. This includes the frequency of the contractual review meetings with providers, and the seniority of staff attending these meetings (including clinicians). There should be a quality review meeting separate to the contractual review attended by senior clinicians from both organisations and other appropriate senior clinicians. In particular, we want PCTs to involve local GPs in the process. This can be achieved by working with their Local Medical Committees, RCGP groups, Faculties, clinical executive groups, local and with practice-based commissioning consortia. Nonetheless, providers need to be clear that they are accountable for the delivery of services. Clarity of accountability is particularly important where provision is split between two or more providers.	Performance management meetings held quarterly and attended by Assistant Directors of each PCT and senior provider management. Data set provided in line with NQRs. No separate Quality review. No local GPs involved in the management of the contract. No PCT clinical involvement.	The new contract will be performance managed by one dedicated part time officer on behalf of all 4 PCTs, led by City and Hackney PCT. This has been designed to ensure more focus is given to contract management once the new contract is in place. C&H will be proposing the precise process they wish to implement and this will need to address the recommendations herewith, including the establishment of a separate Quality review and involvement local GPs. Individual PCT input will be considered when developing the new contract. The preferred provider will be invited to join the Haringey Whole Systems Quality Committee.
2	PCTs should supplement the core National Quality Requirements (NQRs) with a suite of locally developed quality indicators, which include requirements to monitor clinical outcomes	The data set currently in use is in line with NQR requirements. No additional local KPIs. No link to contract payment	The new contract includes some 30 local KPIs and non achievement of these could result in contract termination. A further 5 KPIs including patient satisfaction can attract incentive payments of up to £400,000 per

	trends, patient reported outcomes and undertake more intensive patient and stakeholder feedback surveys. Consideration should be given to quality incentive payments linked to these local KPIs.	mechanism.	annum. PCTs will be able to comment on the KPIs via the Steering Group. Monitoring is via the Steering Group regular contract meetings.
3	In line with National Quality Requirement 5, PCTs and providers should review the current arrangements in place for receiving patient experience reports. PCTs should also consider how other feedback received on the service (whether formally via complaints, or informally via the PALS service etc) could be incorporated into performance management arrangements. They should also ensure that they are regularly sourcing feedback from other stakeholders such as local GPs, A&Es and ambulance services, and examining trends in incidents reported. If feedback indicates any trends, PCTs should ensure they follow these up immediately.	Patient experience reports regularly produced by provider in line with NQR. Also regular analysis of complaints and adverse incidents and tends analysed and actions agreed.	The new contract has a clear specification of requirements for patient experience and other feedback expressed as KPI number 5. Full achievement of the specified standards which are above those in the NQR attracts an incentive payment paid annually. PCTs will be able to comment on the KPIs via the Steering Group. Monitoring is via the Steering Group regular contract meetings.
4	PCTs should support out-of-hours providers to become a valued and integral part of the local health economy, ensuring that they have a place on any local urgent care boards or networks. This would include ensuring the provider is able to develop integrated care pathways with other parts of the system including A&E and ambulance services to ensure delivery of an integrated, efficient	Current provider included in planning and commissioning meetings on Urgent care.	The new contract specification requires the provider to work closely with the local health economy in delivering services during a period of considerable change in urgent care arrangements in all PCTs. (See service specification para 8)

	service.		
5	PCTs and out-of-hours providers should benchmark their services in ensuring the validity of their performance data. For instance, this could include participation in the Primary Care Foundation Benchmarking exercise. Benchmarking will enable PCTs to consider whether the resources allocated to the service are sufficient to ensure delivery of productive and high quality services.	PCT consortium does hold membership of the PCF benchmarking exercise and has used their work to influence current re-procurement.	Membership of the PCF benchmark service will be maintained
6	The Primary Care Foundation should continue to work with participating PCTs, providers and the Department of Health to ensure that the recommendations of their recent benchmark review are implemented, whilst taking into account the findings of this, and the forthcoming CQC report. In particular, there needs to be assurance that commissioners and providers are consistently interpreting the NQRs.	See above	See above
7	SHAs should monitor action taken by PCTs in response to this report and in carrying out appropriate performance management of out-of-hours providers. Ideally, the safety and performance of out-of-hours services and actions arising from this report should be a standing item on PCT, SHA and out-of-hours provider Board agendas for the next 6 months. Boards may then wish to review the frequency of updates they	To be considered by PCT Board	To be considered by the PCT Board

	receive.		
8	The Department should strongly consider the development and introduction of an improvement programme for PCTs to support their commissioning and performance management of out-of-hours services. This should include support to ensure they are effectively monitoring the National Quality Requirements and other key clinical indicators to ensure that the out-of-hours service is safe, effective, efficient and responsive.	PCT would welcome any such support	The new contract allows for changes and amendments to be proposed by either party.
Selection, induction Training and use of clinicians including Locums			
9	PCTs and Providers should continue to work with post-graduate deaneries to ensure the provision of a comprehensive, consistent and well-structured training programme for GP Registrars, which complies with COGPED guidance, and with the Department of Health letter of 17 December 2009.	PCT to review	The lead commissioner will lead this.
10	The RCGP should review the guidance concerning GP Registrars' training in out-of-hours and should update this as necessary. This work should involve engagement with the necessary stakeholders including COGPED.	RCGP Action	RCGP Action
11	Out-of-hours providers should consider the recruitment and selection processes in place for clinical staff to ensure they are robust and that they are	Provider to comment	The new contract contains explicit requirements in respect of staff competence and recruitment covering locum as well as permanent staff. (See Service

	following best practice in this area. This includes evidence of a detailed knowledge and skills outline for staff which sets out the generic qualifications and appropriate experience, skills (including telephone assessment) and knowledge required to work in the out-of-hours service and should be applied to all locums as well as staff who regularly work for the provider.		specification para 11.)
12	Out-of-hours providers should consider the contents of their induction process to ensure that it is comprehensive and is completed before any staff work a first shift for the service. This induction process should be tailored according to the needs of the individual staff member, and would be more detailed for staff who have not previously worked in the local area or in the out-of-hours service. Special consideration should be given to induction requirements for staff who do not usually work in the UK. The induction process should be followed up by appropriate shadowing and mentoring arrangements, particularly for less experienced staff.	Provider to comment	Provider is required to submit full details of its induction process. However there is no requirement that it is completed before staff work the first shift. This should be made explicit in the contract.
13	PCTs should review whether recruitment, induction and mentoring requirements for the out-of-hours provider are set out adequately in their contract with the provider, and satisfy themselves that these are passed through to any sub-contractor or agency,	This is not sufficiently explicit in the present contract.	The new contract and service specification sets out in detail requirements for recruitment induction and mentoring. (See service specification para 11)

	which the provider engages.		
14	Providers should co-operate with other local and regional providers (both in and out-of-hours) to share any concerns over staff working excessive hours for their respective services. PCTs and providers alike should also encourage clinical staff to share information about their working arrangements with all organisations that they work for, and providers should ideally put this requirement in their clinicians' contracts.	Provider to comment	The new contract is explicit in requiring providers to ensure "compliance with all employment legislation, in particular the working time directive".(para 11.1)
15	Out-of-hours providers should consider the adequacy of their clinical governance arrangements (including those for clinical audit) and should consider undertaking trend analysis of clinical performance for common and/or high impact conditions as part of these audits. These could be used to form part of an internal or external benchmark of clinical performance to help raise standards. PCTs should also ensure they consider the cost of the provider undertaking these audits as part of recommendation 5.	Provider to comment	The new contract sets out specific requirements in respect of clinical governance, including monitoring and audit and preparation of an annual clinical governance plan. This will be monitored through the Steering Group.
16	PCTs should regularly check that all the locum and sessional staff on their Medical Performers List have appropriate access to appraisal and continuing professional development (CPD).	PCT To action	PCT to action – lead PCT to carry out checks.
17	Out-of-hours providers should consider the benefit of signing	Providers to comment	

	agreements with locum agencies for preferred provider status to ensure consistency in the quality of any locums required.		
18	The Department of Health and Care Quality Commission should ensure that when registration of out-of-hours providers is introduced in 2012, that the requirement for organisations to source workers who are fit to practise should include those workers sourced by the provider from a locum agency.	For DH/CGC	For DH/CGC
Management and operation of Medical performers lists			
19	The Department of Health should work closely with the GMC to consider to what extent PCTs could rely on the checks of identity and medical qualifications under the GMC's registration procedures. The Department should consider streamlining the requirements in the Regulations for the checking of such documentation by PCTs.	DH Action	DH Action
20	The Department of Health should, as a matter of urgency issue guidance to PCTs to assist them in making decisions about whether or not a doctor has the necessary knowledge of English to be admitted to their Medical Performers Lists.	Interim guidance issued 04.02.10. PCT to implement.	PCT to review. The new contract places responsibility on the provider to ensure that Ensure all Provider Staff are able to communicate in English at a level appropriate to their role so that they are able to communicate effectively with Patients and other persons in relation to The Services, including (where relevant) IELTS/PLAB tests as detailed in the Code of Practice for NHS Employers) . NHS Haringey has contacted the London Deanery to suggest working on a

			pan-London approach.
21	The Department of Health should consider issuing guidance to PCTs about the circumstances in which PCTs may wish to informally invite applicants for inclusion in their Performers List to discuss their applications with the PCT.	DH Action	DH Action
22	In implementing the recommendations of the recent Performers List review, the Department of Health should consider whether all the requirements of the Regulations are appropriate for GP Registrars.	DH action	DH Action
23	PCTs should ensure that all doctors who have not provided primary medical services in the NHS previously be required to complete a period of individually tailored induction before starting to perform primary medical services.	PCT to consider	The new contract does not include this specific requirement. It should be amended to include this.
24	The Department of Health should review how the exchange of information between PCTs and the GMC can be improved.	DH Action	DH Action