PRIMARY CARE

'It's not about Americans in 10-gallon hats, it's about people who can deliver a high-quality service'

Central and Greater Derby PCTs chief executive Prem Singh (far right) with operations director Trish Thompson and Greater Derby PCT professional executive committee chair Dr Ian Matthews.

While North Eastern Derbyshire primary care trust's decision to award an APMS contract to UnitedHealth Europe ended in the High Court, at neighbouring Central and Greater Derby PC managers are confident that UHE will meet local people's needs. Lynne Greenwood report

Key points

- Central and Greater Derby PCTs contract with UnitedHealth Europe is one of the first times an in-hours GP service is being provided under an alternative provider medical services contract.
- Organisations must seek input from stakeholders before deciding what a tender should include.
- The PCTs say they chose UHE because it could best meet local people's needs.

It's a tale of a divided city: two weeks after the Court of Appeal threw out one primary care trust's choice of UnitedHealth Europe to run a GP practice, its neighbours signed a contract with the subsidiary of America's biggest healthcare corporation to do just that.

The city is Derby, where pensioner Pam Smith challenged North Eastern Derbyshire PCT and won in what she called as a 'David and Goliath' case, sending the trust back to the drawing board.

Central and Greater Derby PCTs, which also chose UHE as their preferred service provider to replace a retiring GP, signed their contract in September.

Those involved in the negotiations are delighted, but anxious to stress that the PCTs' driver was not the search for a private provider but one which best met the needs of Normanton

Medical Centre's patient population.

Central and Greater Derby PCTs chief executive Prem Singh says: 'We did not set out to go for a private provider or a big international firm. We selected on the basis of our strategy to use the best means available to secure high-quality primary care services for the people of Derby.'

Their neighbour in the north east of the city said the same. But its contract with UHE was quashed by the Court of Appeal when judges said the PCT breached its duty to consult.

Eastern Derbyshire PCT chief executive Martin McShane said afterwards that the message from the judge was that under section 11 of the Health and Social Care Act organisations needed to be able to demonstrate formally that they had taken stakeholders' views into account. He said that meant seeking input before setting the criteria for a tender (news, page 7, 31 August).

Although that lesson came too late for the Central and Greater Derby PCTs – they were already well beyond that point when the ruling was made – they have clearly managed the consultation process correctly.

It's a process that goes back more than a year to when they first informed the local medical committee and practices that they were seeking a replacement for Dr Jag Paul, the retiring GP at Normanton Medical Centre.

'Before this situation arose, our primary care strategy enabled us to use whatever models we could deploy to secure the best services,' explains Mr Singh. 'That could be the new GMS [general medical services], PMS [personal medical services] or APMS [alternative provider medical services], which we have used for out-of-hours providers. 'We did not immediately jump to the conclusion that APMS would be the solution.'

The PCTs' profile of their GP practices, which include a number of small and single-handed providers, details future retirements and planned changes, allowing them to plan ahead, he says.

Once aware of the 'opportunity' provided by the retirement of Dr Paul, the trusts held discussions with the local medical committee and the city's primary care community to assess the level of interest in providing services at the modern, purpose-built Normanton Medical Centre. None were expressed at that point.

A series of formal consultations followed wit patient and public involvement forums, the PC health panel and the local authority overview a scrutiny committee.

The practice's 3,000-plus patients were informed of the plans by letter and through information notices displayed in the centre, which continued to operate with the use of locums. Although patients were happy to be tol of proposed changes, their main concerns were quality and continuity of care, say the PCTs.

When the position was advertised, 20 expressions of interest were received, four of which completed tenders. When tendering beg a decision on what model would be used was deliberately left open so practices could still apply.

'The practices were engaged and made awar of the opportunities all the way through and, when the trust finally went out to tender, many them requested information packs. It was expected that some of the practices would bid f the contract but in the end none of them did,' sa Greater Derby PCT professional executive committee chair Dr Ian Matthews.

'But we did not have any preconceived →

A PRIVATE PROVIDER IN PRIMARY CARE

'WE ARE FOCUSING IN PARTICULAR ON AREAS OF DEPRIVATION'

When UnitedHealth Europe director of primary care Dr Peter Smith says the company is 'extremely pleased' to have signed the alternative provider medical services contract to run a practice in Derby, what would otherwise be an anodyne statement takes on a different sense when it so closely follows disappointment in another part of the city just weeks earlier.

He restricts his comments on the unsuccessful outcome of the North Eastern Derbyshire primary care trust dealings to saying: 'It was a very positive process, but in the end there was deemed to be a problem with consultation.

'Obviously, our biggest concern was for the people of the area. The process was first advertised a year ago and now there will be a significant delay before care can be brought up to scratch.'

The situation will be different for the population served by Normanton Medical Centre in the most deprived area in Derby – itself the 65th most deprived of England's 354 council areas.

Dr Smith says UHE is 'excited' by the contract with Central and Greater Derby PCTs to run the practice. 'We want to build on the work to develop services further for the local community,' he says.

Before that, UHE must recruit permanent staff, who will give a long-term commitment to a practice where there has been significant use of locums.

It plans to use a wider skill mix than before, including a nurse practitioner and healthcare assistant. Early priorities will include a full needs assessment, based on a survey of all patients.

'It is clear from existing data that there are clinical priorities but we want to learn about the needs of the local community in their own words,' says Dr Smith.

The premature mortality indicator shows the Normanton population is twice as likely to die under the age of 75 as those in Derby's more affluent Mickleover area.

It has a high percentage of patients from minority ethnic communities and a high incidence of diabetes.

UHE's plans include a full screening of all patients, the introduction of a dedicated diabetes service and providing improved mental care services.

Dr Smith says any plans for new services will be considered alongside those of other practices in the community.

'We will establish links with other practices to see what services we may be able to deliver closer to home,' he says. 'There may be services we can move out of secondary into primary care, which could be delivered in the community. That might not be in Normanton but in an area covered by other practices.'

Clearly, practice-based commissioning could play an important role.

Because UHE is starting at a mid-point in the financial year, it can use the coming months to research where patients are referred for services and where they might prefer to receive them. 'This is a preparatory phase before we start looking at resources,' says Dr Smith.

Longer term, there are plans to expand the services offered to the more neglected sectors of the community, including drug users and the homeless.

Dr Smith says UHE believes it is time to reverse the 'inverse care law', where those with the greatest medical needs are least likely to receive care. 'People have the right to a service that addresses those needs,' he says.

On the issue of UHE's involvement in primary care – criticised by detractors as an example of profit-making companies taking over family doctor surgeries – Dr Smith says the company has a total commitment to patient care.

'It has the same motivation as myself as a GP,' he says. 'It is all about patient care. And we are focusing in particular on areas of deprivation.'

Shake on it: UHE primary care director Dr Peter Smith (left) and Prem Singh.

23← ideas. We wanted to be reassured about who could provide the best service.'

Future stability

That service, he says, had to be offered by a provider with financial stability, a sound organisational record and long-term commitment. It had to include two main elements: the first was the provision of safe, good-quality care and continuity of service which took into account the quality and diversity issues of the practice; the second was a plan for evolving the service into a more holistic rather than traditional model.

So what did UHE offer and how did it meet the specified criteria? In a nutshell, says Mr Singh, the ability to provide a quality service immediately and to develop it for the future, particularly to include extended hours provision in line with the PCTs' primary care strategy.

There was a possibility for improving some services using practice-based commissioning.

'Some of the potential flexibilities of practice-based commissioning free up opportunities for service delivery and service redesign,' says Dr Matthews. 'UHE has a vision of providing a much more holistic approach to care rather than the traditional model, which can include issues like education and nutrition. But it is an evolutionary process and we will work with them to develop the most appropriate service.'

Mr Singh goes further. He believes that UHE will not only provide the services to their registered patients, but will also add value to the primary care community.

'Primary care is changing,' says Mr Singh. 'It is not just what you do in your practice that matters, but how you co-ordinate with other players.'

If it wasn't already clear enough after the experience of North Eastern Derbyshire PCT, Trish Thompson, Central and Greater Derby PCTs' lead on its successful APMS contract, has no doubt about the lessons others could learn from their work.

'The issue around consultation and local engagement has got to be key, underpinned by the strategic direction of the organisation and the vision for primary care in future'

'The issue around consultation and local engagement has got to be key, underpinned by the strategic direction of the whole organisation and the vision for primary care in the future. All that needs to be well established before you embark on the process.'

Allowing sufficient time – for planning, development and operations – was vital.

She says the PCTs have gained expertise in many areas around procurement, including developing the specification, advertising, tendering and bidding.

'We have learned how to use the flexibilities in the contract to get the best deal for patients, obviously supported by our lawyers,' adds Ms Thompson. 'We have learned never to have closed minds, to consider all possibilities and to work with them.

'It was about taking some risks and holding our nerve when the process became more wobb in the north of the city, and working carefully through the processes at every stage.'

Jonathan Hayden, senior solicitor at Mills an Reeve, the law firm acting for Central and Great Derby PCTs, advised on the negotiations and subsequent contract with UHE.

'This is one of the first times an APMS contra has been used for an in-hours service,' he says. 'Unlike GMS, for which there is a national contract, the APMS route allows greater flexibil offering both parties more opportunities to tailo the contract specifically to their needs.'

He says a good working relationship with the PCTs was essential during detailed negotiations to draw up the contract.

'It is only when the PCT and its advisers have this kind of relationship that each has a clear understanding of the priorities.'

This underlines the importance of UHE workir with the rest of the primary care community in the area. Dr Matthews surprisingly uses the word 'neutral' to describe the reaction of the community to the awarding of the contract to UHE. He goes on to say it has opened the eyes of many practices in making some national issues 'real'.

'It would be interesting if we rewound this process and started again now whether we wou see a different approach from those practices,' h says. 'Some had felt this would never happen bu it has now revealed opportunities for the future and the need to engage in a wider field.'

He says local practices are happy to engage with UHE, both around practice-based commissioning and taking forward a strategy fo improving premises.

'It may result in more competition – it will raise standards – but they are up for that,' adds Dr Matthews.

Voice of dissent

And was there anything to mirror the criticism delivered by Dr Elizabeth Barrett, the GP in Nor Eastern Derbyshire PCT who was one of the unsuccessful bidders, that UHE viewed its bid merely as a loss leader designed to position the company in the lucrative commissioning marke Does the same ring true for the contract from Central and Greater Derby PCTs?

'While the contract price was of course important, it was just one issue to be considered and not the determining factor,' says Dr Matthews. 'We allowed a level playing field for anyone making a bid. The driver was: "who can provide the correct service model?"'.

Mr Singh also has a message for the lobby th views private providers as a step on the privatisation route.

'Let's be clear that GP practices are private businesses,' says Mr Singh. 'They are independe contractors, which is in many ways no different from the multinational company providers working at a local level. If private providers are seen as either a threat or as adding value, I pref to view them as adding value. For us, the prima impact was to secure the best provider.

'If the secondary impact is that the primary care community here or elsewhere sees that competition is now a reality, I don't think that's bad thing for patients.

'And if primary care nationally raises its gam if competition helps to drive up standards, I thi that too is a good thing.

'This is not about the image of Americans wearing 10-gallon hats, it's about people who ca deliver a high-quality service.' ●