

### 1.16.1 Delivery Model (Proposed Approach)

Please provide detail of your proposed approach to deliver the Service Specification focussing on your proposed delivery model for all elements. Your plans should include your approach to remote consultations and how you would address digital poverty and should specifically highlight how all areas of the service specification will be delivered.

(Maximum Word Count 4000)

Words used = 4000 (service-delivery model excluded from word count in the clarification questions)

#### 1.16.1.1-Proposed delivery model for all elements

This sub-section outlines our approach to designing a contract-specific service, the proposed service-delivery models for the two lots and service aspects they have in common.

##### a)-Designing a contract-specific delivery model

###### a.1)-Experienced, knowledgeable team

Although Vocare has delivered GP-OOH services across Staffordshire since 2015, this contract includes very different arrangements as NHS-111 and CAS move to West Midlands Ambulance Service (WMAS) and each Lot covers part of the previous geographical area.

Vocare therefore formed a solution-design team to build an effective, safe and value-for-money solution to meet needs and standards for the two Lots. This team contains considerable local experience of Staffordshire and GP-OOH services, including provision to the prisons, via our subcontractor, Gables Offender Healthcare Ltd.

Leading our design team is the Staffordshire Operational Director, [REDACTED], who has worked in IUC service delivery and GP-OOH [REDACTED] and has excellent knowledge of the service-delivery requirements, patient expectations and system working.

Other key members include the Staffordshire Clinical and Medical Directors,

[REDACTED]  
[REDACTED]  
[REDACTED]

Bringing direct contract-experience input were our Clinical Service Manager, [REDACTED] who manages the service [REDACTED], and the Operations Manager, [REDACTED], who has been involved in delivering GP-OOH across Staffordshire [REDACTED].

This team was fully supported by Vocare's regional/national support teams and corporate functions such as finance, HR, procurement and fleet.

### a.2)-Specification analysis

We analysed the specification to determine differences to our existing contract e.g.:

- Transfer of 'speak to' dispositions' from CAS into the GP-OOH environment with a significant change from triaging everything to accepting NHS-111/CAS dispositions.
- Increased sites offering place-based care that will align to provisional UTC locations with ability to move as UTC locations are designated following public consultation.
- Move from the Covid-19 recovery model to BAU.
- Increased virtual consultation, including video.
- Increased skill mix, replacing more GPs with ANP/ACP/UCP/Pharmacists etc.
- Dedicated Clinical Shift Lead for each shift using ANPs rather than Pathways Clinical Advisors.
- System partner integration with e.g. Midlands Partnership Foundation Trust, Community Rapid Intervention Service etc.

We analysed factors likely to influence service delivery over the contract term such as Covid-19 recovery and Staffordshire's UTC-implementation programme.

**Lot specificities:** As a bidder for both Lots, we reviewed differences between the lots, including geography, demographics, local health economy and population health, e.g.:

North	<ul style="list-style-type: none"> <li>• Locations based on heat maps of activity around ST6 postcodes with a centre in middle of this location.</li> <li>• Royal Stoke OOH site moving forward will facilitate pathways to support ED with primary-care presentations OOH.</li> <li>• Moorlands base provides cover for wider patient population reducing travelling to access healthcare and co-locating with community services e.g. District Nursing.</li> </ul>
South	<ul style="list-style-type: none"> <li>• Locations based on activity data four main areas, Burton, Tamworth, Cannock and Stafford.</li> <li>• Stafford assigned on designation and proposed UTC status.</li> <li>• Overnight provision in the south east includes video consultations based on availability of premises and low activity levels, supported by home visits if required to reduce need for patients to travel to Burton/Stafford.</li> </ul>
Prisons	<ul style="list-style-type: none"> <li>• Reduce need for ambulance/ED transfers.</li> <li>• Skills development to deliver minor injuries, wound care and phlebotomy, which are now in the specification</li> </ul>

**CCG objectives and NHS Outcomes Framework:** Our analysis included accounting for the need to meet CCG objectives and to support the NHS Outcomes Framework e.g. a seamless service incorporating in-hours and out-of-hours transfers; maximising use of a consult-and-complete model; video consultation to support patient care in rural remote. For example, we ensure Vocare clinicians support our patients and local health economy with NHSOF. Last month we audited all our GPs in OOH services to ensure antimicrobial stewardship and prescribing practices are of excellent standards.

**a.3)-Solution development**

Having analysed the requirements, we considered our experience in Staffordshire alongside our national GP-OOH experience to design an efficient service that fits with delivery of other system partners and benefits patients/families/carers. We bring both historical and current understanding of local population-health demographics e.g. areas of deprivation. We also have collaborative relationships with Staffordshire services. Having provided face-to-face services during local/national surge and escalation, we are equipped to meet our local population needs during system pressures.

We have in-depth knowledge/experience of OOH patient requirements. We have clinical expertise for improving patient quality services and providing safe, effective and holistic admission avoidance. Our clinicians support local GPs in meeting NHS Outcome Frameworks by knowing the value of good consultations and the effect doing something well has on patients and the local health economy. Our clinical team has experience of working with NHS-111 service providers e.g. Yorkshire and the North East. Our experience as the current Staffordshire NHS-111 provider has been pivotal in our clinicians acquiring skills in non-patient facing assessment/treatment.

We considered the flow into, through and out of the service. We explored which skill sets and roles are suitable at each stage and what is needed to maximise ability to 'consult and complete' irrespective of whether it is a telephone/video consultation or a home, centre or prison (south) visit.

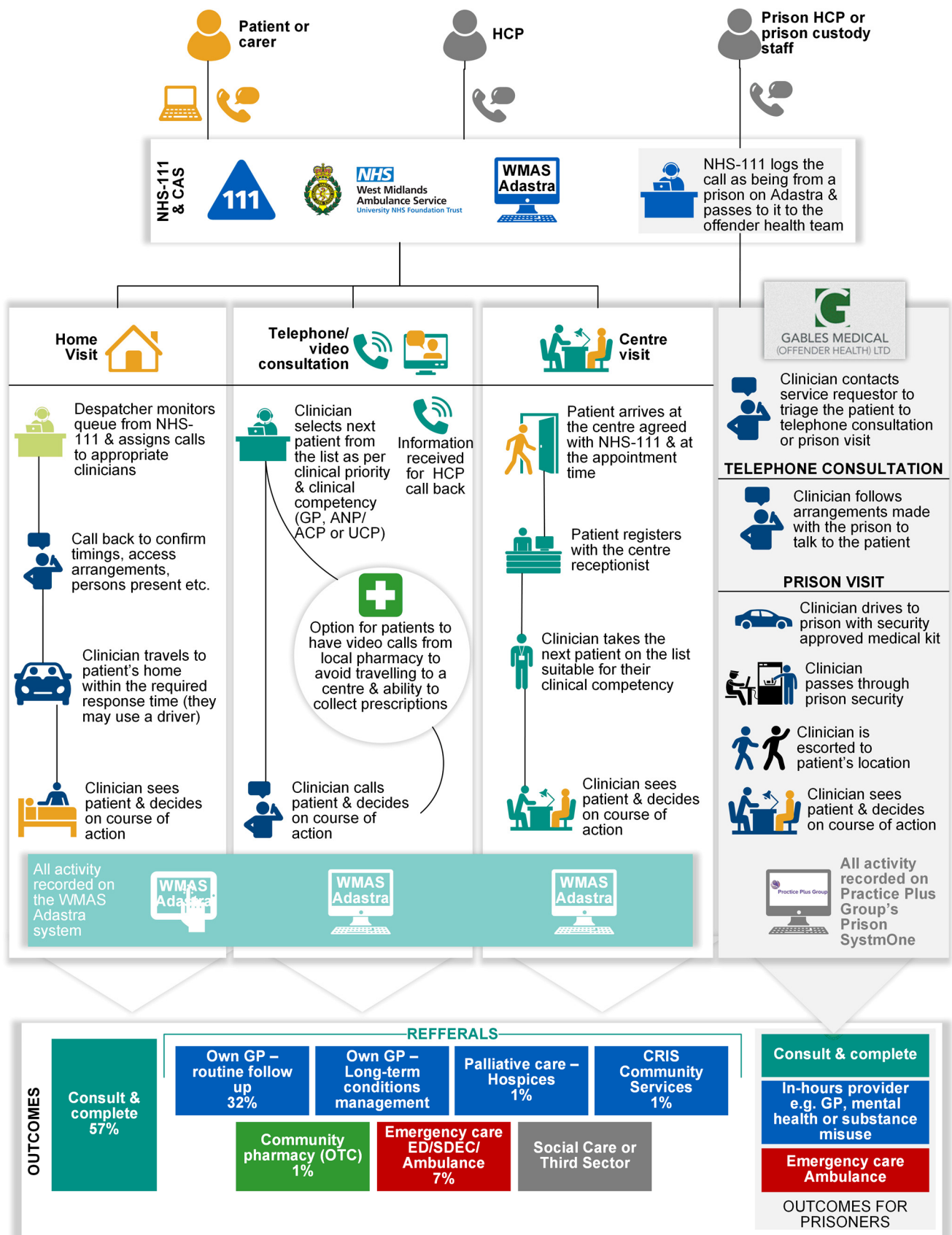
We designed a contract team with modelling based on an MDT approach for operational and clinical staffing, supported by experienced managers with clinical, medical and operational skills and a single point of contract accountability. The team will adhere to the Group-wide assurance framework and be supported by various corporate functions, e.g. HR/governance/finance/IT.

Other factors integral to service design included how the IT solution will work with Vocare teams mandated to use the WMAS instance of Adastra rather than the usual arrangement of requests transferring from the NHS-111 Adastra to Vocare's Adastra.

We then explored the optimum arrangement of premises across each lot and what spaces should operate when to accommodate demand variations, as well as expected levels of equipment, ranging from fleet requirements to clinical equipment and medications.

**b)-Delivery model description**

Figure 1 shows how patients and HCPs will access the service (via NHS-111), the disposition-dependent steps within the service and how they will exit. We are showing the model for the South lot, which differs from the North with inclusion of prison-related services.



### **b.1)-Accessing the service**

Patients (and carers) will only be able to access the service via WMAS' NHS-111. NHS-111/CAS will then determine their disposition. Where HCPs call, NHS-111 will log the call and add it to our 'speak to' disposition list via the DOS and the ITK link. Callers will have relevant data captured in WMAS' Adastra system.

As in Figure 1, referrals from NHS-111/CAS will be assigned to one of three responses (prison referrals in the South Lot are addressed below). For 'speak to' and Centre visits dispositions, requests will be picked up by clinical urgency then chronology order by the next available clinician with the appropriate clinical competency. For home visits, the requests will be assigned by a Despatcher onto lists for the clinicians on shift, as per their clinical competency and current location. In line with the specification, we will not validate referrals.

Our clinical workforce will comprise the following staff types, GPs, ANPs/ACPs, Pharmacist and UCPs. The first three will be prescribers and UCPs will use agreed PGDs.

Vocare will ensure the DOS contains all relevant information for WMAS to select the most appropriate Centre for patients requiring Centre visits e.g. geographical location and local transportation. As per the Specification, patients will include those who are homeless and temporary residents.

**Prison access:** Although Q1.18.1 South Prisons covers this delivery model, we want to acknowledge that it will be part of our delivery model as outlined in Figure 1 in the South Lot. NHS-111 will log calls from the prison (HCP/prison-custody staff) on Adastra using the prison address and pass them to Vocare's prison healthcare specialist, Gables Offender Healthcare. A Gables GP will triage the request and assign it to a clinician with relevant competency to speak to or visit the patient. The only options will be telephone advice, home visit to the prison or transfer to ED by ambulance. Materials on self-care that would be sent/given to a patient outside prison will need to be arranged via the in-hours provider, Practice Plus Group, and will be included in the consultation notes.

### **b.2)-Clinical activity**

Each shift will have a nominated ANP clinical lead who will manage clinical risk and queues for the service and who will be able, where needed to redistribute cases and escalate clinical concerns. Each shift will also have a non-clinical Team Leader managing non-clinical activity of Centre Receptionists, Drivers and Home-Visit Despatchers.

Consultation activity, irrespective of service stream, will be recorded in WMAS' Adastra system. To assist clinicians' clinical judgement and skills, they will have access to NHS-111 information, the patient's summary care record and integrated care record and use of PACCS and EPS.

For some patients, we may use the Good SAM app for video calling and/or use of its speech-to-text and translation



functionality e.g. those with hearing impairment. We will also have access to Language Line for translation and BSL for hearing-impaired patients.

We have modelled the service based on the tender's demand information and have integrated our knowledge of variation over shifts, days, seasons and the influence of e.g. winter flu, bank holidays and local events such as concerts and sporting events, e.g. increased out-of-area patients for Alton Towers or Drayton Manner theme park.

*b.2.1)-Telephone advice:*

Clinicians will select the next patient on the list suitable for their clinical competency. Where clinically indicated, clinicians can transfer patients to Home Visit or Centre Visit service streams. Senior clinical advice will be available from the Clinical Shift Lead and Vocare's 24/7 clinical-advice function.

Including digital technology offers patients options when accessing care e.g. using GoodSAM video conferencing instead of traditional telephone triage with benefit of integrating the consultation outcome to include email or SMS notifications with booking times and safety-netting advice.

For some hard-to-reach patients and rural settings, our pharmacy solution offers options for patients to attend pre-booked video consultations in a supported environment with integrated electronic prescribing to the pharmacy if required. This solution reduces requirements for patients to travel longer distances, provides a fast and easy access point and digitally inclusive as the patient does not require IT.

*b.2.2)-Centre visits:*

NHS-111 will provide the patient with information on the location and Centre facilities as well as their appointment time. Signposting will direct them to the receptionist to register arrival. Signage will include electronic wall boards and notice/leaflets explaining the patient journey and service. As with 'speak to' dispositions, the next available clinician will take the next appointment within their clinical competency. Clinicians will have access to primary-care diagnostics equipment and point-of-care testing (e.g. urinalysis, blood-glucose testing).

To model this service element, we considered historical data on percentage per clinician type and area demographics to decide on an expected productivity rate of 4 patients per hour, accounting for patients generally being unknown to clinicians.

*b.2.3)-Home visits:*

A Despatcher will call patients allocated to the home visit list to give a visit ETA and obtain information such as who is present, access arrangements e.g. key safes and presence of animals. Recording this information in Adastra makes it readily accessible to attending clinicians. All telephone calls will be recorded.

The Despatcher will allocate the patients to the on-shift clinicians out on visits using the Adastra workflow. We will allocate GPs to more complex palliative-care cases, cases with co-morbidities (e.g. dementia) and where conditions are more advanced or difficult decisions regarding admission or treatment refusal are likely. We will usually focus UCPs on e.g. chest infections, UTIs, death verification. The Despatcher will also send the address details to the Tom-Tom webfleet management solution that tracks our vehicles. Clinicians assigned to home visits will be able to drive themselves or use a driver.



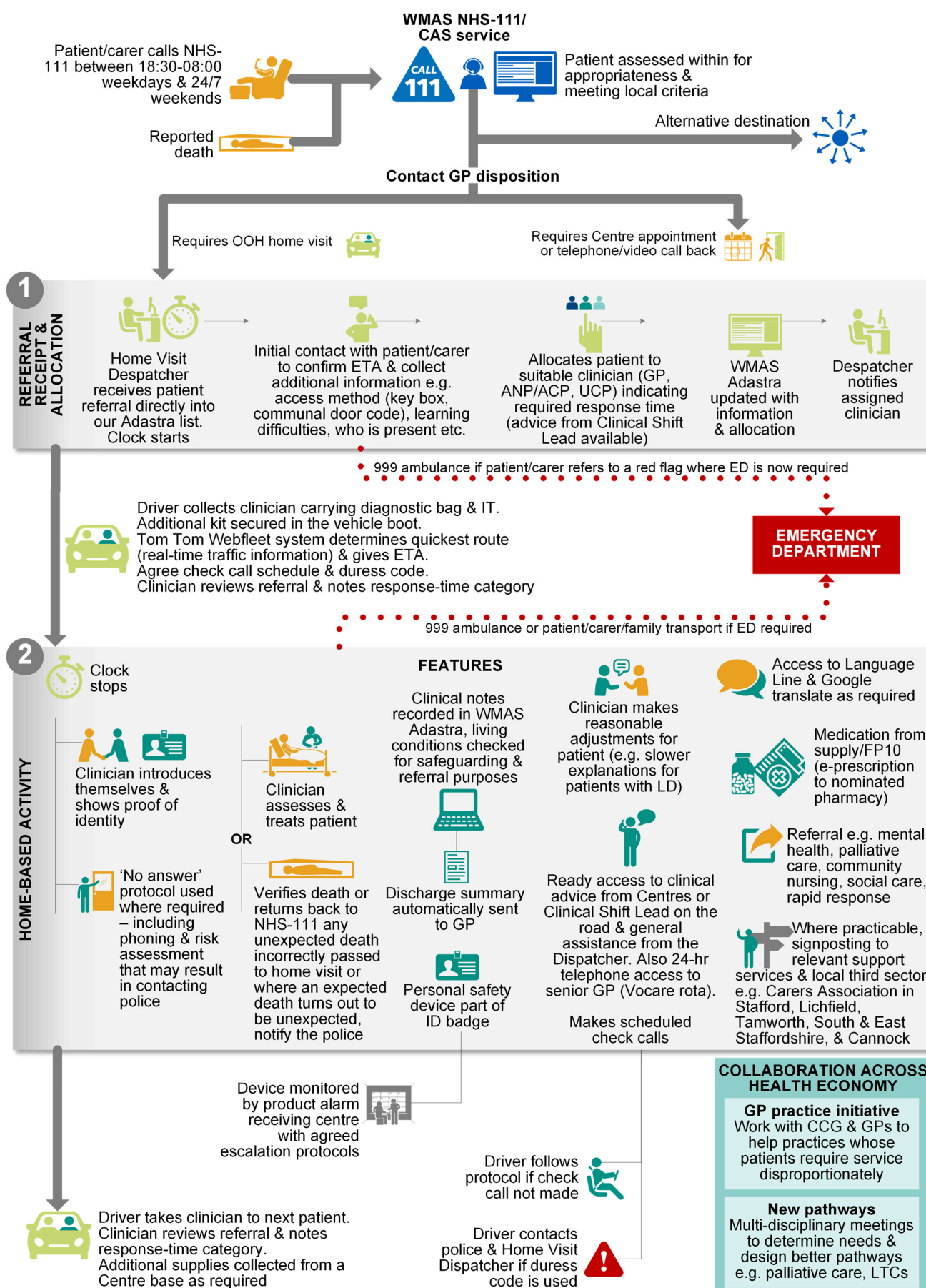


Figure 2: Home visit service delivery

**Fleet:** Due to rural locations and likelihood of adverse weather in winter, 4x4 vehicles will be available. All vehicles will be liveried in line with NHSE guidance for urgent-care vehicles.

**Equipment:** Each vehicle will have clinical equipment available (itemised in the relevant question) and included oxygen and nebulisers and an AED. Cars will also carry secured medications bags.



**Productivity:** From delivering home visits in Staffordshire and other contracts, we have a wealth of data on durations. We understand that some visits (e.g. complex palliative-care visits or patients with dementia) can require 90 minutes and therefore we model on an average of 60 minutes per visit. Rotas will be constructed against known peaks e.g. fourth days of long weekends, winter increasing flu-related complications, January 6 for deaths (ONS).

#### *b.2.4)-Prison visits*

From delivering this service in Staffordshire's prisons, we are aware of the importance of using clinicians who understand how prisons and prison healthcare works and the importance of parity of care to that in the community. Our clinicians will drive themselves and carry kit suitable for the prison environment. They will bring suitable identification and not attempt to carry anything that contravenes security requirements. Productivity rates will account for travel time and time to go through security and to reach the patient.

#### **b.3)-Exiting the service**

As shown in Figure 1, the outcome of all three community-based service streams are episode completion or referral to the range of services indicated. The most prevalent referral will be to patients' registered GPs for routine follow up or long-term conditions management. Using GP-Connect, we will be able to make appointments for patients in primary care and to services such as UTCs. We will use electronic referrals wherever possible/appropriate.

We will continue to build relationships not only with the GP practices across the Lot(s) but also wider NHS and local services to effect efficient pathways (e.g. CRIS, ED, including SDEC, mental-health services and palliative-care services) and to pass on recommendations to patients/families/carers.



We will maintain a local stakeholder map of NHS providers and local third-sector organisations able to help support patient healthcare and wellbeing e.g. parent and child groups, disability support ( e.g. Calibre Audio Library), learning-disability support (e.g. Chiltern Music Therapy), veterans groups (e.g. drop-in sessions through SSAFA Staffordshire), homeless support. Much of this information will come from DOS/MiDOS, but we will also build direct relationships with many of the local providers including local social-prescribing link workers. We will register with local foodbanks to be able to issue vouchers to patients we see in Centres and home visits e.g. Cannock & District, Rugeley and Stoke-on-Trent Foodbanks.

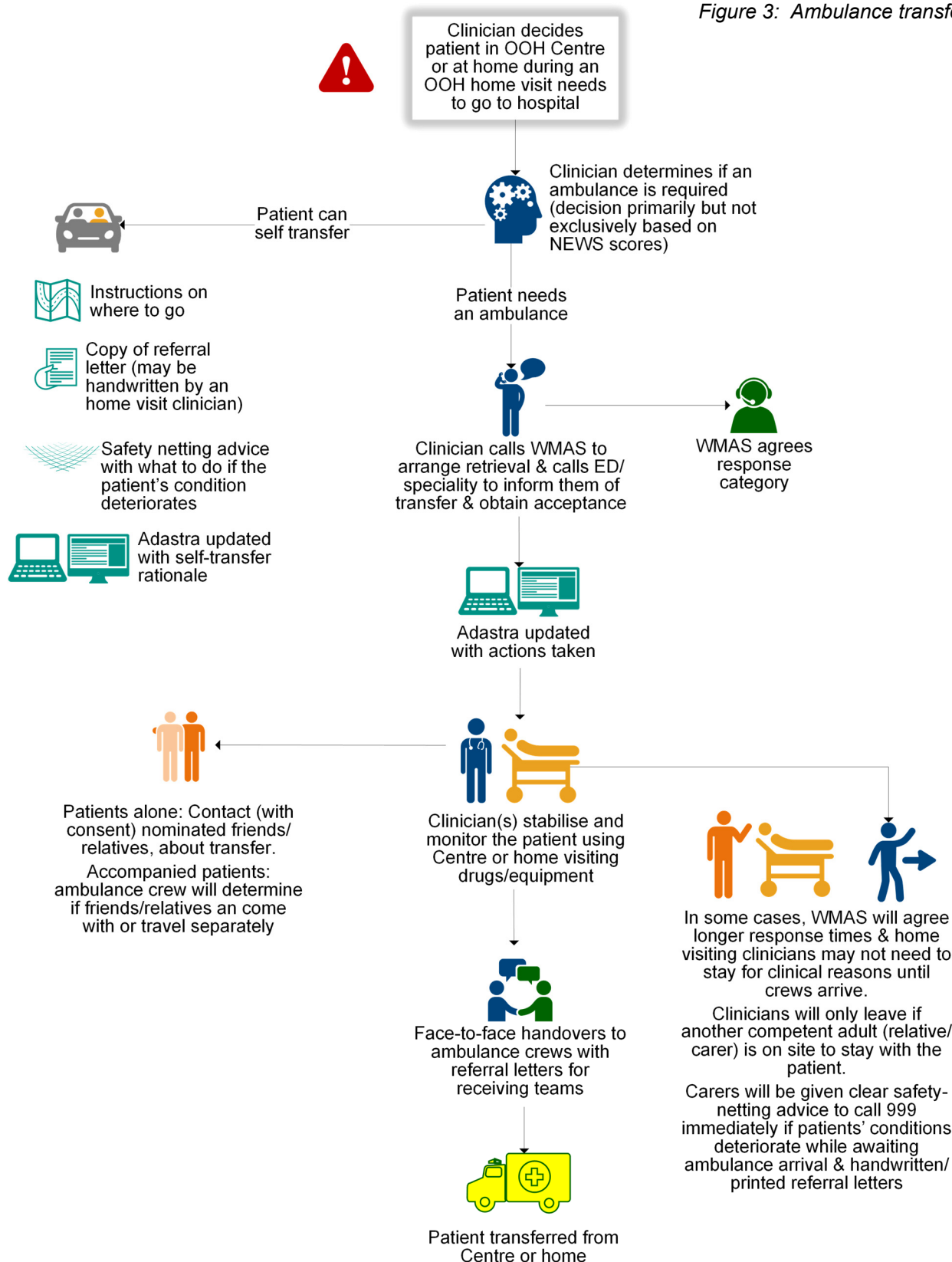
**Information:** Following each consultation, the Adastra system will send a PEMS via ITK. Clinicians will be able to email or text message self-care and conditions-related information and links to approved sites such as strengthening exercises to patients. Should a patient not be registered with a GP, we will be able to provide a copy of their consultation notes to pass to a GP and instructions on registering. Information relating to prisoners will be entered, as now, directly into Practice Plus Group's prison SystmOne instance, continuing the existing agreement and thus ensuring all patient identifying information remains in that environment. Home-visit patients will receive handwritten clinician notes.

**Ambulance transfers:** When clinicians determine that patients in a centre require ambulance transfer, they will call WMAS for retrieval and the relevant ED (consultant/matron) or specialities (e.g. surgeons/medics/gynaecology) to inform them of the transfer, documenting it in Adastra. Clinicians and WMAS call handlers will agree the response-time category, depending on patient acuity. The clinicians will stabilise/monitor the patient until retrieval. Face-to-face handovers to crews will include paper copies of referral letters for receiving speciality/ED teams. Where patients are alone, we will contact (with consent) nominated friends/relatives about transfers. Crews will decide if friends/relatives can travel in ambulances or, more commonly, travel separately and meet at ED.

Clinicians undertaking home visits will decide whether patients need ambulances (using NEWS scores). Since these patients are housebound, significant numbers needing ED will require ambulances. Clinicians will agree urgency categorisation with WMAS and document call numbers. They will call ED/specialities to make referrals, documenting acceptance in Adastra. They will stabilise/supervise patients using drugs/equipment they carry to manage deterioration (including BLS equipment/defibrillators) and contact next of kin/family/friend with consent.

In most cases, clinicians stay until ambulances arrive, giving a face-to-face handover of patients' current conditions/observations and suspected diagnosis. We will provide handwritten referral letters. Where longer response times are agreed with WMAS, clinicians may not need to stay until crews arrive. Clinicians will only leave if another competent adult (relative/carer) is on site with the patient, to whom we will give referral letters as above. Carers will receive clear safety-netting advice to call 999 immediately if patients' conditions deteriorate before ambulances arrive.

Figure 3: Ambulance transfers



**c)-Aspects common to all contacts**

Irrespective of whether patient consultations are remote or face to face, in the community or prison, our team will follow the same operating procedures for maintaining patient safety, managing safeguarding and offering health promotion (via Making Every Contact Count). All team members, including Gables clinicians working in the prisons, will operate escalation routes for concerns and will have access to senior clinical advice at all times e.g.:

- Clinical Shift Lead on all shifts.
- GP advice available to all staff as required.
- 24/7 Medical Director on call.

**c.1)-Telephony systems**

We use the Mitel connect system for all inbound/outbound calls and the Redbox call-recording system, which is configured to record all patient calls and retain them for the required length of time. We use diversely connected systems to make and receive external calls/video, ensuring the highest sound/visual quality possible.

**c.2)-Clinical-record systems**

As mandated, Vocare will use WMAS' Adastra as the clinical-record system for all community-based activity. We will make arrangements with WMAS to be able to extract activity data to determine performance insights and continuously improve.

As the existing GP-OOH provider for the Staffordshire prisons, Vocare's specialist contractor, Gables Offender Healthcare, has an arrangement with the in-hours provider Practice Plus Group to access its prison SystmOne to capture consultation records. We will continue this existing successful arrangement, which meets patient safety and information-governance requirements and aid continuity of care for these patients.

**c.3)-Prescribing and medicines management**

Vocare has a well-established, senior pharmacist led, Medicines Management Team of Head of Pharmacy, Pharmacists and NVQ level 3 Pharmacy Technicians. Responsibility for monitoring and managing supply and demand and auditing prescribing practices is local with monthly senior review. Management and stock control for OOH practitioners is undertaken by a full-time Level 3 Technician in Staffordshire with regional clinical support. Medicines distribution is supported by our Drivers so stock is managed centrally and delivered equitably across Staffordshire.

**c.4)-Incident management and business continuity**

Vocare has a comprehensive range of incident-management policies applicable to this contract and we are preparing for the national move to the Patient Safety Incident Response Framework expected in 2022. We have a full range of business-continuity and disaster-recovery plans in line with NHS Emergency Preparedness, Resilience and Response Framework. We participate in Local Resilience Forum-wide exercises. Gables clinicians will be familiar with prison incident-response arrangements, including potential for lockdown while onsite.

**c.5)-Performance management**

Our approach to quality management, governance and performance management are covered in specific questions on these topics, however, all service-delivery elements will adhere to a common quality-management approach with continuous improvement. To evidence high-quality performance, we will collect performance data on all aspects of service delivery, including through IT systems, audits and surveys. We will analyse data to confirm KPI achievement and other required standards and identify unwarranted variation and emerging trends as well as any performance that require rectification.

**d)-Operational hours and service handover**

Operational hours are 18:30–08:00 Monday–Thursday and 18:30 Friday to 08:00 Monday over weekends. Bank holidays are as per weekends.

Handover protocols are well established with in-hours primary care using predefined timeframes for cases received into the booking system or triage queue. This includes ensuring patients the OOHs system are seen/treated to avoid handing patients back to in-hours colleagues. The DOS automatically opens 30 minutes before service delivery and automatically stops profiling end points 30 minutes before service-provision closure.

**Home visits:** Where NHS-111 passes patients for home visits to us within an hour of the service closing, Vocare clinicians will attend if patients need of urgent care or in the event of an unexplained death. In other routine circumstances, we will hand them to their in-hours GP.

**1.16.1.2-Remote consultations****a)-Telephone consultations****a.1)-Audio only**

We will undertake demographic checks using three specific pieces of information to confirm we are talking to the correct person, checked against the NHS Spine.

Our clinicians will complete an in-house training package in telephone triage. During Covid-19, we rolled this training out to primary-care clinicians across Staffordshire and Stoke-on-Trent on behalf of the CCGs. Recognising the differences in audio consultations, our clinicians will use additional questioning and soft skills to draw pertinent clinical information in the absence of visual clues. In the event of persistent poor telephone reception or other technology issues, we will forward patients for face-to-face assessment.

**a.2)-Video calls**

Vocare will offer options for video calling via GoodSAM. It provides visuals for hard-to-diagnose conditions and can enable clinicians to rule out certain symptoms e.g. cellulitis, rashes, ear conditions, wounds e.g. leaking infected wounds, leg ulcers, unwell children (beneficial for example for a single mother with other children at home at 2am).



We selected GoodSAM due to its NHSX kitemark (competitive tender process by NHSE) and its governance/security protocols. It has been selected for the National NHS Volunteers programme and will support future innovation.

Vocare is deploying GoodSAM across all contracts for video functionality, which is strategically aligned with NHSE deployment and linked to the IUC. GoodSAM is used by most NHS-111 services.

Evidence from GoodSAM and NHSE indicates call times were reduced from 15 minutes to 6 minutes. Benefits include:

- 1-way video maintaining the call.
- Multiway video bringing in others (e.g. senior clinician/next of kin).
- HD photo sharing.
- No need for Apps.
- Provides patient location.
- Ability to transcribe and translate to improve patient experience.

#### **a.3)-Seeking senior clinical advice**

Our teams will be able to seek clinical advice remotely (telephone/video) e.g. for complex cases or if specialist/geographical knowledge is required. They will be able to contact the Clinical Shift Lead on duty and access on-call arrangements if escalation is required.

#### **b)-Centre visits**

Remote consultations will be available for accessing senior clinical advice. They will be a contingency arrangement to manage unexpected Centre visit demand surge.

#### **c)-Prisons**

Due to security restrictions on mobile devices, we do not expect to use video calls for these patients unless the in-hours provider implements a telemedicine system that we can access.

### **1.16.1.3-Digital poverty**

#### **a)-Digital poverty in Staffordshire**

Digital exclusion comprise three key barriers:

- Connectivity (infrastructure/internet access).
- Accessibility (including low-income homes, people with disabilities etc.).
- Digital skills (being able to use computers/internet).

Pre-Covid, digital exclusion was improving in Staffordshire but still very much an issue. 4% of premises do not have access to superfast broadband and three districts are identified as medium likelihood of digital exclusion (East Staffordshire, Newcastle and Stafford).

Five cohorts are identified nationally as most likely to be excluded:

- Older people
- Disabled people.
- Low income households.
- Women.
- People who leave education early.

**b)-Addressing digital poverty**

Any patient experiencing digital poverty will always have the option of a face-to-face consultation in a Centre. In addition, as we will be calling them back for a telephone consultation, the call will not use their data. Where such patients wish to complete satisfaction surveys, the Centres will have a device available.

Use of our pharmacy-based solution for video calls using GoodSAM will address digital poverty as patients will not require IT.

As part of our local stakeholder mapping, we will connect affected patients to organisations tackling digital poverty e.g. Staffordshire Adult Community Learning Service offers courses to address digital exclusion.