# Invitation to tender

*Evaluation of the Increasing Continuity of Care in General Practice programme*

***7 January 2019***

**Prepared by**
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**Deadline: midday, 4 February 2019**

**Attached documents:**

- Sample contract
- Sample tender response form
- Theory of change for the programme

## 1. Summary

The Health Foundation is seeking a provider to undertake a mixed method evaluation of its Increasing Continuity of Care in General Practice programme.

The primary aims of the programme are to understand whether improvement approaches can be used to increase continuity of care and to explore whether increasing continuity of care can improve patient outcomes.

Our aim in commissioning this evaluation is to develop and share learning about the process of improvement at each of the five projects and their sites, through establishing:

- the model of improvement and approach being used
- whether continuity of care has increased
- patient and staff views on continuity of care, their experiences of each intervention and the impact it has had
- any unintended consequences of improving continuity of care, for example reducing access, which will enable us to contribute to the wider policy conversation around the future of general practice and GPs working at scale
- how any change in continuity of care occurred within that specific environment.

The evaluation will be commissioned via an open tendering process. The successful team will be appointed in March 2019, to start work in the same month. The evaluation will last approximately 24 months and the final evaluation report will be due in March 2021.

We anticipate bids of up to £250,000 (inclusive of VAT and expenses).

Applicants must complete their application on an online portal called AIMS. Please familiarise yourself with the online application portal at the earliest possible stage of your application, as we may not be able to respond in a timely fashion to any technical queries as the deadline for application nears.

The deadline to submit proposals is 12.00 (midday) on 4 February 2019.

We have also commissioned the Improvement Analytics Unit (IAU) to conduct a separate quantitative evaluation of the projects, which will explore whether increasing continuity of care can improve patient outcomes. The IAU is a partnership between NHS England and the Health Foundation that provides robust analysis to help the NHS improve care for patients.

## 2. About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high-quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line, to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care, and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

## 3. Background to programme

The Increasing Continuity of Care in General Practice programme is inspired by Health Foundation research[1] which demonstrated that patients with ambulatory care sensitive conditions who see the same GP a greater proportion of the time have fewer unplanned hospital admissions. The research also looked at several potential opportunities for improvement that could be used to increase continuity at GP practice level.

The primary aims of this programme are to understand whether improvement approaches can be used to increase continuity of care, and to explore whether increasing continuity of care can improve patient outcomes. It will focus on the process of improving continuity of care in practice, and aims to surface learning on the effectiveness of different structural solutions, enabling technologies and cultural conditions required to successfully increase continuity of care in a general practice setting.

The programme will also explore the relationship between increased continuity and increasing access to general practice services. It will seek to identify the possibilities, benefits and unintended consequences of increasing continuity of care in the current context, where the GP workforce is under strain,[2] there is concerted policy pressure to increase access,[3] and patients' needs are becoming more complex.[4]

The programme has been developed with the advice and support of the Royal College of General Practitioners.

### Context

The Health Foundation research that inspired the programme[1] focused on longitudinal continuity; where a patient interacts with the same health care professional across a series of discrete episodes.

This form of continuity is valued particularly highly in general practice, but over the last 20 years there has been a trend away from prioritising longitudinal continuity in favour of promoting increased access. In England, the previous Labour Government introduced a target that, by 2004, people should be able to see a general practice professional within 24 hours and a GP within 48 hours. The target itself was removed by the Coalition Government in 2010, but the emphasis at a national level on speed of access remains. Recent attempts to promote access have been supported by the GP Access Fund, formerly known as the

[1] Barker I, Steventon A, Deeny SR, 'Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data', *BMJ* 2017; 356.
[2] Davies E, Martin S, Gershlick B, 'Under Pressure: What the Commonwealth Fund's 2015 international survey of general practitioners means for the UK', Health Foundation, February 2016.
[3] NHS England. *General Practice Forward View*. 2016.
[4] Steventon A, Deeny S, Friebel R, Gardner T, Thorlby R, 'Emergency hospital admissions in England: which may be avoidable and how?', Health Foundation briefing, May 2018.

Prime Minister's Challenge Fund. In addition, NHS England is working with practices to enable patients to get routine appointments during evenings and at weekends.

The current configuration of many large-scale practices makes it challenging for GPs and practice managers to prioritise longitudinal continuity. On top of this, an increasing proportion of GPs work part time and there is a high number of locum workers, which means that many practices struggle to offer patients continuity with one single GP.[5]

Policy initiatives to encourage continuity have been limited and ineffective. For example, a Health Foundation evaluation found that continuity did not improve for patients aged over 75 who were offered a named accountable GP.[6] Recent research published in the *British Journal of General Practice* also confirmed that longitudinal continuity of care is declining.[7] In addition, there is an influx of new digital consultation tools designed to increase access, such as GP at Hand, which can also reduce longitudinal continuity.

The increasing complexity of patients' needs is also an important consideration. Recent research from the Health Foundation showed that one in three patients admitted for an overnight stay in hospital in 2015/16 had five or more health conditions (up from one in 10 in 2006/07).[8] It is likely that this group of patients – with multiple, complex, long-term conditions – would most benefit from increased continuity of care.

Continuity can be considered across three domains:

- **Managerial:** Where handovers of care between clinicians, teams and organisations are timely and efficient, and patients' needs and preferences are respected and met at every step in their journey.
- **Informational:** Where clinicians have access to accurate, up-to-date, patient records and patients are not required to repeat their symptom history to multiple clinicians.
- **Relational:** Where clinicians develop a therapeutic relationship with patients that spans various health care events, resulting in accumulated knowledge of the patient and care that is consistent with the patient's needs.

The prevailing policy context, and the wide range of possible ways to increase continuity, mean that this programme is focusing on the discovery stage of innovation testing, rather than being a wider demonstration programme. The programme will therefore attempt to identify whether there are feasible, acceptable and implementable ways to increase continuity, rather than try to find a universal blueprint for what works. The attached programme theory of change provides further detail of our thinking.

[5] Royal College of General Practitioners. *Continuity of care in the modern general practice*. 2016.
[6] Barker I, Lloyd T, Steventon A, 'Effect of a national requirement to introduce named accountable general practitioners for patients aged 75 or older in England', *BMJ Open*, 2016; 6(9).
[7] Paddison C, Abel G, Campbell J, 'GPs: working harder than ever', *Br J Gen Pract* 2018; 68(670): 218–219.
[8] Steventon A, Deeny S, Friebel R, Gardner T, Thorlby R, 'Emergency hospital admissions in England: which may be avoidable and how?', Health Foundation briefing, May 2018.

## The five projects

The programme is supporting five large-scale GP practices and federations to carry out targeted improvement work to increase continuity in their practices. Four of the projects will run from January 2019 to December 2020, and the project led by Valentine Health Partnership will run from January 2019 to June 2020. Each project has an initial set-up phase of varying length, with implementation of interventions starting in April/June 2019.

| Title | Lead | Aim |
|---|---|---|
| How well do I know and trust my doctor? | One Care Ltd, a GP-led organisation that represents and supports practices in Bristol, North Somerset and South Gloucestershire | To improve continuity through interpersonal care between a patient and a single health care professional (or micro-team) for all appointment types across GP practices, leading to better personalised care for patients and improved job satisfaction for staff.<br><br>Introducing team-based models of general practice in which micro-teams take responsibility for a group of patients and share their care. |
| Continuity by design | Pier Health, a GP provider for the Weston-Super-Mare and Worle areas of North Somerset | To improve continuity of care and reduce variations across nine GP practices, leading to reduced workload, and improvements in patient and staff satisfaction.<br><br>Helping patients to develop a therapeutic relationship with their preferred clinician by introducing micro-teams and implementing systems that match clinical capacity to demand. |
| Improving continuity of care for patients in South Cumbria | South Cumbria General Practice Collaborative, a federation of 25 GP practices | To help patients to see their preferred GP in order to improve continuity of care and clinical outcomes, reduce hospital use, and increase patient and staff satisfaction.<br><br>Will involve identifying, testing and implementing practical and digital innovations (such as micro-teams, online consulting methods, and consistent coding and record keeping) across multiple GP practices. |

| | | |
|---|---|---|
| Continuity counts – a whole-practice approach to improving GP relational continuity | St Leonard's Research Practice, Exeter | To improve continuity between registered patients and their personal doctors in order achieve health improvements across five GP practices. The project is based on a series of workshops for GPs, patients and administration staff.<br><br>Will introduce interventions including a continuity toolkit, measurement methods and promotional materials that will increase the commitment to continuity among practice staff and patients. |
| Relational continuity for general practice patients with new and changing symptoms | Valentine Health Partnership, Woolwich, London | To investigate whether offering a period of relational continuity with a named GP results in benefits in terms of improved experience of care and better outcomes for patients.<br><br>Will use data analysis to identify healthy patients with new or changing symptoms who may benefit from continuity, and will implement operational systems that support people to achieve continuity and assess its impact. |

Further details about the projects can be found on the Health Foundation website.

## 4. Details of the work

### Rationale for the evaluation

The primary purpose of commissioning this evaluation is to develop and share learning about the process of improvement at each of the five projects and their sites, through establishing:

- the model of improvement and approach being used
- whether continuity of care has increased
- patient and staff views on continuity of care, their experiences of each intervention and the impact it has had
- any unintended consequences of improving continuity of care, for example reducing access, which will enable us to contribute to the wider policy conversation around the future of general practice and GPs working at scale
- how any change in continuity of care occurred within that specific environment.

To be able to answer these questions we are commissioning this external mixed method evaluation and a quantitative evaluation with the Improvement Analytics Unit (IAU).

**Aims, scope and requirements for the mixed method evaluation**

The aim of this evaluation is to understand if, and how, improvement approaches can be used to increase continuity of care.

Given that there are only five awards, each trialling a different approach to improving continuity, the successful supplier is expected to deliver a series of evaluated case studies rather than an extensive programme evaluation. However, the evaluation should synthesise learning, wherever possible, to offer programme-level insights.

The evaluation will answer at least the following questions:

1. What improvement approaches have been used?

2. What impact have the projects had on continuity of care?
    - Has continuity of care increased for patients?
    - How has the programme contributed to our understanding of what continuity of care means?
    - What improvement approaches worked best for improving continuity of care?

3. What are the experiences of participating patients and staff?
    - What approaches were used to engage patients and staff?
    - What were the advantages and disadvantages of participation for different patient groups and staff?
    - What has been the wider impact on workforce?
    - What is the wider learning about patient and staff views on continuity of care and how do these vary across different groups of patients?

4. What (if any) are the benefits and unintended consequences of attempting to improve continuity of care?

5. What are the factors that affect the success of and, where appropriate, spread of continuity of care improvement interventions?
    - What are the facilitators, barriers and other contextual factors?
    - What is the learning about how best to overcome these barriers?

6. What are the resources needed to improve continuity of care?

To answer the questions outlined above, we are seeking an evaluator who can support us with the design and delivery of a mixed method evaluation, that captures the experience of patients and staff, and seeks to understand the underlying improvement approaches for each of the projects.

There are three workshops for the programme, planned for September 2019, March 2020 and October 2020. These will be delivered by a support partner and will provide an opportunity for the evaluator to observe the award holders sharing learning at different phases of the projects. There will also be an end of programme event in December 2020, which is an opportunity to share insights from the evaluation. The successful provider will be expected to attend these four events and should ensure they form part of their planning.

The provider will be responsible for designing, managing and conducting the evaluation; analysing the findings; and producing a coherent report and presentation that synthesises the key findings into a core set of lessons. We expect the evaluation to be developmental and supportive in nature; providing timely feedback to project teams throughout the programme as insights emerge, rather than only at pre-determined times. We would also expect the evaluator to work with the project teams to develop individual logic models.

The Health Foundation will work with the successful provider to refine the evaluation questions and approach before they submit a final evaluation protocol. We will also work with the provider to agree on interim and final report structures, and expect the provider to set the findings in the context of the wider strategic narrative.

**The Improvement Analytics Unit (IAU) evaluation**

The IAU will be conducting a separate evaluation of the projects. This is currently being designed and will explore whether increasing continuity of care can improve patient outcomes. These outcomes will be agreed with the Health Foundation, the external mixed-method evaluator and project teams.

To avoid over-burdening sites with evaluation requirements, the level of contact the IAU will have with project sites will be kept to a minimum. They will work with sites in January 2019 to develop statistical analysis plans and to define the outcome measures, and will focus on data sharing agreements and access requests. It is anticipated that they will start data analysis in December 2019 and report in January 2021.

**Audiences and presentation**

In commissioning any piece of research or evaluation, we ensure that an outline communications plan accompanies the evaluation plans from the start, and that this is fully developed through to completion.

The primary audiences for this work include:

- The programme award holders
- Internal teams at the Health Foundation, including Data Analytics, Improvement and Research
- Royal College of General Practitioners
- NHS England
- NHS Improvement
- Practices that are not involved in the awards, and their workforce

The secondary audiences for this work include:

- Other academics
- *British Medical Journal*
- National Voices
- The Q Initiative
- Nuffield Trust
- The King's Fund
- Providers of digital tools for delivery of general practice
- NHS providers and commissioners

- Policymakers
- Anyone interested in evaluation who could learn from this

The Health Foundation will draw on the support of an advisory group, comprised of representatives from some of these audience groups and key stakeholders. This group will provide strategic and academic direction, as well as constructive challenge and rigour, to all elements of the design and delivery of the programme and its evaluation; ensuring it meets its overarching aims and objectives. Feedback from the advisory group should be integrated into the structure and design of the final report.

We will work closely with the provider to develop key messages and to draw out the implications of the findings, and any communications and public affairs (including media) related to the evaluation and its findings.

We will work with the provider to consider different presentational options for the different audiences. We are keen to ensure that the development process of this work supports our wider stakeholder engagement work.

Our aim in terms of dissemination is to provide outputs that are useable by those in policy and practice who are research literate but time poor. We may, therefore, commission an independent writer to produce a Health Foundation learning report based on the provider's evaluation report. In such an instance, we expect our provider to work with the writer to provide insight into the key findings, and feed back on early drafts of the learning report.

We will also expect our provider to join us for any roundtable meetings with key stakeholders that may be necessary, to add to the debate about the findings, and/or test and validate the findings.

Please ensure that your proposal makes reasonable allowance for the time required to fulfil these obligations with regard to dissemination throughout the duration of the evaluation.

### Intellectual property

In commissioning this evaluation, the Health Foundation will own the intellectual property generated (please see the intellectual property clause in Schedule 6 of the sample contract).

### Working with us

Where at all possible, the Health Foundation takes a partnership approach to its work. We will want to meet or speak with the provider regularly (any costs incurred for meetings should be factored into the budget). We anticipate holding monthly evaluation working group meetings, at the Health Foundation offices in London, for the first four months. We will then continue to hold monthly update calls as the evaluation progresses, and hold face-to-face meetings in April 2020 and December 2020. The quantitative evaluator from the IAU will attend the evaluation working group meetings in April 2019, April 2020 and December 2020, to share learning across the evaluations and provide updates. The work will be managed by a Research Manager, with strategic and content input provided by a strategic lead at the Health Foundation.

Our proposed governance structure for this programme can be found in Annex 1. Please ensure that you allocate sufficient resource to contribute to both the Advisory Group and Evaluation Working Group, as outlined with the governance structure, noting the frequency of both groups.

### Working with the project teams

Each of the project teams are aware of the evaluation and have agreed to comply with all reasonable requirements of any external evaluator. The evaluator should consider how to avoid over-burdening sites, given their heavy workload, and how best to feed evaluation findings back to teams as they go. This will include how best to utilise meetings that are already scheduled.

## 5. Deliverables

The following deliverables should be provided:

- Evaluation protocol (w/c 25 March 2019)
- Interim report (w/c 16 March 2020)
- First complete draft of final report (4 February 2021)
- Presentation to Advisory Group (February 2021)
- Final draft of report (March 2021)

In addition, attendance is expected at the three programme learning workshops, the end of programme event, biannual advisory group meetings and evaluation working group meetings during the programme.

## 6. Costs

Responses to this invitation should include accurate pricing, inclusive of expenses and VAT. It is emphasised that assessment of responses to this tender invitation will be on perceived quality of service and demonstrable ability to meet the brief, rather than lowest cost, but value for money is a selection criterion.

Based on previous similar work commissioned by the Health Foundation, we anticipate bids of up to £250,000 (inclusive of VAT and expenses).

We will commission this evaluation by issuing a contract for services and, as such, we expect VAT is likely to be payable on all aspects of the work.

*Please consult your contracting team and/or finance team to ensure that VAT has been included appropriately before submitting your proposal and budget.*

## 7. Information call

We will hold an **information call from 10.00-11.00 on Monday 14 January 2019**. The call will last one hour. If you would like to attend please **register your interest to join before**

**17.00 on Friday 11 January 2019**. Joining instructions will be sent to you in advance of the call.

We would ask that you email any questions you would like answered on the information call to **ContinuityofCare@health.org.uk** by **17.30 on Thursday 10 January 2019**.

Information calls offer applicants the opportunity to hear more about the programme and ask questions to clarify understanding. Please note that we will not be able to answer specific technical questions about individual tender responses.

You are strongly encouraged to participate in the information call.

## 8. Tender response requirements

Providers are requested to complete a tender response form on AIMS in presenting their response. A PDF form is included as an example – **do not** use this to submit your application, this must be done online.

Detailed provider information to include:

- Organisation name, address, registered address (if different) and website address
- Description of the organisation's activities or services
- History and ownership
- Organisational governance and management structure
- Most recent company accounts

The tender response must include:

- Summary of your proposed approach
- Summary of the experience of the key personnel who will be involved in the project
- Costs, including a summary of the day rates and required days of those employed on the project, inclusive of VAT and expenses
- Risk management
- Any other relevant information the Health Foundation should take into account
- Primary contact name and contact details
- Details of the team carrying out the work – names, roles and expertise relevant to the tender
- Client references, including a list of comparable organisations to which you have supplied a similar service and a brief project description for each
- A statement of your willingness to reach a contractual agreement that is fair and reasonable to both parties

## 9. Instructions for tender responses

The Health Foundation reserves the right to adjust or change the selection criteria at its discretion. The Health Foundation also reserves the right to accept or reject any and all responses at its discretion, and to negotiate the terms of any subsequent agreement.

This work specification/invitation to tender (ITT) is not an offer to enter into an agreement with the Health Foundation; it is a request to receive proposals from third parties interested in providing the deliverables outlined. Such proposals will be considered and treated by the

Health Foundation as offers to enter into an agreement. The Health Foundation may reject all proposals, in whole or in part, and/or enter into negotiations with any other party to provide such services, whether it responds to this ITT or not.

The Health Foundation will not be responsible for any costs incurred by you in responding to this ITT and will not be under any obligation to you with regard to the subject matter of this ITT.

The Health Foundation is not obliged to disclose anything about the successful bidders, but will endeavour to provide feedback, if possible, to unsuccessful bidders.

Your bid is to remain open for a minimum of 180 days from the proposal response date.

You may, without prejudice to yourself, modify your proposal by written request, provided the request is received by the Health Foundation prior to the proposal response date. Following withdrawal of your proposal, you may submit a new proposal, provided delivery is effected prior to the established proposal response date.

Please note that any proposals received which fail to meet the specified criteria contained in it will not be considered for this project.

### 10. Selection criteria

Responses will be evaluated by the Health Foundation using the following criteria (in no particular order):

- Skills and expertise in evaluation techniques for complex interventions
- Knowledge or awareness of the health and social care sector and health care settings, ideally general practice
- Appropriateness of proposed methodology
- Appropriate project management, risk management and quality assurance expertise
- Demonstrable capacity to deliver the evaluation on time, on budget and to the required standard, with proven ability to flex resource capabilities and adapt to changing environments where required
- Ability to work collaboratively with a range of stakeholders
- Strong communication skills
- Value for money
- Willingness to travel to project sites and programme events

It is important to the Health Foundation that the chosen provider is able to demonstrate that the right calibre of staff will be assigned to the project; therefore, the project leader who will be responsible for the project should be present during the panel interviews if you are selected.

### 11. Selection process

Please complete the online tender response form on AIMS by midday on 4 February 2019.

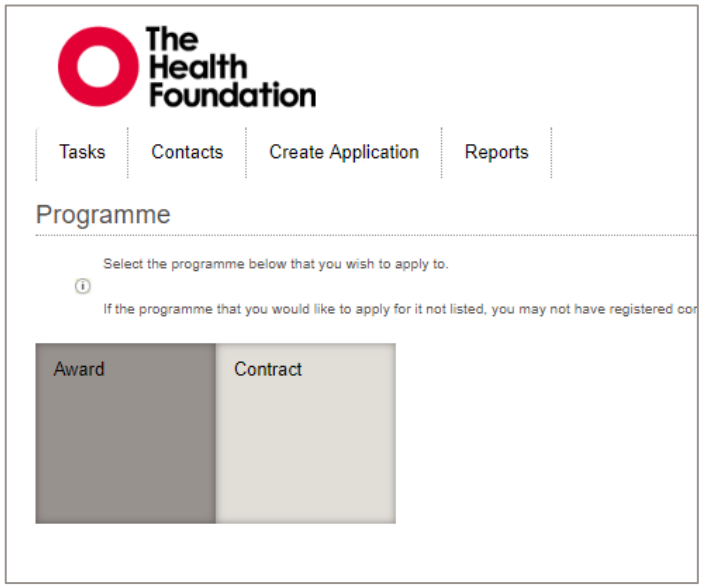
**Please read the AIMS user guide before starting to complete the form. This is available on our website and via the online form on AIMS.**

***AIMS quick start***

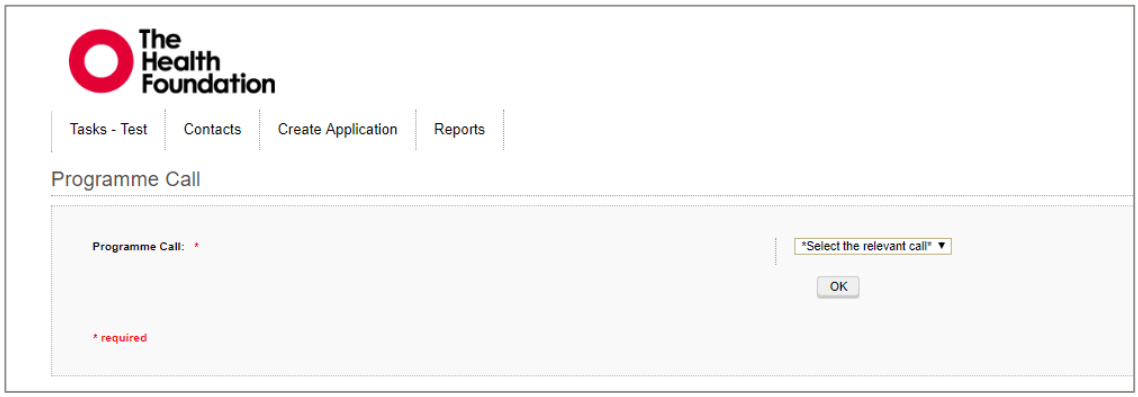
Once you have registered with AIMS and have activated your profile via the verification email, you can start a tender response. If you are applying on behalf of a team or organisation, register with the organisation via the *'Contacts'* tab before doing so. Then click on '*Create Application'* and select to apply on behalf of the organisation you have just registered with.

***Open tender instructions***

Select the '*Contract*' programme, as shown below.




On the next screen, click into the drop-down menu and select the *'Evaluation of the Increasing Continuity of Care in General Practice programme'* in the drop-down for *'Programme call'*, as shown below.




A response to your application will be made by **20 February 2019**.

Interviews will be held on **5 March 2019.**

The final decision will be communicated by **8 March 2019.**

The start date is to be agreed following the final decision (but would be as soon as practicable).

## 12. Confidentiality

By reading/responding to this document you accept that your organisation and staff will treat information as confidential and will not disclose it to any third party without prior written permission being obtained from the Health Foundation.

Providers may be requested to complete a non-disclosure agreement.

## 13. Conflicts of interest

The Health Foundation's conflicts of interest policy describes how it will deal with any conflicts which arise as a result of the work which the charity undertakes. All external applicants intending to submit tenders to the Health Foundation should familiarise themselves with the contents of the conflicts of interest policy as part of the tendering process and declare any interests that are relevant to the nature of the work they are bidding for. The policy can be found and downloaded from the Health Foundation's website at: www.health.org.uk/about-us/

# Annex 1 – Proposed governance structure

**Programme Group**

Purpose: Ongoing oversight of the projects, including project management updates and challenges and opportunities emerging from the work
Chair: Programme Manager
Members: Assistant Director of Improvement Programmes, Programme Officer, Research Manager
Meeting frequency: Monthly

**Evaluation Working Group**

Purpose: Evaluation contract management and programme co-design
Chair: Research Manager
Members: Programme Manager and Evaluator/s
Meeting frequency: Monthly

**Advisory Group**

Purpose: Strategic and academic direction, as well as constructive challenge and rigour, to all elements of the design and delivery of the programme and its evaluation, ensuring it meets its overarching aims and objectives
Chair: Assistant Director of Improvement Programmes
Members: Senior Research Manager, Research Manager, Programme Manager, Assistant Director of Data Analytics, expert academic stakeholders and representatives from the audience groups highlighted on page 8
Secretariat: Programme Officer
Meeting frequency: Bi-annually (with additional meetings when required)