Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Ensuring the Continuity of Health Care Services and Designating Commissioner Requested Services

Governing Body meeting

Item 13i

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Key Messages

- The CCG has a statutory duty to identify and agree with our providers those services for which there is no acceptable alternative provider due to:

  a) There being no alternative provider close enough; or
  b) Removing them would increase health inequalities; or
  c) Removing them would make dependent services unviable.

  Services that meet the above criteria will need to be designated as **Commissioner Requested Services** (CRS).

- Providers of CRS will require a Monitor Provider licence, regardless whether they are currently exempt (*see appendix A*). The Continuity of Services conditions in the licence oblige providers of CRS to send Monitor information indicating how financially stable they are and to accept further investigation and support if they get into financial difficulty.

- In the unlikely event that a provider of CRS looks as if it might fail, Monitor will appoint an expert Contingency Planning Team to work with providers, commissioners and patient representatives to develop a solution that protects CRS.

Assurance Framework

Assurance Framework Number
4.1 Ineffective commissioning practices (Domain 3).

How does this paper provide assurance to the Governing Body that the risk is being addressed?
Although 'ensuring the continuity of health care services and designating commissioner requested services (CRS)' may not have been explicitly considered as part of the risk identified in 4.1, a failure to undertake the necessary level of service review could prevent effective commissioning practices from being undertaken.

Is this an existing or additional control?
Additional.

Equality/Diversity Impact
Although there are no direct equality/diversity issues to note; there may be indirect issues to consider in terms of the health inequalities component of the designation process.
Public and Patient Engagement
There is no formal requirement to engage with the public and patients; although Monitor recommends that decisions regarding the designation (or de-designation) of services should be communicated to other interested parties (as well as to the provider). This may include neighbouring commissioners, NHS England, local authorities, Health and Wellbeing Boards and local Healthwatch.
Recommendations
The CCG Governing Body is asked to note the content of the paper and agree to passing the responsibility for mobilising the work programme to CET, to ensure effective delivery within the identified timelines.

Further Information
Monitor Guidance on Designating Commissioner Requested Services (March 2013): http://www.monitor.gov.uk/node/2462 Monitor Briefing on Provider Licence and Commissioner Requested Services (January 2014): http://www.monitor.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-commissioners/supporting-the-c

Ensuring the Continuity of Health Care Services and Designating Commissioner Requested Services

1. Introduction

NHS Sheffield CCG has a statutory duty to identify services for which, in the rare event of provider failure, there is no acceptable alternative provider. This might be because:

- There is no alternative provider close enough; or
- Removing them would increase health inequalities; or
- Removing them would make dependent services unviable.

The CCG has responsibility to identify and agree with our providers, that any such services that meet the above criteria will need to be designated as Commissioner Requested Services (CRS).

In short, providers of services designated as CRS become subject to the Continuity of Services conditions in Monitor's provider licence. These conditions oblige providers of CRS to send Monitor information indicating how financially stable they are and to accept further investigation and support if they get into financial difficulty.

In the unlikely event that a provider of CRS looks as if it might fail, Monitor will appoint an expert Contingency Planning Team to work with providers, commissioners and patient representatives in our local health economy to develop a solution that protects services for the failing provider's patients and ensures they have access to sustainable health care.

2. Key points

2.1 Current Position

All services provided by Foundation Trusts (FTs) (that were previously identified in their terms of authorisation as mandatory services) will now be automatically classified as CRS. All other services commissioned by the CCG (for example from independent sector providers) will not automatically be classified as CRS.

The only exception to this rule is where a provider is delivering services as part of a sub contractual arrangement with one of our FTs. In these circumstances, given the 'prime' contract is with the FT, then services delivered by sub-contractual providers will be subject to the same automatic classification approach as noted above (this is explicitly noted in Monitor guidance). Providers of such services will therefore require a Monitor Provider licence (regardless whether they are currently exempt), and will be subject to Monitors Continuity of Services conditions. This has implications for some of our local providers if we pursue MSK services through the prime contractor route of STH.

By default, therefore, the current list of CCG Commissioner Requested Services is essentially those commissioned from our FTs (including their sub contractual partners).

Monitor strongly recommends that commissioners review, as soon as possible, whether this is the correct set of services that would need to be protected in the event of provider failure. We have until 31st March 2016 to undertake this review; although once complete it is recommended that we periodically reassess which services are designated as CRS, to ensure that the designation remains appropriate in light of any changes in the local health economy (e.g. where a new provider has entered the market place).

2.2 Suggested Approach

Given the implications of designating a service as CRS, on both the provider (who will require a Monitor Provider Licence even if they are currently except) and the local community (for whom a CRS designated service will be protected in the event of provider failure), it is important that we undertake a thorough review of all services to ensure that only those that genuinely fulfil the criteria (as detailed in section 1) are designated. This may therefore involve de-designating some services currently provided by FTs and designating some services provided by other providers. **The rational for whether a service is designated however should be based on the individual service not the provider.** To provide some practical context, it is assumed that we will always want an A&E service within Sheffield and hence related trauma and other emergency services and so these are likely to be designated CRS. There may be other services where we could envisage are less essential which we could fall outside of CRS designation.

There are potential financial implications for the CCGs which might depend on the proportion of services which we designate as CRS. Monitor has indicated that from April 2015 it will need to create a national fund to manage situations where trusts get into financial difficulty and CRS services need to be protected in local communities. Values in range of £200m to £400m have been quoted informally. Currently this fund is provided via NHS England but one option under consideration for April 2015 onwards is to impose a levy of CCGs and Providers reflecting the level of CRS designated services. For Sheffield this could be an annual cost of over £1m.

We should be mindful of the implications of designating a service as CRS, particularly when it is provided by a provider who is currently exempt from the Monitor Licence regime. The Continuity of Services conditions oblige providers to send Monitor information indicating how financially stable they are and to accept further investigation and support if they do get into financial difficulty. For very small providers, this could prove to be an onerous task. This is all the more important when such providers are delivering services through sub-contractual arrangements with FTs, and are therefore immediately bound to apply for a Monitor Provider Licence, simply on the basis that all such services have automatically been classified as CRS (when in normal circumstances they may be exempt from doing so). Services should therefore be reviewed at a specialty level except for where services have been subcontracted by a FT, when subspecialty should be used; thus ensuring that the review process is relevant and proportionate.

The suggested approach is to undertake a review of all services, using the phased approach as recommended by Monitor as part of their designation framework (*see Appendix B*). This will require a degree of expertise regarding the local health economy and each service specific market place. It is suggested therefore that this

review be led by the respective Clinical Portfolio's; utilising the service specific knowledge of the (senior) commissioning managers and the clinical expertise of the GP leads (particularly around service interdependency and the impact on patients if services were to be delivered away from current locations). Although it is difficult to determine the precise amount of time this review will take, indicative estimates of resources have been provided to enable portfolio's to allocate dedicated time in which to undertake this work within their overall work plan(s). A summary of this is detailed in *Appendix C*.

Once portfolios have concluded the required reviews of CRS, Governing Body will need to formally agree those services identified as commissioner requested. Periodic updates will therefore come back to Governing Body as and when a review of a provider has concluded.

It is proposed that CET will be the mechanism for overseeing the allocation of commissioner and clinical input into the process.

Appendix A
Monitor Provider Licence Exemptions

All providers of health care services for the purposes of the NHS will need a Monitor licence from April 2014, unless exempt (under regulations made by the Department of Health).

Providers in the following categories will be exempt:

- Providers which are not required to register with the Care Quality Commission;
- Small providers of NHS-funded health care services whose annual turnover from the provision of NHS services is less than £10 million;
- Providers of primary medical and dental services (although primary care services commissioned by CCGs are included, subject to the other exemption criteria);
- Providers of NHS continuing health care and NHS-funded nursing care; and
- NHS trusts (which will only be licensed upon authorisation as an NHS foundation trust).

However, all these exemptions, other than the one applicable to NHS trusts, cease to apply if the services delivered by the provider are designated by a commissioner as Commissioner Requested Services. In this case, the provider must hold a licence.

Appendix B

Designation Process

Phase 1 - Prepare	**Phase 2 - Initiate**	**Phase 3 - Assess**	**Phase 4 - Review**	**Phase 5 - Refresh and Update**
At this stage we will need to identify the desired long-term outcome, given the needs of our local population and the current local configuration of health services	At this stage we should notify providers and other stakeholders that we are beginning work to identify CRS and are seeking their input.	Here we designate or de-designate services as CRS. It is recommended that we use the Monitor Designation Framework Excel Tool: http://www.monitor.gov.uk/node/2462	Providers are formally notified of our decisions. Providers may refuse the designation of a service as a CRS. If so, and if we remain of the view that the service should be designated as a CRS, we have the opportunity to seek a review from Monitor to determine whether the provider's refusal was unreasonable.	Over time, as providers enter and exit a local health economy or service, and technological changes enable services to be delivered in different ways, we should review our designation decisions to ensure that they remain appropriate.
Issues to Consider • Need to determine the list of all services that will be reviewed (list of specialties by provider). • Need to determine which services have been subcontracted by an FT, and therefore where subspecialty will be applied.	Issues to Consider • Need to determine which stakeholders will be informed and level of input required. • Clearly illustrate the process that will be followed and implications of designation.	Issues to Consider • Agree a consistent approach to the designation process which is clear and well understood across portfolios. • Ensure 'similar' services provided by different providers are cross checked to ensure consistency.	Issues to Consider • Standard letter to be sent to all providers, including the rationale used to reach decision. • Records should be kept as to how decision reached should a challenge be raised. • Monitor notified (where required).	Issues to Consider • Consider phased approach to refresh process; a rolling programme throughout the three years.
Timescales April 2014 – September 2014	Timescales October 2014 – December 2014	Timescales January 2015 – September 2015	Timescales October 2015 – March 2016	Timescales Every 3 Years from April 2016
Resource Requirements (Hours) Sheffield Teaching Hospitals Commissioning 7.5 Clinical 3.75 Sheffield Children's Hospitals Commissioning 7.5 Clinical 3.75 Sheffield Health and Social Care Commissioning 7.5 Clinical 3.75 Independent Sector Providers Commissioning 3.75 Clinical 2 VCF Sector Providers Commissioning 3.75 Clinical 2 CCG Commissioned Primary Care Commissioning 3.75 Clinical 2	Resource Requirements (Hours) Sheffield Teaching Hospitals Commissioning 3.75 Clinical 0 Sheffield Children's Hospitals Commissioning 3.75 Clinical 0 Sheffield Health and Social Care Commissioning 3.75 Clinical 0 Independent Sector Providers Commissioning 7.5 Clinical 0 VCF Sector Providers Commissioning 7.5 Clinical 0 CCG Commissioned Primary Care Commissioning 7.5 Clinical 0	Resource Requirements (Hours) Sheffield Teaching Hospitals Commissioning 37.5 Clinical 15 Sheffield Children's Hospitals Commissioning 37.5 Clinical 15 Sheffield Health and Social Care Commissioning 37.5 Clinical 15 Independent Sector Providers Commissioning 22.5 Clinical 7.5 VCF Sector Providers Commissioning 22.5 Clinical 7.5 CCG Commissioned Primary Care Commissioning 22.5 Clinical 7.5	Resource Requirements (Hours) Sheffield Teaching Hospitals Commissioning 3.75 Clinical 0 Sheffield Children's Hospitals Commissioning 3.75 Clinical 0 Sheffield Health and Social Care Commissioning 3.75 Clinical 0 Independent Sector Providers Commissioning 7.5 Clinical 0 VCF Sector Providers Commissioning 7.5 Clinical 0 CCG Commissioned Primary Care Commissioning 7.5 Clinical 0	Resource Requirements (Hours) Sheffield Teaching Hospitals Commissioning 13.75 (per annum) Clinical 5 (per annum) Sheffield Children's Hospitals Commissioning 13.75 (per annum) Clinical 5 (per annum) Sheffield Health and Social Care Commissioning 13.75 (per annum) Clinical 5 (per annum) Independent Sector Providers Commissioning 10 (per annum) Clinical 2.5 (per annum) VCF Sector Providers Commissioning 10 (per annum) Clinical 2.5 (per annum) CCG Commissioned Primary Care Commissioning 10 (per annum) Clinical 2.5 (per annum)

Appendix C

Resource Requirements (Approx.)

Phase	Commissioning Manager Time	Clinical Time
1	34	17
2	34	0
3	180	68
4	34	0
Sub-Total	282 Hours (38 Days)	85 Hours (11 Days)
5	71.25 Hours (9.5 Days)	22.5 Hours (3 Days)

2014/15		
	128 Hours (17 Days)	40 Hours (5 Days)
2015/16		
	154 Hours (20.5 Days)	45 Hours (6 Days)
Annually (Ongoing)		
	71 Hours (10 Days)	23 Hours (3 Days)