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NHS Sheffield Clinical Commissioning Group

Contracting Options Appraisal for Urgent Primary Care

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Primary Care Commissioning Committee meeting

21 December 2017

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Purpose of Paper

This paper sets out the key contracting information on services currently providing urgent care (excluding through GP practices and acute hospital inpatient care) within the Sheffield healthcare system. It highlights there is a gap between certain contract end dates and the envisaged commencement of a new service model, subject to the outcome of the current public consultation. The paper provides two options to address this position. The information provided should enable the Primary Care Commissioning Committee to decide whether to approve the preferred option.

Key Issues

The key issues articulated include:

- The background on the on-going urgent primary care review (Section 1)
- The current contracting arrangements for urgent care services (Section 2)
- The strategic context (Section 3)
- The proposed options (Section 4)

Is your report for Approval / Consideration / Noting

Approval

Recommendations / Action Required by the Primary Care Commissioning Committee

PCCC is asked to agree to extend the 4 affected contracts as detailed in section 2 and outlined in option 2 of section 4 above, to 31 March 2019. A PIN should be issued at the same time.

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?

1. To improve the quality and equality of healthcare in Sheffield
2. To improve patient experience and access to care

Are there any Resource Implications (including Financial, Staffing etc)?
Staff from across the organisation will be required to provide input into the contract extension process for the identified services should the preferred option be approved.
Have you carried out an Equality Impact Assessment and is it attached?
An EIA has not been completed as this paper does not propose a new service or making changes to service models but extending the contracts of existing contracted services.
Have you involved patients, carers and the public in the preparation of the report?
No

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1. Background

In September 2017 the Primary Care Commissioning Committee approved the commencement of the formal public consultation on options for a revised service model for delivery of urgent primary care. The consultation began on 26 September 2017 and a number of engagement activities are being held to engage with the public, patients and other key stakeholders. The consultation was originally due to close on 18 December but this has been extended until 31 January 2018. The information gathered will be used to inform the final business case. The final business case will be presented to the Primary Care Commissioning Committee in September 2018.

In order to achieve the challenging timescales set out above, while in no way pre-empting the outcome of the consultation, a number of work streams need to run concurrently to the public consultation. One of these relates to the contract and procurement arrangements for the services within the scope of the review. These include work streams on the contractual implications of the current services, several of which are currently due to cease before the proposed model is fully implemented; and the manner in which the proposed services are procured and contracted (assuming they are supported by the outcome of the consultation).

The purpose of this paper is to recommend an approach to contractually manage the current services. In order to ensure that this is an informed decision the paper sets out a number of strategic factors that need to be reviewed when considering whether to extend current contracts and for how long.

While the strategic context of the consultation must be acknowledged (see section 3) this paper and the proposed options for contract management are mutually exclusive of the consultation itself. The reasoning behind this is that regardless of the outcome of the consultation there would be a requirement to provide these services as a minimum during the interim period (1 July 2018 till March 2019).

2. Current Contract Arrangements

The CCG currently has contracts for a number of services that stand to be affected by the Urgent Primary Care review as follows:-

Note	Service	Contract End Date	Notice Period	Contractual Basis	Organisation
1.	Walk in Centre (WiC)	Jun-18	6 Months	Cost &Volume (C&V)	STH

2.	**Extended Access**	**Jun-18**	**6 Months**	**Block**	**PCS**
2.	**Extended Hours (Stocksbridge)**	**Jul-18**	**12 Months**	**Block**	**Lloyds Pharmacy**
2.	**Wicker OOH Pharmacy**	**Jul-18**	**12 Months**	**Block**	**Wicker Pharmacy**
	STH A&E	Mar-19	12 months if value over £5 Million	C&V	STH
1.	Minor Injuries Unit	Mar-19	6 Months	C&V	STH
	Emergency Eye Care	Mar-19	6 Months	C&V	STH
	GP Out of Hours service *	Mar-19	6 Months	Block	STH
	SCH A&E	Mar-19	6/12 Months (TBC)	C&V	SCH
	111	Mar-19	15 Months	Block with other CCGs	YAS
	Minor Ailments	Mar-19	12 Months	C&V	Various Providers

Notes

1. Services would cease under proposed service model and would be replaced by new services that would require new contractual agreements
2. Services will continue under the new proposed service model but have contracts that are currently due to end prior to expected start of transition

* It should be noted that 3 practices currently commission Care UK to provide their Out of Hours Service

Governing Body (appropriately noting conflict of interest issues) in May 2017 agreed an extension to 30 June 2018 for the WiC and Extended Access services and this was supported via delegated authority. The rationale for this short extension was on the basis that this would provide 4 months from GB making the decision on the solution to be implemented for urgent primary care to implement an exit plan, alter the existing service offer or confirm timescales for procurement.

3. Strategic Context

There are a number of strategic factors that need to be reviewed when considering whether to extend current contracts and for how long. These are outlined below:

a) Urgent Treatment Centre (UTC) national timescales

The national expectation is that all areas will have Urgent Treatment Centres in place by December 2019. However, the CCG would wish to avoid implementation of the proposed UTC(s) in the run up to winter (Q3) or in August (because of the junior doctor handover). This would mean that at the latest the CCG should be considering commencement of the proposed UTC(s) by the beginning of July 2018, with the earliest commencement being April 2019. Further work is required to refine this timescale over the next 6 months.

b) Mobilisation of the UTC(s)

The need for and potential benefits of double running either or both of the existing services (WIC and MIU) at the same time as the UTCs needs to be considered. When Rotherham CCG launched their UTC, they officially closed their Walk in Centre but maintained a skeleton staff at the site during core hours for the first 2 weeks of the service. This was risk mitigation against a seriously unwell patient attending the site thinking the service was still in place. This strategy was supported by communications focussing on the "relocation" of the WIC rather than promoting a new service so as to not drive demand. This approach was born out by the observed activity levels post go live. It is also pertinent to consider whether to factor in any slippage for the potential start date of the UTCs due to overruns with any procurement process.

c) Integrated Urgent Care (IUC) national timescales

The national expectation is that all areas will have combined NHS 111 and GP Out of Hours services into fully Integrated Urgent Care 24/7 services by March 2019. The Sheffield vision for IUC is to have our GP Out of Hours service clinicians to provide some of the clinical workforce required by the Integrated Urgent Care service to ensure that where possible, local clinicians are talking to Sheffield patients when they ring 111.

This service transformation is being led at a regional level by Huddersfield CCG with sub regional support being provided by the South Yorkshire ACS and Sheffield CCG. The team are in the process of drafting a service specification based on national requirements and considering how some of the technical aspects of the requirements e.g. direct booking of GP appointments can practically be implemented.

These timescales are important because of the interlinkages between these requirements and the proposed UTC(s) in terms of staff, location and the benefits of integration. If the IUC service were to be commissioned locally rather than regionally, it would have been advantageous to have integrated it with the UTC(s). The regional footprint of the IUC complicates this but any opportunities to align the delivery of the IUC with that of the UTC(s) and neighbourhoods should be maximised.

d) Neighbourhood Development

The activity modelling undertaken to date assumed that approximately 40% of the activity currently seen by the Walk In Centre will be treated within the neighbourhood setting within the revised model. The initial feedback received from the public consultation suggests that this could be an underestimate and that more people would chose to be seen within their neighbourhood rather than at a UTC. Either way, the neighbourhoods need to have sufficient sustainable capacity to treat these patients, in additional to their current cohort, within 24 hours of request or an alternative interim provider needs to be in place prior to the Walk In Centre closing. To achieve this consistently across all neighbourhoods is going to take at least 12 months as a best case scenario, but it would be prudent to recognise this process may well take longer.

Development of the neighbourhoods is also contingent on having solved several 'non-negotiable' issues (including interoperability, medical indemnity and governance). National work is ongoing to resolve these and a local task group is

considering how to develop work arounds to ensure that these issues are resolved, but this is going to take at least six months.

e) Financial implications

One of the key tenants of the review is that there should be no cut in net funding under the model; it is not an exercise in cost cutting. However the overarching financial situation must be respected and any procurement of services, both in the interim period and beyond, must provide value for money.

The development of the neighbourhoods would benefit from pump priming in the early stages. This could be achieved through savings generated from increasing the value for money of existing services, by redeploying the investment from existing services at their current contract expiry dates or by utilising external non recurrent sources of funding available through the ACS.

As set out in the options below, allowing any of the existing services to expire at their current expiry dates would create significant additional pressure on remaining services. This would jeopardise performance and clinical safety. Some savings could be generated from re-negotiation of contract values or service specifications, although the political and practical implications of this would need to be further considered.

f) Length of the Walk In Centre contract

One Medicare formally requested that the CCG consider an extension beyond that of June 2018 when this was offered to them. The company proposed that a further 9-12 month extension would enable them to manage staff retention issues and would tie in with their lease arrangement timescales.

4. Options for Interim Contracting

There are a number of options to address the gap between current and expected future provision. The option of a full procurement process for the interim contracts was considered as part of due diligence, but was considered unfeasible given the timescales. The remaining options are set out below:

Option 1 – Allow contracts to lapse without extension/replacement

This amounts to a “do nothing” option in that the contracts due to finish in June/July 18 (see section 2) would be allowed to lapse without being extended or being replaced by a new contract.

Pros

- Cost saving from not replacing the contracts could be invested into primary care part way through 18/19

Cons

- Likely to be perceived as cuts to services by the public
- Neighbourhoods too immature to implement model with sufficient capacity – resulting in further deterioration in access to urgent GP appointments
- Likely to result in increased minor illness injury attendances at A&E, jeopardising performance of the 4 hour target
- Would fail to deliver national GP extended access targets, generating significant scrutiny by NHS England

Risks

- Possibility of decreasing the standard of care for patients

Option 2 – Extend contracts until Mar-19 to achieve a uniform contract end date
Under this option the WIC, Extended Access, and Wicker OOH would be offered contract extensions until 31 March 2019 to bring them in line with other contracts and to ensure service provision until transition.

Pros

- Allows for a clear demarcation point for the transition from old service model to the new, while still ensuring service provision up until the point of transition
- Avoids double paying for concurrent services
- Helps support the possibility of a partnership working options for future contracting by harmonising contract end dates

Cons

- The option is dependent on all current providers agreeing to the contract extensions

Risks

- New services, namely the UTCs, might not be ready to commence service delivery from the beginning of April 2019. This could be mitigated by a further 1-3 month extension as necessary nearer the time.
- There may be a risk of challenge from bidders who previously missed out on these contracts; however this risk may be mitigated by issuing a Prior Information Notice (PIN) explaining to the market the reasons for our actions.
- Risk that current providers will not agree to extend to March 2019

Out of the options presented above, the CCG's Executive team recommend option 2 as it allows an interim period of stability prior to transition, without requiring the resources and risks associated with a full procurement process. Any pump priming investment for neighbourhoods would need to be derived from increasing the value for money of current contracts or through the use of non-recurrent investment.

5. Recommendations

PCCC is asked to agree to extend the 4 affected contracts as detailed in section 2 and outlined in option 2 of section 4 above, to 31 March 2019. A PIN should be issued at the same time.

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11 December 2017