NHS Rotherham Clinical Commissioning Group

Governing Body – 2nd March 2016

Emergency Centre Specification and Contract

Lead Executive:	**Keely Firth**
Lead Officer:	**Becci Chadburn**
Lead GP:	**David Clitherow**

Purpose:

To seek approval from Governing Body members for the proposal for the development of service specifications and the issuing of contracts for the Emergency Centre.

Background:

1. ACTION AND DECISIONS TAKEN TO DATE

Rotherham CCG Governing Body approved the full Business Case in August 2014 for a new model for urgent and emergency care in Rotherham, supported by a new Emergency Centre at Rotherham Hospital.

The build is progressing well, a decision has been made regarding the IT solution and a key area now requiring development is the service specification and contract.

Many clinical commissioning groups (CCGs) have started to develop contracting tools to drive more transformational and sustainable service integration and both NHSE and Monitor have encouraged innovative approaches particularly in the Urgent Care sector.

The following extract from the Monitor substantive guidance on the NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 ***(PPCCR)*** [IRG 35/13 of 2013] states that:-

"Some models for integrated care may involve the creation of an "integrated pathway" for all or a number of services that a patient requires. This might be structured in a number of different ways. For example, a commissioner may procure an integrated pathway from a single provider responsible for delivering all aspects of the patient's care, or it might appoint a "lead" or "prime" provider that is responsible for delivering some of the services itself and arranging for other providers to provide the remaining services, or it might commission services from an "alliance" of providers that will work together to provide different elements of the patient's care. The extent to which these models are likely to deliver better integrated care and their impact on competition and choice will need to be considered by the commissioner on a case-by-case basis."

With this guidance in mind, CCG officers gathered information from a range of sources which was presented at the confidential Governing Body meeting in February. This is included at Appendix A in order to provide a clear and transparent representation of the decision made. The section is shaded in grey to highlight that it is from a previous paper.

The decision was based upon the most suitable option to meet the procurement objectives set out in the PPCCR and achieve the following four core aims:

- ***To ensure that clinical governance is clear and robust;***
- ***To hold providers to account for outcomes;***
- ***To hold providers to account for streamlining the delivery of patient care across the peripheries of service providers;***
- ***To ensure a clear financial framework for providers***

In providing the next steps in this paper there is further assurance that the decisions taken in 2014 and at the last meeting:

(a) secures the needs of the people who use the services,

(b) improves the quality of the services, and

(c) improves efficiency in the provision of the services,

Appendix A provides a copy of the information supplied to the Governing Body in February together with the proposal to proceed with the Prime Provider model which was approved.

2. NEXT STEPS – SERVICE SPECIFICATION AND CONTRACT

The objective of this section of the paper is to set out the proposed process for developing the service specifications and issuing of contracts whilst evidencing the CCG's consideration of the PPCCR.

(i) Developing the specifications

CCG officers are in the process of producing the service specifications and there is significant importance attached to the development of the specification by the CCG. The CCG recognises the potential for service improvement and the realisation of efficiencies in the new model of care and is equally aware that the current service specifications cannot easily be transferred into the new model. A period of analysis and development is required. Under the proposal, that task will be undertaken during the periods from 2017-2020.

There have been three key sources of information with regard to designing the new model of care:

- The CCG's commissioning GPs have been influential in determining the vision for the service pathways at the Emergency Centre since 2012. The GPs provide an insight into patients' needs from a locality perspective across 34 practices.

- Both existing providers have assisted the commissioner to understand how services are currently provided and how the new model of care can be delivered.

- The CCG commissioned the Emergency Centre Intensive Support Team (ECIST) to review the planned model in 2014/15 and they have just undertaken another recent review.

The Monitor ***PPCCR guidance*** acknowledges that some providers may have a more extensive role in service redesign without this being discriminatory.

The CCG's approach to secure independent advice from ECIST as well as external clinical input (ie not involved in current provision) has ensured that no provider has been given a more extensive role in engaging with the commissioner on service design that would give them an unfair advantage.

(ii) Arrangements for the Contracts

In practical terms, three years is the minimum time period over which the development of a specification for the market can be run effectively. There will be a three stage process for issuing the contracts:

- Existing contracts for the Walk in Centre and the GP Out of Hours Service are intended to be in place until May 2017 (when the new centre opens) with Care UK.

- The CCG will continue to contract with TRFT for the ED service but given the requirement to deliver the integrated model of care from when the centre opens, TRFT will become the prime provider for the additional elements too. The CCG will specify a requirement to continue to use Care UK as the sub contracted provider from May 2017 until the end of March 2020. The rationale for this is explained under (iii) below.

- By April 2019, TRFT will be expected to have collated data from the new IT system regarding patient attendances and case mix from the new models of care which will have optimised the flow of patients within the most appropriate and safe clinical governance frameworks.

  This intelligence will inform an updated specification and it is intended that others in the market will have an opportunity to bid for subcontracted services. TRFT will seek to follow a formal procurement process for the sub contracted services from April 2020.

  The extension is necessary to gather data and develop a functional integrated service specification as detailed in (iii) below.

- The CCG will undertake periodic reviews of the prime provider model and assess the extent to which the objectives have been achieved at key stages throughout the three years.

(iii) Rationale for the proposed arrangements

- Contract extensions until 2020 were approved by the CCG Governing Body in 2014. The aspect not considered at the time was the prime provider model and the need for TRFT to sub-contract with Care UK instead of the CCG extending the contracts until 2020 with Care UK as originally approved by the Governing Body.
- The time line proposed offers a realistic and practical allowance for the following sequential activities to take place:

  - *Patients and providers will take time to adapt to the changes in services provision;*
  - *The patient pathway will be innovated due to the added value that the new building will bring but this will take time to optimise as will the improved service where access to the first available clinician from either of the two providers will be implemented;*
  - *These patient benefits will require extensive focus for the first 18-24 months and only after this period of time will the true nature of patient activities be understood and quantified;*
  - *This holistic approach will be better optimised by allowing the model to flow without diversions such as financial, clinical or corporate boundaries;*

- Moving forward, the CCG remains committed to this contractual approach. It is made clear in the Monitor guidance that there is no default process that

commissioners should use to secure services including competitive tenders. The CCG has had regard to the **PPCCR** and concludes that this approach is compliant.

The following extract from the ***PPCCR guidance*** states that:-

"..There is no requirement in the Procurement, Patient Choice and Competition Regulations for commissioners to publish a contract notice before awarding a contract to provide those services.
When deciding how to procure services, including whether or not to publish a contract notice, commissioners will need to ensure that their decision is consistent with:

(i) their general objective, when procuring services, to secure the needs of people who use the services and to improve quality and efficiency including through the services being provided in an integrated way (Regulation 2 of the Procurement, Patient Choice and Competition Regulations);

(ii) the requirement to secure that arrangements exist to enable providers to express an interest in providing any NHS health care services (Regulation 4(4) of the Procurement, Patient Choice and Competition Regulations);

(iii) the requirement to act transparently, proportionately and not to discriminate between providers (Regulation 3(2) of the Procurement, Patient Choice and Competition Regulations);

(iv) the requirement to commission services from those providers that are most capable of securing the needs of health care service users and improving the quality and efficiency of services, and that provide the best value for money in doing so (Regulation 3(3) of the Procurement, Patient Choice and Competition Regulations); and

(v) the requirement to consider appropriate means of improving NHS health care services, including through enabling providers to compete to provide services (Regulation 3(4) of the Procurement, Patient Choice and Competition Regulations).

The CCG has considered this guidance and the regulations carefully and can provide assurance that it has made a balanced judgement based upon the unique circumstances in Rotherham.

Recommendations:

Governing Body members are asked to approve the proposed approach to developing the specification and issuing of the contracts between 2016 and 2020 set out in 2(ii) above.

In this paper, there are two broad frameworks that are considered – a **prime** contract and an **alliance** contract.

In a **prime provider contract**, the CCG contracts with a single organisation which then takes responsibility for the day-to-day management of its own direct services and other providers that deliver care within the contracted scope or pathway.

An **alliance contract** sees a group of separate providers enter into a single agreement with a CCG to deliver services, where the CCG and all providers within the alliance share risk and responsibility for meeting the terms of a single contract.

In practice, these contracts are merely the 'scaffolding' for the integrated model and it will be the terms of the contract that will act as a lever for collaboration.

Whichever contract the CCG decides upon, the new pathways in the Emergency Centre and Out of Hours will still be tendered for in line with the original timescales – the tenderer being either the CCG or TRFT.

Research and Evidence

CCG Officers have undertaken a number of activities to research the different options, assess the risks and evidence the opportunities to mitigate the risks including the management of clinical insurance.

The steps taken to date include the following:

*(i) researching the technical properties of the different contract types **(Appendix B**);*

(ii) conference call with Monitor regarding the procurement issues of each option;

(iii) discussions with members of the Emergency Centre Intensive Support Team (ECIST);

(iv) discussions with Finance Directors of organisations working with similar contracts;

(v) discussions with a national expert on Alliance Contracts;

(vi) discussions with the two providers currently providing the service.

Review of findings

1. Technical properties of the different contract types

The key components of each type of contract are set out at **Appendix B** and a summary of risks and benefits is provided in the section later in this paper.

The CCG would wish to hold a contract which optimises the full benefits of the new centre to patients through effective clinical intervention, facilitates robust clinical governance and clear clinical insurance standards, minimises risk to the commissioner and is not bureaucratic and complicated to administer.

Conversely, the contract will need to incentivise providers to innovate and collaborate in order to achieve the outputs, manage the risks and generate the incentives.

2. Conference call with Monitor regarding the procurement issues of each option;

The Monitor representative provided a helpful overview of the lines of enquiry that would be followed in the event of a challenge resulting from a procurement decision by the CCG. The CCG would need to evidence to show it had taken its decisions consistently with the Procurement, Patient Choice and Competition Regulations, which includes requirements

that the decision had been made via a transparent process where the needs and benefits to patients had been duly considered and offered the optimum solution for the model of care being developed.

Monitor also provided helpful challenge around potential risks – most of which are identified in this paper with mitigating solutions provided where possible.

3. Discussions with members of the Emergency Centre Intensive Support Team (ECIST);

ECIST members have been involved in the projects at various stages. The workforce model was endorsed by ECIST in 2014 and in 2015 we had a discussion around governance across the two models.

The discussion was helpful but inconclusive regarding the most appropriate contract type to proceed with. However – what did come out of the conversation was that clinical negligence arrangements were more complex in a model with multiple providers and insurance arrangements.

Where the service is on one site, one provider with sub-contractors is likely to be a less complicated approach.

4. Discussions with Finance Directors of organisations working with similar contracts;

The management of clinical risk appears to be simplified when dealing with one provider and set of outcomes. The prime provider will undertake a procurement to select a partner and governance arrangements worked up to maximise the benefit of services being on one site.

More examples are emerging where GPs are forming Limited Liability Partnerships or Federations to bid for elements of this work.

5. Discussions with a national expert on Alliance Contracts;

What makes an alliance contract different is the risk management. In traditional contracts the risks are allocated by the owner to the party deemed most able to manage them. In an alliance, there is a collective ownership of risks, opportunities and responsibilities associated with delivery of the whole project. Any ‘gain’ or ‘pain’ is linked with good or poor performance overall and not to the performance of individual parties.

Another difference is in the focus on relationships not transactions. The concept of collective responsibility is key. Once the contract is in place, the participants work as a fully integrated team throughout implementation. The commercial framework underpins this sense of ‘your success is my success; your failure is my failure.'

Alliance models appear to offer the most benefits when complex integrated care is provided across many sites.

6. Discussions with the two providers currently providing the service.

There have been robust discussions with both parties and views have been presented.

Whilst there have been mixed experiences of integrated working, both parties have expressed a willingness to continue to work together to achieve the objectives of the Emergency Centre.

To further develop the close working, we have undertaken an independent review upon which to base an organisational development plan and further improve joint working for the future. Both parties are very supportive of this approach.

Analysis of key issues and of risks

Prime Provider Model

Benefits

- Clinical governance arrangements simpler and safer
- Increased direct control over provision across a care pathway
- Demand risk shifts to provider
- Enables money to move within the pathway
- Clear governance arrangements through contractual/sub-contractual mechanisms
- Simpler for commissioners to manage – less bureaucracy

Risks

- Possible provider monopoly

  Mitigation – the service that we are commissioning (Emergency and Urgent Care in Rotherham) has a significant element that can realistically only be provided by one provider in Rotherham - the additional services would be tendered for by TRFT instead of the CCG.

- Perverse incentives – may limit patient choice

  Mitigation – as above

- Provider organisation may not have sufficient skills in contracting, supply chain management and commissioning

  Mitigation – TRFT already manages other providers through sub-contracts so is experienced in this areas however the CCG will offer intensive specialised support in the transition and set up phase for <u>all</u> parties to ensure that the appropriate actions are considered and completed.

Alliance Model

Benefits

- Strong incentives to collaborate
- Risk is shared equally
- Limits dominance of single organisation
- Retains the active involvement of commissioners across all providers

Risks

- Significant reliance upon clearly defined governance arrangements which may not be compatible

  Mitigation – both parties have acknowledged that standard operating procedures would have to be co-produced and governance arrangements modified for both parties to stay “safe”.

- No clear evidence or models for streamlined clinical insurance arrangements

  Mitigation – both parties can obtain separate insurance although it could be more expensive under this model.

- Complex for CCGs to manage

  Mitigation – capacity would need to be diverted away from other priorities to support the contract.

- Requires existing relationships founded on strong trust

  Mitigation – both parties would engage with an OD plan to enhance relationships.

- Not supported through the NHS Standard Contract

Conclusion

(i) The development of new ways of working across the NHS has enabled innovation and creativity encouraged by NHS England and Monitor.

(ii) The work undertaken has illustrated that there is no clearly defined option that the CCG can "clone" to fit to the Rotherham model. However there is an emerging theme with hospitals where services are to be integrated on a single site – the prime provider contract.

(iii) Whilst there are risks and benefits of both contract models, the alliance model adds a layer of bureaucracy and complexity to what is a relatively straightforward single site integrated model of care.

(iv) The prime provider model relies upon an appropriate level of competency and capacity with the provider to manage sub-contractors, risk share arrangements and clinical relationships.

(v) The alliance model shares risk across CCGs and providers. The prime provider model enables the risk to be borne and managed by the providers.

(vi) The CCG continues to be capped on running costs and would not be in a position to increase capacity to support a complex contract. If the alliance model was more appropriate for the circumstances then the CCG would look to prioritise capacity to work within this framework, however, it does appear to add unnecessary complexity to the arrangements.

(vii) The clinical negligence arrangements have not been clearly defined in any contract types but the prime provider contracts have generally enabled a much clearer and safer approach to the management of clinical governance and insurance and could prove to cost less in totality.

After due consideration of the available facts and opinions, the CCGs preferred option is to proceed with a Prime Provider Contract.

Committee history:

OE 25th January 2016
SCE 27th January 2016
GPMC 27th January 2016
Confidential Governing Body 3rd Feb 2016
Public Governing Body 2nd March 2016

Recommendations:

Governing Body members are asked to note the contents of the paper and agree with the recommendation to proceed with the Prime Provider model.

Prime Provider Contract

(i) A prime provider model is a delegation of contract management responsibilities to a single organisation that is accountable, in a relatively straightforward way, for delivering outcomes. This helps to keep complexity to a minimum. The CCG contracts with a single organisation to both provide an element of the commissioned service as well as taking responsibility for the day-to-day management of other providers that deliver care within the commissioned pathway through sub-contractual arrangements. The prime provider could be a new or existing provider from within the local health economy, or a consortium of providers.

(ii) The intention is that the prime provider has greater leverage for transformation by directly building its provider capacity and delivery model to meet the terms of the contract. The size and nature of the sub-contracts could change over time; the prime provider might choose to deliver the majority of services itself, or sub-contract for large portions of care.

(iii) A prime provider would typically receive a budget to provide all care specified in the contract. The prime provider would also use this budget to 'buy' additional services (through sub-contracts) that it cannot deliver directly. These models entail CCGs transferring their commissioning responsibilities and risk to a prime contractor or provider.

(iv) A prime provider contract reduces the risk of fragmentation by removing the need for the introduction of an additional organisation to manage the integration of services. In addition, there are clear advantages for successfully managing the contract if the prime provider has direct control over at least a portion of the services being delivered.

(v) When compared to the NHS standard contract, the prime provider model allows for more effective incentivisation of performance, through the terms of the subcontracts. This incentivisation goes hand in hand with the payment model used, often a mixture of capitation and payment-for-performance.

(vi) When selecting new service providers, the prime provider will be subject to the same obligations as a CCG or NHS England with respect to NHS rules on commissioning and procurement. This includes ensuring that procurement processes are conducted appropriately, and that the prime provider is not acting against patients' interests if it is putting in place arrangements that restrict competition.

(vii) This contractual form shifts risk from the commissioner to the accountable lead provider, who is responsible for achieving commissioner defined outcomes for the specified population within the allocated budget.

Alliance Contract

(i) An Alliance contract brings together a set of providers into a single arrangement with a CCG to deliver services. The key difference from the prime provider model is that the commissioner and all providers within the alliance share risk and responsibility for meeting the agreed outcomes. They are not co-ordinated by a prime contractor and there are no sub-contractual arrangements.

(ii) All organisations within the alliance are equal partners and they must instead rely on internal governance arrangements to manage their relationships and delivery of care.

(iii) This model requires more complex governance arrangements than the prime provider or prime contractor models. In addition, the alliance contracting model relies on a high level of cooperation and trust between providers, and is therefore most suitable in areas with a history of collaboration.

(iv) The intention of this approach is that integration and collaboration are formalised through the contract, as commissioners and providers within the alliance are legally bound together to deliver the specific contracted service. As such, they should be incentivised to innovate and identify efficiencies across the system, rather than solely within their organisation. An alliance contract typically binds commissioners and providers together to share risk and rewards.

(v) The alliance model is not supported through an NHS standard contract.

(vi) Compared to a provider contract, an alliance contract is potentially more complex for CCGs to put together; in addition, they would still retain considerable responsibility for co-ordination and act as a 'partner' of the alliance.

(vii) A contract of this type carries both greater risk and greater reward for providers, who are accountable for their own performance and that of other providers within the alliance. Success is judged by the performance of the alliance overall rather than the performance of single organisations within it.

(viii) The members of the alliance will need to decide a governance framework through which the money can flow and decisions can be made, as well as a model of service delivery and must determine the mechanisms by which they will hold each other to account. Given the mutual dependencies, an alliance contract might be most suitable where there are well-established provider relationships.

(ix) Relationships based on strong mutual trust are key to the success of the alliance model, and might also benefit the integration and delivery of other service areas.