Corby Clinical Commissioning Group

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NHS CORBY CLINICAL COMMISSIONING GROUP

Policy for Managing a Practice Closedown

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Audience:	All Staff of NHS Corby CCG (including members of the Governing Body), All contractors, Bidders and members of the CCG

Consultation

Date	Name	Title and /or Organisation
Sept 2016	Primary Care Commissioning Committee	Primary Care Commissioning Committee, NHS Corby CCG

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Emma Follis	08 Sept 2016	Draft 1.0	For approval	Draft
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Contents

1. Introduction

This policy outlines the approach to be taken when a time-limited primary medical services contract is coming to an end. Where an urgent contract needs to be put in place, please refer to chapter 5 (Which medical contract when?).

2. Scope

2.1 Time-limited contracts can be in place regarding GMS, PMS and APMS contract types. GMS contracts, however, do not usually have an end date but it is possible for a temporary GMS contract to be put in place for a period not exceeding 12 months, for the provision of services to the former patients of a contractor following the termination of that contractor's contract.

2.2 PMS agreements may be in perpetuity or for a time limited period. Commissioners should review the relevant PMS agreement to establish if there is a defined end-date.

2.3 APMS contracts tend to be for a fixed-term period of three to five years, often with an option to extend for a maximum of a further two years. The main purpose for time limiting these contracts was to provide commissioners the scope for testing the market and ensuring value for money.

2.4 In each of the cases above there are generic principles that will apply and individual circumstances that will need to be considered. This policy covers the steps to be taken in advance of the end of any contract and will support the Commissioner in planning procurement cycles and future service provision.

2.5 The Commissioner must consider whether the expiring contract contains provisions relating to the end of the contract that impact on any practice closedown actions. The NHS England Standard GMS Contract 2014/15 and the NHS England Standard APMS Contract 2014/15 contain provisions relating to the consequences of termination including a requirement that the

contractor co-operates with the Commissioner and arrangements for a financial reconciliation exercise.

2.6 Contracts may come to an end by reasons other than by expiry including by:

2.6.1 being terminated by either the Commissioner or the contractor (in which case refer to the policy on contract breaches and termination (chapter 7));

2.6.2 an adverse event (in which case refer to the policy on adverse events (chapter 10));

2.6.3 the death of the contractor (in which case refer to the policy on the death of a contractor (chapter 12)); or

2.6.4 retirement of the contractor (in which case refer to the policy on contract variations (chapter 6)).

3. Timetable for Managing Contracts Coming to an End

3.1 The Commissioner needs to be aware of the end dates of all contracts held so that advance planning can be undertaken to ensure both capacity and timescales can be aligned with the key stages outlined below.

3.2 It is essential that the Commissioner ensures continued communication with contractors throughout the stages to enable them to have a clear understanding of the processes, expectations and obligations. Outlined in Annexes 1 and 2 are guides to communications with contractors and a proposed checklist for documentation recording.

3.3 In each of the stages below there are a range of activities that may need to be undertaken, depending on the Commissioner's preferred route, and the Commissioner may usually discuss with the appropriate LMC throughout.

4. Summary of Key Stages

4.1 There are three key stages:

4.1.1 Stage 1 – minimum 9 to 15 months before contract end (all essential):

4.1.1.1 Needs assessment;

4.1.1.2 Impact; and

4.1.1.3 Engagement proposal.

4.1.2 Stage 2 – 12 months before contract end:

4.1.2.1 Notice period – exit plan;

4.1.2.2 Commence procurement and either:

4.1.2.1.1 Begin negotiations for continuation with contractor; and

4.1.2.1.2 Begin exit arrangements of incumbent provider and mobilisation of any new provider.

4.1.3 Stage 3 – at contract end:

4.1.3.1 Contract end – possible dispersal of patient list:

4.1.3.2 Variation to contract/extension: and

4.1.3.3 Commencement of new provider.

5. Stage 1 – 9 – 15 Months before Contract End

5.1 The considerations that should be given when completing each action are provided below. This list is not exhaustive but does provide a platform for Commissioners to fully assess the existing and future service needs of its population. Commissioners should ensure that all appropriate stakeholders are given the opportunity to input into the needs assessment for their population, including but not limited to public health.

Needs assessment

5.2 Is there still a demand for this service in this locality and a requirement for it to continue? For example to reduce inequalities in access or health outcomes

5.3 Does the contract specification still address current local priorities?

5.4 Has the contract delivered on the expected outcomes?

5.5 Has it provided added value to the local population and service provision?

5.6 Have you assessed the potential service needs for any forthcoming new developments?

5.7 What is the capacity of other local providers and the market for other providers to deliver services?

5.8 Have you given consideration to any specialist services needs in the locality?

5.9 Are there any needs which are not met by the contract, which could be delivered?

Impact

5.10 Have you considered available outcome and delivery data held nationally and locally, regarding the current service and impact on other providers?

5.11 Have you compared the cost of the current service against other providers i.e. cost per head of population whilst taking into account any differences in the scope of the services provided?

5.12 Is the current service still affordable within projected future budgets?

5.13 Has the contract delivered on the expected financial outcomes?

5.14 What other objectives might be set within the existing budget?

5.15 Have you considered the potential impact on service users/patients?

5.16 Have you considered the potential impact on other service providers, e.g. GPs, pharmacy, local trust, out of hours, community services?

5.17 Have you considered the potential impact on the current provider, i.e. continued viability within the locality?

5.18 Have you considered patient choice and equality?

5.19 Have you considered the potential risks i.e. reputational (adverse publicity, commissioner/provider relationship), market testing, timescales and financial?

5.20 Have you considered how the expiry of the contract affects compliance with the general duties? For further information, please refer to chapter 4 (General duties of NHS England).

Engagement proposal

5.21 Each situation will need to be managed regarding each individual circumstance and the nature of the procurement process to be followed, if at all. However, where it has been deemed appropriate to complete a form of engagement before taking action, the Commissioner should consider:

5.21.1 have arrangements been made for involvement of patients and the public (please refer to chapter 4 (General duties of NHS England) for more information on this requirement)?

5.21.2 have other local providers and other interested parties i.e. LMC, local members of parliament, review and scrutiny committee, etc. been engaged?

5.21.3 have the local CCGs been engaged?

5.22 If the answer is 'no' regarding any of the above, the Commissioner should be able to identify the grounds under which they felt engagement was unnecessary and these should be included in the report defined below.

Completion of Stage 1

5.23 Completion of stage 1 will provide all the information required to enable the Commissioner to make an informed commissioning decision on whether to re commission, procure or allow the service to end. At this stage, the Commissioner should develop a detailed report (a template is provided in Annex 3) about the investigations undertaken, engagement and outcomes. This report shall demonstrate that the Commissioner has considered all possible options and the rationale behind the decision taken.

6. Stage 2 - 12 Months before Contract End

6.1 Below are the potential next stages following stage 1 based upon the Commissioner's decision regarding the proposed way forward. It is important to note that where a contract has a duration or an end date specified, and the intention is to allow the contract to naturally expire, there is no requirement to

issue a formal termination notice. It would be best practice to issue a formal letter of notice detailing the Commissioner's intentions and the obligations on the contractor throughout the remainder of the contract period.

Notice period – exit plan

6.2 Issue a letter of notice of intentions.

6.3 Develop an exit plan (a template is provided in Annex 4) with the contractor with clearly defined commissioner/contractor responsibilities. This should be developed whether the contract is to cease or transfer to a new provider. Commissioner should review the contract and ensure any exit arrangements detailed in the contract are followed.

Procurement

6.4 Ensure any new contract is procured in accordance with procurement law. Commissioners must also act in accordance with any procurement protocol issued by NHS England.

6.5 Once a preferred provider is established, agree an operational management plan (a template is provided in Annex 5 – this template should only be used where the contract does not contain exit arrangements as any such arrangements take precedence over the template).

Begin negotiations for continuation of the contract with the existing contractor, if appropriate.

6.6 Extending any contract beyond a previously agreed end date could be considered a material change to the terms of that contract which could lead to a procurement challenge.

6.7 If there is no extension period already included in the contract, the Commissioner will need to consider carefully whether such an extension should instead be subject to a full procurement process to ensure best value and mitigate the risk of challenge from previous and/or potential alternative service providers. If the Commissioner's decision is that no procurement process is necessary then it must ensure it is aware of the necessary steps which must be taken to satisfy procurement law and any procurement protocol issued by NHS England.

6.8 Once the decision to extend has been reached and all correct processes have been followed the Commissioner will need to consider:

6.8.1 the length of extension;

6.8.2 any alterations to the existing contract (including the financial arrangements); and

6.8.3 any agreement of new key performance indicators.

Completion of stage 2

6.9 Completion of stage 2 will provide the Commissioner with the firm foundations and detailed preparations ready to manage the end of the contract.

7. Stage 3 – At Contract End

7.1 Below are the possible outcomes culminating from stages 1 and 2.

Contract end

7.2 Service ceases.

7.3 Dispersal of list if applicable (please refer to comments on managing patient lists in the termination section of the policy on contract breaches and termination (chapter 7)).

7.4 Communication to be sent out to all those parties involved e.g. management of patient communication working with provider, management of the press, notification of contract end to relevant stakeholders.

Variation to contract – extension

7.5 Contract variation issued and signed off by both parties.

Commencement of new provider

7.6 Issue of new contract.

7.7 Operational management plan implemented.

7.8 Relevant communications undertaken, internally and externally.

7.9 On completion of stage 3, the Commissioner will have reached an agreed, structured outcome about the management of contract end.

Annex 1

Guide to Communication with Contractors

1. All direct communications, whether face to face or over the telephone, should be recorded in writing and held on the file.

2. All written communications with contractors should not arrive ‘out of the blue’ as the contractor should be aware of the situation from a prior meeting or telephone call.

3. These meetings should cover as a minimum, reasons for extension/contract end, future plans for the service/exit plan, terms of extension/management of the list, communication strategy with staff and patients.

4. All meetings should be minuted by an agreed party and shared with the contractor for acceptance as an accurate record of the discussions.

5. Following all meetings the minutes should be accompanied by any action plan agreed regarding the next steps with responsible parties identified.

6. Staged follow-up meetings should be held at appropriate intervals, to ensure all actions agreed upon are being implemented and are on track to have been appropriately executed before contract end or extension.

Annex 2

Checklist for Documentation Recording when Contract Ends

1. Statement of rationale – clear and objective reasons providing justification for the decision to cease the service at contract end.

2. Minutes from all meetings held throughout the process.

3. Assessments – copies of needs assessment, impact findings and engagement proposal. This information could be documented by way of the detailed report at the completion of stage 1.

4. Formal notice of termination (where required by the contract) or notice of intention to end contract – a copy of the letter sent to the contractor stating that the Commissioner will be terminating the contract / will not be renewing the contract when it expires.

5. Exit plan – a copy of the exit plan agreed with the contractor to ensure that all elements of the services are managed smoothly and effectively.

6. All written communications between the contractor and the Commissioner about contract end including any file notes of telephone conversations that are pertinent to the decision making process.

Annex 3

Template Detailed Report

Consolidation report to inform commissioning decision
1. Introduction and background to existing service a. Length of current provision b. Type of contract held c. End date of contract d. Current population/demographics e. Current services provided outside of core f. Current performance against contracted requirements g. Current contract value h. Current premises arrangements
2. Needs assessment a. Summary of needs assessment findings to be inserted b. Is there still a demand for this service in this locality and a requirement for it to continue? c. Does the contract specification still address current local priorities? d. Has the contract delivered on the expected outcomes? e. Has it provided added value to the local population and service provision? f. Have you assessed the potential service needs for any forthcoming new developments? g. What is the capacity of other local providers and the market for other providers to deliver services? h. Have you given consideration to any specialist services needs in the locality?

i. Are there any needs which are not met by the contract, which could be delivered?

3. Impact

   a. Summary of impact findings to be inserted.

   b. Have you considered available outcome and delivery data held nationally and locally, regarding the current service and impact on other providers?

   c. Have you compared the cost of the current service against other providers i.e. cost per head of population whilst taking into account any differences in the scope of the services provided?

   d. Is the current service still affordable within projected future budgets?

   e. Has the contract delivered on the expected financial outcomes?

   f. What other objectives might be set within the existing budget?

   g. Have you considered the potential impact on service users/patients?

   h. Have you considered the potential impact on other service providers, e.g. GPs, pharmacy, local trust, out of hours, community services?

   i. Have you considered the potential impact on the current provider, i.e. continued viability within the locality?

   j. Have you considered patient choice and equality?

   k. Have you considered the potential risks i.e. reputational (adverse publicity, commissioner/provider relationship), market testing, timescales and financial?

   l. Have you considered how the expiry of the contract affects compliance with the general duties?

4. Options appraisal

   a. List dispersal

   b. Extension of current arrangements

   c. Reconfiguration of service

   d. Procurement of new provider

5. Engagement

a. Summary of engagement process followed and outcomes to be inserted

b. Have you made arrangements for the involvement of patients and the public ?

c. Have you engaged with other local providers and other interested parties e.g. LMC, local members of parliament, overview and scrutiny Committee?

d. Have you engaged with the local CCGs?

6. Conclusion

a. Recommended outcome regarding commissioning decision to be inserted for consideration and final decision by the Commissioner

Annex 4

Template Exit Plan

1. Introduction

1.1 The exit plan is a list of processes to manage the exit of any contractor from performing a service.

1.2 This should be developed in accordance with the terms of the contract as a minimum.

1.3 The exit plan comes into effect as the notice to cease the service is issued by the Commissioner and a joint exit group should be established comprising staff of both parties to manage the contract coming to an end. The role of the joint exit group will be to manage all activities to ensure a smooth culmination of the contract or transition to a new provider, where appropriate.

1.4 Unless it is set out within the contract, there is no obligation on behalf of the contractor to comply with the establishment of a joint exit group; however a joint approach would be in the best interest of their registered population/service users.

2. Template Exit Plan

2.1 This template exit plan is for use where no exit arrangements are set out within the contract.

Areas for consideration	Details of tasks to be undertaken	Timescales	Responsible lead
1. Clinical	Up-to-date clinical summaries for all patients; referrals and transfer of care; prescriptions; test results; patient related communications		

Areas for consideration	Details of tasks to be undertaken	Timescales	Responsible lead
2. Workforce	Consideration of staffing issues – if contract ceasing, the responsibility regarding the staff would normally sit with the contractor. If the service is to transfer to a new provider, TUPE may apply		
3. Documentation and records	All relevant documentation and records will be transferred to the relevant primary care support services organisation or the new provider, whichever is applicable. See note below The transfer of records must be conducted in accordance with NHS security requirements.		
4. IM&T	All relevant electronic documentation and records held by the contractor are to be transferred in a recognised industry-standard computer format to the relevant primary care support services organisation or the new provider whichever is applicable See note below The transfer of records must		

	be conducted in accordance		
Areas for consideration	**Details of tasks to be undertaken**	**Timescales**	**Responsible lead**
	with NHS security requirements. Licences should be transferred where possible		
5. Premises	Consideration of the practice premises and whether the premises will cease to be used or whether arrangements could be negotiated with the new provider An inspection of the premises must be conducted to ensure that no records or equipment are left behind.		
6. Equipment	Consideration of any IT hardware or other equipment held by the contractor that requires return to the relevant owner. Full stock list should be compiled defining which items will be remaining. The transfer or disposal of equipment must be conducted in accordance with NHS security requirements.		

Areas for consideration	Details of tasks to be undertaken	Timescales	Responsible lead
7. Facilities	Consideration of any existing facilities contracts and whether these will cease or transfer to a new provider		
8. Patient and Public involvement	Consideration of the needs to engage and inform throughout.		
9. Drugs	Practice held drugs will need to be disposed of but are technically likely to be owned by the contractor whose contract is terminating. The Commissioner should seek assurances about the safe and effective disposal of such drugs.		
10. Other	As required		

Note on the transfer of records;

In accordance with *the National Health Service (General Medical Services contracts) Regulations 2004, para 73 (7), to the extent that a patient's records are computerized records, the contractor complies with sub-paragraph (6) if it sends to [the Board] a copy of those records--*

(a) in written form; or

(b) with the written consent of [the Board] in any other form.

Practices using GP2GP (versions approved for full record transfer) can take advantage of the enhanced functionality by stopping the need to provide a computer printout. The process reports to the sending practice, confirmation of receipt of the full electronic record. In that case it is not necessary for the sending

practice to printout copies of any of the computerised records. Practices need approval from NHS England for this. NHSE needs to be assured that due process has been undertaken by the sending practice. Providing sending practices comply with the full GP2GP V2 software and processes NHS England can be confident. Requests by practices using version 2.2 to stop paper printouts should normally be agreed.

- The sending practice should follow normal practice in reviewing records before they are transferred to ensure they are accurate and complete;
- Sending Practices must confirm, using the GP2GP functionality, that the requesting practice system has successfully received the full patient record with no missing attachments.
- Sending practices must print any attachments that haven't transferred during the GP2GP process and add these to the Lloyd George notes and send to the receiving practice.

Any practice that continuously encounters problems receiving full records should make the matter know to its CCG in order to ensure that appropriate action is taken, whether at the level of the previous practice or the CCG, as appropriate. Please bring any unresolved issues to the attention of the LMC

Annex 5

Template Operational Management Plan

1. Introduction

1.1 It is good practice for any new contract to contain an operational management plan, which should be produced by the new contractor and contain detailed information regarding the implementation of the service.

1.2 This plan should describe their key tasks, milestones, timeframes and responsible leads including the stages leading up to contract commencement.

1.3 Implementation of the operational plan should commence before the contract start date, to ensure that the new contractor will be in a position to begin service delivery on the contract start date.

1.4 The timeframes for completion of each element must be agreed with the Commissioner to provide assurance of the contractor's readiness at the appropriate stages of the project.

2. Template Operational Management Plan

Areas for consideration	Details of tasks to be undertaken including milestones – examples	Timescales	Responsible lead
1. Clinical	Clinical team identified and in place; due diligence checks completed		
2. Workforce	Workforce identified and in place		

Areas for consideration	Details of tasks to be undertaken including milestones – examples	Timescales	Responsible lead
3. Training and induction	Have all team members received adequate training and formal induction including information governance training??		
4. IM&T	Have all relevant electronic/hard copy files been transferred from the previous provider? Is the IT infrastructure in place and ready for use? Have necessary licences been acquired? Have staff been trained on use of IT system? Go-live date of any new system		
5. Premises	Are the premises secured and lease arrangements in place if applicable? If new build – what is the completion date? (Time should be allowed for 'snagging' before opening)		
6. Equipment	Identification of all equipment required licences and maintenance contracts secured		

Areas for consideration	Details of tasks to be undertaken including milestones – examples	Timescales	Responsible lead
7. Facilities	Are all relevant facilities management contracts in place?		
8. Communication with patients	As required		
9. Other			