Monitor

Annex 1

The Designation Framework

Defining *Commissioner Requested Services* and *Location Specific Services*

28 March 2013

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Chapter 1
Executive summary

Executive summary

Background to the framework

Monitor's main duty is to protect and promote the interests of patients. We do this by regulating the provision of health care services to ensure it is effective, efficient and economic, and maintains or improves the quality of services.

We assess NHS trusts for foundation trust status and license foundation trusts to ensure they are well-led, in terms of both quality and finances. The new provider licence will apply to other eligible providers of NHS-funded care from April 2014.

The licence enables us to:

- set prices for NHS-funded care in partnership with the NHS Commissioning Board;
- enable integrated care;
- safeguard choice and prevent anti-competitive behaviour which is against the interests of patients; and
- support commissioners to protect essential health services for patients if a provider gets into financial difficulties.

Monitor will also support commissioners to ensure that, in the rare event of the failure of a health care provider, key services for which there is no suitable alternative provider continue to be available to patients in that locality.

To support our role in ensuring the continuity of services, Monitor is introducing two service definitions:

1. *Commissioner Requested Services*: services that will be subject to regulation by Monitor in the course of a licensee's operations; and
2. *Location Specific Services*: The subset of *Commissioner Requested Services* that, in the event of a provider failure, must be identified and kept in operation at that specific locality.

Monitor is obliged to publish guidance for the sector on the process of designating services as *Commissioner Requested Services/Location Specific Services*. This document sets out a step-by-step framework that will guide stakeholders through this process and will form the basis of Monitor's guidance.

The framework

We have developed a four-stage framework:

Stage 1: Information gathering

This stage allows commissioners and other users of the framework to collect the information they will need in subsequent stages. Information ranges from the characteristics of the service under consideration, to the users of that service. This stage also allows framework users to begin to understand the sorts of data they will need to use the framework, as well as where there might be data gaps.

Stage 2: Whether suitable alternative providers exist

Stage 2 of the framework considers whether commissioners have sufficient alternative sources of supply if a provider fails. This is done by first looking at whether there are any alternative providers; second, whether those alternatives would have the capacity and capability to cope with the increase in demand that results from a provider ceasing or reducing service provision; and finally, whether there would be scope for capacity to be built over a reasonable time period, to deal with the increase in demand.

Stage 3: Whether there are any health inequality impacts

The Health and Social Care Act 2012 (the Act) also defines *Location Specific Services* by reference to the impact their withdrawal would have on health inequalities.

Executive summary

Stage 3 looks at whether any disadvantaged groups, who tend to have poorer health outcomes, are affected disproportionately by the withdrawal of a service.

Stage 4: Whether there are any impacts on interdependent services

The nature of health care services means that decisions about whether to designate one service cannot be made in isolation. Stage 4 allows commissioners and other users of the framework to consider whether interdependent services need to be designated in addition to the primary *Location Specific Services*.

The framework may be used:

a) In normal operations

Commissioners should use it when considering whether to designate a service to Monitor's Continuity of Services regime, for example if they feel that there is not enough alternative provision of that service. Alternatively, they could choose to de-designate services, for example in response to a provider request to remove the service from the Continuity of Services regime, on the basis that there are sufficient alternative providers of those services should the provider in question become financially distressed.

b) In distress or at the point of financial failure

Commissioners should use the framework to identify which services should be classified as *Location Specific Services* to ensure that all services remain available to patients, in the rare event that the provider becomes insolvent.

In identifying the services that might be designated *Commissioner Requested Services/Location Specific Services*, commissioners may approach this in different ways for example using service-lines, sub-specialities, programme budget categories, contracting bundles and Healthcare Resource Groups. The framework is designed to accommodate different approaches, so long as they are applied consistently and allow the set of alternative providers to be identified.

An Excel-based toolkit, based on the framework, has been developed to help commissioners through each of the stages. The toolkit can be found here on Monitor's website.

Case studies

Hypothetical case studies have also been developed to test the framework, and to illustrate the sorts of evidence-based arguments that commissioners and other users will need to construct to justify the decisions they make. Though hypothetical, each has been developed working with actual commissioners and providers applying the framework to services provided in their health economies.

The case studies bring to life some of the issues that are likely to arise when commissioners will be charged with using the framework, which have then been fed back into framework development.

Five scenarios have been covered:

1. a pathology service provider in a deprived urban area;
2. a paediatric service in a rural deprived area;
3. an urgent care provider in a deprived urban area;
4. a rheumatology service in a mixed rural and urban area; and
5. a private mental health provider in an urban area.

Chapter 2
Background

Monitor has a new role in supporting commissioners to maintain service continuity

Monitor has a range of tools at our disposal to deliver our regulatory responsibilities as the sector regulator for health care. We license providers of NHS services and this is a key part of the new regulatory system.

As part of our role Monitor is required to support commissioners to maintain service continuity to patients. There are two functions to this role:

1. implementing a series of measures, through the new provider licence, to protect patients by reducing the likelihood and impact of provider failure; and
2. direct intervention in the event of a provider failing to secure the on-going delivery of services to patients.

Commissioner Requested Services and Location Specific Services

To support our role in ensuring the continuity of services, Monitor is introducing two service definitions:

1. *Commissioner Requested Services*: Services that will be subject to Monitor's regulatory regime to reduce the impact and incidence of failure; and
2. *Location Specific Services*: The subset of *Commissioner Requested Services* that, in the event of a provider failure, must be identified and kept in operation at that specific locality.

The Act requires that commissioners may only classify a service as one which must continue to be provided – that is, as a *Location Specific Service* – if ceasing to provide that service, in the absence of alternative provision, is likely to:

a) have a significant adverse impact on the health of persons in need of the service; or
b) have a significant increase in health inequalities; or
c) cause a failure to prevent or ameliorate either a significant adverse impact on the health of such persons or a significant increase in health inequalities.

Monitor's provider licence supports our continuity of service role

To provide some continuity, initially all services that were previously identified under a foundation trust's terms of authorisation as being mandatory services will be classified as *Commissioner Requested Services.*

Commissioners will have the ability to designate services as *Commissioner Requested Services*, should they meet the requirements set out by Monitor's guidance, or de-designate services which are deemed not to meet the requirements set out in the guidance.

Ensuring the continuity of services

To support our new role, Monitor has developed Continuity of Services conditions in the new provider licence that all providers of *Commissioner Requested Services/Location Specific Services* will have to comply with. These include:

- A requirement to continue to provide *Commissioner Requested Services/Location Specific Services* unless otherwise agreed with commissioners.
- A requirement to provide assurances in relation to access to the resources required for the delivery of *Commissioner Requested Services/Location Specific Services*.
- A requirement to maintain a level of financial performance (measured by a risk rating).
- Restrictions on the disposal of assets relevant to the delivery of *Commissioner Requested Services/Location Specific Services*.
- A requirement to contribute to a *Commissioner Requested Services/Location Specific Services* insurance scheme (termed the 'risk pool').

Should a provider be judged by Monitor's *Risk Assessment Framework* (see the *Risk Assessment Framework* consultation document) to have become distressed, Monitor could impose further conditions designed to ensure the continuity of services.

Equally, Monitor may choose to commence a contingency planning process that would help commissioners, working with providers, to identify the services that must be designated should a provider go on to become insolvent, and how this might best be achieved.

Intervention

If a provider of *Commissioner Requested Services/Location Specific Services* goes into failure - that is, fails to pay its debts as they fall due - it will be placed in special administration and a special administrator will be appointed. The objective of the special administrator is to secure the continued provision of the services identified by the commissioners. This can be done either through a rescue of the failed provider or through a transfer of services to one or more alternative providers. Only once services are secured will creditors be able to recover debts.

For foundation trusts, Monitor will oversee Trust Special Administration. Court-based Health Special Administration will apply to companies providing NHS-funded services.

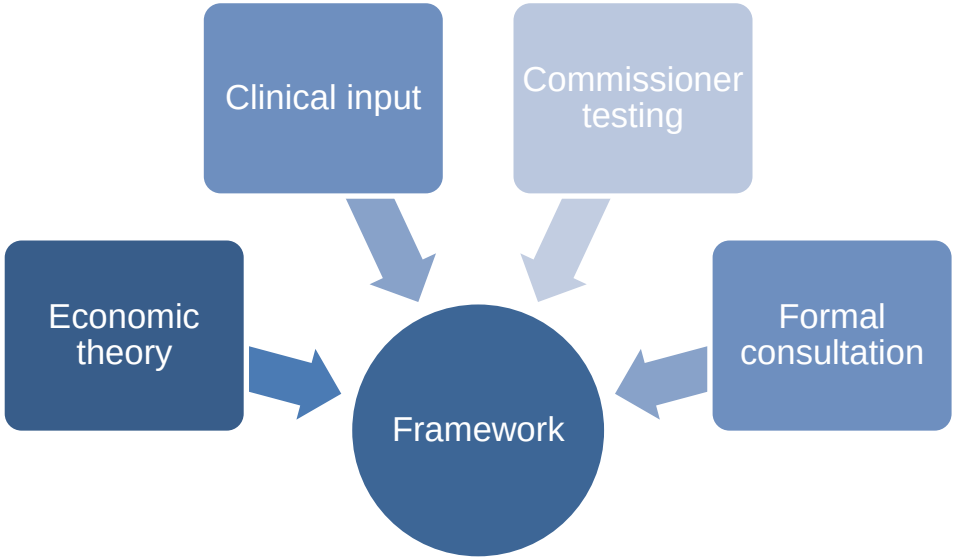
Monitor also has powers to set up a fund, or 'risk pool', to cover the costs of special administration. Using these powers Monitor can levy providers and commissioners for contributions to the risk pool.

Purpose of this framework

Monitor is obliged to publish guidance on the process of defining services which should be designated under the Act. The purpose of this document is to set out a step-by-step framework that will guide stakeholders through this process, and will therefore form the basis of Monitor's guidance.

The framework has been developed using insights from clinicians, economists, commissioners and providers. Commissioner and provider case studies have also been conducted to test the framework, and to bring to life the issues associated with defining *Commissioner Requested Services/Location Specific Services* locally.

Fig. 1: Approach to framework development



Chapter 3
The framework

Purpose of the framework and the approach we have taken to developing it

The framework

The framework is a set of targeted questions designed to help users construct evidence-based arguments to consider whether a particular service, provided at a specific location, needs to be designated. This chapter focuses on those questions, setting out the rationale for each, as well as possible answers. The answers give an indication of the type of output expected from each question and are not meant to be exhaustive.

Our approach

We have developed four stages of questions, which form a step-by-step process for framework users to follow. These stages broadly cover:

1. the features of the patient service;
2. whether any alternative providers could manage provision;
3. health inequality implications of withdrawing the service; and
4. the impact of CRS/LSS designation on interdependent services.

The framework has been developed as a guide for commissioners, providers and stakeholders, who, together, will have responsibility for defining *Commissioner Requested Services/Location Specific Services*. It is unlikely that 'patient services' will be defined in the same way by all parties. Some will define them in terms of commissioning units, others sub-specialities, service-lines, HRGs and so on. Our approach to developing the framework has been to allow sufficient flexibility to accommodate these different approaches.

Key test for Commissioner Requested Services/Location Specific Services

The test in the Act is whether withdrawing a service has a significant adverse impact on the health of patients and/or on health inequalities in the absence of alternatives.

The test we have developed therefore centres on whether there are suitable alternative arrangements and on whether there are health inequalities' implications from withdrawing a service. The significance of these effects should be locally determined, underlying the need for commissioners to take account of the views of important stakeholders, such as clinicians (including appropriate clinical specialists), patient groups, Health and Wellbeing boards, and others in the decision-making process. Before using the framework, commissioners and other users should also consider whether, in their view, it is necessary to provide the service.

How will the framework be used?

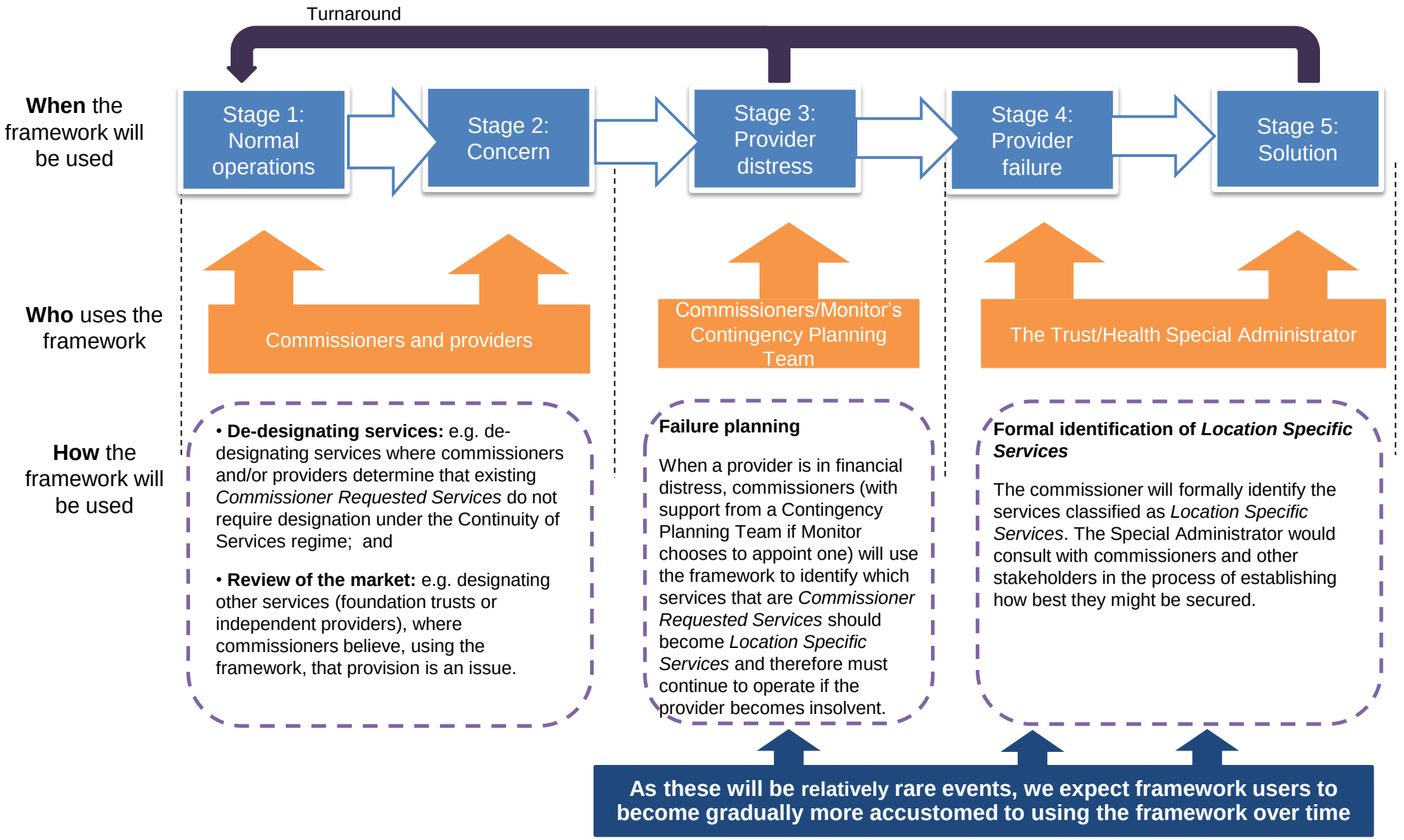
Fig. 2 illustrates the circumstances under which the framework would be used by its three principal types of users:

1. Commissioners – when making decisions about which patient services, and therefore the providers of those services, should be included or removed from Monitor's Continuity of Services regime and designated as *Commissioner Requested Services*;
2. Monitor's Contingency Planning Team (CPT) – supporting commissioners – to identify which services should be defined as *Location Specific Services* and remain in operation at that specific locality if a provider becomes financially insolvent; and
3. The Special Administrator – when seeking to ensure that all *Location Specific Services* are available to patients, in the exceptional event of provider failure.

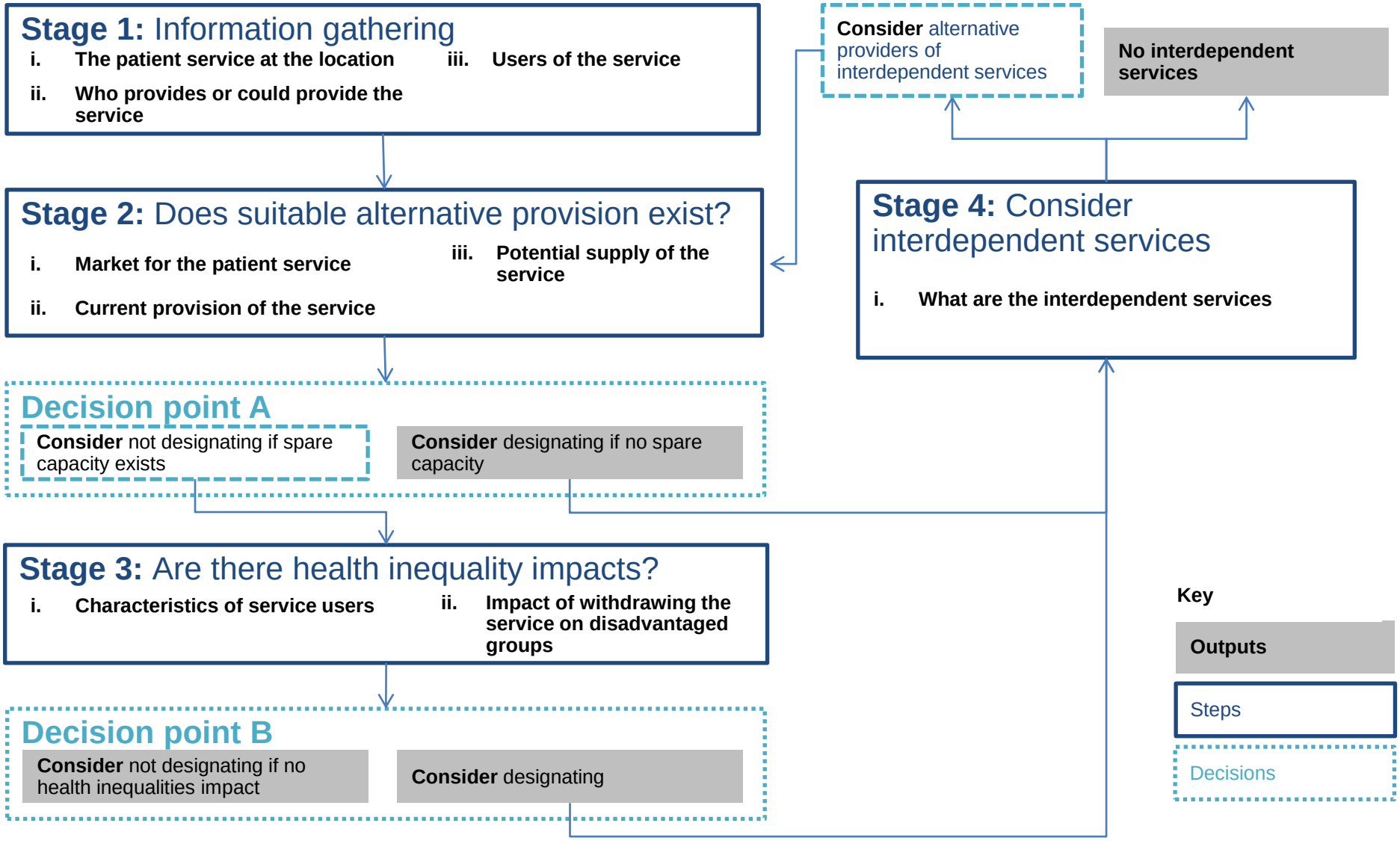
Providers will also use the principles underpinning the framework, either when commissioners designate their services as CRS (during the process itself and if appealing against their designation), or during the process of seeking commissioner agreement to the removal of their services from the scope of Monitor's Continuity of Services regime.

Who will use the framework and how will they use it?

Fig. 2: Users of the framework, and when and for what purpose they will use it



The framework: A high-level process for assessing whether services should be considered as Commissioner Requested Services/Location Specific Services (LSS)



The framework has four key stages

Stage 1 – Gather information

Decisions about designating services will need to be evidence based. In the first stage the emphasis is on collecting some of that key evidence and highlighting data that will be needed in subsequent stages of the framework.

The three broad areas where information is needed are:

1. the features of the patient service being considered at a specific location;
2. alternative providers of similar services; and
3. users of the service.

There will be many common data sources across these areas, so by encouraging framework users to gather information upfront, this will lessen the overall burden of information collection.

Stage 2 – Does a suitable alternative exist?

This is the first test of a *Commissioner Requested Service/Location Specific Service*, and assumes that, in the view of the framework users, the service must be provided to patients.

There are two parts to this stage:

1. whether alternative providers of a similar service exist within a reasonable geographical distance from patients (where similarity is measured in terms of outcomes); and
2. whether those alternatives have sufficient capacity to manage the increased demand, as would be the case if a provider failed and could no longer provide services to patients.

Stage 3 – The impact on health inequalities

The second test for a *Location Specific Service*, as set out in Section 65DA of the NHS Act 2006 (as inserted by section 175 of the Health and Social Care Act 2012), is whether:

"*..ceasing to provide the service would, in the absence of alternative arrangements for its provision under this Act, be likely to -*

a) have a significant adverse impact on the health of persons in need of the service ***or significantly increase health inequalities****; or*

b) cause a failure to prevent or ameliorate either a significant adverse impact on the health of such persons or a significant increase in health inequalities.

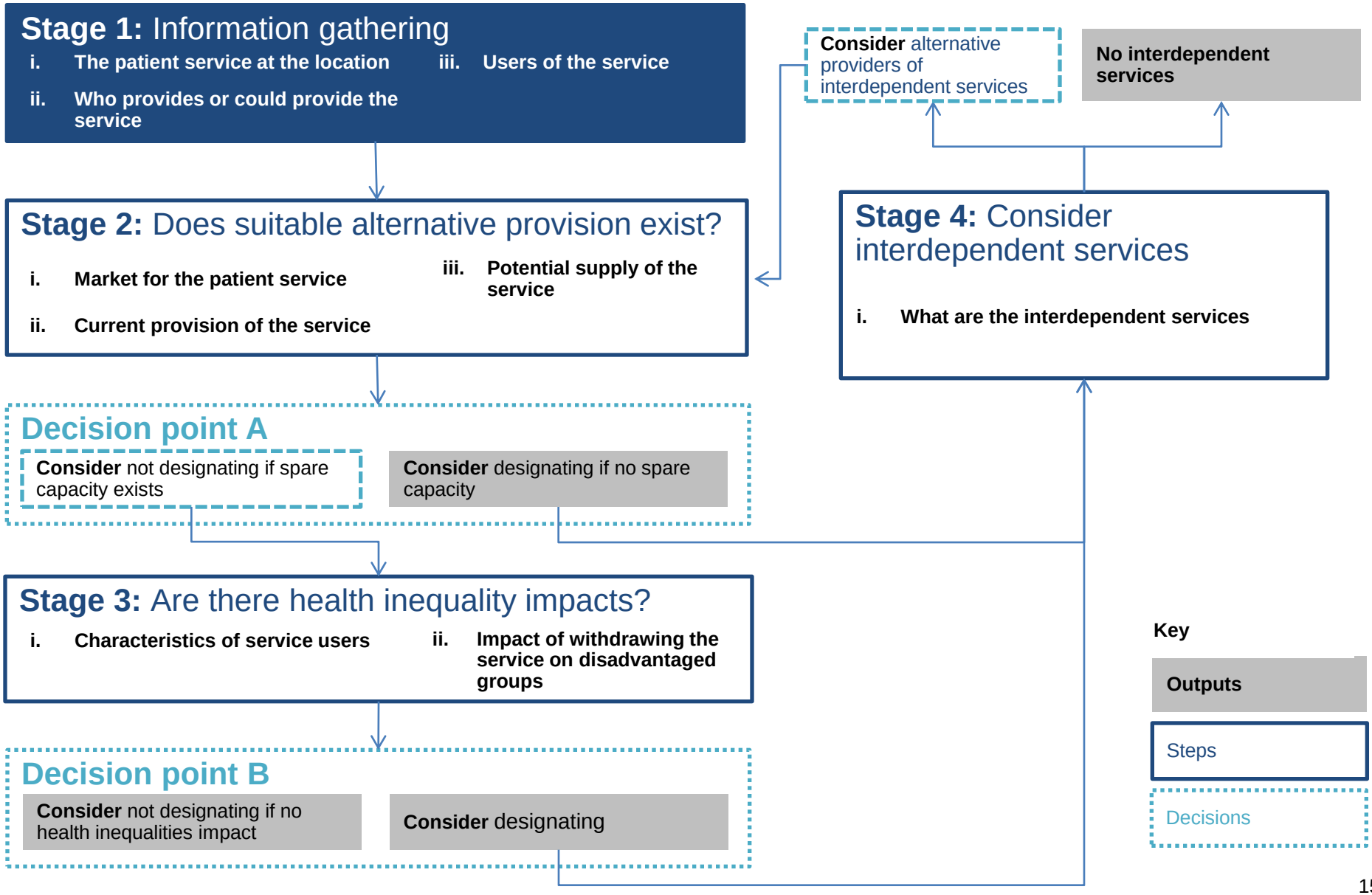
A key step in this stage is to identify users of the service and to test whether disadvantaged groups would be disproportionately affected by the closure of a service.

Stage 4 – The impact on interdependent services

The interlinked nature of health care services means that decisions about one service cannot be made in isolation. Therefore, any decision to designate a service, or in other words continue to run it when a provider has failed, must also take account of any supporting service(s).

Interdependencies should not be limited to services provided in the same specific location – for example, it might be possible for orthopaedic surgery cover for an A&E department to be provided from a neighbouring provider. This may also be particularly relevant in the context of integrated care networks, where a part or parts of the network are deemed *Commissioner Requested Services/Location Specific Services*.

Stage 1: Information gathering



Stage 1: Information gathering

Why is this stage important?

To stand up to scrutiny, the process of designating *Commissioner Requested Services/Location Specific Services* must be based on evidence. In the information-gathering stage, framework users can start to collect this evidence, which will be applied in subsequent stages of the framework. Further benefits of gathering information upfront include:

- enabling framework users to get an early indication of the detail and scale of information needed; and
- providing an opportunity to identify evidence gaps relatively quickly, which in turn allows for putting in place mechanisms to collect that information.

In this stage the focus is on defining the service. This will inevitably involve preparatory thinking about the nature of the service, e.g. its urgency, the profile and location of users and their access to services, and the existence of suitable alternative providers. Case work has indicated that in going through the subsequent stages, the definition may be revisited – indeed it is likely to be an iterative process as the characteristics of the service become clearer as the analysis progresses.

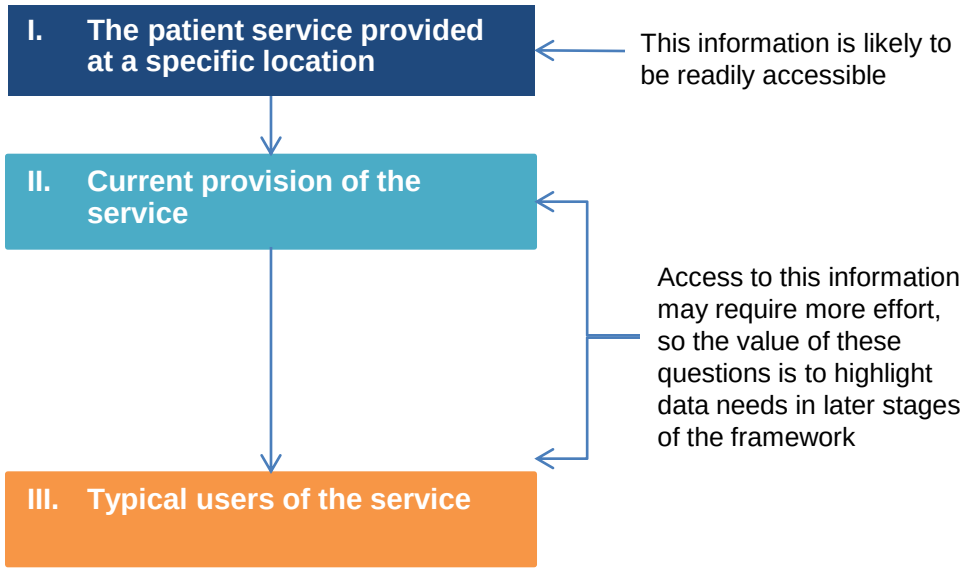
What is the output of this stage?

A list of the key data needed to determine whether a service provided at a particular location should be designated *Commissioner Requested Services/Location Specific Services*.

Key steps in this stage

A total of eight questions guide commissioners and other users of the framework through this stage. This information will cover three principal areas:

Fig 3: Categories of information



Stage 1: Information gathering
The three main categories of information

Category	Question	Purpose
The patient service provided at a specific location	1A. What is the patient service?	This information will be the entry point to the framework, so it will be important for all decision makers to use consistent definitions of 'a service'
	1B. How clinically urgent is the patient service?	This information will help framework users assess whether speed of access by patients is an important consideration
	2. What volumes are provided at the location?	This information will help to determine the level of activity the service accounts for
	3. How is the service delivered?	This information describes how the service is currently delivered, which will be important when considering alternatives
	4. Which key factors drive the safe delivery of the service?	This information will help framework users to assess the implications of a CRS/LSS designation decision on this and interdependent services
Current provision of the service	5. Do other providers of similar services exist?	This information will help to determine which providers could potentially be alternative sources of supply
	6. Are they providing that service on a broadly similar scale?	This information will therefore help to determine whether alternative providers have scope to increase their capabilities and capacity
Typical users of the service	7. Who typically uses the service?	This information will help to determine whether ceasing to provide a service will have an impact on health inequalities
	8. Where do they tend to be located?	This information will help to determine who the closest alternative provider(s) is to patients

Stage 1: Information gathering
The service provided at a specific location

Defining the service in question

Differences in service definitions between different users of the framework will become evident in Question 1A. The framework can accommodate these different approaches, so long as users apply their definitions consistently throughout. In Question 1B, framework users start considering the clinical characteristics of the service. Specifically, in 1B framework users can begin to infer different degrees of adverse impact that withdrawing a service would have. For example, all things being equal, it is reasonable to assume that withdrawing provision of a service for immediate and life-threatening conditions has a more significant adverse effect than withdrawing a service for treatments that are planned in advance. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) classifications are a relatively simple way of classifying surgical interventions, and provide a good starting point for describing levels of clinical urgency here.

Urgency	***When intervention is required***
Immediate	Intervention required within minutes of decision to intervene
Urgent	Intervention required within hours of decision to intervene
Expedited	Intervention required within days of decision to intervene
Routine	Intervention planned in advance (elective)

Table 1. Clinical urgency scale
Source: National Confidential Enquiry into Patient Outcome and Death

Investigating volumes

Question 2 requires framework users to collect activity data. This data is used to get a sense of the scale of commissioning activity that the services account for.

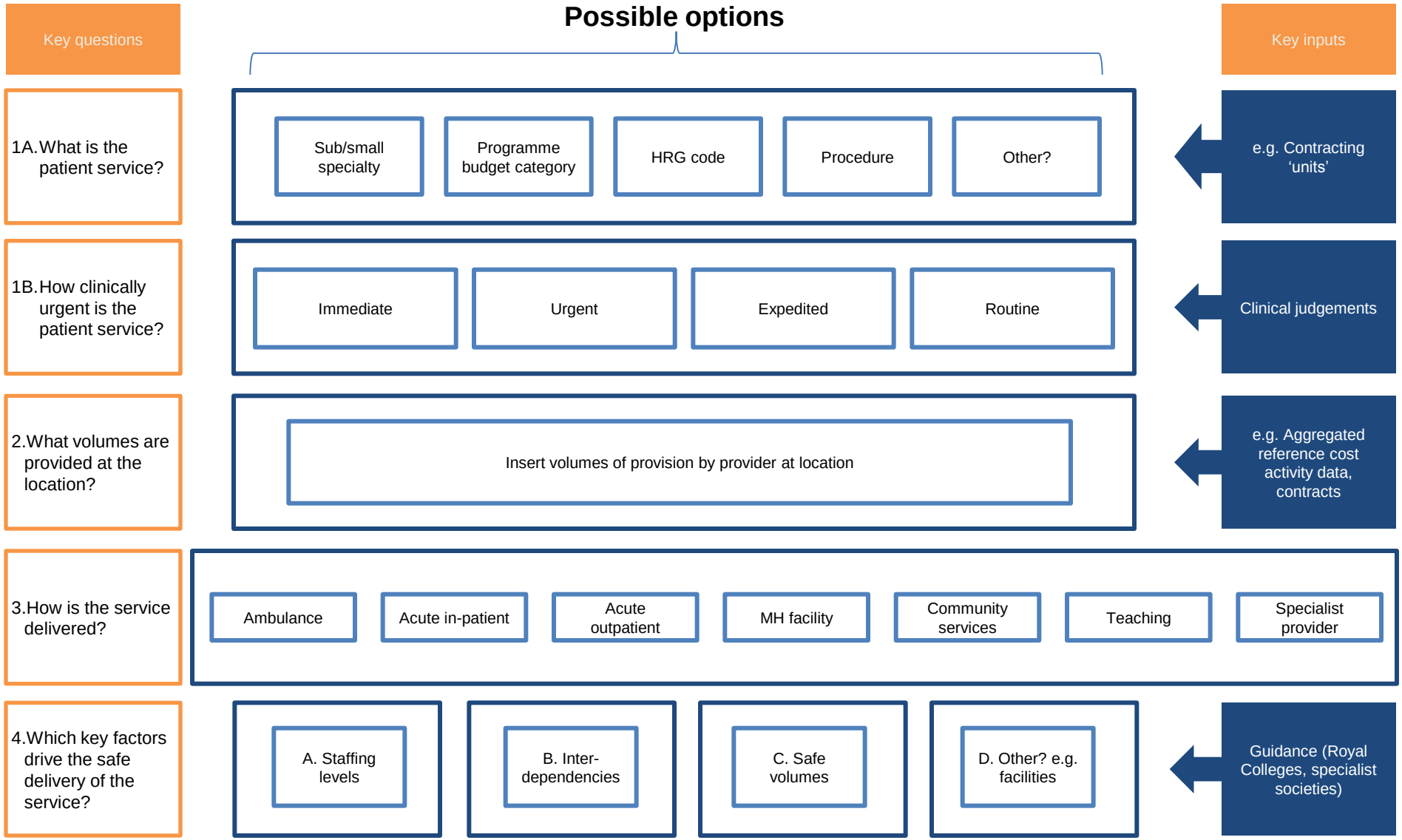
Clinical characteristics of the service

Further to Question 1B, Questions 3 and 4 further capture the clinical characteristics of each patient service. The further detail collected in these questions will feed into the review of alternative providers, and the impact on interdependencies in later stages of the framework.

Underlying each question in this section, and throughout the framework, is the assumption that, in the view of the framework user, the service provided at the location is necessary for the purposes of patient care. Framework users should therefore satisfy themselves that the service that they are considering is one that they feel must be provided to patients.

Stage 1: Information gathering

The service provided at a specific location – example options and inputs to guide data collection



Stage 1: Information gathering
Current provision of the service

Data on potential alternative provision underpins the fundamental test of whether suitable alternative arrangements exist (set out in Stage 2 of the framework).

There are two questions in this part of the information gathering stage that serve as prompts for Stage 2 of the framework:

5. Do other providers of similar services exist?

6. Are they providing that service on a broadly similar scale?

At this stage, framework users can begin to think about whether alternative providers can deliver the increased capacity needed to deal with the increased demand created if the existing provider were to cease or reduce provision.

Alternative providers

The focus on 'similar' services in Question 5 recognises that a service provided in the same way, but in a different location, is not a perfect substitute.

To encourage framework users to think broadly about alternative providers, similarity should be based on the outcomes of the intervention, rather than the method of delivery. Alternatives should include those that provide a similar service in the same setting, in different settings (e.g. in the community vs acute) or, where possible, in different ways altogether (e.g. using telehealth).

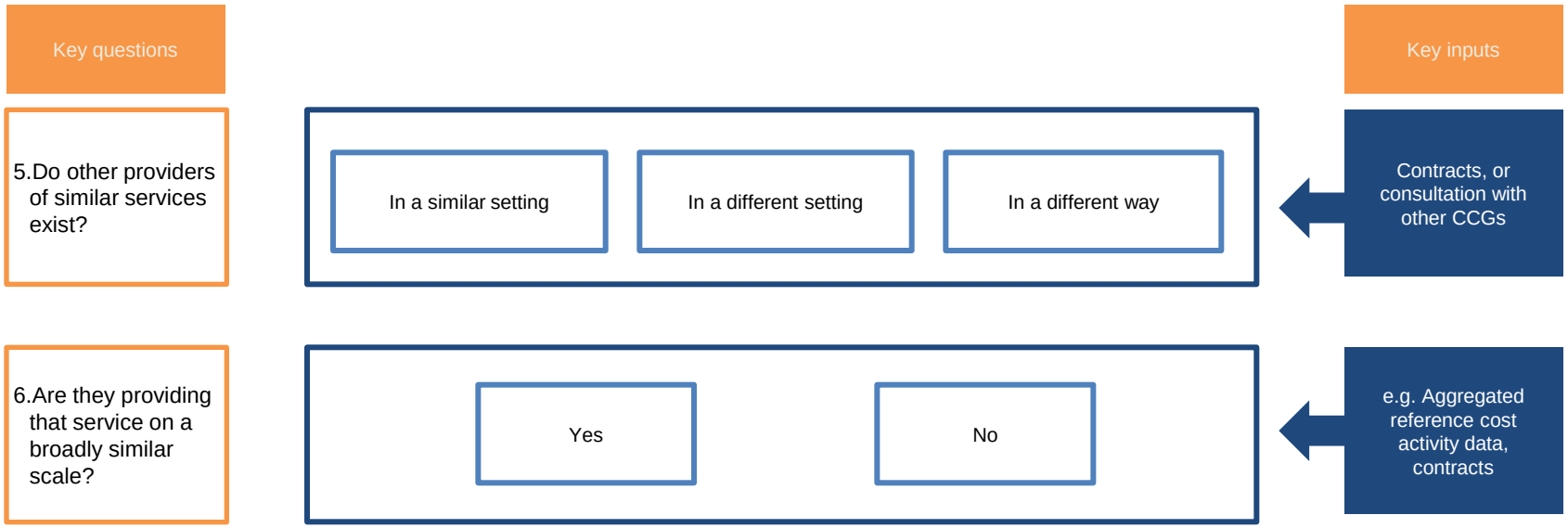
Current and potential capacity

They might also include totally different ways of approaching the problem, provided outcomes are of reasonable quality and safety (e.g. medical management vs surgery).

Question 6 helps framework users think about capacity and is a prompt for Stage 2, when more detailed capacity information will be needed.

An important point here is that the different levels of clinical urgency of a service, as identified in Question 1B, will have implications for which alternatives to consider. For example, providers of services for immediate and life-threatening conditions can be considered as alternatives for providers of routine treatments, but the same may not apply in reverse. In the example of maternity services, a provider of maternity and A&E services (A) could be considered as an alternative for a provider with a maternity service only (B). But in the case of ectopic pregnancies, which are immediate and life threatening and are treated in A&E, provider B could not be considered as a suitable alternative for provider A.

Stage 1: Information gathering
Alternative provision



Stage 1: Information gathering
Users of the service

Although this is set out here as the final part of information gathering, it will be appropriate to gather information on the broad user profile earlier on, as this will be a key factor in the definition of the service and in identifying alternative providers.

In this stage, framework users will also collect information on patients, for the health inequalities test of a *Commissioner Requested Service/Location Specific Service* (Stage 3).

The two questions that guide framework users are:

7. Who typically uses the service?
8. Where do patients tend to be located?

Commissioners, working with local authorities, are likely to have already collected some of this information as part of the Joint Strategic Needs Assessments (JSNA) - see Box 1. This information and any priorities identified in the JSNA are good starting points when thinking about health inequality issues.

In some cases, however, JSNAs will only give a very high level picture of service users and/or may vary in the depth of analysis. Supplementary research will be needed where either is the case.

Box 1 - Joint Strategic Needs Assessments

The objective of a JSNA is to assess the health needs of the local population. They were introduced in 2007 as a statutory duty for upper-tier local authorities and NHS authorities, because it was recognised that strategic planning for health and well being was best done in partnership and based on evidence. They must be produced on an annual basis.

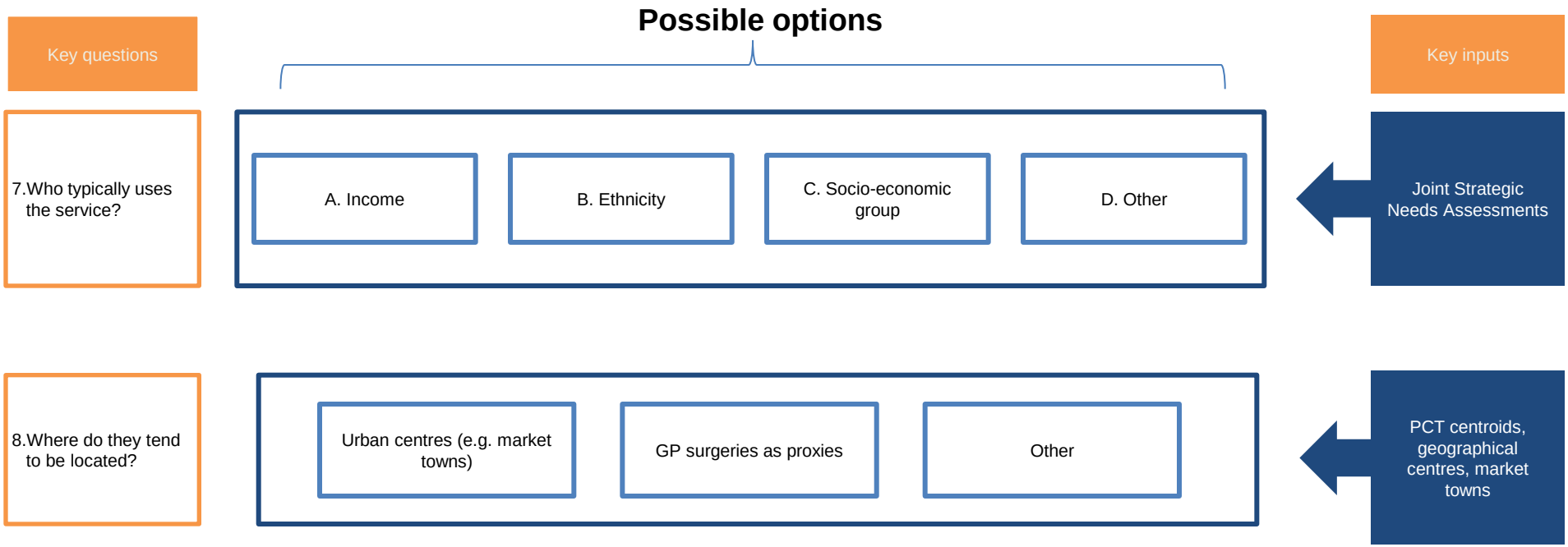
JSNAs are ideally expected to include the following:

- Population level data – e.g. Information on migration, gender, age and ethnicity
- Social and place data – e.g. Information of housing quality, environment, benefits uptake and vulnerable groups
- Lifestyle determinants of health – e.g. Information on smoking, alcohol and drug abuse
- Epidemiology – e.g. Information on morbidity, mortality, life expectancy and long-term conditions
- Service access and utilisation – e.g. Information on emergency admissions
- Evidence of effectiveness – e.g. Commentary on good practice, literature reviews, NICE guidelines and quality standards
- Community perspectives – e.g. Views, expectations and experiences of service users about what contributes to good local health

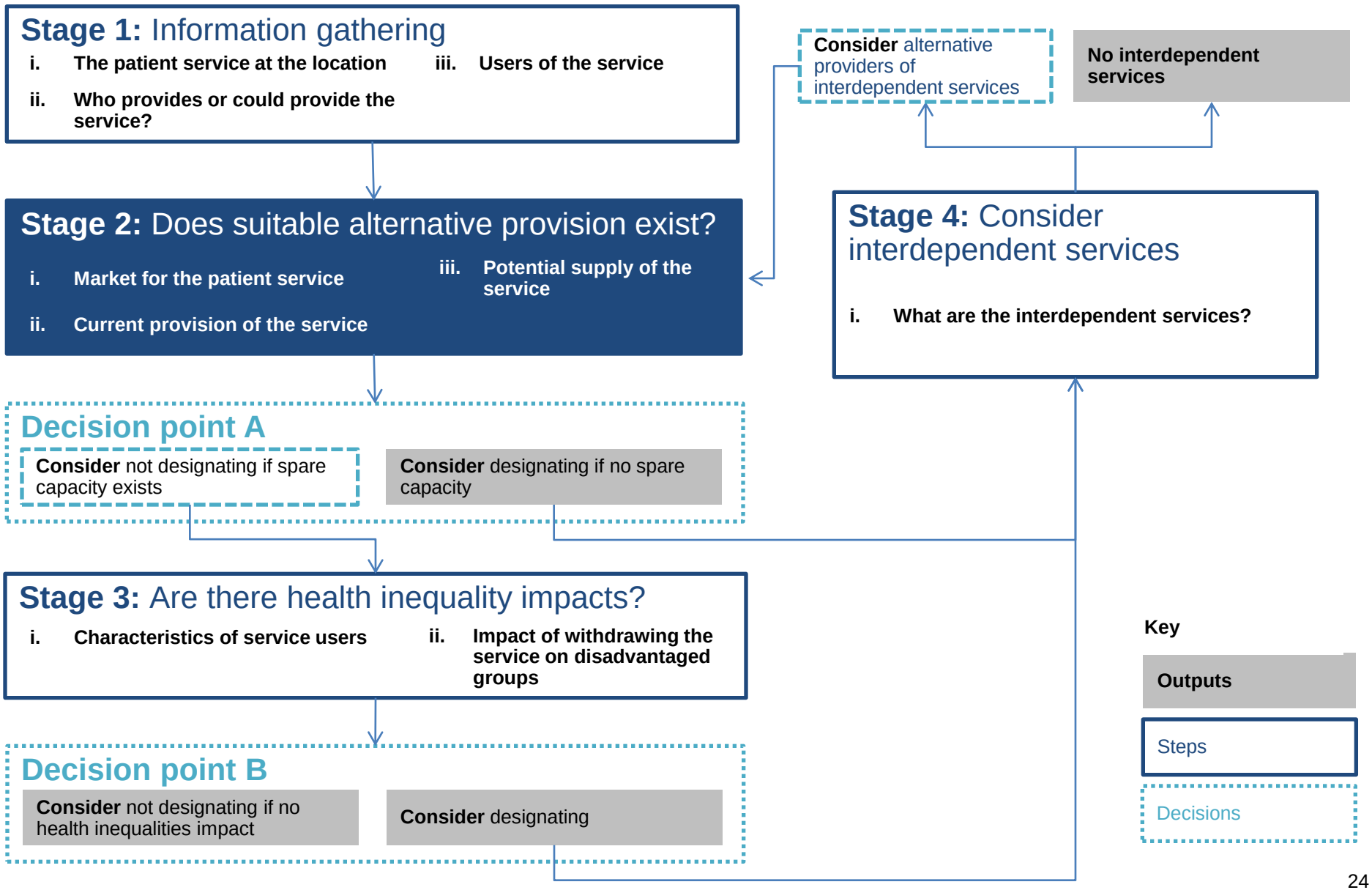
The data collected as part of a JSNA is likely to provide useful evidence to framework users.

Source: Joint Strategic Needs Assessment: A springboard for action (Local Government Improvement and Development)

Stage 1: Information gathering
Users of the service



Stage 2 and Decision A:
Does suitable alternative provision exist?



Stage 2: Does suitable alternative provision exist?

Why is this stage important?

Under the Act, commissioners can only classify a service as a *Commissioner Requested Service/Location Specific Service* if, among other matters, there is an absence of alternative arrangements, so this is the test used in the framework.

The objective of this stage is to establish whether there are 'suitable' alternative arrangements. This broadly comprises three parts:

1. Do alternative providers of a similar service exist, either nearby or as far away as commissioners are willing to send patients?
2. Would those alternative providers have the capacity and capabilities to cope with the levels of increased demand that would result were a provider to leave the market?
3. Could new alternatives enter the market over a reasonable time period?

The framework breaks each into smaller steps.

What is the output of this stage?

- an assessment of the market for each health care service relative to the patients that currently use them;
- a list of providers of services with equivalent outcomes that could offer those services to those patients, irrespective of delivery method; and
- the total volume of provision in each market and the market share of each provider identified.

Key steps in this stage

Do alternative providers exist?

There are two further questions in this step

1. What is the market for the service?
2. Who are the alternative providers in that market?

i. What is the market for the service?

Competition authorities deal with the issue of defining markets and substitutes in their assessments of mergers and market power (see Box 2), so there are some lessons from that area that can be usefully applied here.

To assess a geographical area from which alternatives should be drawn, framework users will need first to consider what the patient service is (defined in Stage 1), and **how far they are willing to send patients to receive the service safely** based on where patients live (Question 9). This is likely to be different for different services – for immediate and life-threatening intervention, such as cardiac arrest, clinical standards will set a limit on how far patients can travel to receive treatment. For other types of services, mental health and some specialist cancer services for example, commissioners may be able to safely send patients further distances to receive care. Patient type, frequency of use and mode of transport will also be important factors in determining how far patients can be sent to receive care. For example, frail and elderly patients, or patients that rely on public transport (particularly in rural areas), will be less able to travel longer distances to receive services, or may require extra help to do so.

Combining proxies for patient locations, such as PCT centroids, geographical centres or market towns in rural areas, with clinically appropriate travel times, framework users can establish a geographical boundary for each service.

Stage 2: Does suitable alternative provision exist? *Alternative providers?*

ii. Who are the alternative providers in that market?

Alternative providers would then comprise any other providers of similar services that fall within the determined geographical boundary (Question 10).

For some services, such as elective services, clinically appropriate travel times will be less relevant. In these cases a more direct approach of considering what the alternatives might be, without assessing the market in any detail, may be more appropriate. Commissioners can do this by simply considering to which alternative providers they would be willing to send patients. Referral patterns are useful sources of evidence for this. However, they should be used with caution. On the one hand, they underestimate available alternatives because they reveal the closest alternative providers, reflecting the status quo, which may not reflect patients' interests or preferences. On the other hand, they risk an over-emphasis on the preferences of the most mobile patients, who are able and willing to travel long distances to receive services that may not be suitable for all patients (such as the frail and elderly). By also considering providers to which at least 5% of patients have been referred, framework users can to some extent control for these effects.

Whether using travel times or the more direct provider identification approach, framework users should think broadly about how services are delivered. In other words, the set of alternatives should not be limited to current providers. It may include consideration of how pathways and delivery method may change, or the contribution of potential new providers. Here, the question is to determine a realistic timeframe.

A crucial consideration is that alternatives must be judged to be able to deliver a service of a reasonable level of quality that meets at least the minimum Care Quality Commission (CQC) requirements. Subject to this proviso, then all providers that could provide a service, irrespective of delivery method, should be considered.

In the context of an integrated care pathway, framework users should also consider the role a provider plays in that pathway, and the ability of alternative providers to fill that role in practice. In stage 4, interdependent services, it may also be the case that other elements of the integrated care pathway will come under review. In effect, the end result may be that one or more parts of integrated pathways are protected – or indeed none, should alternative provision be feasible along the complete pathway.

Box 2: Approaches to defining markets

The Office of Fair Trading (OFT) and Co-operation and Competition Panel (CCP) have tried to define markets in health care, and therefore offer useful pointers for framework users, particularly for Question 9, in terms of grouping services and determining how far to safely send patients.

OFT (review of private health care)

- Defining the product is left to expert clinical opinion.
- Use 30-minute drive time approach to define markets around hospitals.
- More sophisticated market definition techniques have sound theoretical foundations, but may be far too complex for practical use (requiring too much data).
- A good geographic market definition technique will recognise (and capture) differing preferences and patient types.
- Aggregating services into clusters can however lead to incorrect market definitions.

CCP

- Look at the extent to which prices can be increased, or quality reduced without a supply response ('hypothetical monopolist test') to determine the relevant 'product' and geographical market.
- When looking at alternative providers, they consider it less likely that a provider of a different specialty can enter the market. In this case they look at the existence of sunk costs; spare capacity in terms of beds/operating theatre slots; whether there are incentives for entry (i.e. higher margins than from current services); and whether minimum volumes are required for accreditation as a clinically safe provider.
- Treat each specialty as a separate market, but also consider groups of services where the services face similar constraints and competitors.
- Consider providers within 60 and 45 minutes by public transport, and 30 and 20 minutes travel time by private transport, though they accept that patients have shown themselves willing to travel further.

Stage 2: Does suitable alternative provision exist? *Spare capacity?*

Capacity and capability to cope with demand?

Once alternative providers have been identified, framework users should assess their ability to cope with the increased demand that might arise if the provider in question were to cease provision of the patient service. Total activity across all identified providers can be estimated, for example, by using reference cost activity data, or contract information (including contracting by other commissioners where required). It can then be used to get a sense of the share of provision for which each provider accounts.

Framework users should seek assurance from alternatives that they would be able to cope with the increased demand should the provider in question cease provision. They should always do this when the market share of the provider in question is high, but users should use their judgement in considering when it is appropriate to seek assurances more widely.

A lack of such assurances would provide evidence to suggest that, at least in the short run, there is not enough spare capacity to deal with the failure of the provider in question.

Possibility of new entry over a reasonable time period?

The potential for increasing capacity, over an appropriate time period, should also be considered. An 'appropriate' time period should be judged by the length of time services can be funded by the risk pool (one year).

New capacity will come from two principal sources:

- existing providers; and
- new entrants, including:
  - existing providers that do not currently provide the service in question; or
  - entirely new entrants to the market.

Previous tenders for contracts could be a useful source of information.

Throughout this stage, and throughout the gradual process over which we expect the framework will be used, co-operation between commissioners is encouraged. This will be very important in managing situations where multiple commissioners are using the framework to assess the same providers, with the potential for complication that this might bring.

Active conversations between commissioners and providers are also encouraged. Both these and discussions with commissioners will be key to understanding different service delivery models, capacity constraints and so on, as well as the ability of existing and new providers to build their capacity and capabilities. These discussions should also be a natural part of commissioner efforts to commission from a wide pool of providers, and in doing so limit the reliance on any one provider.

Discussions with patients and patient representative groups are also encouraged as a key source of information. For example, such discussions will help to give a sense of how suitable alternative providers actually are for different segments of the population and therefore whether they meet the needs of all users (e.g. frail and elderly versus young people).

Decision A

After completing this step, framework users should be in a position to make a decision about whether all or part of a service needs to be designated CRS according to Monitor's Continuity of Services regime (or LSS if the provider is at the point of failure); or de-designated:

- If insufficient alternative capacity exists (e.g. when assurances from alternative providers cannot be given) the framework user should consider designating the whole service or a portion of the service.
- If, on the other hand, sufficient capacity does exist to deal with the increase in demand, within the appropriate timeframe, then the framework user should consider not designating the service.

There are two important points to stress here. First, the framework only guides commissioners through the process of designating services. Framework users are the ultimate decision makers and can choose to go against the recommendations of the framework, so long as they are satisfied that the factors and evidence they have taken into account sufficiently justify their decisions.

Second, it is possible to designate all of a service or just a subset within a speciality, as long as safety requirements continue to be met. For example, commissioners might decide that penetrating eye injuries are only being treated by one provider in the health economy, while routine ophthalmology services are offered more widely. In this case, emergency ophthalmology services, like the treatment of penetrating eye injuries, could be designated while all other ophthalmology services at that location are not.

If the capability to cope with increased demand exists only over time, designating a portion of a service may be a sensible measure.

What proportion of a service to designate will depend on when the framework is being applied.

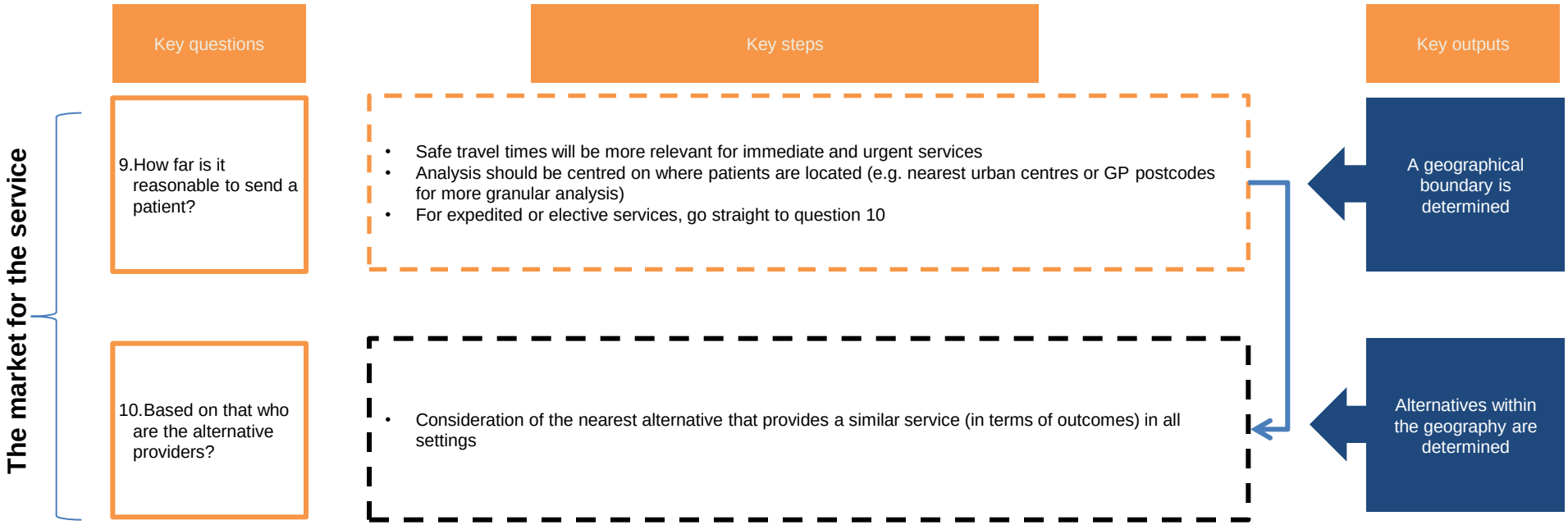
In normal conditions (i.e. before a provider goes into distress), commissioners may be intending to encourage entry into the market. Designating a minimum level of a service as CRS may be a sensible option at that point.

The time period required for market entry is also likely to differ by service. For example, for services that are capital intensive, or have other significant barriers to entry, new capacity will take longer to build. This suggests that a larger proportion or all of the service should be designated CRS.

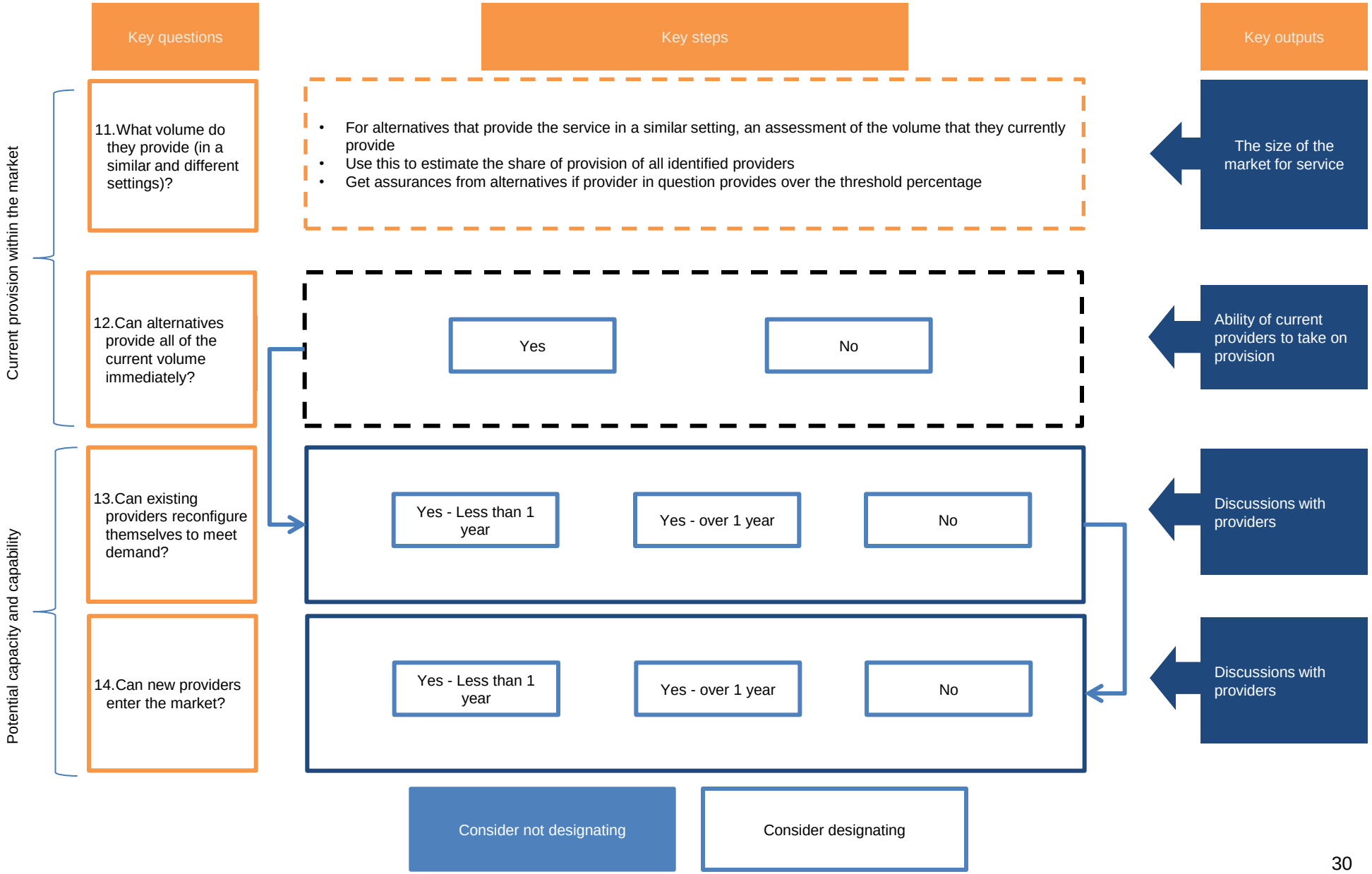
For some services however, like community services, where barriers to entry tend to be relatively low, new capacity can be built relatively quickly. In these cases, designating a smaller proportion, none, or not designating the entire service may be more appropriate.

If framework users determine that a service should not be designated CRS/LSS, the next stage is an assessment of impact on health inequalities of withdrawing the service (Stage 3). For services that are designated, framework users can proceed straight to Stage 4 (assessing interdependent services).

Stage 2: Does suitable alternative provision exist?



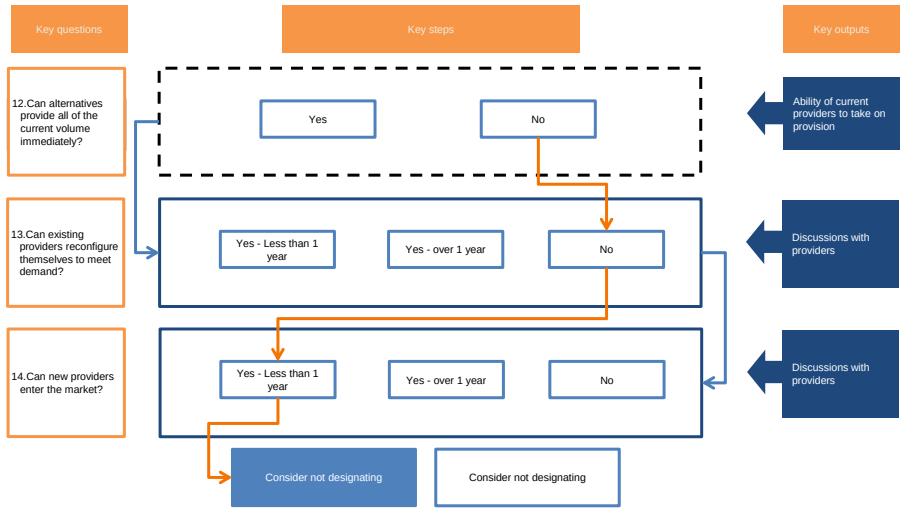
Stage 2 and Decision A:
Capacity to provide the service?



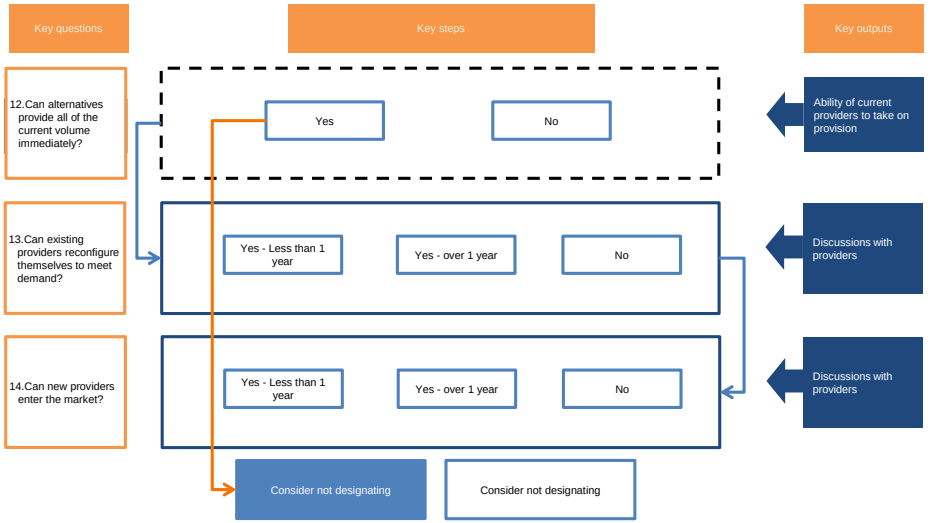
Decision point - examples

Examples of decision paths that would lead to a recommendation to consider not designating

a)

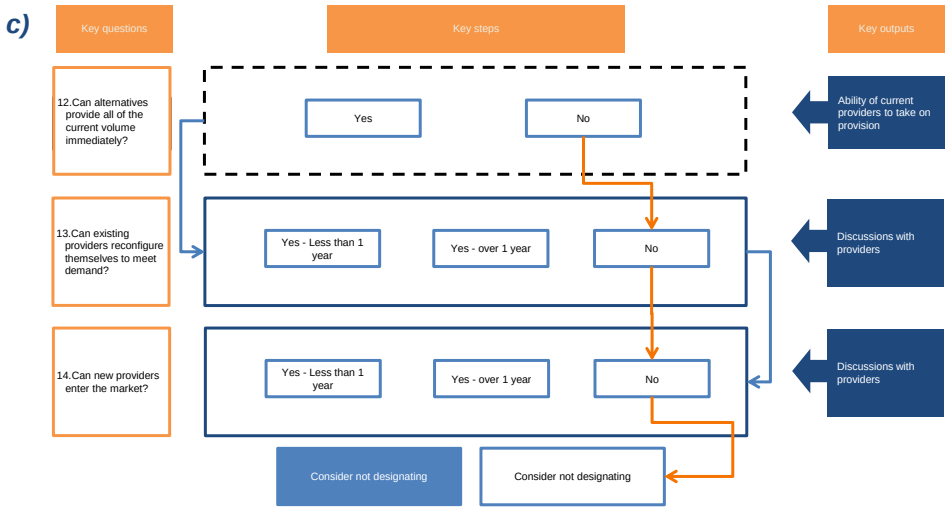


b)



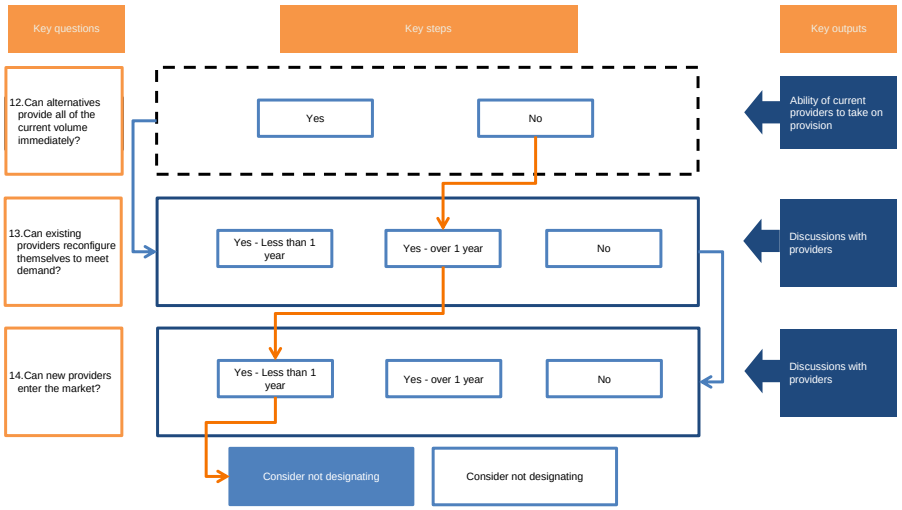
Example of a decision path that would lead to a recommendation to consider de-designating

c)

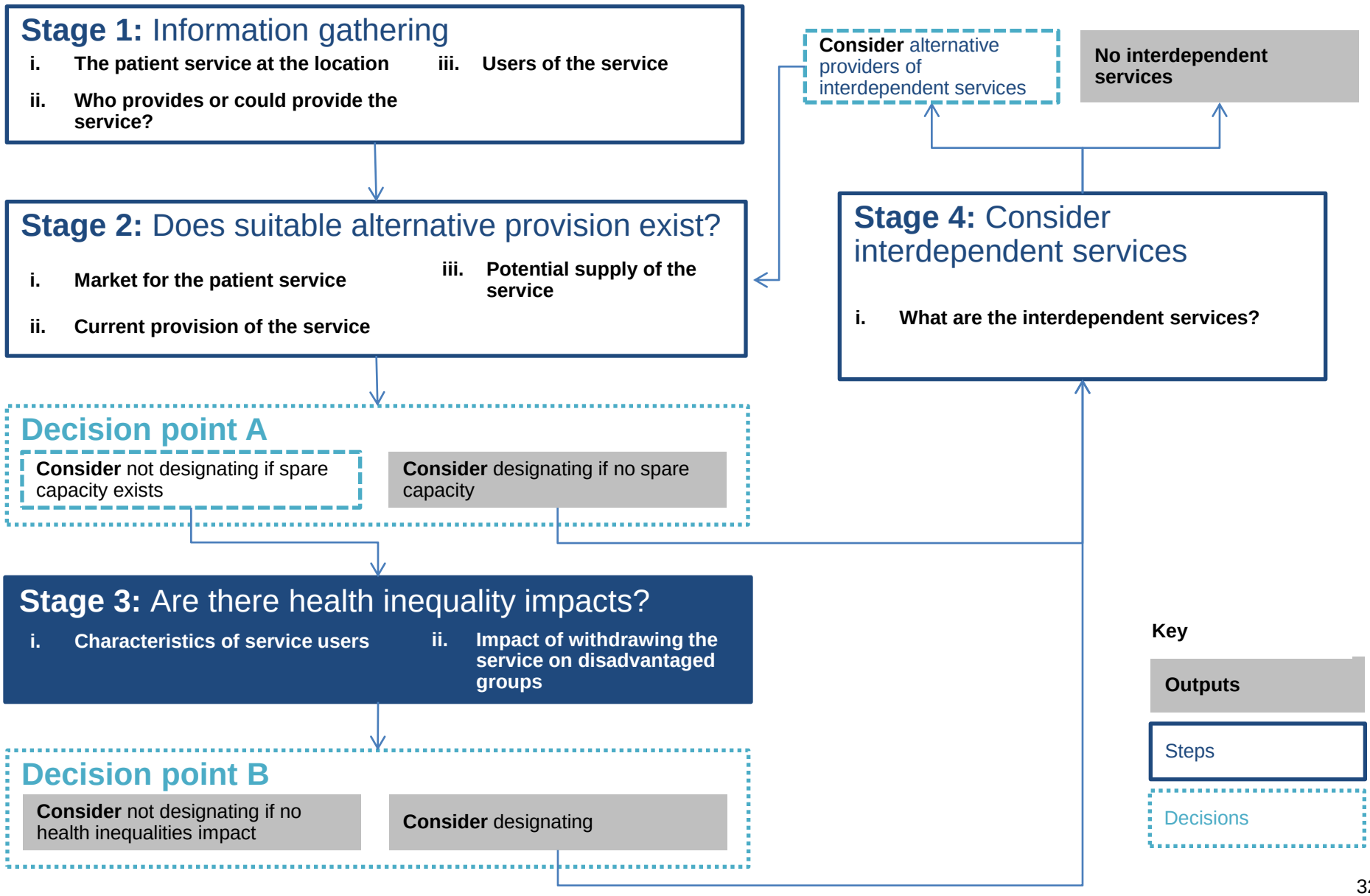


In this example there are two methods of achieving suitable capacity but new entrants into the market would be quicker

d)



Stage 3: Are there health inequality impacts?



Stage 3: Are there health inequality impacts?

Why is this stage important?

In the event that a foundation trust enters Trust Special Administration, section 65DA of the NHS Act 2006 (as inserted by section 175 of the 2012 Act) provides that commissioners can only determine that services should be designated LSS if ceasing to provide the service would, in the absence of alternative arrangements for its provision, be likely to:

(a) have a significant adverse impact on the health of persons in need of the service or significantly increase health inequalities; or

(b) cause a failure to prevent or ameliorate either a significant adverse impact on the health of such persons or a significant increase in health inequalities.

Similar requirements are likely to be put in place via secondary legislation in respect of Health Special Administration.

This inequalities test is the objective of Stage 3.

What is the output of this stage?

- Population of service users broken down by characteristics (income, ethnicity, gender, socio-economic group, other protected characteristics under equalities legislation) and indication of JSNA priorities;
- Existence of adequate public transport facilities for accessing the service, within clinically appropriate travel times;
- Perceived barriers felt by hard to reach groups; and
- Additions to the list of services that should be considered *Commissioner Requested Services/Location Specific Services* from Stage 2, based on the impact on disadvantaged groups, or JSNA priorities of withdrawing services.

Key steps in this stage

The World Health Organisation defines health inequalities as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mortality rates between people from different social classes. Therefore, the key to this stage is identifying the characteristics of the patients who use the service, any priorities identified in Joint Strategic Needs Assessments (JSNA), and any special factors that might make them less well served by alternatives.

This can help commissioners to understand where lower health outcomes might result from the withdrawal of a service in a specific location.

Patient characteristics that should be considered should include those which are known to drive health inequalities, such as socio-economic group, as well as any relevant protected characteristics from equalities legislation (e.g. age, disability and race).

JSNAs may in some cases only give a high-level view of local demographics. In these cases, more detailed supplementary research may be needed before a decision can be made.

Given potential weakness of data, one approach is to consider, particularly in the context of socio-economic deprivation, the adequacy of public transport links to alternatives. Their absence may mean that deprived communities may be disadvantaged by the displacement of the current service provision.

In other cases, there may be factors that may affect inequalities, for instance, perceived barriers felt by hard to reach groups which may not be addressed solely by analysing transport accessibility. Commissioners should explore for instance whether there are unique relationships involved in existing service provision for hard to reach groups which may not be replicated through alternative provision.

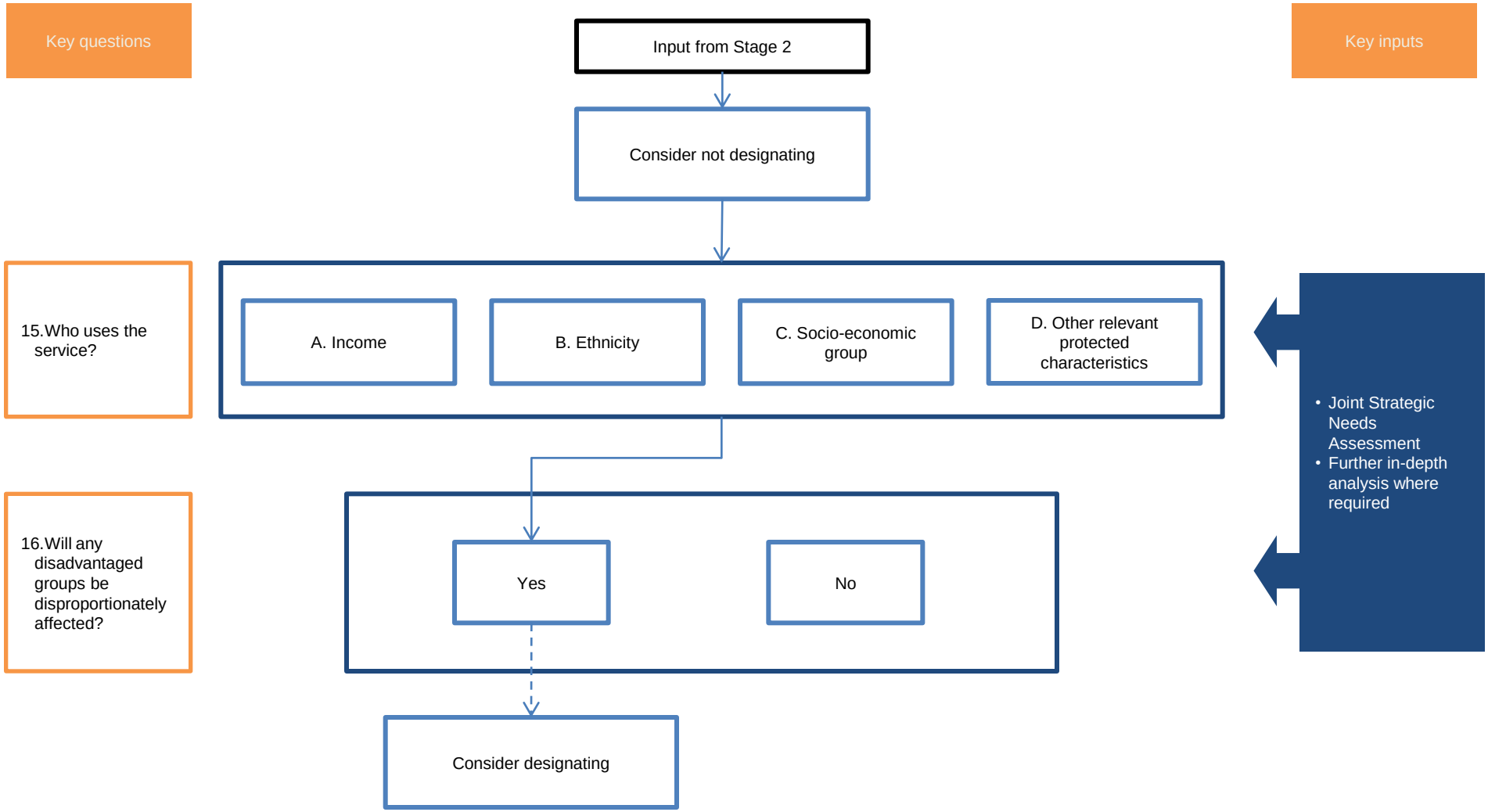
Decision B

In Monitor's view, services should only be designated *Commissioner Requested Services/Location Specific Services* for health inequality reasons if disadvantaged groups, who have lower health outcomes, can be shown to be disproportionately affected by withdrawing a service. For example, evidence suggests that epilepsy is more common in deprived communities, who in turn have lower health outcomes. An epilepsy service provided in a deprived area would therefore be more likely to be designated CRS/LSS, on the basis that withdrawing the service would most likely exacerbate differences in the health outcomes of its patients relative to the average.

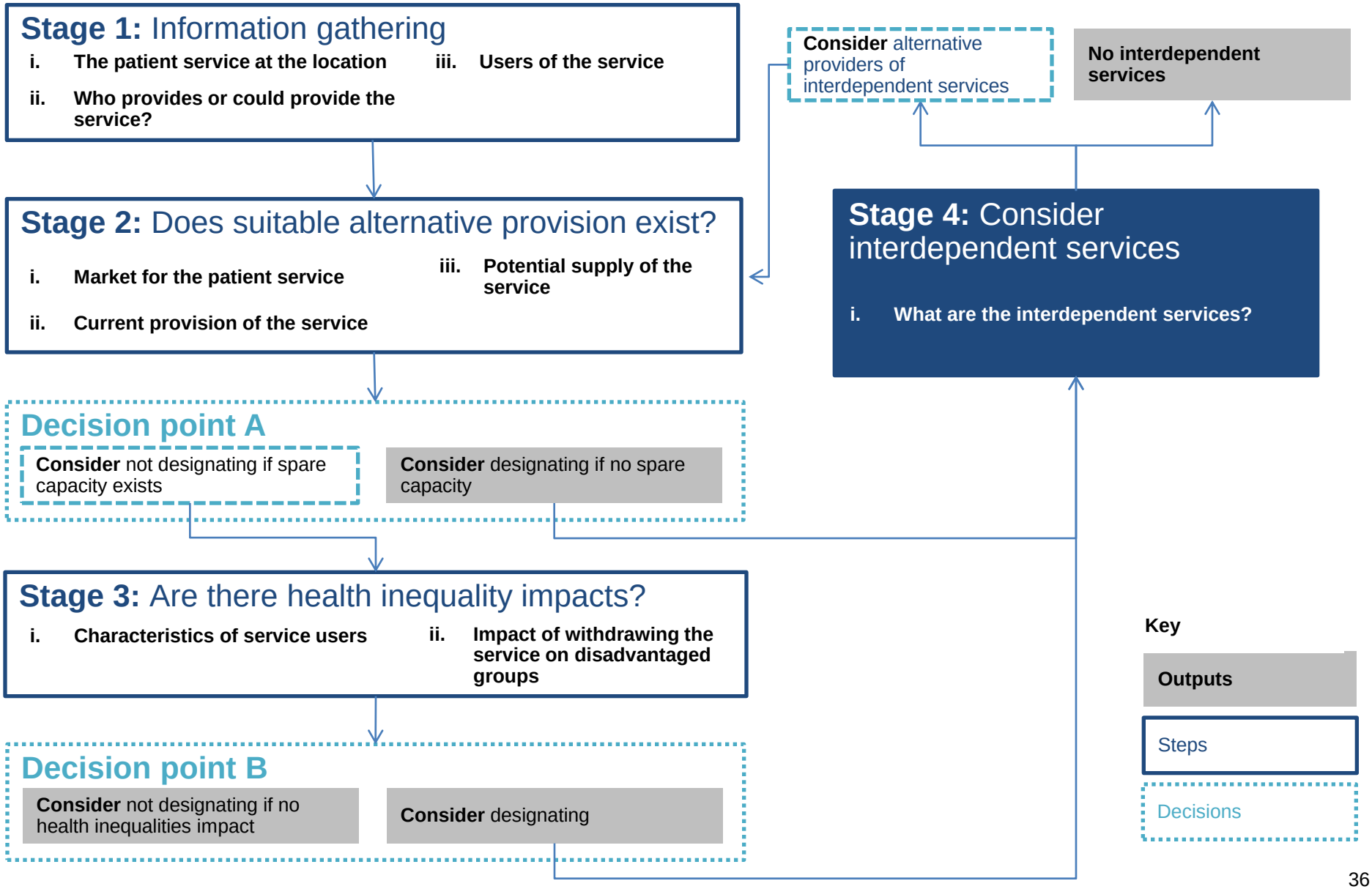
However, if alternative providers existed which were easily accessible by those groups, designation would not be required. By contrast, impediment to access, such as travel that imposed relatively substantial costs on these patients, can be considered grounds to designate the service, on the basis that the alternative provision is not considered sufficient by the framework user.

The significance of impact on outcomes, and the suitability of potential alternatives should be defined locally by framework users. This underlies the need for expert and patient views to taken into account in the decision-making process.

Stage 3 and Decision B:
Are there health inequality impacts?



Stage 4: Consider interdependent services



Stage 4: Consider interdependent services

Why is this stage important?

Health care services, by their nature, are often interlinked. This implies that decisions to designate or de-designate services as CRS/LSS often cannot be made in isolation.

In Stage 4, framework users will need to consider whether interdependent services also require designation. Using a similar methodology to Stage 2, framework users should first consider whether there are alternative providers of the interdependent services and whether those alternative providers have capacity.

Advice from clinicians suggests that clinical urgency will be an important determinant in the decision to designate an interdependent service. All things being equal, where the clinical urgency is immediate - in other words, where access to the interdependent services is required within minutes of the initial intervention - framework users will most likely find it difficult to identify alternative providers.

What is the output of this stage?

- A list of interdependent services that should be designated *Commissioner Requested Service/Location Specific Service.*
- This could include designating as a *Commissioner Requested Service* a whole interdependent service, with a view to designating LSS only the portion that is interdependent with a designated service.

Key steps in this stage

Key to this stage is identification of the key interdependent services, using clinical judgements and guidelines from sources such as the Royal Colleges (Question 17). Interdependent services required prior to, such as diagnostic services, during, such as anaesthetist services, and post, such as physiotherapy services, must be considered. Framework users may also need to take into account services provided by different providers. This will be particularly important in the context of integrated networks.

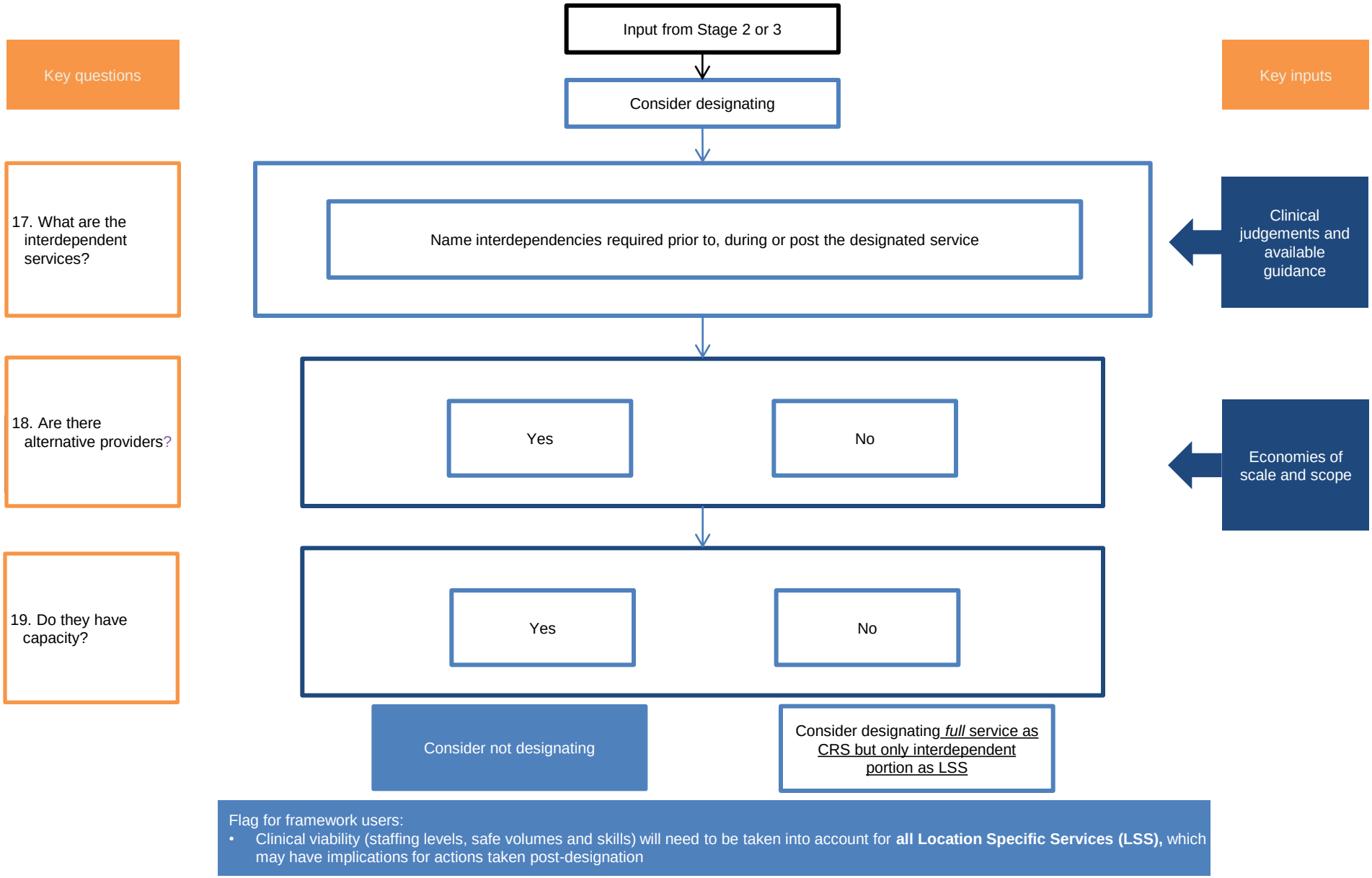
Decision point

Framework users can then make judgments about whether to designate all or part of the interdependent service as CRS/LSS based on whether there are any suitable alternatives, similar to previous stages.

Framework users will also need to take into account any economies or diseconomies of scale and scope in providing the LSS-designated and supporting (interdependent) service. Monitor has commissioned further work in this area – see our website. The key point, however, is that the likelihood of adverse impacts on patients should be the overriding concern. In other words, once a service is defined as *Commissioner Requested Services/Location Specific Services*, the local adjustment mechanism should be the vehicle for managing any further implications for cost.

With all designated services, framework users will also need to ensure that the service can continue to be offered safely. For some treatments such as paediatric cardiology, a minimum number of procedures may be required for the service to remain safe. This may have implications on whether interdependent services, such as routine treatments, need to be designated as well, so that required volumes can be maintained.

Stage 4: Consider interdependent services

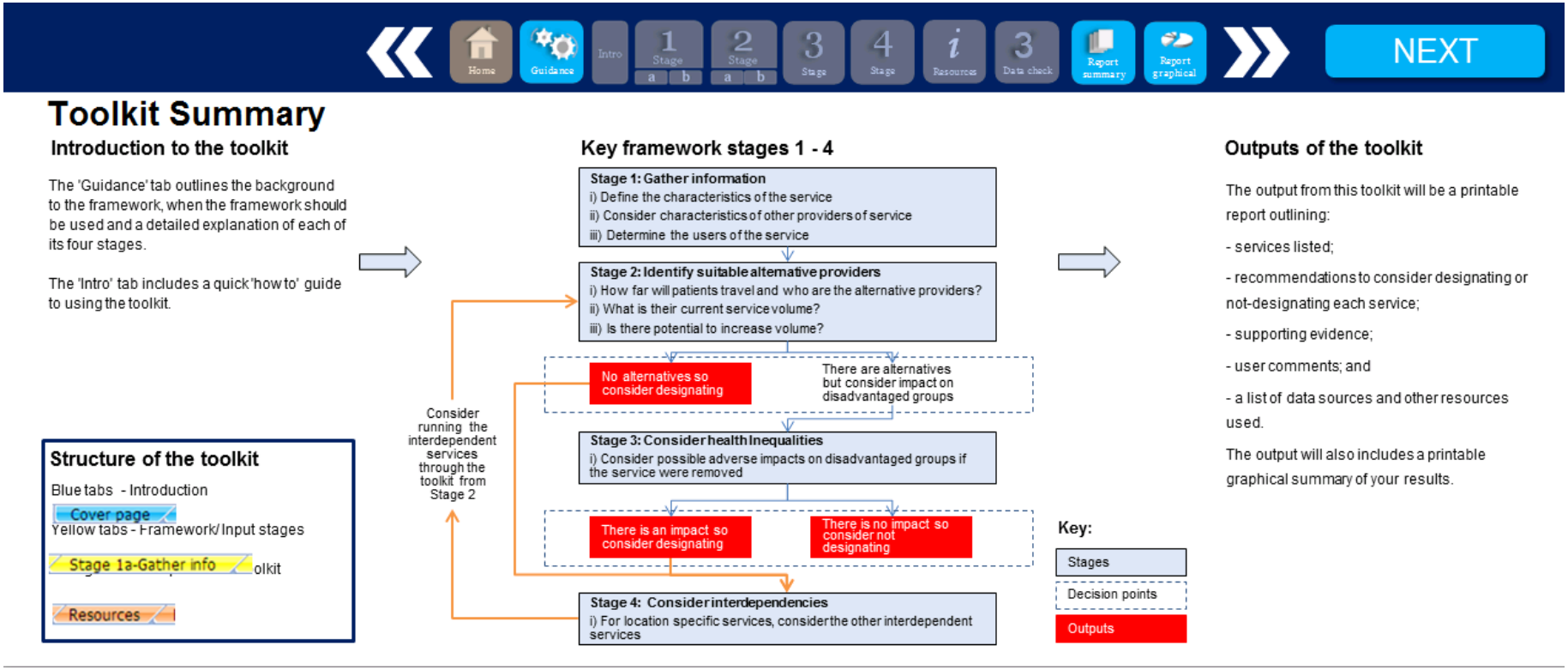


Excel-based toolkit

An Excel-based toolkit has been developed to help commissioners through this process.

Some of the stages have been split into two and the questions amalgamated and converted to yes/no answers to make the process more user friendly. The toolkit is available [on Monitor's website here](), alongside guidance on how to use it.

Fig 4: CRS/LSS Excel-based toolkit



Chapter 4
Case studies

Purpose of the case studies

Purpose

The purpose of the case studies is to test the framework and to provide practical examples of the evidence-based arguments that the framework and toolkit will help users construct when making decisions about designating services as CRS/LSS.

Methodology

Case study participants were sent a draft version of the guidance in advance and asked to think about how they might apply it, either to a service that they commission (Clinical Commissioning Group participants) or a service that they offer (provider participants). This was followed up with a visit to discuss feedback, and to develop each case study. Finalised case studies were then shared with each participant for final comment.

Why they are important

The case studies are important because they will help to build Monitor's understanding of the issues that framework users will face when identifying *Commissioner Requested Services/Location Specific Services.*

They seek to cover a range of scenarios, including urban and rural settings, and public and private providers. Though hypothetical, "real life" case study participants have been used to make them as realistic as possible.

Outputs from the case studies

In each case study we outline the:

- background to the service in question;
- hypothetical scenario; and
- case for designating the service as CRS/LSS using the framework and toolkit as a guide.

In each of the case studies, the framework questions have been used to build a narrative that will be similar to decisions made by framework users. Framework users will be able to use the excel-based toolkit to follow each question in the framework in more detail.

Summary of the case study experience

Case study participants reacted positively to the framework and suggested that it could be used in other ways, such as when thinking about how services are delivered. Key challenges they faced when applying the steps were:

- availability of detailed data;
- the need for clinical input, for example to understand interdependencies;
- the need for provider input, for example to understand capacity; and
- the importance of independent advice, for example on ability of other providers to deal with increases in demand.

Case study 1: Pathology provider in a deprived urban area

About pathology services

Pathology services (also known as laboratory medicine) cover the screening of blood, fluids, tissue and other samples for the purpose of providing knowledge and diagnostic information on patients. Test results directly inform clinical decisions and ultimately the quality and speed of patient care – it is estimated that approximately 70% of clinical decisions are made as a result of pathology test results*.

There are two main pathology specialities:

- blood sciences including clinical biochemistry, haematology, blood transfusion, immunopathology and cytogenetics; and
- cellular pathology & infection including histopathology, cytopathology, mortuary service, microbiology & virology.

In England, approximately 697million pathology tests are conducted every year. This is comprised of 500 million biochemistry, 130 million haematology, 50 million microbiology, 13 million histopathology and 4 million cytology tests. An estimated 35%-45% of these tests originate from primary care, and there are approximately 25,000 pathologists working in England.

For patients, the journey typically begins with a request for a blood sample by a GP. The patient then has the blood taken by a phlebotomist either in another part of the GP surgery, a health centre, or a hospital outpatient department. For some tests, the results can be communicated back to the GP within hours (e.g. haematological or biochemical analysis). Microbiological analyses will take longer (1-3 days) and histopathology results longer still (up to a week). The GP is then able to communicate the results back to the patient, at which point diagnosis and treatment can be discussed.

*Modernising pathology services in London NHS London – Pathology modernising programme (2011)

* 'Report of the Review of NHS Pathology Services in England – Review for the Department of Health' Chaired by Lord Carter of Coles (2006)

Applying the framework

For this case study we consider the potential closure of an acute provider in a deprived urban area.

Stage 1

About the service

The nature of pathology services suggests that the majority should be considered as routine in terms of their clinical urgency. However, some pathology sub-specialities require quicker turnaround times, such as testing blood for kidney function which requires results within the hour. These types of sub-specialities can be considered as 'urgent' for the purposes of the framework, and account for 20% of all pathology cases conducted at the provider in question. The remaining 80% of the nearly 8 million tests in the area were considered routine by the commissioners using the framework.

Who provides the service?

The provider in question is a multi-site acute NHS trust provider, with the site in question located in a deprived community. It specialises in blood transfusions and tests, clinical biochemistry, haematology and histology services.

In this particular urban area, pathology services are provided by nearly 30 NHS trust laboratories, each providing between 1–20 million tests per annum, primarily for their own trusts/hospitals.

Case study 1: Pathology provider in a deprived urban area

There are also a small number of commercial providers, one public and private sector joint venture, and a small number of service level agreements. It can therefore be assumed that there are a number of alternative pathology service providers, with many providing services on a broadly similar scale to the provider in question.

Users of the service

The Joint Strategic Needs Assessment for the area suggests there is a relatively low life expectancy and a health inequalities gap, with male life expectancy just over two years lower than the national average. There are high preventable mortality rates, primarily from cancer, cardiovascular disease and chronic respiratory disease. There is also a high burden of disease – diabetes, mental health, diabetes, obesity, HIV.

Independent research suggests that around 48% of the population is drawn from minority ethnic groups. The area is also characterised by high levels of unemployment (11%) and poorer households (18% living on less than £15k a year). In comparison with England as a whole there is a higher incidence of disease and reduced life expectancy caused in the main by cancer and coronary heart disease.

<u>Stage 2</u>

Who could provide pathology services to local residents?

The nature of pathology services means that the primary challenge comes from the transportation of samples between sites (e.g. from the GP surgery, where the sample is collected, to the hospital laboratories where it is tested). Except for specialised pathology services, transportation to a lab, rather than the lab itself, is the key issue.

Therefore the key determinants of the market for pathology services will be availability of local transport, speed of analysis and the speed of conveying results (e.g. IT availability). For the purposes of this case study however, commissioners conservatively assumed that for the routine service, potential alternative providers can be drawn from any of the other 26 active NHS trust laboratories in the area. In total these provide approximately 110 million tests a year between them.

For urgent services however, where tests must be completed within the hour, only the three closest trusts, who also provide these services, were considered in the market. Between them, they account for 55 million urgent tests a year.

These are reasonably conservative estimates because, given the factors that drive the market for pathology services, there are potentially other providers within the region and even further afield that could potentially offer alternative supply, in both the urgent and routine tests.

Can alternative providers take on the increased capacity?

Using the volume data, collected from the reference cost database, the provider in question accounts for around 6% of routine pathology services (out of the larger, 26 provider market), and around 3% of the urgent pathology services (in the much smaller, 3 provider market). On the face of it, this relatively small share of activity suggests there is potential for alternative providers to be able to cope with an increase in demand if the provider in question were to reduce or cease provision.

Further evidence, from discussions with other providers, suggests that there is excess capacity in the urban area. Providers are able to increase capacity by 10-30%, incurring minimal marginal costs in the process. We can therefore assume that the increased demand

Case study 1: Pathology provider in a deprived urban area

resulting from the provider in question withdrawing from the pathology market could be absorbed, if not immediately then within a year.

On this basis, the framework would suggest not designating the service provided at this location as CRS.

Stage 3

Are any disadvantaged groups affected?

There are also significant health inequalities within the area at present – while male life expectancy is just over two years lower than the national average, there is an eight-year gap between the men living in the least and most deprived parts of the area, and a four-year gap for women. It could be argued, therefore, that withdrawing the service from the local community could have a further, detrimental impact on health inequalities.

However, we can reasonably expect this to be offset by the high levels of alternative provision, combined with the typical patient journey (which starts with the GP, of which there are 36 practices in the area where samples could potentially be taken).

For these reasons, commissioners, using the framework, felt that pathology services provided at this particular provider should not be designated CRS.

Stage 4

What are the interdependent services prior to, during or post the provision of this service?

This is not applicable since the service has not been designated CRS.

Case study 2: Paediatric services in a deprived rural area

About paediatric services

Paediatrics covers a wide range of general and specialist services that deal with the health needs of infants, children and young adults (from birth to 16/17 years of age).

Services within the paediatrics department vary from immediate paediatric A&E, ambulatory and intensive care, to routine paediatric cardiology and dermatology.

Generally the paediatric service is split into out-patient appointments, 24-hour paediatric A&E, in-patient wards and paediatric intensive care.

As of 2009 there were 263 paediatric services in the UK, comprising of general, community and tertiary services. Of these, 218 ran an in-patient service. Of the in-patient providers, 30 were classed as very small (defined as <1,500 annual emergency paediatric admissions) and 75 small (1,501-2,500 annual admissions) representing 14% and 34% of the total respectively. Medium (2,501-5,000) and large (>5,001) providers accounted for 47% and 5% of provision respectively.

Applying the framework

For this case study we considered whether or not to designate paediatric services as CRS in a general hospital that serves a community in a deprived rural area. The general hospital is just one site of a large foundation trust that has other sites across the very rural county.

Stage 1

About the service

The total volume of paediatric services provided at the location is 492 consultations/month, spanning a range of clinical urgency levels:

- Day case/In-patient elective and Non-elective – approximately 227 attendances/month, representing 46% of total paediatric provision.
- Out-patient appointments, follow-ups and those undergoing procedures – approximately 265 attendances/month, representing 54% of paediatric provision.

Who provides the service?

The foundation trust has a number of sites that broadly service different population centres across the large rural county. These include a paediatric service at the site in question, plus two other sites.

Users of the service

According to the Joint Strategic Needs Assessment (JSNA) for the area, the main disadvantaged groups are children and younger people (particularly those from unemployed families), elderly people and other disadvantaged groups, such as ethnic minorities.

Case study 2: Paediatric services in a deprived rural area

The county has a higher than national average occurrence of circulatory disease and cancer. Smoking and alcohol-related admission are also above the national average.

The unemployment rate is as high as 10% in the town where the provider is situated, compared to 4.4% in the wider county and 4% nationally. Evidence also suggests that mental health issues are more prevalent among that group (50-60 suicides occur per annum, above the national average).

Obesity is also high in children, with one in five ten-year-olds classified as clinically obese. Within the ageing adult population, there is a 20-year gap in life expectancy and a high prevalence of long-term conditions (LTCs). The community in question is also one of the most deprived in the UK.

<u>Stage 2</u>

Who could provide paediatric services?

Besides immediate and life-threatening paediatric services, referral patterns suggest that patients are willing to travel up to just over two hours to receive services. However, the characteristics of the county present a number of challenges. There are approximately 500,000 people in the county, with 60-70,000 within the community in question.

The county population is spread over approximately 2,635 sq miles with population settlements spaced around the perimeter. In terms of alternative providers, there is a multi-site provider that offers paediatric services (approximately 1,300 consultations/month in total). Sites can be found:

- one approximately 46 miles from the community in question, with a travel time of 1hr 30 min by car; and
- another approximately 70 miles from the community in question, with a travel time of 2hrs by car.

There are also single-site potential alternatives, including one around 50 miles away - a travel time of 1-2 hours (approximately 510 consultations /month); a second around 70-80 miles away (approximately 500 consultations/month); and a third also around 70-80 miles away (approximately 791 consultations/ month).

There are also 83 GP practices across the county.

The total volume of these identified providers is approximately 3,100 patients/month, putting aside the significant travel times from the community in question.

However, not all of the alternatives offer the range of paediatric services that the provider in question does. This suggests that a further disaggregation of paediatric services may be needed.

Can alternative providers take on the increased capacity?

Using the above data, we estimate that the provider in question accounts for 16% of all paediatric service activity. This share of activity suggests that existing alternative providers could absorb the increased demand.

Case study 2: Paediatric services in a deprived rural area

The considerable distances between providers, however, suggests that transferring patients to other providers may only be suitable for some services (urgent, expedited and routine) and not for others (immediate and life-threatening services).

Commissioners are willing to use the existing provider in a triage capacity for paediatric patients, stabilising them and either admitting them (in the case of life-threatening conditions) or transporting them to the identified alternative providers for less serious conditions. A similar successful exercise has already been implemented over the past 12 months, albeit for a different service.

Could new providers enter the market?

Owing to the geographic spread of the population and the existing potential providers, there is currently little incentive for new providers to enter the market. A recent attempt by commissioners to invite a new provider into the area proved unsuccessful because of the low volume of patients, as expected in rural areas, and the lack of clinical adjacency.

On this basis, commissioners using the framework felt they should consider designating immediate and life threatening paediatric services as CRS. However, they also felt that they should consider not designating the non-immediate services as CRS at this stage.

Stage 3

Are any disadvantaged groups affected?

JSNA data suggests that the area has a disproportionately high level of child obesity and poverty, compared to the national average. Removing paediatric services, which are primarily used by this group, would have a direct impact on health inequalities.

This would be exacerbated by the large geographic distances to alternative providers.

Based on this, commissioners felt that they should be designating all paediatric services as CRS.

Stage 4

What are the interdependent services prior to, during or post the provision of this service?

The paediatric team links closely with neonatology and maternity as well as imaging (such as radiology), pathology and ophthalmology services. A&E services are also vitally important to paediatric services in this area.

There are approximately 600 paediatric-related A&E cases/month at the provider in question. On the basis that commissioners were unwilling to send immediate and life threatening cases to distant providers, using the framework they came to the conclusion that they would protect or opt-in A&E services for the purpose of paediatric services, since they are vital for treating the most serious cases.

Case study 3: Urgent care provider in a deprived urban area

About secure urgent care

Urgent care describes a situation where medical attention is needed by a patient, but the case is not immediately life-threatening. People who use urgent care services can reasonably expect 24/7 availability of consistent and rigorous assessment of the urgency of their care, and an appropriate response to the diagnosed need. This can be provided by a number of health care service providers, including:

- GPs;
- Out-of-hours GPs;
- Pharmacists;
- NHS dentists;
- Walk-in centres;
- Ambulances; and
- Local A&Es.

However, a significant number perceive urgent and emergency care as one and the same. The result is that patients often use A&E services for non life-threatening conditions. However, of the alternatives listed, A&E departments are the best equipped, in terms of diagnostic tools, like scanning and imaging equipment, to determine whether cases are emergency, urgent or more routine.

Applying the framework

This case study considers a scenario when a local A&E provider - which also houses the Urgent Care Centre on its ground floor - fails. The service is provided in the same areas as the pathology service in the previous case study.

<u>Stage 1</u>

About the service

The scenario is considering the urgent care centre in the A&E department, so this suggests that the clinical urgency level of the services provided is 'urgent'. Reference cost data suggests that there are approximately 6,685 consultations/month, needing 'urgent' or category 1 treatment, at the A&E provider, which have been used as proxies for urgent care cases as treated at the provider's urgent care centre.

Who provides the service?

There is a mix of providers that offer similar services in the same setting and similar services in different settings in the area. There are GP practices (36 in total); local out-of-hours GP services (provided by local GPs, and hosted in the A&E of the failing provider); two walk-in-centres; a Pharmacy First service; ambulance services; NHS Direct; as well as neighbouring A&E services (including those provided at four closely located hospitals).

Users of the service?

The urgent care service is provided in the same area as the pathology services in the first case study, where the Joint Strategic Needs Assessment showed relatively low life expectancy, pointing to a significant health inequalities gap. This lower life expectancy was driven by premature mortality from a number of preventable conditions.

Independent analysis suggests that A&E and walk-in centre services are used by young people (0-4 and 20-30) in particular.

Case study 3: Urgent care provider in a deprived urban area

Stage 2

Who could provide urgent care services?

Referral evidence suggests that commissioners are willing to send patients as far away as 4.5 miles to another hospital to receive urgent care services, which suggests a number of potential alternative providers:

- Walk-in-centres: since data on this particular walk-in centre is unavailable, estimates from a similar size centre close to the area suggest that the number of patients using this service is around 5,500 patients/month;
- A&E services at four other neighbouring hospitals. Reference cost A&E data for these locations suggest that they deal with a total of approximately 10,766 consultations /month requiring category 1 treatment;
- Pharmacy first services – dealing with approximately 3,500 patients/month;
- 36 GP centres – all offering more extended hours;
- Ambulance services - 60 in the area, responding to approximately 7,800 calls/ month; and
- NHS Direct.

This suggests that a total of at least 24,500 patients per month use urgent care services in this area, not including GP visits and NHS Direct.

Can alternative providers take on the increased demand?

On this basis, urgent care at the provider in question accounts for around 25% of activity in the market. As this is a reasonably significant proportion, commissioners should seek to get assurances from alternative providers that they would be able to cope with the increase in demand if the provider failed. If the identified alternatives were unable to provide excess capacity immediately, commissioners would need to consider whether alternative providers could build capacity, either through more intensive use of the assets they use in the provision of urgent care, or through reconfiguration.

Case management, used to help patients co-ordinate their care (aimed to help around 1,100 patients reduce their reliance on emergency services), would also support the ability of alternatives to deal with increased demand.

Could new providers enter the market?

Existing providers could further move into the market:

- GPs offering the extended services - a recent survey suggested GP practices in the borough were offering 48-hour access to a GP 68% of the time, as opposed to the London average of 81%. The barriers to setting up a walk-in centre are arguably sufficiently low as to allow a new entrant to enter the market.
- One GP out-of-hours service, which is hosted in the failing provider could move into new hosting premises.
- In terms of new entrants, further discussions with potential entrants would be needed.

Based on current and prospective alternative provision, commissioners felt that they would consider not designating urgent care services provided at the failing provider as LSS.

Case study 3: Urgent care provider in a deprived urban area

Stage 3

Are any disadvantaged groups affected?

The area's strategy for urgent care suggests that just over 30% of A&E services are used for non-immediate urgent care and primarily by disadvantaged people, for reasons including perceived inability to access GP services, especially out of hours, and feelings that A&E offers higher quality services than primary care.

The demographic mix of the area also suggests that urgent care services may be used by disadvantaged groups, so withdrawing the urgent service could have a significant adverse impact on health inequalities.

However, Stage 2 showed that there were a large number of easily accessible alternative providers of urgent care services. Based on this commissioners did not feel that there were grounds to designate urgent care services provided at this location as LSS.

Stage 4

What are the interdependent services prior to, during or post the provision of this service?

This is not applicable since the service has not been protected.

Case study 4: Rheumatology services across an urban/rural area

About musculoskeletal services

Musculoskeletal (MSK) services, of which rheumatology is a sub-speciality, are defined as the assessment, treatment and management of congenital and familial conditions affecting the joints, soft tissues and connective tissues. In addition to rheumatology, MSK services also include trauma and orthopaedics as well as the treatment of a number of auto-immune conditions.

Common in the UK, MSK related conditions are a major cause of disability, pain and illness - it is estimated that one third of the adult population and 12,000 children suffer with an MSK related illness.

MSK problems are also the main cause of repeat GP appointments, accounting for up to 30% of primary care consultations.

For rheumatology in particular, common conditions include arthritis, back pain and osteoporosis, which tend to increase with age and can, in some cases, result in long term disability. It is estimated, for example, that 40% of people over 70 have osteoarthritis of the knee.

MSK services are currently delivered in in-patient, outpatient, paediatric or community settings, though only a small proportion of patients require hospital admissions or treatment using equipment that can only be found in a hospital setting.

Applying the framework

In this case study, we considered whether to designate rheumatology services as CRS in a large general hospital that serves a community spread across three densely packed urban areas (market towns), surrounded by a rural area. This is in the context of a review of MSK provision by local commissioners, who, among other things, are considering the integration of existing MSK services, re-contracting with providers and the expansion of preventative community services.

Stage 1

About the service

The total volume of rheumatology services provided at the location is approximately 150 patients per month, including new appointments and follow ups. All rheumatology services provided at the location can also be classified as ‘routine’ in terms of their clinical urgency.

Who provides the service?

Across musculoskeletal services, the CCG commissions a number of different providers, with the majority of its expenditure in secondary care settings (>80%), though this does include both in-patient and out-patient provision.

Case study 4: Rheumatology services across an urban/rural area

Users of the service

There are approximately 430,000 people living in the urban and surrounding rural area, according to the Joint Strategic Needs Assessment (JSNA). The key demographic challenges include:

- An ageing population – there was a 6.1% increase in the general population from 2001-2008, with a 23% rise in those aged 85+. This trend is set to continue up to 2021, with the over 85s increasing in number at a rate 6 times faster than the total population.
- An increasingly diverse population – 19.2% of the population are from minority ethnic groups, compared to 13% nationally.
- Increasing number of births – largely among mothers born outside of the UK.

As well as a large elderly population, approximately 32% of the population is under 24 years old in the two main urban centres, compared to 28% in the surrounding rural areas. In addition, there is a high level of deprivation among children and the older population, although the area is not ranked among the most deprived areas in England. Although the area has a higher than national average life expectancy, there is a large gap in life expectancy within the population. The most affluent and deprived areas have an average of nine years' difference in life expectancy.

<u>Stage 2</u>

Who could provide rheumatology services to residents within this area?

Since the service under consideration is routine (i.e. elective), the market for provision has been defined by reference to those providers to which commissioners would be willing to send patients. For patients living in rural areas and in two of the market towns, commissioners are willing to send them to surrounding counties, since at present they are already travelling to receive rheumatology services. The same applies to patients in the market town where the provider is based, on account of the strong transport network. On that basis, commissioners considered the market to be the market town in which the provider is located and any of the immediately surrounding counties.

Given this, the alternative providers for rheumatology services to the site in question include:

- 58 GP surgeries (with over 80% which operate late opening hours and are open on weekends);
- 10 hospitals with A&E services (including one private provider);
- 4 community services providers; and
- 2 walk-in centres.

Available data from the 10 hospital providers only suggests that they account for around 643 patients per month in the identified market.

Case study 4: Rheumatology services across an urban/rural area

Can alternative providers take on the increased capacity?

Using the above data, we estimate that the provider in question accounts for approximately 18% of rheumatology service activity. However, this is likely to be an underestimate since it is only based on the activity of acute providers. Commissioners felt that demand could be met both in the acute sector and by the alternative providers listed.

Could new providers enter the market?

As part of the review of MSK services in the area, commissioners felt that there was scope for new providers to enter the market. Community service providers in particular were considered to be the most likely candidates for entry, since, in the CCG's view, the lack of hospital-based interdependencies, such as theatre services, meant that there is no need for elective rheumatology services to be provided in a hospital setting. Different models of delivery, for example in the Pennines, were also seen as potentially new ways of establishing extra capacity.

Stage 3

Are any disadvantaged groups affected?

The proportion of elderly people in the area is set to rise sixfold by 2021. Currently almost 20% of people living in the packed urban areas, and almost 25% in the surrounding rural area, are over 60. Given the high correlation between age and consumption of rheumatology services it is possible that elderly people in the area could be disproportionately impacted by the withdrawal of these services at the provider in question.

However, the strength of the local transport network for patients in the urban areas, and the fact that rural patients are travelling anyway, meant that even on health inequalities grounds, commissioners felt that they should not designate the rheumatology service as CRS.

Stage 4

What are the interdependent services prior to, during or post the provision of this service?

This is not applicable since the service has not been designated CRS.

Case study 5: A private mental health provider in an urban location

About the market for secure mental health services

Secure mental health comprises high, medium and low secure in-patient services. All patients in secure care have been detained under the Mental Health Act as being at risk of harming themselves and / or others. In many but not all cases, their detention will have been in response to a criminal offence.

High security

There are only 3 high secure facilities within the country – Ashworth, Broadmoor and Rampton hospitals – all of which are NHS providers. Patients in high secure hospitals present an immediate and serious danger to members of the public, and need treatment for significant periods of time.

Medium secure

Medium secure services are part of an integrated care pathway, specifically designed to meet the needs of adults with serious mental illness who require care in a secure setting. Patients will usually have a history of criminal offending, though some may be referred from general mental health services. Patients may also be transferred from high secure services. Medium secure care is provided by a range of NHS and independent providers.

Low secure

Low secure services are provided for patients with disorders that are too challenging to be treated in a community setting. Like medium secure services, low secure services are provided by a range of NHS and independent sector organisations.

Applying the framework

This case study looks at whether to designate medium and low secure services as CRS at a mental health provider in an urban area. The provider in question also offers rehabilitation services to male patients. Note that this case study has been developed with a provider, not a commissioner, to give their perspective on using the framework.

Stage 1

About the service

At the location, there are 61 beds, 17 of which are dedicated for rehabilitation. The way secure mental health services are commissioned (see Stage 2) suggests that clinical urgency level of these services is 'planned' or 'expedited'.

Who provides the service?

There are 31 independent sector providers of medium secure mental health nationally, and a further 38 independent providers of low secure services, accounting for around 2,500 and just over 1,000 beds respectively. However, there are a further 123 independent sector providers who can accept patients who have been detained under the Mental Health Act, which accounts for a further 3,288 beds[1]. There are also almost 70[2] NHS Mental Health Trusts, and figures for all mental provision show that the NHS accounts for over 70% of mental health provision[3].

Users of the service?

A large percentage of patients are referred from courts, which suggests a demographic profile typical of a prison population. Recent data shows that 46% of patients come from ethnic minority groups against 54% classified as White (British).

[1] 'Mental Health and Specialist Care Services – UK Market Report 2010/11', Laing and Buisson (2011)

[2] 'Mental Health Bulletin - Fourth report from Mental Health Minimum Dataset (MHMDS) annual returns' NHS Information Centre (2010)

[3] 'Mental Health and Specialist Care Services – UK Market Report 2010/11', Laing and Buisson (2011)

Case study 5: A private mental health provider in an urban location

Stage 2

How far can patients be sent to receive the service?

Currently, commissioning of medium and low secure services is done by Specialised Commissioning Groups (SCGs). As regional bodies, they aim to place patients in the local, also known as catchment, area if it is in the best interests of patients. However, as of 1 April 2013, all secure mental health services will be commissioned by the NHS Commissioning Board.

Assuming the current commissioning model, it is not unreasonable to assume that the market for low and secure mental health services is *regional*. However a complaint to the CCP by one medium secure mental health provider, Hanover Healthcare, in the North West suggested that the SCG, North West Specialised Commissioning Group (NWSCG), was placing patients outside of the North West Region, and as far away as Newbury (200 miles). Therefore although a regional market has been assumed, a provider could use this as evidence of a national rather than regional market for secure mental health services. However, as it is the subject of a complaint they would need to demonstrate that it was reasonable practice.

Who are the alternative providers

Regionally, there are at least 8 NHS and independent sector providers, representing capacity in excess of 1,255 beds. Based only on this regional view of the market, the provider in question accounts for less than 5% of the market.

Do they have capacity now or potentially?

The low share of activity and the high number of alternative providers suggests that there is alternative capacity to absorb demand. This is supported by further anecdotal evidence. In terms of short-term emergency cases, such evidence suggests that there is immediate alternative provision within the local area. In the case of a 2008 fire at a nearby provider, 68 patients had to be evacuated. Nearby NHS providers were able to house 19 patients, with independent sector units absorbing the remainder.

These cases suggest that, at least in the immediate term, there is enough capacity to allow alternative providers to absorb demand, if provision at the location in question were to cease. Further to this, Laing and Buisson estimates that there are over 1,000 beds in the urban area alone and over 2,000 regionally, suggesting long term capacity as well.

At a national level, Laing and Buisson estimates that occupancy rates in the independent sector are around 80-85%, including providers of mixed and female-only secure mental health services. If the market were defined nationally, this would also suggest that there is capacity to absorb demand if services at the location in question were to cease.

Could new providers enter the market?

In terms of other new entrants, the high capital costs associated with secure mental health services suggest that new entry within a year may not be possible. New providers may also need time to build reputations before they are commissioned, and would need to be registered with the Care Quality Commission (CQC).

Case study 5: A private mental health provider in an urban location

However, since current capacity would appear to be sufficient to absorb demand if services at the location in question ceased, the provider of that service would be able to make the case to their commissioners not to consider designating the service as CRS.

Further examples of failed providers continuing to meet the needs of patients while in administration also support this view.

Stage 3

Are there health inequality impacts?

The evidence does suggest that 46% of patients come from ethnic minority groups against 54% classified as White (British).

However the absolute volume of patients (39 in total), the nature of the service (with patients that have been deprived of their liberty), and the high number of alternative providers suggest that disadvantaged groups would not be adversely affected. The provider would be able to make this case to their commissioner not to consider designating the service as CRS on health inequality grounds.

Stage 4

What are the interdependent services prior to, during or post the provision of this service?

This is not applicable since the service has not been designated as CRS.

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