MIDDLESBROUGH COUNCIL

Options Appraisal

Report Title: Substance Misuse Clinical Service Options – Urgent Issue

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Date: 5 May 2023

PURPOSE OF THE REPORT

1. The contract for the clinical (substitute prescribing) service is currently out to tender but there is a very significant chance of market failure. The incumbent provider, Foundations Medical Practice, has recently served (early) notice and we require a new provider in place for 1st October 2023. This issue necessitates urgent attention from relevant department leads in order to agree a plan that ensures service continuity for this vital, statutory service provision.

BACKGROUND

2. The specialist prescribing service in Middlesbrough is currently contracted with Foundations Medical Practice. Historically this service had been delivered as part of a coterminous arrangement with the CCG (now ICB). The current provider has been delivering the service for over 15 years. Due to a review of primary care, the coterminous arrangement was severed and Middlesbrough Council determined that the substance misuse clinical service needed to go to the market.

3. Prior to this, in 2020, a two year contract was awarded (via VEAT Notice) due to a suitable contract not being in place. This was due to end on 31st March 2023, however, a one year extension was agreed to enable a review, specification design and procurement process to be undertaken within safe timescales.

4. The ICB elements – two separate primary care services, one for those affected by substance use and the other for asylum seekers, plus the South Tees violent patients service - were also due to continue within the same timescales. However, Foundations served early notice on the asylum seeker practice and that ceased on 31 March 2023.

5. The annual value of the council contract has been £800,000, however, there was a 20% uplift applied to 2023/24 to enable Foundations Medical Practice to deliver the additional year and apply cost of living increases to their staff. This enabled up to nine months for the mobilisation period, due to the complexities of the service. It requires a case management system capable of prescribing controlled drugs, a mixture of clinical and support staff, appropriate clinical governance arrangements and a suitable building to operate from.

6. On 31 March 2023, Foundations served their six months of notice on all of their remaining South Tees contracts. This meant that all of their primary care patients had to be swiftly dispersed within the PCNs, to ensure continuity of primary care provision. It also meant that a new substance misuse clinical provider needed to be operational on 1 October 2023.

7. The council tender process was already live at this point, however, there has been extremely limited interest – the majority of models have a single/lead provider service, which places the onus and control to the delivery organisation, however, this wasn't possible nor the best option for Middlesbrough. There is a significant likelihood of market failure at this stage, which presents a critical issue in terms of ensuring service continuity. The process was extended

8. Less than five months to ensure a new provider can be operational is a risky timescale and there is no realistic prospect of getting the current provider to continue beyond 30 September 2023.

OPTIONS

9. The realistic options within the current circumstances are:

A. Do nothing.

B. Direct award to suitable provider.

C. Offer direct award to GP Federations/PCNs.

D. Bring in-house.

10. The following table contains an overview of each of the options:

Option	Pros	Cons	Costs - these are likely to be high level / estimated at this stage
A. Do nothing	• *N/A*	• *Non-delivery on statutory function;* • *Will increase drug and alcohol-related deaths;* • *Reputational damage;* • *Will result in financial penalties due to external grant funding conditions;* • *Will significantly increase demand for services;* • *Will significantly increase acute safeguarding issues, increasing pressure on adults and children's services;* • *Staff pressure will increase sickness levels and turnover;* • *The vast majority of those currently stable in treatment will disengage and return to illicit drug*	*Incalculably high.*

		use and/or harmful drinking; • *Associated increases in crime and ASB;* • *Increased levels of drug litter and open use in the town.*	
B. Direct award of contract to a suitable provider	• *Could secure a suitably experienced provider to ensure continuity of service;* • *Reduces capacity impact on the rest of the substance misuse service model and council staff;* • *May have their own prescribing system (case management);* • *Should have existing, appropriate clinical governance structure;* • *May be resilience for clinical/ prescribing capacity (depending on the provider);* • *Potentially reduced TUPE/ redundancy liabilities for the LA;* • *May already know the area (depending on the provider).*	• *Likely to lead to increased costs in order to secure a suitable provider within the circumstances (e.g. to mitigate risks such as underwriting redundancy liabilities);* • *Very limited market interest in the tender, therefore, may not yield a suitable provider willing to take this on;* • *Potential that the process may fail during negotiations, which would leave no timescales to get alternative provision in place;* • *Unsure if the <5 month timescales may not be enough time for this option already;* • *Maximum contract award is 18-24 months, which would leave the service in a state of flux and require another tender to be undertaken in the meantime – there is a* • *Less control for the LA – e.g. may have to compromise on the delivery model in order to secure the provider;* • *Introduces a new provider to the existing substance misuse model – i.e. they have to work with Recovery Solutions and Recovery Connections staff;* • *If the provider does not have their own prescribing system, it would increase costs and impact on the timescales.*	*Likely to exceed the current £700k budget (i.e. with the uplift already added). This would negatively impact on in-house staffing capacity.* *Will increase further if a new prescribing system/licences needed to be purchased.*
C. Offer a direct award to PCNs/ GP practices via the GP Federation	• *Will have their own prescribing system (case management) – if SystemOne, this would ensure continuity from the existing service;* • *Will have existing, appropriate clinical governance structure;* • *Likely to provide resilience for clinical/ prescribing capacity;*	• *Already huge pressure on primary care, exacerbated by both of the Foundations practices having their patients dispersed;* • *Patient group is unlikely to yield a great deal of interest in this contract;* • *Would need to be offered to all PCNs, which means that it will be a significant, timely process to appoint;*	*May deliver within current budget envelope but likely to want additional funding due to the circumstances.*

	• *Potentially reduced TUPE/ redundancy liabilities for the LA;* • *Will already know the area as a local organisation;* • *Possibly improved access if a PCN took this on (e.g. multiple sites/ practices);* • *Could foster improved collaboration with primary care/ICB.*	• *Potential that the process may fail during negotiations, which would leave no timescales to get alternative provision in place;* • *Unsure if the <5 month timescales may not be enough time for this option already;* • *Likely to require existing clinicians to undertake additional training in order to prescribe the substitute medication;* • *Likely to be less appetite for risks re. potential TUPE liabilities (than a large national organisation or LA).*	
D. Bring the service in-house	• *Will enable the model to be implemented as planned;* • *Maintaining control of integrated approach with recovery teams – should enable us to future proof the service and be more responsive to changing needs;* • *Existing resilience from STPH Clinical Advisor and specialist stop smoking service clinicians;* • *Existing experience within STPH of transferring services, inc. clinical, in-house;* • *Will enable us to 'grow our own' non-medical prescribers and clinical staff to create greater resilience;* • *TUPE transfer of existing staff would safeguard local expertise/ knowledge;* • *Brining in-house existing management staff would mitigate pressures on LA team/staff;* • *Service will be delivered from existing estates;* • *Maximises the minimal mobilisation timescales and removes uncertainties associated with other options;* • *Existing options for the prescribing system are available;* • *Commitment already gained from TEWV (re. providing clinical governance and clinical*	• *Timescales are very tight (as with all options);* • *Can only be achieved if strategic commitment across multiple departments is in place from the outset – this could conflict with other priorities;* • *Potentially increases risks to the LA (can be mitigated by ensuring appropriate clinical governance is in place);* • *Increased pressure on current service staff during mobilisation and implementation periods;* • *Additional costs associated with buying-in required support in terms of SOP/Policy development, CQC registration process and clinical governance arrangements (mitigated by not having to pay management fees associated with other options). Please note: all options would require CQC registration but it's only reflected within this option, as it would require additional support provision. The other options would entail the provider doing the registration from within their management fee/organisational capacity.*	*Most financially beneficial option, as capacity would be maximised for whole service model (i.e. no external management fees).*

	resilience/ capacity support); • *Can streamline the in-house delivery and reduce duplication;* • *Having a multi-disciplinary in-house team should offer additional development opportunities and increase staff retention (of hard to recruit roles);* • *Maintains collaborative working with ASC and other LA teams, which is beneficial for safeguarding concerns and early prevention, etc.;* • *Maintains total control over working arrangements with primary care, pharmacies and ICB in order to minimise any potential unintended/negative impact on the local system and maximise collaboration opportunities;* • *Potential for national recognition re. an innovative and unique model.*		

SUMMARY AND IMPACT OF RECOMMENDATIONS

11. Option D is the recommended option – bringing the service in-house enables the incredibly tight timescales to be maximised, subject to necessary agreements being swiftly reached. Having developed options for the prescribing system (utilising the existing stop smoking service system in the short-term with the CDP system prescribing module currently being developed) and having the support of in-house clinicians to implement the service, we are confident that it is achievable.

12. Options B and C both dramatically reduce the mobilisation period and create uncertainty due to the associated processes. Due to the rarity of this situation, the processes required for either of these options would require planning and negotiation (as they are somewhat undefined) before they could even commence. In comparison, South Tees Public Health have already successfully brought both the specialist stop smoking and health child programme clinical services in-house.

13. Please see the following table, which outlines the impact of each option in terms of processes required and considerations specific to each one. This only covers options B and C combined (as they are both direct awards) and option D, as option A is not feasible.

	Options B and C – Direct Award	Option D – Bring In-house
Process required	• **Can only commence following an unsuccessful procurement process** • (*For option C only*) Liaise with ST ICB re. approaching GP Federations and offering the opportunity to PCNs/GP Practices to deliver the service • Commence discussions with potential providers by directly approaching suitable organisations (option B) and offering to all local PCNs (option C) – timescales are likely to be at least a couple of weeks, if not longer • If a suitable provider is successfully identified, commence negotiations on the delivery model and funding required • Amend the specification, budget (likely to require a significant increase to mitigate the risks) and, potentially, the service model (compromises may have to be made) based on the outcome of negotiations • Carry out organisational checks – timescales *TBC* • Contracting – can be actioned within a few days on the LA side but then dependent upon the provider organisation then reviewing and signing the contract in a timely fashion • Commence mobilisation period: the provider organisation would take the lead on creating the SOPs and policies required, the TUPE process, training/CPD plan, as well as the elements below • The LA would work with the provider on the delivery locations/buildings occupation and communications plan – for stakeholders and service users.	• **Can commence immediately as there are no implications for the procurement process** • Removes any uncertainty re. securing a suitable provider and/or compromising on the optimal service model • Immediately start work with HR and Legal on the TUPE process • Commence discussions with staff from the current service swiftly in order to secure those essential to delivering the service (see 'Staffing considerations section below) • The overall mobilisation period can also commence immediately – the LA would take the lead on creating the SOPs and policies required and the CQC registration process (further details are below) • Work is already underway in terms of delivery locations/buildings occupation • The communications plan can be managed in-house and supported by staff from existing services to provide assurance to stakeholders and service users • Support from Legal/Commissioning and Procurement to get contracts/agreements in place for the specialist support requirements – see the following sections for details.
CQC Registration	The provider would be responsible for demonstrating how they will comply with their SOPs and policies, and commencing the CQC registration process, including a named manager. As long as providers can demonstrate that these pathways are in place and provide assurance that they are being adhered to, delivery can commence on the back of the application being submitted to the CQC, i.e.	The LA would be responsible for demonstrating how we will comply with the SOPs and policies, and commencing the CQC registration process, including a named manager. As long as we can demonstrate that these pathways are in place and provide assurance that they are being adhered to, delivery can commence on the back of the application being submitted to the CQC, i.e.

	the process does not have to be completed before delivery can commence.	the process does not have to be completed before delivery can commence. The current Operations Manager would be the named CQC Registered Manager and specialist support (outlined below) would assist with the documentation development and process.
Prescribing case management system	A suitable provider would almost certainly have a prescribing system already in use, however, it may require the purchase of additional licences and tailoring to the local system's pathways. This would include making it compatible with the current CDP case management system, which is already utilised by the existing services and would remain as the dominant client record. It would necessitate the continuation of 'dual entry' in terms of two concurrent systems being used. Finally, arrangements would have to be made re. access to summary care records from primary care/health system, to ensure that appropriate prescribing decisions can be made.	A prescribing module for the current CDP case management system is already being developed, which will enable a single solution to client records and remove the current 'dual entry' requirements. The mobilisation period being reduced by six months has resulted in the timescales for this to be implemented becoming unfeasible (as robust testing is required, etc.). Public health has developed a contingency plan, whereby the current prescribing system being used by the Specialist Stop Smoking service, Promatica, will be utilised to enable delivery to commence on 1st October.
Staffing considerations	The contract would have to be signed off prior to any TUPE and training/development discussions commencing. This presents a risk that essential staff (particularly the non-medical prescribers who are essential to delivery) will find other employment due to the uncertainty. There are only 2 x FTE Non-medical Prescribers (NMPs) currently working within Foundations who are on the TUPE list. This is insufficient capacity to deliver the service on a full time basis. The lack of remaining time (before 1st October) would mean that it would be extremely doubtful that any organisation would be able to recruit the additional clinical staff required for delivery. It would likely have to come from existing staff/resources within their organisation, which would be difficult for most providers to manage.	The TUPE process, including staff consultation and providing assurance to essential, existing staff, can be actioned immediately. Urgent training/development needs to enable the in-house option to function effectively can also be undertaken without delay. The support outlined in the row below will ensure that all staffing components will be in place within the timescales. Any additional recruitment could start immediately, giving more potential to have full prescribing capacity by the implementation date. However, there is enough identified capacity to operate the service full time from 1st October.

Support/capacity requirements	The onus would be on the provider, however, the input of local knowledge and expertise from public health and the wider LA would be essential in order to meet the timescales.	Most of the necessary specialist support resources have already been identified and secured by STPH, with work ongoing to acquire the remaining inputs, as below: • STPH already has specialist clinical and pharmacy lead advisors within the team and on board with this process; • The Clinical Lead is a GP who is already contracted to deliver clinics for Foundations and is committed to continuing to do this if the service is brought in-house; • An additional, current GP delivering clinics for Foundations would also be willing to continue delivering the service • There are 2 x NMPs within the in-house Specialist Stop Smoking service and we have commitment from them to support the mobilisation, implementation and with any clinical capacity issues; • Secured TEWV commitment to support the clinical governance arrangements and supervision, provide service continuity via clinical support if and when required and, in the longer-term, consultant psychiatrist input for the clinical/treatment service; • NECS and/or independent clinical consultant to develop necessary SOPs, policies and pathways via dedicated specialist support. Although there are costs involved with all of these elements, this additional capacity is essential in order to meet the timescales and enable safe, ongoing delivery of the service. The savings from not having to pay management fees to an external organisation can be utilised.

Overall timescales	As an absolute minimum, this process will take at least one month, however, the likelihood is that it would be significantly longer. Timescales cannot be accurately defined due to the uncertainties, particularly that there is no guarantee that we will secure an organisation willing to take on the service delivery within the current circumstances. Even if we do, there would be no guarantee that they would be taking the service on until a formal contract was signed. Having a maximum timescale of 4.5 months to achieve all of the necessary steps is extremely risky.	There are few formal, preliminary steps to take. Finalising agreements with the support provider organisations and liaising with other LA departments will be the only elements that need to be undertaken in advance. Work on all of the other aspects can commence immediately, which maximises the remaining timescales and removes uncertainty. This is particularly important to ensure that the NMPs are secured at the earliest opportunity and an appropriate prescribing system is in place.

14. The Council's organisational risk as the provider is not substantially different from being the commissioner of an external organisation. The responsibility for clinical decisions and prescribing predominantly rests with the clinicians and their associated registrations. The non-medical prescribers hold sufficient clinical autonomy to largely operate the service on a day-to-day basis. Doctors provide senior clinical oversight via their input with the clinical governance framework ensuring delivery is conducted and monitored appropriately. If any incidents were to occur, the Council would be implicated, whether as the commissioning or delivery organisation. Either way, having the appropriate levels of senior clinical involvement is essential and will continue to be the case.

15. There are a wide variety of considerations regarding the mobilisation period. These include ensuring daily prescriptions can be transferred and continued overnight and ensuring that all appointments (of varying timescales up to twelve weeks) can be planned and fulfilled. There are also considerations around access to the service from new locations/buildings, communications to service users and stakeholders and the development of SOPs and policies associated with CQC registration, which all have to be in place. This is already tight within the (less than) five months period, so we simply cannot afford to lose any more time.

16. Removing the need to pay management fees and enhanced funding to external providers (to ensure that they will take on the current risks), means that value for money within the current financial envelope can be maximised. If additional funding was required, there is a likelihood that this would reduce capacity within the current Recovery Solutions team, which is already under pressure. The in-house option allows greater control over this and opens the possibility of multi-functional roles in the longer-term.

17. Working with an external provider, who would be in a strong negotiating position due to the circumstances, would almost certainly entail making compromises in the way that we want to deliver the local model. By delivering in-house, combining the clinical service with the existing Recovery Support team, we can respond more dynamically to the needs of the local population and ensure a co-ordinated approach to support. It will also enable us to further build on the existing collaboration with social care services and council priorities, such as locality working.

18. Ultimately option D removes the most uncertainty and would enable progress to be made as quickly as possible. There is no option to have any gap in service provision, given the duty to deliver this service and the vulnerabilities of the client group. In the longer-term, an in-house model can also realise the greatest benefits, as outlined in the table above.

19. Bringing the service in-house will require the support of senior leadership, as it necessitates senior decision-makers in relevant departments being fully on board with the process in order to meet the timescales. Regular (initially weekly) project leadership meetings would be scheduled for the duration of the mobilisation and implementation periods to ensure that any barriers can be swiftly overcome.