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ISLINGTON

JOINT OVERVIEW AND SCRUTINY COMMITTEE ON HEALTH

27 November 2015

SECOND DESPATCH

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY, 27 NOVEMBER 2015 AT 10.00 AM
COMMITTEE ROOM 1, HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4AX

Enquiries to:	**Vinothan Sangarapillai, Committee Services**
E-Mail:	**vinothan.sangarapillai@camden.gov.uk**
Telephone:	**(Text phone prefix 18001)**
Fax No:	**020 7974 5921**

SUPPLEMENTARY AGENDA

Issued on: 24th November 2015

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 27 NOVEMBER 2015

SUPPLEMENTARY AGENDA

Wards

9. NHS 111/OUT OF HOURS GP SERVICES - COMMISSIONING

(Pages 3 - 18)

To consider NHS 111/Out of Hours commissioning.

AGENDA ENDS

Barnet Clinical Commissioning Group
Camden Clinical Commissioning Group
Enfield Clinical Commissioning Group
Haringey Clinical Commissioning Group
Islington Clinical Commissioning Group

Commissioning of an integrated NHS 111 and GP out-of-hours service across north central London: Update

November 2015

1. Purpose

This report provides an update to the north central London Joint Health Overview and Scrutiny Committee on the commissioning of the integrated NHS 111 and GP out-of-hours (NHS 111/OOH) service across Barnet, Camden, Enfield, Haringey and Islington (the five NCL CCGs).

GPs representing the NCL CCGs attended the JHOSC on 25 September 2015, and discussed extensively the core principles behind this service model, the engagement that had been carried out, and the timeline for the procurement. The NCL CCGs were asked to return with detail on some of the areas covered verbally in discussions on that occasion, specifically:-

- How commissioners will undertake monitoring of the contract and, in particular, obtain relevant performance information
- Detail on the key performance indicators; and
- Procurement and KPI differences between individual boroughs.

2. Background

NCL CCGs have presented this matter to the JHOSC on four prior occasions. This paper will not cover everything that has been discussed before, but below is a summary of the programme.

2.1. NHS 111

NHS 111 is a free telephone number to help people who have urgent, but not life-threatening, conditions get advice and access the most appropriate service to meet their needs. Trained advisers use a tool called NHS Pathways[1] to assess patients and direct them to the most appropriate service.

The NHS 111 service in NCL is currently provided by a single provider – London Central & West Unscheduled Care Collaborative.

2.2. GP out-of-hours services

Out-of-hours services are available so that people can access primary care, for urgent problems, when their GP surgery is closed, usually at night or over the weekend. GPs and other clinicians offer advice and face-to-face appointments if needed. Patients get access to the out-of-hours service by first calling NHS 111.

The out-of-hours services in NCL are currently provided by two different organisations – Barndoc Healthcare Ltd for Barnet, Enfield and Haringey, and Care UK for Camden and Islington.

2.3. Proposed integrated NHS 111 and GP out-of-hours service

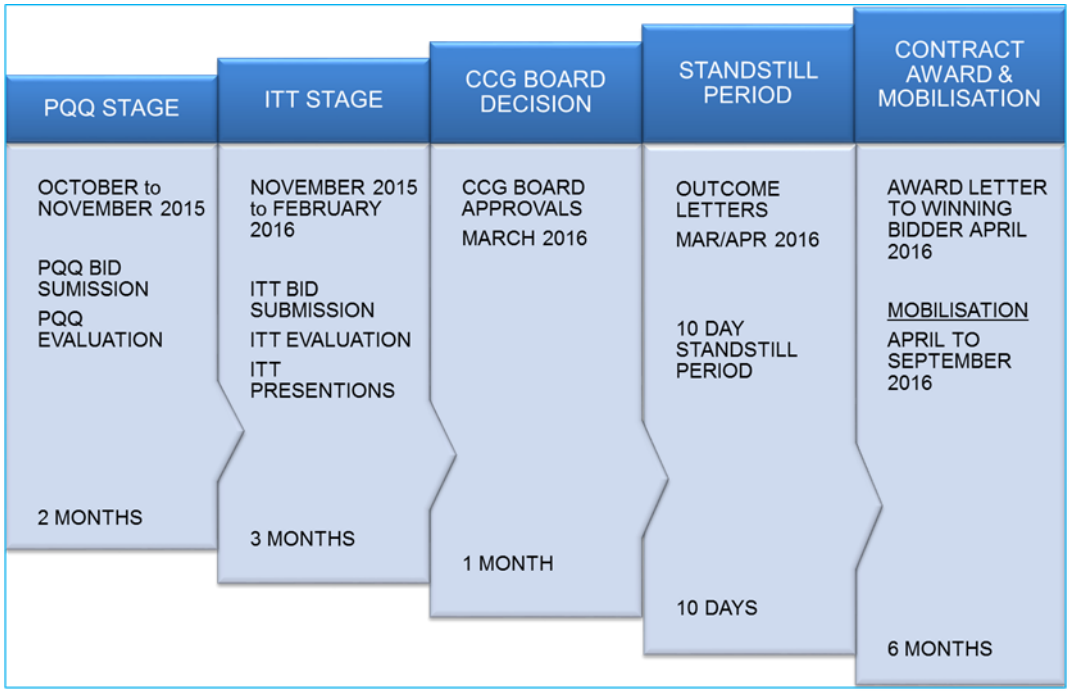
The NCL CCGs are commissioning NHS 111 and OOH as an integrated service across north central London, and this integrated service is expected to begin in October 2016.

[1] NHS Pathways is a suite of clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call. It has an integrated directory of services, which identifies appropriate services for the patient's care if an ambulance is not required.

3 Update on the procurement

3.1 Timeline

The procurement for the integrated NHS 111 and GP out-of-hours service remains in line with the timeline below:-



The Pre-Qualification Questionnaire (PQQ) stage, inviting expressions of interest, was opened on 1 October and closed on 2 November. We are currently in the process of evaluating the responses to the PQQ to determine which participants can be carried forward to the Invitation to Tender (ITT) stage. For reasons of commercial confidentiality, we are unable to give information about the identity of the potential bidders.

As has been discussed at previous meetings and consistent with standard procurement methods the evaluation of bids at the ITT stage will require a balanced scrutiny of quality and cost. The NCL CCGs have opted to weight the evaluation to favour quality in a ratio of 80:20. This means that 80% of the marking used to differentiate bidders will be assigned to quality questions and measures.

There are patient/public representatives - selected from members of the Patient and Public Reference Group (PPRG) which has been involved with the procurement process since April 2015 – on the Evaluation Panel, and we are planning to have additional representatives supporting the OSCE (Objective Structured Clinical Examination) stage, wherein bidders will be tested on their response to a range of specific, locally-devised scenarios.

3.2 Service specification

We engaged on the draft service specification for this service in July and August, and received hundreds of comments from our Patient and Public Reference Group, GPs and other clinical experts, specific interest groups, service users and members of the public in the five boroughs.

In light of these comments the specification was revised extensively. We are unable to include the final version in this paper as it remains a confidential document because of its commercial

sensitivity, until the Invitation to Tender (ITT) has been published. However, we have included a summary of the main changes as a result of our engagement, at Appendix A.

The service can be summarised as follows:

This service is designed for patients, carers and their families when:

- They need medical help fast, but it is not a 999 emergency.
- They do not know whom to contact for medical help.
- They think they need to go to A&E or another NHS urgent care service.
- They need to make an appointment with an urgent care service.
- They require health information or reassurance about what how to care for themselves or what to do next.

The integrated urgent care services which encompasses NHS 111 and the out-of-hours service must:

1. Be available 24 hours a day, 365 days a year (366 days in a leap year) for telephone advice;
2. Receive referrals through telephony and online channels;
3. Provide consultations with GPs and other clinicians during the out-of-hours period;
4. Connect service users to clinicians where indicated;
5. Provide access to health records and patient notes
6. Request an ambulance without delay where indicated; and
7. Provide a consistently high quality service irrespective of the geographic area served.

3.3 Commissioning Standards

NHS England published new Commissioning Standards for Integrated Urgent Care on 30 September 2015. These have been circulated to JHOSC already, and are available at https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf. As anticipated, and in part because NCL leads have taken a key role in steering their development, these standards are very much in line with the service model that NCL CCGs have been developing. E.g.

> (p10) The offer for the public will be a single entry point – NHS 111 – to fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, advice and treatment and to shared standards and processes and with clear accountability and leadership.
>
> Central to this will be the development of a 'Clinical Hub' offering patients who require it access to a wide range of clinicians, both experienced generalists (GPs, dentists, pharmacists) and specialists.
>
> *(Note: It is important to note that the term 'Clinical Hub' (as used in the Commissioning Standards for Integrated Urgent Care) is a functional description, it being a joined up network of clinical support to be drawn upon depending on the person's need. It is not about a new building or a specific service.)*

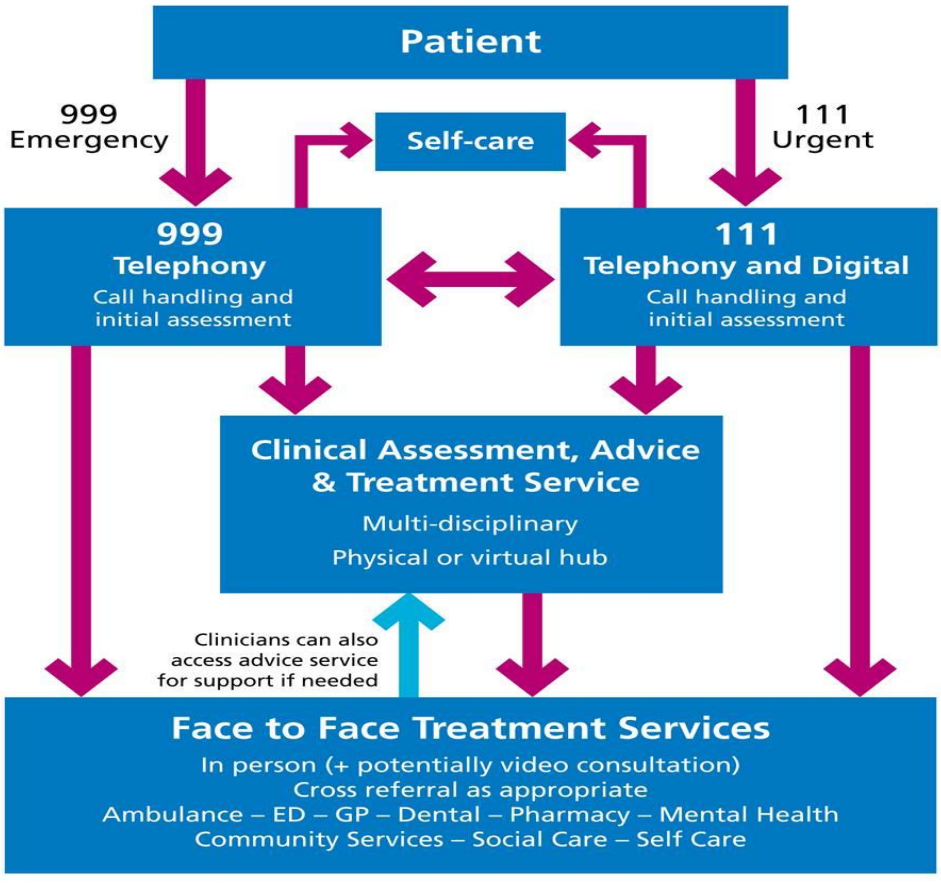
(p17) The lead or co-ordinating commissioner arrangement should be considered, in which commissioners serving a wider area are brought together to commission an integrated service.

(p17) It is envisaged that both large and small providers will have an important part to play in delivering a successful and Integrated Urgent Care service. Providers will need to collaborate to deliver the new investment required in technology and clinical skills, and to ensure that services are aligned. It is for this reason that commissioners should consider using the procurement process to encourage current NHS 111 and Out-of-hours organisations to collaborate or work within a lead provider arrangement, to deliver the standards for an Integrated Urgent Care service.

(p20) Integrated Urgent Care will have the capability to make an electronic referral to the service that can best deal with a patient's needs as close to the patient's location as possible.
 Integrated Urgent Care should aim to book face to face or telephone consultation appointment times directly with the relevant urgent or emergency service whenever this is supported by local agreement.

(p31) The clinical workforce will be comprised of generalist clinicians (paramedics, nurses and GPs) who have specialised skills and competences in remote and telephone assessment and management, supported by specialised clinicians from a range of professions cover specific clinical areas, including mental health, dental health and paediatrics.

The model for Integrated Urgent Care services as described by NHS England is illustrated below:



3.4 Contract management

We will establish a governance structure within which a lead CCG will be responsible for the overall contract management. The contract will however be overseen by representatives of all five CCGs, who will hold the future provider/s to account, through regular quality review meetings and ongoing monitoring to ensure all aspects of the service adhere to the highest of standards and meet the needs of service users in each of the five boroughs.

As at present, there would be monthly meetings involving representatives of both providers and commissioners. These involve a Contract Technical Group looking at financial and similar aspects of the provider's performance, and a Contract Quality Review Group (CQRG) looking at performance data, serious incidents, complaints and service user feedback.

The Patient and Public Reference Group, with input from local Healthwatch, is currently considering how best to involve service users in the contract review process – one suggestion is that there will be one or more public or Healthwatch representatives on the CQRG, who will in turn feed back to a broader patient/public group who may have a role in oversight of the whole NCL Urgent and Emergency Care Network.

Outside of these monthly meetings, commissioners and relevant bodies (i.e. Healthwatch) will have the right to make unannounced inspections of NHS 111 and GP out-of-hours sites, as part of best practice, information sharing and a collaborative approach to joint working. During the mobilisation period the CCGs will continue to work with public and patient representatives to develop the quality and activity reports that can be shared more widely.

Taken together, these approaches will give us early insight into any issues which may arise, and enable us to work with the providers to ensure these are addressed and do not have a significant impact on patients.

If commissioners continue to have concerns about a provider's performance, they will be subject to the terms for financial penalty and ultimately suspension or contract termination, as set out in the NHS standard contract[2]. Relevant excerpts from this are included at Appendix B.

3.5 Quality requirements and key performance indicators

Monthly reporting on a detailed set of performance measures will provide the CCGs with early notice should the provider struggle to meet the expected standards. As at present, there will be a published set of National Quality Requirements (NQRs) allowing for comparability between the local service and those elsewhere, as well as some measures reflecting local priorities. The contract will be flexible, allowing measures to change over time, so we can be sure we are checking the right things.

The current NQRs for NHS 111, published on the NHS England website[3], collect performance data in areas such as:-

- Percentage of calls answered within 60 seconds
- Percentage of calls transferred to a clinical advisor

[2] https://www.england.nhs.uk/nhs-standard-contract/15-16/

[3] https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/nhs-111-minimum-data-set-2015-16/

- Percentage of call-backs with 10 minutes
- Percentage of calls resulting in ambulance dispatch
- Percentage of callers recommended to attend primary or community care.

These measures are intended to assess whether the NHS 111 service is fulfilling its role within the broader urgent and emergency care system, and operating in a sufficiently robust way so that service users can have confidence in it.

The out-of-hours service is subject to the same reporting mechanism, so that we will have comparable service-appropriate data, locally derived and compared month by month, but also benchmarked to regional and national metrics. An important measure in this section, in terms of demonstrating the benefits of service integration will be the number of callers whose issue is dealt with wholly within the integrated urgent care service, without onward referral.

There is also a set of patient experience indicators, based on regular surveys sent out to callers. This data records patients' satisfaction with the service, their outcomes (i.e. whether they complied with the advice from the integrated urgent care service, and whether their problem was resolved) and what service they would have used had 111 not been available – again, this is a way of checking that service users have confidence in the service, and that it is diverting patients from A&E and other parts of the system that are under pressure.

The provider/s will also be required to have processes in place that allow patients and carers to share experiences and provide feedback about the service on an ongoing basis. This patient feedback will form part of the monthly reporting to CCGs.

There is also a mechanism for doctors and other clinicians to submit feedback forms on an ongoing basis as part of Clinician Feedback. There will be regular commissioner-provider meetings to review clinical interactions from initial call to ultimate disposition. This will enable qualitative assessment of contacts on a case-by-case basis, and provide a much richer sense of how the service is performing. All calls in the integrated urgent care service are also recorded – commissioners will listen to a selection of recordings to ensure the quality of this part of the service, and this is also a useful tool for assessing any complaints that are received.

Clinical audit of all cases is a requirement of the continuous quality improvement element of this service. Commissioners will require the provider to undertake clinical audit at a local level. Commissioners will review data on all referrals that are made within the integrated urgent care system –this means we can ensure that providers are making appropriate referrals for all callers, and that different providers within the system are working together in an integrated fashion, in the best interests of patients and the health system as a whole.

The provider/s will also be required to meet any changing quality requirements established by NHS England for NHS 111 and OOH services.

3.6 Local service developments and indicators

Representatives of all five NCL CCGs have been involved in developing the service specification and procurement model for this service. To a large extent, therefore, the new service model is intended to meet all the service needs of all the population – where one CCG has proposed improvements to the model based on local experience, these have been applied across all five CCGs, so that all our service users will benefit.. An example of this is the requirement to adopt

end of life care plans within the service for Haringey patients; this has been adopted for all boroughs involved in this service.

As has been discussed previously, the local approach to integrating NHS 111 and the out-of-hours service came out of local work in Camden and Islington with The Primary Care Foundation (PCF). The PCF observed in detail the exact ways in which the disconnect between the services impacted on patients, and made recommendations about the importance for patient safety of having an integrated service and removing unnecessary delays in call transfer between services.

It is this work, and the model that has evolved out of it, that has gone on to inform NHS England's approach to commissioning integrated urgent care. Since then, we have conducted a huge amount of local engagement, and local residents and commissioners have been involved at every stage to inform the development of the specification.

There are many service requirements included in the specification to reflect input from local patients, public and clinicians. These broadly fall into the following areas (see Appendix A):-

1. Clinical quality and safety
2. Clinical Governance and Integrated Governance
3. Operational
4. Technical
5. Patient and Public Involvement
6. Social Marketing and Communication
7. Performance and Contract Management
8. Workforce
9. Access and Availability

The performance indicators described above will be reported on a borough-by-borough basis (based on the location of the caller so that individual CCGs can continuously monitor whether the provider is meeting local variations in need and providing a consistently good service.

Local needs vary between (and within) the NCL boroughs. There are variations in the types of people who use our services, in terms of age, ethnicity, levels of deprivation and prevalent conditions. The future providers will be expected to flex their service delivery to ensure they meet all these needs – for example to adjust the numbers, skill mix and shift hours of staff at the out-of-hours bases to fit with local demand – exactly as already happens. The key principle is that there should be equity of access and service delivery for patients across the whole of NCL. Equity of access is not the same as services being identical.

There is also local variation in the other services commissioned by the NHS or local authorities. For example, a mental health crisis hotline is currently commissioned for patients in Camden and Islington and will be a referral point used by the integrated urgent care service in those boroughs – elsewhere the equivalent patients will be supported in a different way.

Similarly, while all NCL CCGs are developing extended GP services, these projects are at different stages, will offer different services in different areas, and will continue to develop over the five-year lifetime of the urgent care contract and beyond. These developments will clearly have a big impact on 111/OOH referrals during the 8am-8pm period and at weekends, and the volume of calls received from different areas at different times – the new providers will need to be sensitive to this variation, and adapt their service accordingly. The specification makes this requirement clear.

North central London CCGs have commissioned a comprehensive Directory of Services to ensure that, outside the scope of NHS 111/OOH itself, there is comprehensive understanding of what local services are available when. This will greatly enhance the quality of advice and referral provided by NHS 111. One of the significant benefits of the new model, as we track patient pathways through and out of the urgent care service, is that we will be equipped to assess where needs are or are not being met across the whole health system. For example if referrals in a particular area or for a particular service type are not working smoothly or proving satisfactory for patients, this is where it will show up, and how CCGs will be alerted that there are changes that need to be made.

4 Recommendations

- JHOSC members are asked to consider and comment on the information provided.
- The JHOSC is asked to consider at what stage they would like a further update on this programme, bearing in mind the projected milestones which should see the contract awarded in April 2016, and the new service beginning in October 2016.

5 Appendices

Appendix A: Principal changes to 111/OOH service specification following public engagement

Appendix B: Financial penalties and contract termination procedures – the NHS Standard Contract: General Conditions

Appendix A: Changes to the Service Specification

Structure

As a result of the feedback from patients and the public we have edited the structure of the service specification and reorganised the presentation style. A summary has also been included to assist audiences that may not be familiar with the technical detail. The terminology has been modified to add clarity where providers are required to deliver functions, for example changes from 'should' to 'must'. A diagrammatic summary has been added to assist readers with the type of service to be delivered and to help reflect where the service fits into the rest of the system.

1. Clinical quality and safety

The commissioners and members of the governance committees will be able to enter the provider's premises for governance purposes and to check on service delivery. This group will also include patient representatives.

The clinical quality of the service will be monitored using regular clinical audit; this will operate at a borough level and also based on the professional group for clinicians in the service. The audit standards will include the professional standards that have been set by the relevant Royal College or Professional Body, for example the Royal College of GPs audit standard will be a requirement within this service.

2. Clinical Governance and Integrated Governance

The information security requirements have been refined so that it is clear that data cannot be shared outside of the permitted use for this service and certainly cannot be used for any commercial purposes.

3. Operational

The role of the clinical hub within the service has been clarified so that providers are aware of the precise scope of the service within north central London, to reflect the integration with local services in each of the boroughs. For example, with care homes in Barnet and mental health services in Camden and Islington.

The location of call centres is also specified with the added desire to make this close to the boroughs of north central London. The location of bases for out-of-hours GP appointments must be within the boroughs of north central London.

The minimum data requirements for service users have been changed to remove ethnicity, based on the public feedback.

Callers will have more direct access to clinicians and this will be based on any care plans that have been agreed with a patient's GP. This function has been introduced following feedback from NCL residents.

Callers falling into a number of categories will now have more direct access to a clinician including the following, these have been added following feedback from patients and the public in NCL

- Patients that are not happy with the initial advice given
- Patients who may want an ambulance but are unsure
- Those patients that want support with self-care or home care but do not want to visit an Emergency Department
- Patients with multiple symptoms and those patients who also have complex medical

histories
- Patients with clinical care plans including those who have an end of life care plan

The public wanted a more responsive service when seeing a GP in the out-of-hours period, therefore the time periods for responses have been shortened to improve the patient experience.

4. Technical

The online access to this service has been expanded for north central London.

The clinical decision support system will be more flexible so that it can be changed in the future to meet the needs of users in north central London.

Patients will be able to consent to record sharing when they call and will be able to make individual decisions on access to their patient record.

Telephone call routing has been improved so that calls for certain patients in north central London such as under 5s and over 85s will be routed to a clinical advisor more rapidly rather than being first managed by a health advisor.

5. Patient and Public Involvement

The provider will be required to involve the public and patients on an ongoing basis with service development.

The provider will need to develop their patient feedback techniques to reflect the local needs of each borough in north central London.

6. Social Marketing and Communication

As a result of very specific feedback from NCL residents the commissioners will require the provider to work with local organisations and groups within each borough to promote the service and help promote access.

7. Performance and Contract Management

The specification sets out that payment model and the performance indicators will be refined during the course of this contract and that the provider will be required to move to the new payment system.

The contract model will use the NHS standard contract but will include an annual review process that will enable the opportunity to agree any contract variations and changes that need to be made in response to developments in primary care and other parts of emergency care.

Public representatives will be part of the group that oversees the contract and will have an opportunity to provide ongoing recommendations for service development.

Contract monitoring data will be presented at an individual borough level which is a requirement that has resulted from public feedback.

Outcomes: The service will have a balanced set of key performance indicators which will include clinical outcomes and operational outcomes (e.g. where a patient was referred to)

The KPIs will be monitored monthly to start with, however north central London will be moving towards real time reporting so that outcomes can be more closely monitored. North central London is now a pilot site for real time reporting.

8. Workforce

The workforce component has been modified to ensure that the service includes clinicians that are familiar with local pathways, services and protocols such as local borough level formularies and services that exist in each borough. The clinicians will be supported with a local directory of services but will need to be familiar with the local services that they may be referring to and will need to demonstrate how they will integrate with local services in each borough, including local GP services.

The training requirement has also been expanded to ensure that the service is connected to local practices through the training of GP registrars in order to help improve the number of local GPs working in the service that are familiar with the needs of patients in each borough in NCL.

9. Access and Availability

The population that the service is being delivered for and the specific needs of each of the local boroughs is cited in the specification to reflect the local authority health profiles for each borough. This includes the need for specific accessible service locations within each of the boroughs of north central London. The times of operation of the service are clearly set out in the service specification. The performance indicators for north central London will include access and availability of the service to ensure that residents for each borough receive an equitable service.

Access to the service will be expanded to ensure that all people in north central London irrespective of where their GP is will be able to access this service.

Appendix B: Financial penalties and contract termination procedures – the NHS Standard Contract: General Conditions

GC9 Contract Management

9.4 If the Co-ordinating Commissioner believes that the Provider has failed or is failing to comply with any obligation on its part under this Contract it may issue a Contract Performance Notice to the Provider.

9.6 Unless the Contract Performance Notice has been withdrawn, the Co-ordinating Commissioner and the Provider must meet to discuss the Contract Performance Notice and any related issues within 10 Operational Days following the date of the Contract Performance Notice.

9.11 If a Remedial Action Plan is to be implemented, the Co-ordinating Commissioner and the Provider must agree the contents of the Remedial Action Plan within:

9.11.1 5 Operational Days following the Contract Management Meeting;

9.12 The Remedial Action Plan must set out:

9.12.1 actions required and which Party is responsible for completion of each action to remedy the failure in question and the date by which each action must be completed;

9.12.2 the improvements in outcomes and/or other key indicators required, the date by which each improvement must be achieved and for how long it must be maintained;

9.12.3 any agreed reasonable and proportionate financial sanctions or other consequences for any Party for failing to complete any agreed action and/or to achieve and maintain any agreed improvement (any financial sanctions applying to the Provider not to exceed in aggregate 10% of the Actual Monthly Value in any month in respect of any Remedial Action Plan).

9.16 If, 10 Operational Days after notifying the Governing Bodies, the Co-ordinating Commissioner and the Provider still cannot agree a Remedial Action Plan due to any unreasonableness or failure to engage on the part of the Provider, the Co-ordinating Commissioner may recommend the Commissioners to withhold, or itself withhold (on behalf of all Commissioners), up to 2% of the Actual Monthly Value for each further month a Remedial Action Plan is not agreed.

9.19 If either the Provider or any Commissioner fails to complete an action required of it, or to deliver or maintain the improvement required, by a Remedial Action Plan in accordance with that Remedial Action Plan, then the Co-ordinating Commissioner or the Provider (as appropriate) may, at its discretion apply any financial or other sanction agreed in relation to that failure.

9.20 If a Party fails to complete an action required of it, or to deliver or maintain the improvement required, by a Remedial Action Plan in accordance with that Remedial Action Plan and does not remedy that failure within 5 Operational Days following its occurrence, the Provider or the Co-ordinating Commissioner (as the case may be) may issue an Exception Report:

9.20.1 to the relevant Party's chief executive and/or Governing Body; and/or

9.20.2 (if it reasonably believes it is appropriate to do so) to any appropriate Regulatory or Supervisory Body,

in order that each of them may take whatever steps they think appropriate.

9.21 If the Provider fails to complete an action required of it, or to deliver the improvement required, by a Remedial Action Plan in accordance with that Remedial Action Plan:

9.21.1 (if the Remedial Action Plan does not itself provide for a withholding or other financial sanction in relation to that failure) the Co-ordinating Commissioner may, when issuing an Exception Report, instruct the Commissioners to withhold, or itself withhold (on behalf of all Commissioners), in respect of each action not completed or improvement not met, a reasonable and proportionate sum of up to 2% of the Actual Monthly Value, from the date of issuing the Exception Report and for each month the Provider's breach continues and/or the required improvement has not been achieved and maintained, subject to a maximum monthly withholding in relation to each Remedial Action Plan of 10% of the Actual Monthly Value;

9.22 If, 20 Operational Days after an Exception Report has been issued under GC9.20, the Provider remains in breach of a Remedial Action Plan, the Co-ordinating Commissioner may notify the Provider that any sums withheld under GC9.19 or GC9.21.1 are to be retained permanently. If it does so having withheld those sums itself on behalf of all Commissioners, the Co-ordinating Commissioner must distribute the sums withheld between the Commissioners in proportion to their respective shares of the Actual Monthly Value for each month in respect of which those sums were withheld.

GC16 Suspension

16.1 If a Suspension Event occurs the Co-ordinating Commissioner:

16.1.1 may by written notice to the Provider require the Provider with immediate effect to suspend the provision of any affected Service, or the provision of any affected Service from any part of the Services Environment, until the Provider demonstrates to the reasonable satisfaction of the Co-ordinating Commissioner that it is able to and will provide the suspended Service to the required standard;

16.8 Following and during the suspension of a Service the Provider must:

16.8.1 not accept any further Referrals of Service Users who require the suspended Service;

16.8.2 at its own cost co-operate fully with the Co-ordinating Commissioners and any interim or successor provider of the suspended Service in order to ensure continuity and smooth transfer of the suspended Service and to avoid any inconvenience to or risk to the health and safety of Service Users, employees of the Commissioners or members of the public including:

16.8.2.1 promptly providing all reasonable assistance and all information necessary to effect an orderly assumption of the suspended Service by any interim or successor provider; and

16.8.3 ensure there is no interruption in the availability of CRS or Essential Services including, where appropriate, implementing any Essential Services Continuity Plan.

Termination: Provider Default

17.10 The Co-ordinating Commissioner may terminate this Contract or any affected Service, with immediate effect, by written notice to the Provider if:

17.10.1 any Condition Precedent is not met by the relevant Longstop Date; or

17.10.2 the Provider ceases to carry on its business or substantially all of its business; or

17.10.3 a Provider Insolvency Event occurs; or

17.10.4 the Provider is in persistent or repetitive breach of the Quality Requirements; or

17.10.5 the Provider is in breach of any regulatory compliance standards issued by any Regulatory or Supervisory Body or has been issued any warning notice under section 29 or 29A of the 2008 Act, or termination is otherwise required by any Regulatory or Supervisory Body; or

17.10.6 two or more Exception Reports are issued to the Provider under GC9.19 (*Contract Management*) within any rolling 6 month period which are not disputed by the Provider, or if disputed, are upheld under Dispute Resolution; or

17.10.8 there is:

17.10.8.1 a Provider Change in Control and, within 30 Operational Days after having received the Change in Control Notification, the Co-ordinating Commissioner reasonably determines that, as a result of that Provider Change in Control, there is (or is likely to be) an adverse effect on the ability of the Provider to provide the Services in accordance with this Contract; or

17.10.8.3 a breach of GC24.9.2 (*Change in Control*) and the Provider has not replaced the Material Sub-Contractor within the relevant period specified in the notice served upon the Provider under GC24.10 (*Change in Control*);

GC18 Consequence of Expiry or Termination

18.2 If, as a result of termination of this Contract or of any Service following service of notice by the Co-ordinating Commissioner under GC17.4 or 17.10 (*Termination*), any Commissioner procures any terminated Service from an alternative provider, and the cost of doing so (to the extent reasonable) exceeds the amount that would have been payable to the Provider for providing the same Service, then that Commissioner, acting reasonably, will be entitled to recover from the Provider (in addition to any other sums payable by the Provider to the Co-ordinating Commissioner in respect of that termination) the excess cost and all reasonable related administration costs it incurs (in each case) in respect of the period of 6 months following termination.

18.3 On or pending expiry or termination of this Contract or termination of any Service the Co-ordinating Commissioner, the Provider, and if appropriate any successor provider, will agree a Succession Plan.

18.4 For a reasonable period before and after termination of this Contract or of any Service, and where reasonable and appropriate before and after the expiry of this Contract, the Provider must:

18.4.1 co-operate fully with the Co-ordinating Commissioner and any successor provider of the terminated Services in order to ensure continuity and a smooth transfer of the expired or terminated Services, and to avoid any inconvenience or any risk to the health and safety of Service Users or employees of any Commissioner or members of the public; and

18.4.2 at the reasonable cost and reasonable request of the Co-ordinating Commissioner:

18.4.2.1 promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the terminated Services by a successor provider;

18.5 On and pending expiry or termination of this Contract, or termination of any Service, the Parties must:

18.5.1 implement and comply with their respective obligations under the Succession Plan; and;

18.5.2 use all reasonable endeavours to minimise any inconvenience caused or likely to be caused to Service Users or prospective service users as a result of the expiry or termination of this Contract or any Service.

18.7 On expiry or termination of this Contract or termination of any Service:

18.7.3 subject to any appropriate arrangements made under GC18.4 and 18.5, the Provider must immediately cease its treatment of Service Users requiring the expired or terminated Service, and/or arrange for their transfer or discharge as soon as is practicable in accordance with Good Practice and the Succession Plan.

18.8 If termination of this Contract or of any Service takes place with immediate effect in accordance with GC17 (*Termination*), and the Provider is unable or not permitted to continue to provide any affected Service under any Succession Plan, or implement arrangements for the transition to a successor provider, the Provider must co-operate fully with the Co-ordinating Commissioner and any relevant Commissioners to ensure that:

18.8.1 any affected Service is commissioned without delay from an alternative provider; and

18.8.2 there is no interruption in the availability to the relevant Commissioners of any CRS or Essential Services.