Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Musculoskeletal Care in Sheffield Commissioning for Outcomes

F

Governing Body meeting

3 April 2014

Author(s)/Presenter and title	Julia Newton, Director of Finance. Alastair Mew, Senior Commissioning Manager. Ian J Atkinson, Head of Contracting
Sponsor	Dr Zak McMurray, Joint Clinical Director Julia Newton, Director of Finance

Key messages

Over recent months Governing Body has considered both in public and private session the case for commissioning city-wide Musculoskeletal services (MSK) on an integrated basis, through an outcome based contract with a prime contractor, where remuneration will partly be dependent on patient outcomes rather than units of activity. Governing Body has previously confirmed an enthusiasm to pursue this model in principle.

Governing Body has always been keen to ensure that whatever approach is finally taken it delivers the best outcome and value for patients in Sheffield. In October Governing Body agreed that in the context of close working with key partners in the city on a number of major programmes, the project team should pursue the option of exploratory discussions with Sheffield Teaching Hospital Foundation Trust (STHFT) against a set of criteria. In January 2014, Governing Body had feedback from this work which was very positive.

In the February private session, members considered in more detail whether the CCG was confident that a decision to work towards an outcome based contract with STHFT as prime contractor was appropriate within the context of national Regulations on procurement and competition. Governing Body agreed to defer a final decision on this issue until certain further actions had been completed including informal discussions with Monitor, on which it received feedback in the March private session.

So as not to delay momentum on the project, Governing Body in public session in February agreed that further clinical discussions on the model should happen not just with STH but other key local providers and the public. This work is now commencing.

This paper now invites Governing Body to make some formal decisions on the way forward to take the project to the next stage.

Assurance Framework (AF)

How does this paper provide assurance to the Governing Body that the risk is being addressed?
This development will address the following risks – 1.2, 2.1, 4.2, 4.5. This piece of work has had strong clinical leadership involved internal and external clinical input, patients, will adopt best practice and an evidence based approach

Is this an existing or additional control: Existing

Equality/Diversity Impact
Has an equality impact assessment been undertaken? NO. This will be undertaken on an ongoing basis as the work progresses.
Public and Patient Engagement
Initial scoping workshops led by Sir Muir Gray involved patients and the most recent work has been supported and scrutinised by an external expert patient. The CCG will have a clear strategy of engagement as part of the project delivery process.
Recommendations
The Governing Body is asked to: 1) Formally agree that the CCG now works towards awarding a five year outcomes based contract with effect from 1 April 2015 to a prime contractor and that subject to completion of a successful negotiation process and final approval of that by Governing Body, the contract would be awarded to Sheffield Teaching Hospitals NHS Foundation Trust. 2) Agree that the contract must ensure maintaining patient choice as set out in the NHS Constitution. 3) Agree that to achieve the stated model of delivery this will mean that the CCG will not seek to competively procure those services within the current MSK community contract, which is scheduled to end in May 2015. 4) Agree that the scope of the contract is elective MSK provision commissioned by the CCG including community and acute services as set out in the business case considered by Governing Body in October 2013. 5) Agree to the proposed project plan and proposed governance structure to achieve delivery of a new contract from April 2015.

NHS
Sheffield
Clinical Commissioning Group

Musculoskeletal Care in Sheffield
Commissioning for Outcomes

Governing Body meeting

3 April 2014

1. Introduction / Background

This paper is split into two parts (A&B):

Part A - summarises the proposed commissioning model and the considerations made regarding procurement and contract

Part B - focuses on the proposed governance and project delivery.

Part A

2. Proposed future model of care for MSK services

2.1 Governing Body has previously agreed in principle to development of an outcomes based contract that will integrate existing MSK provision using a 'Prime Contractor Model'. The contract will use outcome measures to determine quality and the currency for contract management. The revised model will see care closer to home through moving care into the community and away from the acute setting where appropriate. The new model is also intended to support improved patient involvement in their own care options and a collaborative approach towards a complex program budget area allowing clinicians, managers and patients to co-produce and monitor a new type of relationship between commissioners and providers.

2.2 The clinical scope of the service (to be fully worked up in granular detail as part of the project) is broadly as follows: Adults (aged 16 and over) who are either registered with a general practice member of NHSS CCG or otherwise the commissioning responsibility of NHSS CCG, and are eligible for NHS care. This system of care should encompass the diagnosis, treatment and management of all diseases of the musculoskeletal system and connective tissue. The scope would exclude urgent care.

3 Procurement approach and contract form

3.1 Recommendations 1 to 3 are made to Governing Body following on from the detailed discussions which have already taken place in private sessions and the considerable work to provide the evidence to support these recommendations. This work includes taking formal legal advice and informal consultations with Monitor (The Health Care regulator for competition and co-operation). The advice received confirmed that the CCG is within its rights to make a 'direct award' of contract, where the CCG can clearly evidence that it has considered the

requirements of the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 and what is in the best interest of patients. Governing Body considered evidence against a number of key questions (highlighted below)

1. How the CCG has evaluated and identified the healthcare needs of the population (through health needs assessment, engagement of community, patients, clinicians and best practice).
2. How the CCG have taken a holistic view of the needs of healthcare users and ensured equitable access regarding different groups.
3. Consideration to ensure sustainability of service.
4. How working on an integrated basis has not prevented competition.
5. Evidence ongoing commitment to patient choice.
6. Taken into consideration any other potential providers and provide evidence of the objective process undertaken to identify the most capable provider, without going out to formal procurement. That the CCG has acted transparently, treating providers equally and in a non-discriminatory manner.

A summary of the evidence presented to Governing Body against each of the key questions is identified in Appendix 1

Part 2 - Governance and project delivery

This section is written subject to Governing Body confirming its agreement to recommendation one.

4. Project Structure

4.1 To achieve the vision of delivering an outcomes based approach for the delivery of MSK services by April 2015, will require the establishment of a formal project management approach, which will include a detailed project plan (see Appendix **2** below) and robust risk analysis and management. Named project management leads from the CCG and STHFT will be responsible for co-producing detailed development and implementation plans. External assurance around key project processes and delivery of key milestones will continue to be provided by Internal Audit.

4.2 If the vision for MSK services is to be fully achieved joint working and partnership will be key. Recognising the scale and complexity of implementing the new model, existing joint working arrangements will need to be formalised and this will see the introduction of an MSK Joint Project Board who will oversee delivery (meeting bi monthly). An MSK Joint Working Delivery Group (JWDG) will be established. The group will meet formally on a fortnightly basis and will be responsible for project delivery and accountable to the project board. Separate sub-groups will be established from the delivery group as appropriate. Clear terms of reference, agendas and minutes will be recorded for each group. The JWDG will be attended by lead clinicians and management teams from the directorates providing MSK care within STHFT along with the CCG clinical and management leads and other providers where appropriate.

4.3 It is envisioned that the JWDG will provide oversight and support to the individual workstreams as the project develops ensuring continuation of the successful partnership working and the co-production of the future clinical model and the final service specification (Appendix 1 below).

4.4 From a CCG perspective the existing internal MSK project Board will continue with representation from the CCG clinical and management leads, chaired by an executive director and accountable to the CCG Commissioning Executive. The Board will meet on a monthly basis with formal agendas and minutes circulated. These internal governance arrangements will also be broadly mirrored within STHFT.

5. Patient representation and engagement

5.1 Whilst involving patients will be a vital element in the development of clinical model effective engagement and communication more broadly with the patients and public of Sheffield is also of paramount importance to ensure that future services and the focus of their outcome measures genuinely reflect the needs of local people.

5.2 Detailed engagement and communications strategies and plans are currently being developed by the CSU (to be shared and worked up in partnership with JWDG and this process is being supported by the clinical and management leads with additional input and scrutiny from the CCG's non-executive directors. This project will also act as the flagship for the CCGs new 'Involve Me' network.

5.3 These plans will ensure that all key groups and partners are actively engaged and can contribute to the process (including those considered hard to reach) and enable a two way dialogue so that the views of patients and the public are fed into clinical discussions and that as the model develops in detail emerging thinking can also be continuously tested with patients and the wider public.

5.4 It is suggested that wider patient advocacy, in more formal settings such as the project boards, continue to be provided by Neil Betteridge who has significant executive experience of representing the patient voice nationally and within government and whose input to date has been considered invaluable by both the CCG and STHFT.

5.5 A briefing note, including the engagement plan, will be sent to the Health and Social Care Oversight and Scrutiny Committee. Subject to further work to articulate the differences patients will see as a result of this work, it is not considered that the changes proposed to how we commission MSK constitute significant service change in terms of requiring formal consultation. However, the period of engagement is likely to be as long as most formal consultations and the outcome of that engagement work will inform the work of the JWDG and future papers to Governing Body.

6. Developing the model

6.1 The development work will also include two key workshops involving patients, clinicians and management teams. These will incorporate the work provided by the supporting workstreams and be facilitated by the clinical leads from the CCG and STHFT. From a change management perspective these workshops will start the process of turning the clinical vision into the new operational service model and mapping the changes needed to move from current services and structures to the future state. The output of these workshops (and other development work) will be fed back to the joint board for discussion and support. At this stage it is anticipated that there will be two workshops with the first in June and the second in September with the final co-produced service specification completed by the end of October.

7. Recommendations

The Governing Body is asked to:

1) Formally agree that the CCG now works towards awarding a five year outcomes based contract with effect from 1 April 2015 to a prime contractor and that subject to completion of a successful negotiation process and final approval of that by Governing Body, the contract would be awarded to Sheffield Teaching Hospitals NHS Foundation Trust.

2) Agree that the contract must ensure maintaining patient choice as set out in the NHS Constitution.

3) Agree that to achieve the stated model of delivery this will mean that the CCG will not seek to competively procure those services within the current MSK community contract, which is scheduled to end in May 2015.

4) Agree that the scope of the contract is elective MSK provision commissioned by the CCG including community and acute services as set out in the business case considered by Governing Body in October 2013.

5) Agree to the proposed project plan and proposed governance structure to achieve delivery of a new contract from April 2015.

Paper prepared by: Alastair Mew, Senior Commissioning Manager; Dr Ollie Hart, MSK Clinical Lead, Ian J Atkinson, Head of Contracting

On behalf of: Dr Zak McMurray, Joint Clinical Director
Julia Newton, Director of Finance

March 2014

Appendix 1

Consideration of CCG duties in relation to NHS Procurement Regulations

Questions 1 and 2:

1. The CCG has evaluated and identified the healthcare needs of the population (through engagement of community, patients, clinicians and best practice).

2. Evidence how the CCG have taken a holistic view of the needs of healthcare users and ensured equitable access regarding different groups.

The CCG has completed a healthcare needs assessment of MSK services which identified the MSK needs of people in Sheffield. The needs assessment included epidemiological needs (incidence and prevalence), comparative needs (how Sheffield services compare to other areas), and corporate needs (the views of service users, the wider public, and clinicians). Including the views of service users has ensured that the CCG has taken a holistic view of needs. Data on equitable access is not available, but – as one example - local data on chronic pain included in the needs assessment show that chronic pain is more prevalent amongst certain population groups (older people, women, and people living in deprivation). This information will be used to ensure that services are provided where they are most needed.

Improving the musculoskeletal health of people in Sheffield will contribute directly to several of the five outcomes in Sheffield's Joint Health and Wellbeing Strategy, these include Outcome 2: health and wellbeing is improving; Outcome 4: people get the help and support they need and feel is right for them; and Outcome 5: the health and wellbeing system in Sheffield is innovative, affordable and provides good value for money.

One of the key reasons for SCCG wishing to pursue this innovative approach is due to a long history of successful and extensive redesign in this area. This has been led by local clinicians and incorporated their wide ranging experience of local patient needs across all elements of care pathways.

Examples of recent redesign/understanding of different local groups:

- A key element of the scoring criteria for community MSK services were convenience of travel, parking and close proximity to public transport.

- Introduction of innovative P1NP testing for the follow up osteoporosis management by local GPs has reduced the need for patients to attend Secondary Care for on-going monitoring.

- A local 100 hour pharmacy is contracted to supply wrist splints as a conservative treatment for carpal tunnel syndrome. The long opening hours, ease of location and drop in facilities ensure this is significantly easier for local patients to access than Secondary Care.

- The CCG has received the Shine award funding a pilot for health trainers specifically commissioned to target groups of patients struggling to engage with healthcare.

- Sheffield patients have benefitted from an award winning website developed by local GPs (sheffieldachesandpains.com) which provides high quality, multi-media and advice for patients with MSK problems and chronic pain. Much of the content has been produced in collaboration with local secondary care clinical experts from STHFT.

- The local foundation trust has an extensive network of community services and are actively committed to delivering services from the new National Centre of Sport and Exercise Medicine (NCSEM) venues (in areas of social deprivation).

- STHFT is a key stakeholder in NCSEM and Move More Sheffield, projects aimed at improving the mental and physical health and enabling physical activity. This development has been informed by extensive public consultation in partnership with the eleven key agencies in Sheffield.

- The recent work has additionally used external experts to represent patient voice and actuarial support to understand current and future demand.

Question 3:

3. Evidence of consideration to ensure sustainability of service.

The CCG has engaged actuarial support in order to gain a greater understanding of future demand on MSK services. The clear conclusion that can be drawn from this is that in the face of increasing demand and limited funding there is significant risk in attempting to maintain the current model. It is therefore proposed that the prime contractor model which has clinical leadership at its core is best placed to ensure future sustainability of services as it ensures limited resources are focussed in the areas offering greatest clinical value and benefit to patients.

MSK conditions also impact on a number of programmes of care (cardiology, respiratory, diabetes and mental health) and the proposed changes will enable the ability to manage costs not only programme wide but also allow the transfer and focus of funding into areas delivering the best clinical value to patients across the system rather than remaining within individual specialties as current.

- The existing provider STHFT has a successful track record of providing these services citywide through trusted relationships and has established service capacity and infrastructure in primary, community and secondary care locations with care provided by experienced and expert staff with extensive knowledge of local patients and their needs.

- There is already a local track record of clinicians working collaboratively with the CCG to develop integrated care pathways for the benefit of patients which provides confidence around sustainability of delivery. Examples would be the

introduction of the back pain pathway and local MSK teams adopting EQ5D outcome measures with the most recent being the new foot and ankle pathway which has enabled 400 additional patients per year to receive care from a community based provider rather than secondary care. The community provider in this case offers excellent quality and patient focussed care and has just won a customer services award for the sixteenth year in a row.

- STHFT has an excellent track record of training of medical and Allied Health Professionals ensuring future sustainability of the work force. It is also of the highest importance that the prime contractor provides education for the primary care teams as part of working clinical relationships. This is an integral part of ensuring the sustainability of the service and due to the complexity of patients and interrelation of services, the wider health economy.

- The recent exploratory work with STH managers and clinicians has given confidence to their willingness and ability to follow a prime contractor, outcomes based approach to care. (As demonstrated in the evidence provided in the January 2014 report to Governing Body.)

- STHFT has also been a leading co-partner in the National Centre for Sports and Exercise Medicine (NCSEM) project, and co-collaborates with the CCG on the Move More Board. Both initiatives have significant contribution to strategy setting for physical activity in the city, which offers an excellent opportunity to develop preventative strategies for MSK disease. There are significant advantages in co-production of PA strategy with CCG, STH and Sheffield City Council.

- The CCG current view is that an alternative provider for elective MSK services would have a negative impact on existing commissioned services and threaten their operational effectiveness and sustainability. For example, it is anticipated that there would be significant impact on linked areas such as the Orthopaedic Trauma Centre where there is a need to maintain a critical service mass to ensure ongoing viability. Also, artificial splits would be created in specialties such as pain services which support patient cohorts for MSK and also neuropathic pain.

SCCG is confident that the proposed approach will ensure not only sustainability of services but also deliver high quality and best value.

Questions 4 and 5:

4. Evidence how working on an integrated basis has not prevented competition.

5. Evidence ongoing commitment to patient choice.

SCCG is confident that competition from a service provision perspective can be maintained and this can be evidenced by a number of locally developed integrated pathways which involve a number of local providers which have not limited competition or patient choice.

NHSS CCG has consistently honoured the requirements to maintain patient choice as set out in the NHS Constitution. The option for patients to choose their care provider will exist for the proposed MSK pathway when a care intervention is deemed to be necessary for example when joint replacement surgery is required.

An example of the CCG's commitment to patient choice and ensuring that a range of providers (both NHS and Independent Sector) are able to offer care to patients locally would be the local spinal pathway. This pathway ensures that referrals are only made to spinal surgeons following multidisciplinary team (MDT) discussions. However, once an onward referral has been agreed to be the most appropriate care option for the individual patient full choice of provider is offered. If a patient attempts to circumvent this process (or their GP refers to the surgeon directly) they are referred (virtually) to the MDT for consideration and again, if onward referral is agreed to be appropriate the original patient choice of preferred provider is honoured.

In designing the specification for the contract with the prime contractor, the CCG would ensure that patient choice is appropriately offered at the relevant point(s) in the pathway and would monitor compliance with this.

Question 6:

6. Evidence how the CCG has taken into consideration any other potential providers and provide evidence of the objective process undertaken to identify the most capable provider, without going out to formal procurement. That the CCG has acted transparently, treating providers equally and in a non-discriminatory manner.

Due to the nature of the local health system, the complex links to supporting non-MSK specialties (e.g. cardiology, respiratory, diabetes and mental health) and diverse needs of local patients the CCG is of the opinion that STHFT as the key provider of local health care is best placed to deliver this service. Clinical leads within the CCG are concerned that it would disadvantage local patients and impact negatively on the wider health system if through a competitive procurement STHFT was not successful as we would likely destabilise a range of other essential services provided by the trust.

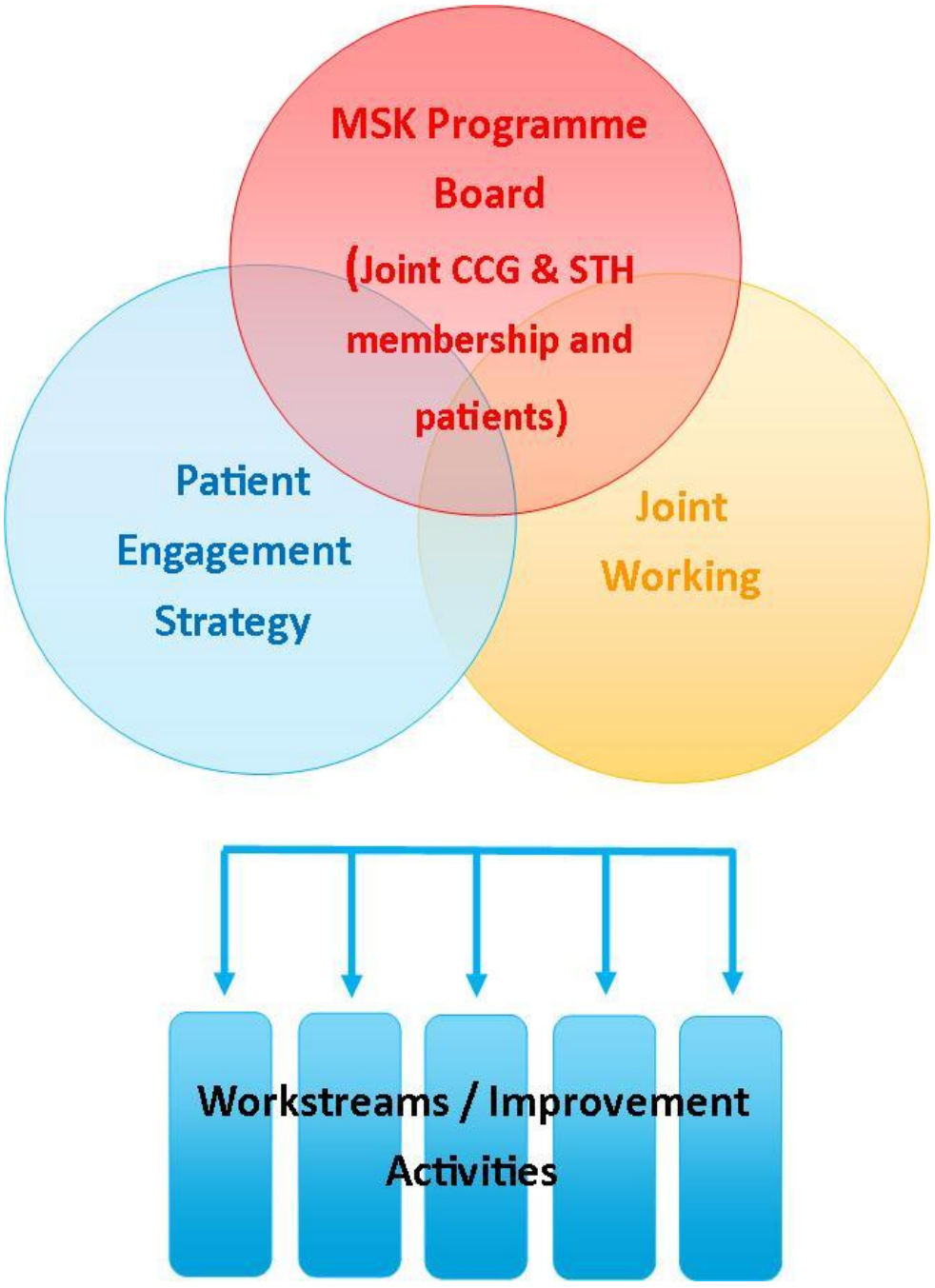
The CCG has also undertaken some modelling which, based on the information available to us, would lead us to question that at the current time there is sufficient theatre capacity in the city to deliver the total level of estimated activity without the use of STHFT's premises. This assumes that in any competitive procurement STHFT would seek to be the prime provider and make their own bid rather than offer to work with another prime contractor. The limits on other current capacity would likely mean that in any option not involving STHFT substantial numbers of patients would be obliged to travel outside of Sheffield to receive care which directly contradicts the local strategic aim of delivering care closer to home. Clearly new capacity could be developed in the city but we would question whether this would be achievable in the timescales we are considering.

In terms of ensuring value for money the CCG is engaging external expert actuarial advice in order to undertake international benchmarking to ensure budgets are aligned to a ‘tightly managed system’ and offer value for money.

The Governing Body was keen for a transparent, objective and robust process to test out with STHFT whether a partnership approach is feasible to deliver the intended commissioning model and desired outcomes for the CCG. This is why Governing Body agreed a set of criteria for the assessment which were then shared with STHFT and against which evidence was subsequently collected and presented to Governing Body. The CCG also commissioned a review by Internal Audit of the governance arrangements in place over the feasibility study. The objective was to provide independent assurance to Governing Body that the COBIC Project Board and team has undertaken a process which followed the brief set by Governing Body in line with CCG governance arrangements including its Procurement Strategy; and that the report which the team presented to Governing Body in January 2014 appropriately reflected the outcome of that process. The Internal Audit report provides useful feedback and in summary confirmed that an adequate audit trail exists to demonstrate due process in the feasibility study that took place

Appendix 2

Diagrammatic Representation of Joint Working Arrangements for CCG and STHFT and Inclusion of Patient and Public Voice.



Project Plan **Appendix 3**

In order to achieve implementation from the **1st April 2015** there are a number of key project strands that need to be achieved. These are highlighted in the project plan below:

Key Task	Mar. 2014	Apr. 2014	May. 2014	Jun. 2014	Jul. 2014	Aug. 2014	Sept. 2014	Oct. 2014	Nov. 2014	Dec. 2014	Jan. 2015	Feb. 2015	Mar. 2015	Apr. 2015
Develop communications and engagement strategy and plan														
Undertake communications and engagement with continuous feedback to clinical discussions														
Complete baseline of current services														
Joint working to develop new service and outcomes														
'Future State' workshops														
Joint Project Board (CCG & STHFT)														
Financial and activity analysis														
Contracting Discussions														
Completion of service specification														
Final report to CCG GB														
Mobilisation of new service														
Go live of new service														