Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Sheffield Integrated Commissioning Programme
Active Support and Recovery: Procurement Approach

Governing Body meeting

D

3 September 2015

Author(s)	Rachel Gillott, Deputy Chief Operating Officer Julia Newton, Director of Finance
Sponsor	Idris Griffiths, Chief Operating Officer

Is your report for Approval / Consideration / Noting

Approval. The paper seeks Governing Body approval to pursue a partnership approach with key local providers to collaboratively redesign active support and recovery services, which if this proves successful, would ultimately lead to a direct award of contract to these providers as opposed to the CCG in partnership with Sheffield City Council, pursuing a competitive tendering approach.

The paper provides some background information on the work of the Active Support and Recovery programme to date and next steps. However, it is not asking Governing Body at this time to approve the final service framework, scope of services and funding for this procurement as these all require further work and will be the subject of future papers to Governing Body.

Are there any Resource Implications (including Financial, Staffing etc)?

The recommendation should achieve the best outcomes and value for money in procuring an Active support and Recovery Service. There may be some staff resource implications arising from the decision made, but the amount of CCG capacity required for the procurement is likely to be broadly the same in total, albeit of a different nature depending on the choice made.

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
Strategic Objective - To ensure there is a sustainable, affordable healthcare system in Sheffield. It supports management of the CCG's principal risk 4.6 in the Assurance Framework: "Provider development required to deliver new models of care and achieve CCG stated outcomes does not happen".

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? No.

If not, why not? The choice of procurement method should not have an impact on equality issues.

PPE Activity

How does your paper support involving patients, carers and the public?
There has been significant engagement on integrated commissioning and on the design of Active Support and Recovery. The outcome of this engagement has informed the analysis supporting the recommendation.

Recommendations

It is recommended that Governing Body:

- Approves Option A – a non-competitive procurement approach as outlined in the paper, subject to a positive response from providers during September and a subsequent successful co-production of the service model.
- Notes that an update on the approach and if possible, proposals on scope and funding envelope will be presented to Governing Body in October for approval

Sheffield Integrated Commissioning Programme
Active Support and Recovery: Procurement Approach

Governing Body meeting

3 September 2015

1. Introduction / Background

Sheffield CCG and Sheffield City Council (SCC) have established an Integrated Commissioning Programme, including a pooled budget to cover four key areas of work, with the aim of improving service user experience and outcomes and making the best decisions about the use of the resource available between us. The programme of work covers four areas of work:

- Independent Living Solutions
- People Keeping Well in their Community
- Active Support and Recovery
- Long Term High Support/Ongoing Care

Each of the above workstreams has a project plan and is progressing the joint commissioning intentions of the CCG and SCC. This paper summarises the current position from the Active Support & Recovery workstream, and seeks Governing Body approval on the preferred future procurement approach, following recent discussions and considerations of the possible options, for Active Support & Recovery.

It should be noted that as the proposed procurement uses both CCG and SCC budgets, similar consideration of this issue and approval of the preferred approach is also required by SCC.

2. Summary of Recent Work

Over recent months work has been undertaken in a number of areas as follows:

- Project structure and workplan
- Design workshops
- Public and stakeholder engagement
- Commissioning Approach

2.1 Project Structure and workplan

As part of the current shared programme arrangements with SCC, an agreed timeline was developed to ensure the workstream has a shared understanding of the key stages over the 12 month period to April 2016.

Dedicated project management resources have been secured and lead officers for task and finish work have now been established. The workstream has established a Steering Group to oversee the implementation of the project plan, key deliverables and develop ongoing requirements for the workstream in line with the overall agreed direction of travel.

The workstream is held to account through the Integrated Commissioning Programme Board and the joint Executive Management Group.

2.2 Design Workshops

A series of three design workshops were held in June/July and attended by existing providers including from the third sector and commissioners to consider the current and future state of Active Support and Recovery services in the city, putting the patient at the heart of our design. The context for the workshops was to explore the services and responses required building on the original case for change included in the Better Care Fund Section 75 agreement.

The workshops confirmed the challenges with the current range and organisation of services in Sheffield. These included fragmentation between multiple organisations and front line services, resulting in patients feeling disempowered and frustrated with several and uncoordinated hand-offs between the multiple different services involved in their care. These result in services being inefficient and not adequately responsive or flexible to meet individual needs.

Participants were invited to consider and propose design requirements for the future provision of these services. Fourteen themes emerged from the discussions, including the requirement to be person centred with co-ordination across a wide range of services, utilising a shared single care plan with primary care and senior clinical decision making at the core and with seamless transition between services. Workshop 2 and 3 considered 'outcomes' associated with the 14 themes and what a future model of service provision might look like.

Next steps include;

- Produce a scope document
- Commence detailed design phase
- Establish finance and contracting baseline information

2.3 Public and Stakeholder Engagement

A number of activities have taken place to test out the emerging themes with members of the public for example through the citizens reference group and with member practices through the locality councils and the city wide locality group, with the LMC receiving monthly updates. Senior managers from local providers receive updates at a monthly meeting (Right First Time (RFT) Executive). A learning lunch was held to update CCG commissioning portfolios.

Next Steps: Ongoing activities will be planned throughout the forthcoming phases of this work, to ensure that the principles and concepts of integrated care are fully realised and patient and user involvement is secured throughout the process.

2.4 Procurement Approach

As part of the overall timeline for the worksteam, the Executive Management Group indicated that it would consider the outputs from the workshops and determine the procurement approach that would best meet the future needs of service. The following captures the content and rationale emerging from the discussions amongst the CCG Clinical Executive Team, Governing Body and joint Executive Management Group. It

summarises the principles that would be expected of providers, which arose from the discussions.

- Able to control the whole of the interdependent system actively delivering care outside of hospital
- Able to deliver and secure economies of scale
- Able to change services and innovate
- Able to redirect resource across the system
- Primary care involved in design as well as day to day decisions/directing services
- Establish a senior clinical decision maker overseeing individual patient care
- Maximise involvement of the various organisations with track records in providing services outside of hospital
- Able to provide skilled and experienced staff (& management team) empowered to act in the best interest of the patient/client
- Act independently from individual organisational interest i.e in the best interest of patients/population

The above outputs have strong congruence with the national evidence and strategic requirements that support a move towards integrated care and commissioning. In considering the above, the CCG and SCC executive management teams believe that a direct award of a contract to a partnership of local providers would create the best opportunity to deliver fully integrated care, co-designed with patients and commissioners to meet patients' needs, improve outcomes and experience.

We consider that a competitive procurement arrangement leading to a contract with only one of the current, (or a new), provider would be less likely to achieve the required integration of existing services, partnership between provider organisations and co-design of future service provision.

Section 3 below sets out why a collaborative approach between as many of the existing service providers as possible appears to provide the best opportunity to secure value for money, sustainable services and high quality integrated care for patients/clients.

This arrangement will ideally include all relevant health and social care providers who are currently involved in the provision of the active support and recovery services. This will include acute care, social care, primary care and mental health care providers. It is also intended that third sector providers be included and that achieving this would be a key aspect of the collaborative approach. However, this is dependent of current providers being prepared to work in a fully integrated governance arrangement with other providers. Commissioners will need to determine whether the level of commitment, progress and plans of any proposed alliance are sufficient to meet the future needs of Sheffield residents. Where any provider is unable or unwilling to participate in this approach commissioners will need to determine whether the remaining providers within the alliance can meet the principles outlined above.

3.0 Procurement for Integrated Care

The Health and Social Care Act 2012, attaches importance to integrated care and CCGs have duties to promote integration with the emphasis on local areas to design, commission and deliver care in a more integrated way for their communities. Following the Act the NHS Procurement, Patient Choice and Competition Regulations were issued. The regulations are designed to ensure that NHS England and CCGs procure high-quality and efficient

healthcare services that meet the needs of patients and protect patient choice. The regulations recognise the important role that integrated care can play in improving services and require commissioners to consider, when procuring NHS healthcare services, how services can be improved through the delivery of care in a more integrated way.

The NHS Five Year Forward View (2014) offers a view of how services need to change and is permissive of developing new models of care that are more integrated than at present. However, developments are just starting to evolve. It is acknowledged by the regulatory bodies that flexibilities with current regulations will need to occur. The Integrated Care and Support: Shared Commitment (2014) pioneer programme, which includes Sheffield's Integrated Commissioning Programme (as of January 2015), is one such support network to work through the issues.

Despite this recognition, the regulations have not yet changed and so the findings from the Active Support and Recovery workshops have been considered within the framework and requirements of the existing Procurement, Patient Choice and Competition Regulations. These provide a number of options, allowing commissioners to decide what services to procure and how best to secure them, in the interests of patients, considering whether the services could be provided in an integrated way (including with other health care services, health-related services, or social care services). Commissioners are not required to follow a prescribed process every time they procure services.

3.1 Procurement Options

There are a number of different procurement options that the CCG can consider when it chooses to enter into a process of significant service re-design in order to gain service improvement and each situation should be considered on its own merits. These essentially amount to:

A) The negotiated procedure (i.e. direct award of contract without any form of competitive procurement) - this will allow continuation of partnership working to develop a strong collaboration between commissioners and providers to secure integrated service provision as per the principles outlined in section 2.0; Or

B) Open procedure (Competitive Tender) - of which there are various types.

Discussion

Although there are different forms of competitive tender, this approach when applied to Active Support and Recovery service could easily result in a series of tenders due to the multiplicity of service providers and expertise required, which is more likely to lead to, or at least maintain, fragmentation rather than integration, and possible disruption to service provision throughout any transition arrangements.

The design workshops have demonstrated that integration of active support and recovery is mainly about the integration of existing services, rather than the creation of new services, and that although GP practices are not commissioned by the CCG they do provide the majority of patient care outside of hospital and must be central to the integrated model of service we seek. A partnership of providers, including GPs, is necessary to ensure seamless & integrated provision. It will secure current providers, including primary care, commitment to the model, and allow resources & incentives to be targeted to right place in the system, eroding current organisational boundaries where they prevent that.

There are a number of organisational forms such a partnership could take. In seeking to negotiate a direct award of contract, commissioners and providers will need to agree which model is most appropriate. Models include a prime/lead provider arrangement, an alliance of providers underpinned by written commitments, or the establishment of a new organisation owned by the partners.

Competition can often provide the best basis for achieving value for money. To establish best value for money in negotiating a direct award of contract, we will need to use benchmarking information and have sufficient openness in providers' costings to provide confidence that the best value for money has been achieved.

A direct award of contract is more likely to lead to providers' commitment to the outcomes required from the service, where these cannot be expressed or committed to in contractual terms. Most importantly, the re-designed and integrated service must contribute to a reduction in avoidable admissions and commitment to this is more likely from providers with an ongoing commitment to the sustainability of the health and care economy as a whole.

Monitor Tests

Under the Health & Social Care Act 2012, Monitor has been given the role of ensuring that commissioners have operated within the legal framework established by the regulations. To help commissioners, Monitor has published guidance on how to comply. In effect it sets out a series of questions (or tests) that commissioners should work through.

The programme team have considered the Monitor questions in relation to Regulation 2 (which requires CCGs to act to achieve the following objectives when procuring NHS health care services: securing the needs of health care service users; improving the quality of services and improving the efficiency with which services are provided) and Regulation 3. Our thoughts are summarised in Appendix 1. **These lead the team to propose adopting Option A.**

Next Steps

In order to maintain momentum on this important programme of work, the Joint Executive Management Group has indicated to our existing local providers that subject to the outcome of consideration of this paper by the CCG Governing Body and by Sheffield City Council, our preference is to work in partnership and to co-produce the new service model. We have also asked our providers to consider whether they would be willing to work in some form of alliance to deliver the new service. Providers have been asked to confirm their views by mid-September. If the Governing Body approves this approach and the providers' responses are positive the next steps would be:

- Issue of a statement of commissioner requirements setting out our thoughts on the scope of the service, the key likely outcome measures, essential features, and the financial envelope. The original timetable envisaged that we would do this by the end of September. This deadline is now exceptionally challenging to achieve, but work is ongoing to try to deliver against this milestone. However, we recognise that Governing Body will need to approve the scope and funding envelope and hence if possible we will bring a paper to the 1 October 2015 meeting to allow issue of the statement immediately thereafter, if approved.

- A period of co-design of an integrated service specification

- Production by providers of a method statement describing options for how an alliance may be constituted, including governance and decision making powers of the new body

This initial decision about the preferred approach to procurement does not determine which type of contractual arrangements will ultimately be used going forward and Governing Body will be asked to take a final decision on future contractual arrangements in due course. The work above will need to provide sufficient confidence that an integrated service, delivering the required outcomes within the necessary financial envelope, can be secured for that report to continue to also recommend a direct award of contract.

4.0 Recommendations

It is recommended that Governing Body:

- Approves Option A – a non-competitive procurement approach as outlined in the paper, subject to a sufficiently positive response from providers during September and a subsequent successful co-production of the service model.
- Notes that an update on the approach and if possible, proposals on scope and funding envelope will be presented to Governing Body in October for approval

Paper prepared by: Rachel Gillott – Interim Chief Operating Officer /Lead Director for Active Support and Recovery workstream
Julia Newton – Director of Finance

August 2015

Appendix 1

NHS Procurement, Patient Choice and Competition Regulations: Questions for Commissioners to consider in relation to Regulations 2 and 3 as posed by Monitor.

Consideration	Rationale
1. What steps the CCG has taken to evaluate and identify the healthcare needs of the population (through health needs assessment, engagement of community, patients, clinicians and best practice)?	An outline business case was developed and submitted as part of the Better Care Fund outlining the healthcare needs of the population, in particular, the anticipated growth in older people, with increasing co-morbidities and multiple long-term conditions. Three design workshops involving representatives from providers and commissioners including clinicians have been undertaken. Key design principles and themes have been produced; indicating that co-ordination between and through providers is required to provide the required service improvement in this range of services. These have been tested with citizens, member practice clinicians through Sheffield CCG's Locality Councils, confirming agreement with workshop outputs.
2. Has the CCG taken a holistic view of the needs of healthcare users and ensured equitable access regarding different groups?	Patient and Individual needs have been considered in the design workshops. The design themes and principles have identified the need to ensure future services are provided to meet the 'holistic' requirements of the individual, including carers. There is a wide range of health and social care services and providers, including independent and third sector, engaged in current service provision. A number of engagement activities have been undertaken, including through the Citizen Reference Group. A full equality Impact Assessment is underway.
3. Has the CCG considered the sustainability of services, including the impact that a procurement decision may have on the ability of providers to deliver other services that health care users require?	One of the key drivers for the Integrated Commissioning Programme, and therefore AS&R, is to ensure the sustainability of service into the longer term. Current service provision is through multiple providers with contracts placed with individual providers. There is currently little opportunity to allow collaboration between providers to enable efficiencies to be achieved through integrated provision. Consideration has been given to the benefit of being able to offer longer term contracts. A competitive process could lead to further providers entering the market, increasing complexity of provision, hand-offs and fragmentation of service provision. A competitive procurement approach could lead to a period of uncertainty and instability across the whole system, resulting in a number of risks to the continuity of service provision.

Consideration	Rationale
4. How working on an integrated basis has not prevented competition.	Design workshops for AS&R through May and June have indicated that a range of established and third sector providers in the locality understand and have an appetite for working collaboratively in pursuance of a range of people focused outcomes across the range of services. Seeking to establish a collaborative arrangement with providers will require appropriate governance arrangements to be put in place, to ensure equal levels of influence and decision making is assured. New models of collaborative provision, does not prevent further providers being included in the overall provision, as long as the key design principles and themes are maintained.
5. Evidence ongoing commitment to patient choice.	Having a collaboration of existing providers involved in the future provision will ensure co-ordination of care, use of person centred care plans will ensure patients are at the centre of determining how services meet their needs, including choice as appropriate. In the context of social care packages, where the use of the independent and 3rd sector is currently part of the offer, and will remain a theme in future design in the ongoing provision of the range of AS&R services. Engagement with public and patients has been clear that patient choice is that services must work better, in a smoother and more coordinated and joined up way, providing bespoke responses to meet patient need, identify needs sooner, reduce duplication and provide more comprehensive responses.
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.	All current providers of AS&R are being asked to work in collaboration and have been given the opportunity to engage in the design workshops. Due to the complex and varied range of services needed to meet the needs of patients, including the central role of primary care in securing continuity of care for patients/clients, there is no single provider in the 'locality' who currently provides the full range of services required. It is felt new entrants to the market would proliferate provision and lead to further complexity and fragmentation.
7. That the CCG has acted transparently, treating providers equally and in a non-discriminatory manner.	All providers have been given equal opportunity to express their interest in working together in some form of alliance. We intend to work collaboratively with providers that are committed to an alliance approach to confirm design intent and to develop the service specification. This will lead to considering other potential providers, such as the third sector.