NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 26 November 2013

For: PUBLIC session ☒ PRIVATE Session ☐

For: Decision ☒ Discussion ☐ Noting ☐

Agenda Item and title:	**GOV/13/11/14 Adult Community Health Services in Wiltshire – Procurement Options**
Author:	David Noyes, Director of Performance, Planning and Corporate Services
Lead Director/GP from CCG:	Debbie Fielding – Chief Officer
Executive summary:	The current Adult Community Health Services contract in Wiltshire (Held by GWH) expires in Apr 15. Both Wiltshire Council and the CCG have stated that their intent is to move towards the further joint commissioning of community services. In considering the timing of re-procurement of Adult Community Health Services contract, there is an opportunity to extend the current contract to Apr 16 in order to provide sufficient time for the development of a joint Community Service specification, and the evolution of joint processes, structures and governance to support the future delivery of an integrated service model. This provides an opportunity to start to deliver the shared intent to align the commissioning of Health and Social care provision and potentially provide a more coherent approach to the future of Adult Health and Social Care in Wiltshire. Achievement of this is one of the main aspirations of the Community Transformation programme, and there is significant evidence that the delivery of such an outcome would likely be in the best interests of the people of Wiltshire.
Evidence in support of arguments:	Kings Fund paper on Integrated Care 2011 by Chris Ham & Natasha Curry; Integrated Care Value Case studies undertaken by the Local Government Association with support from integrated care partners looking at the Isle of Wight, Torbay and North West London
Who has been involved/contributed:	Within the CCG – Chief Officer; Chief Financial Officer; Head of Community Transformation Programme. From Central Southern CSU – Senior Procurement Manager External Legal advice from Capsticks Wiltshire Council – Corporate Director and Service Director Adult Care

Cross Reference to Strategic Objectives:	The achievement of the Community Transformation programme objectives is fundamental to the CCG's Vision, and our aspirations in this regard are absolutely shared with Wiltshire Council. These are founded in the future integration of Community Health and Social Care Services.
Engagement and Involvement:	The issue and potential options have been discussed with colleagues from Wiltshire Council.
Communications Issues:	Any decision will need to be widely communicated in the context within which they are taken.
Financial Implications:	Provision exists for the delivery of Adult Community Health Services.
Review arrangements:	The Governing Body will be kept fully apprised of developments in this area by way of updates in the achievement of the Community Transformation programme.
Risk Management:	There is a risk of legal challenge; however the Governing Body debate and decision process will be conducted in an open and transparent manner. Furthermore, there is a strong evidence base regarding the patient/population benefits of an integrated health and social care community service.
National Policy/ Legislation:	Public Contract Regulations (2006) and the Procurement, Patient Choice and Competition Regulations (2013). Public Service (Social Value) Act (2012). The Care and Support Bill (2012) sets out a new statutory principle to embed the promotion of individual wellbeing as the driving force underpinning the provision of care and support and population-level duties on local authorities to provide information and advice, prevention services and market shaping. These duties will be supported by a further **duty to promote co-operation and integration** to improve the way organisations work together. In May 2013, a national collaboration of care and support, including the Department of Health, NHS England, Local Government Association, Care Quality Commission and others, published Integrated Care and Support: our shared commitment. This document established the principles of collaboration, sending a clear signal to the health and social care system that integrated care and support is a national policy headmark. The latest Comprehensive Spending Review, announced in June 2013, set out the future intention for the establishment of an Integration Fund of shared resources between local authorities and the NHS with a view to improving the delivery of integrated community services.
Equality & Diversity:	The enduring delivery of Adult Community Health and Social Care services contributes to achievement across the county. A full Equality Assessment would need to be conducted as part of any extension or reprocurement

	negotiation.
What specific action re. the paper do you wish the Governing Body to take at the meeting?	It is recommended that the Governing Body consider the issues raised within the paper, debate the relative merits of each available course of action, and decide on which way ahead they wish to take.

ADULT COMMUNITY HEALTH SERVICES IN WILTSHIRE – PROCUREMENT OPTIONS

Issue

1. The contract for delivery of Adult Community Health Services in Wiltshire, currently operated by Great Western Hospital (GWH), Swindon, expires on 1 Apr 15[1], and hence a decision on the further extension or re-procurement of this service is required.

Timing

2. Priority; a decision is required prior to Jan 14, since this is the latest practical start date to enable a full procurement process to run in support of an expiration date of 1 Apr 15, should that be required.

Recommendation

3. It is recommended that the Governing Body:

Agree to negotiate a further 12 month extension of the current Adult Community Health Services contract until 1 Apr 16, in order to allow sufficient time for the development of a joint integrated Community Service specification (by the CCG and Wiltshire Council), and the evolution of robust joint processes, timelines, structures and governance to support the future delivery of an integrated service model for health and social care services[2], given the assessment that this is likely to be in the best interests of the Wiltshire population and deliver best efficiencies in commissioning the services.

Context

4. Wiltshire Council and the Wiltshire Clinical Commissioning Group have agreed that it is their joint intent to migrate to a position of Joint Commissioning of Community Health and Social Care services. This direction of travel is clearly articulated in the CCG's latest Commissioning Intentions. There remains work to do to define exactly what this could mean, but the time line associated with the Adult Community Health Services provision contract is such that should re-procurement from 1 Apr 15 be required, we risk being precipitous in defining the specification of this significant contract, when ultimately, given more time to work together with Council colleagues on a more integrated footing, we may specify quite differently and be able to evidence greater benefit to needs of patients. Should the recommendation of this paper be agreed, this would create a better opportunity to successfully achieve the joint intent; this paper does not commit to the specifics of joint commissioning – it is about creating the conditions within which joint commissioning could be more effectively evaluated and/or achieved.

5. Furthermore, in negotiating an extension with the existing provider, the CCG would have the opportunity to re-visit the current service specification and potentially implement some smaller incremental adjustments, coherent with developments within the Community Transformation programme, which are likely to also serve to improve significantly the efficiency and delivery of the service to the benefit of patients.

Background

[1] Initially this contract was due to expire on 1 Apr 14, but has been extended once by 12 months.

[2] Noting that significant work needs to be undertaken to define what could be jointly commissioned and how.

6. The Adult Community Health Services contract in Wiltshire is currently the mechanism for delivering the health element (not adult care services) of nursing, reablement and specialist services in the community, both planned and in response to urgent needs.

7. The vision for the future is to build a County wide, fully integrated, model for care closer to home for the people of Wiltshire. We envisage a sustainable care system, built around individuals and local communities, with a focus on the elderly, most vulnerable, patients, supporting them appropriately to reduce or avert crises. Considerable work remains to be done in taking this forward, building on the achievements of the Community Transformation programme to date. Naturally, affordability will be a key factor, but it is considered that the services we (and Wiltshire Council) commission could be improved by being delivered in a more integrated way.

8. Key to enabling the achievement of this vision will be multi-disciplinary teams, wrapped around primary care clusters, working across community healthcare, social care, mental health primary care liaison service and other community resources (third sector care/voluntary organisations) to provide fully integrated, accessible out of hospital care.

9. The concept is founded and based upon the findings of research such as that reported in the King's Fund 2011 paper on integrated care[3] which found good evidence of the benefits of integrated care for older people. The report found evidence of the benefits of care co-ordination (which is a key component of the Community Transformation programme already being rolled out) for individual service users and carers, especially when multiple approaches are used together. It recommended that integrated care in the NHS should be pursued at all levels to overcome the risks of fragmentation, and of service users 'falling between the cracks' of care, and that policy-makers need to act on the evidence not by promoting a preferred approach but by supporting clinical and managerial leaders to adapt the ingredients of integrated care to improve outcomes for the populations they serve.

10. The King's Fund report studied the progress made in Torbay, which is one example where Wiltshire can take the lessons learned and adapt to the local environment. It found:

Experience in Torbay illustrates how these benefits have been realised in the NHS. Starting from recognition that health and social care services for older people were often fragmented, leaders in Torbay established an integrated health and social care team in Brixham to serve a population of 23,000 people. The team brought together expertise from adult social care and community health services and was co-located under a single manager at the local community hospital. The team worked closely with general practices in Brixham to identify and support older people at risk of admission to hospital.

Integrated teams were subsequently established in four other localities and were given control over pooled health and social care budgets. These budgets were used to increase the provision of intermediate care to support people to remain independent and to enable a rapid response to be made to their needs. Experience in Torbay showed the critical importance of health and social care co-ordinators within the integrated teams. Co-ordinators are not trained professionals and their role is to work closely with professional staff and managers to provide the right care in the right place at the right time. Teams are now able to access information about patients and service users from the integrated information systems that have been established. Having focused initially on creating integrated teams and aligning their work with general practices, the primary care trust and local authority agreed to merge their functions by creating a care trust. This was done in 2005 and provided a platform on which to build on and extend early achievements.

[3] Kings Fund paper on Integrated Care 2011 by Chris Ham & Natasha Curry

Impact

Studies have shown that as a result of integration Torbay has reduced the use of hospital beds, achieved very low delayed transfers of care from the hospital to the community, and it has rates of emergency admissions and re-admissions to acute hospitals that are much lower than in areas with a similar demographic profile. There have also been reductions in the use of residential care, increases in the use of home care, and there are high rates of use of direct payments in social care. The performance of adult social care has improved from a low base as a result of integration.

11. More detailed findings and analysis of Integrated Care Value Case studies undertaken by the Local Government Association with support from integrated care partners looking at the Isle of Wight, Torbay and North West London are at Annexes A, B and C respectively. This work was conducted with a view to highlighting and promoting the evidence of what makes the biggest difference to patient and service user experiences as well as making better use of resources across the system.

12. **The challenge for Wiltshire.** People in Wiltshire today are living longer, healthier lives than ever before. Once fatal diseases can now be cured or managed, adding years or even decades to a person's life. Such progress brings challenges. Our system of health and social care is under ever increasing pressure. The benefits of people living for longer are often reduced by many living with multiple complex conditions.

13. At present the needs of older people in Wiltshire are met by a range of provider services in various locations. These range from the support of a neighbour or relative, through formal home based care or periodic care in hospitals and care homes, to long term care in a residential setting. Such services are often complex, both to deliver and to receive. Wiltshire people have expressed their frustration[4] at the complexity of the system and the need to repeat their personal circumstances to numerous different health and care professionals each time they interact with a different part of the care team. Service users and frontline workers have said that integrated care and early intervention are priorities.

14. **Responding to the Wiltshire challenge.** When service users in Wiltshire were recently asked about their priorities[5] they overwhelmingly indicated that a key priority was for health and care services to enable people to live independently in their own homes for as long as possible. The same group also prioritised the need for older people to be able to access help quickly, especially at a time of crisis – for example if they needed help to leave hospital

15. Commissioning creates the levers for service change. Integrated commissioning should bring innovation, value for money and improved services that cut waste and duplication. Both Wiltshire Council and the CCG recognise that in order to achieve the maximum possible effect, their limited resources will need to be shared. It was for these reasons that Wiltshire Council and the CCG decided that that their shared intent is to migrate to agreements on process and structure for Joint Commissioning to enable greater effectiveness, efficiency, coherence and alignment. Combining the commissioning strength

[4] Two postal questionnaires co-ordinated by Wiltshire Council (one in 2012 and one in 2013) to carers about their experiences in using services

[5] Two postal questionnaires co-ordinated by Wiltshire Council (one in 2012 and one in 2013) to carers about their experiences in using services.

of the two organisations to procure a new integrated community service could offer the opportunity to:

- Target services to give the greatest impact on outcomes
- Avoid duplication of services
- Ensure value for money and efficiency
- Develop co-ordinated services
- Share best practice
- Share expertise
- Share intelligence about needs

16. Given the fundamental role of the Community Health Services provision in delivering the system wide transformation envisaged, the timing and nature of any re-procurement needs careful consideration if we are to realise the vision of radical improvement for the people of Wiltshire.

Estate Implications

17. 10 properties[6] directly associated with the provision of Community Services were transferred from the Wiltshire PCT to GWH in April 2013 following the demise of the Wiltshire PCT, given that the CCG could not own any NHS estate. The basis of transferring the 10 NHS sites to GWH (another NHS organisation) was based on that estate being classified as service critical properties and GWH being assessed as an appropriate custodian. These properties are ring-fenced as service critical properties as long as health services are provided out of them.

18. Wiltshire Council has an ambitious strategy of estate rationalisation within which it is planning on building several new Community Campuses across Wiltshire over the next 5 years. The campuses will allow 106 current properties to be rationalised to promote a greater integration of services across the county. Given the shared vision of Wiltshire Council and the CCG on integrating the delivery of community services, it seems logical to endeavour to have Health Service provision included in the campus programme, and to investigate whether the current health estate value could be used to contribute to the Community Campus plans.

19. Legal advice has indicated that if the existing provider was to lose the current community services contract then the estate would transfer to the new provider if it was deemed that they were an appropriate custodian i.e. they were another NHS FT or NHS Trust. If the service was to be provided by a social enterprise or a commercial organisation then the Secretary of State (SofS) would decide upon the future custodian of the property, which would most likely be NHS Property Services. If a building becomes surplus to requirement then the SofS will ask for the building to be transferred back to the Department of Health i.e. NHS Property Services or if the custodian sells the asset then the SofS will require an element of overage i.e. contribution from the sale proceeds. Any proposed sale of an asset has to have SofS approval and would have had to be passed through the usual local engagement and consultation processes. If an NHS provider were to retain the

[6] Amesbury Health Centre, Calne Health Centre, Salisbury Central Health Centre, Chippenham Hospital, Corsham Health Centre, Devizes Community Hospital, Savernake Hospital, Trowbridge Community Hospital, Warminister Community Hospital, Melksham Community Hospital.

contract and was able to sell the surplus properties, then they would have the ability to transfer resources to Wiltshire Council in order to facilitate the provision of a health service element within a Community Campus.

20. Given this advice it would seem that the benefit to Wiltshire residents of this property asset would be better served if the contract were to stay with "an appropriate custodian" (i.e. an NHS Provider). However, any attempt by the CCG to restrict competition in such a way could be seen as anti-competitive behaviour by the regulatory bodies and disallowed as a result. The CCG therefore requires more time to fully understand our options for estates in the new NHS infrastructure and work with Wiltshire Council and the public to develop a benefits realisation case for the people of Wiltshire around the potential opportunities of combining estate assets. In order to do this the CCG will need to undertake a full public engagement to engage the public in the helping us develop the benefits.

Procurement obligations.

21. The key pieces of legislation covering procurement are incorporated in the Public Contract Regulations (2006) (PCR 2006) and the Procurement, Patient Choice and Competition Regulations (2013) (2013 Regulations).

22. The latter does allow for new contracts[7] to be awarded to a single provider without advertising where the provider is deemed to be "the only capable provider". However, it is not considered that this provision applies in the context of this issue.

23. Expenditure on this service, from a European procurement perspective, must be driven by the principles of transparency, fairness, equal treatment (of potential suppliers) and proportionality (of the procurement process). UK regulation requires a focus on patient choice, service integration and selection of the most appropriate supplier/provider within a framework of procurement best practice. Overlaid across all is a requirement to demonstrate value for money. The CCG has latitude in its procurement decisions and a freedom to manage its processes but it will be held legally accountable for its actions, must act in accordance with the procurement objectives in the 2013 Regulations, keep an audit trail in writing, and it must manage risk appropriately.

Procurement Options for this project

24. The options available to the Governing Body regarding re-procurement, along with the risks and opportunities of each are set out below:

[7] An extension of the contract with GWH is likely to be considered a "new" contract for the purposes of procurement law.

Option	Potential Benefits	Potential Risks
1. Extend existing contract until 1 Apr 2016	• Allows time to develop a Joint Commissioning Strategy for Community Health and Social Care services in line with national mandate for integration. • Allows sufficient time for the development of robust joint processes, structures and governance to support the future delivery of an integrated service model for health and social care services, and the joint development of a Community Service specification. • Allows opportunity for early achievement of joint intent of Joint Commissioning of Community Health and Social Care services with minimum disruption (scope for inclusion to be defined). • Provides the opportunity to develop a "benefits realisation Case" with the public for estate rationalisation and delivery of improved service base potentially from the campus programme. • Gives existing provider enduring stability for delivery of service with	• Existing provider has less immediate incentive to transform services. • This restricts opportunity, negates any competitive tension (and the benefits that may bring) and the CCG may be subject to legal challenge pursuant to the Public Contracts Regulations 2006 or the NHS (Procurement, Patient Choice and Competition (No2) Regulations 2013 (the 2013 Regulations). • Potential intervention by Monitor where there is a perceived breach of the 2013 Regulations including exercise by Monitor of their intervention powers and the possible imposition of a contract variation. .

	consequent effect on interface with public & Local Authority, investment plans and workforce stability. • Allows more time to consult with providers on the shape of future service delivery (with consequent ability for them to develop their capability to service the jointly revised service specification) and compliance with Public Service (Social Value) Act obligations (see below). • Provides the opportunity at extension negotiations for incremental changes to be agreed with the existing provider in order to start to deliver early benefits. • Provides the opportunity to jointly commission elements of the service where integration provides the biggest benefits for patients e.g. Therapies	
2. Re-procure the Service	• Allows competition to drive innovation into the process, economies of scale (to support QIPP targets), effectiveness, quality improvement and increases potential for achieving value for money. • By following best practice procurement and complying with the requirement for transparency, fairness and equal treatment, the potential for legal challenge is reduced. • Use of Monitor's powers (eg	• If a new provider were successful, loss of contract potentially risks enduring viability of current provider (GWH) with potential short term adverse impact on service delivery and consequent impact on local health economy/stability of health system. • The provider market may not be able to respond in a timely manner. • Potential risk to the longer term

	intervention) for breach of the 2013 Regulations less likely. • Provides time for extensive public and patient group engagement.	competition in the market place i.e. a monopoly supplier • May lose flexibility regarding future disposal of estate. • Loss of momentum on current service improvements, for example further development of the Simple Point of Access, and Rapid Response service • Risk that Service Specification is not derived in a fully joint/integrated manner with enduring consequences for the integration agenda.

Risk mitigation and understanding market capability /capacity

25. Draft guidance from Monitor on the Procurement, Patient Choice and Competition regulations states that It is for commissioners to determine ways of improving the quality and efficiency of NHS health care services, including the extent to which improvements can be achieved through services being provided in a more integrated way, by allowing patients a choice of provider and/or by enabling providers to compete for contracts to provide services. The draft guidance also states that "reviewing the market is good commissioning practice and something that commissioners should consider doing as a matter of course".

26. The Public Service (Social Value) Act (2012), which came into effect on 31 January 2013, places a requirement on the CCG, as a commissioner, to consider the economic, environmental and social benefits of their approaches to procurement before the procurement process starts. This obligation places a duty on the CCG to consult with its local community suppliers before formally commencing any procurement.

27. There is unquestionably a risk of legal challenge or an intervention by Monitor should the Governing Body agree with the Recommendation of this paper, since there is still time to run a competitive procurement between now and Apr 15, and the contract has already been extended by 12 months. There are a number of potential community services providers who would be able to compete, and it is not known whether they would seek to challenge this decision, or opt instead to wait and see the outcome of the joint work on producing a more integrated service specification, and make a bid for a potentially wider scope contract in Apr 16. This risk is mitigated to an extent by the CCG's intention to explore and deliver significantly improved services by pursuing the integration agenda. Up to a point the 2013 Regulations assist here, given that they impose a duty upon commissioners to act in accordance with overarching objectives, such as securing patient needs and improving both the quality and efficiency of services and there is a duty to consider and explore integration as a means of delivering on our Procurement Objectives. Regulation 10 obliges Commissioners not to engage in anti-competitive behaviour unless to do so would be in the interests of people who use NHS Services; hence if the Governing Body are persuaded (as is the contention here) that facilitating improved integration is likely to mean better outcomes for Wiltshire people, this proposed contract extension can be robustly justified.

28. Should the Governing Body choose to accept the Recommendation, and opt to negotiate a 12 months extension, it could also be argued that this delay will allow the CCG to better engage with both the market and the Council in order to establish joint commissioning arrangements for integrated health and social care services and the design of those services. It is certainly the case that such an extension is fully coherent with the CCG Strategic Plan/direction of travel regarding the future delivery of integrated community services. In the time and space so created, the CCG would be better able to develop plans and articulate more precisely what the future model might look like.

Resources

29. The latest Comprehensive Spending Review, announced in June 2013, set out the future intention for the establishment of an Integration Fund of shared resources between local authorities and the NHS with a view to improving the delivery of integrated community services. In August, the Local Government Association and NHS England published a joint Statement on this the Health and Social Care Integration Transformation Fund (the ITF). The new fund will not come into full effect until 2015-16, but the joint statement sets a clear expectation that CCGs and local authorities should build momentum in 2014-15 and set two-year plans from March 2014.

30. The ITF will be a pooled budget which can be deployed locally on social care and health, subject to national conditions which must be addressed in jointly agreed plans. There are six national conditions to use of the funds:

- Plans to be jointly agreed, signed off by Health and Wellbeing Boards
- Protection for social care services (not spending)
- 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing, based on the NHS number
- A joint approach to assessments and care planning and where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact of changes in the acute sector

31. Our assessment therefore, is that the direction of travel is seeking to ensure more effective utilisation of resource within and across the health and social care domain. Accordingly, any proposal which facilitates improved joint working arrangements are likely to be beneficial both organisationally, offering better value for money by integrated delivery of services, but more importantly to the wellbeing of our population.

Legal

32. Advice from Capsticks in relation to the key points arising from procurement law/regulation has been sought and incorporated into the body of this report. A summary is at Annex D. Advice on the estates element was obtained from Bevan Britten.

Presentational

33. Presentationally, providing that it is clear that the Governing Body decision is made with the best interests of our patient population in mind and with a view to improving quality, efficiency and secure patient needs in the best possible way, then that decision should not be the subject to public criticism (although note the potential procurement law risks highlighted). There are no known conflicts of interest from any Governing Body member, and any such interest would have to be publically declared prior to any debate in accordance with the CCG constitution.

Annexes:

A. Integrated Care Value Case – Isle of Wight.
B. Integrated Care Value Case – Torbay.
C. Integrated Care Value Case – North West London.
D. Capsticks Legal Advice on Procurement Law/Regulation.

Annex A to Wiltshire CCG Governing Body paper Adult Community Health Services in Wiltshire – Procurement Options

Integrated Care Value Case

Isle of Wight, England[8]

About My life a full life

- The Isle of Wight is the largest off shore island in England with the only combined hospital, ambulance, community, and mental health services in the country.
- The Isle of Wight Clinical Commissioning Group, Isle of Wight NHS Trust and the Local Authority serve a population of 140,000
- The Clinical Commissioning Group has recently been established and gained authorisation, the Isle of Wight NHS Trust is applying for Foundation Status and the Isle of Wight Council is a unitary authority

[8] Copyright ©2013 Integrating Care & the Local Government Association

- **My Life a Full Life** is a coming together of these three organisations, in collaboration with the voluntary and private sector, to deliver a vision for integrated care and support on the Island
- **My Life a Full Life** (MLAFL) programme focuses on people with long term conditions, older people and those with mental health needs, with three priority areas identified:
    - Self Care and Self Management
    - Crisis Response
    - Locality Working
- MLAFL programme commenced in Dec 2012 with the Head of Commissioning for Adult Social Care being released to take up the position as Programme Director for Integrated Care funded by IWC, CCG and IW NHS Trust

Outcomes aimed for by My Life a Full Life:

What difference will it make?

User experience

- Survey developed to measure increase in satisfaction
- Increased numbers of personal budgets
- Reduced incidences of social isolation

Frontline staff experience

- Planned annual staff survey to measure any increase in staff satisfaction
- Targeted reduction in staff sickness and absenteeism

Health and wellbeing outcomes

- Evaluation framework built on individual experience of new ways of working based on locally developed 'I' statements
- Self care and self management supporting quality health and wellbeing outcomes
- People receiving support at times of crisis and cared for closer to home
- People able to have ownership and control over their own medical records

Impact on institutional care

- The Independent Living Centre provides people with access to a wide range of equipment and advice from an occupational therapist in order to assess their mobility needs and try and test equipment
- This will reduce A&E admissions and nursing and residential care

Productivity

- Releasing capacity in statutory services, moving to better use of the voluntary sector and communities
- The Emergency Hub has brought together professionals from the ambulance service, A&E, Wightcare Alarms, mental health and community services to simplify access to emergency care reducing duplication and costs

What we did: integrated care design

Users and Carers

- People promote their own health and wellbeing, identifying exacerbations or changes in condition at the earliest possible stage using Eclipse patient passport
- The Island's user led organisation playing a key role to ensure people have a voice in shaping the MLAFL Vision
- Building individual and community resilience through community hubs, café clinics and care for care good examples

Crisis Response Service

- Multi-disciplinary team operating 24/7 to reduce admissions from emergency hub
- Refers into community services, social care, ambulance, mental health

Single Point of Contact

- Emergency Hub (111 & 999) consisting of ambulance, Wightcare (community alarm service), mental health, OT, social care means users and staff use have one contact point for all community and social care services

Who we did it for and why

Users and Carers

- People's stories paramount to successful delivery – people, carers and the workforce are encouraged to tell us about their stories and what has changed. These stories are used in press releases and the evaluation framework
- Encourage people to live healthy and well within their communities for as long as possible through the introduction of café clinics, community hubs, public health campaigns and health trainers working within voluntary sectors and with communities
- Response to people's desire to have access to their own records and ability to monitor their own condition

Commissioners

- Demonstrate examples of different commissioning models for integrated care – COBIC and Prospectus approaches
- Significant financial pressures on all organisations: need to provide "more for less" whilst also driving quality outcomes
- Help address / resolve issues with funding flows

Changing Demographics of Population

- The IOW's population is older than the England average, with 24.1% of the population over 65 years old.
- The number of people on the IOW aged over 65 with a LTC is expected to increase by 64% by 2033. In 2011 it was estimated there were 44874 people with a LTC and 3566 people with four or more LTCs on the IOW.

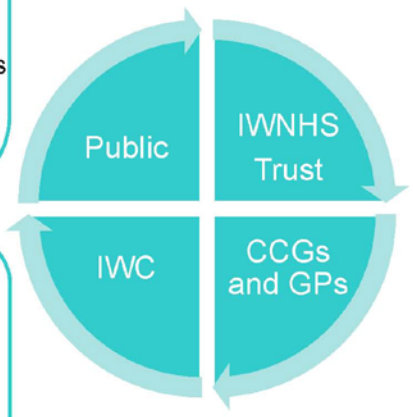
Workforce

- A desire to create relationships, positive behaviour change across all organisations
- Want to create a culture of resolution, working together to deliver a common vision
- Wanted to empower our workforce and increase job satisfaction

Anticipated benefits

Benefits
- Improved outcomes
- Greater freedom and choice through use of personal budgets
- Empowered people
- PPF allows information to be shared between organisations – helping to identify patients at risk

Benefits
- Fewer unnecessary admissions to A&E
- Reduction in bureaucratic systems
- Greater co-ordination of care and support across the organisation and within communities
- Easier to share information with primary care



Benefits
- Reduction in referrals
- Greater co-ordination ensuring right agency responds
- Reduction in admissions to long term care

Benefits
- Support closer to practices
- Greater co-ordination and communication between health and social care
- Clear evaluation process

Lessons learned

Marketing

- People who use care and support are not aware of the programme
- Targeting and marketing the Vision is essential to success
- Engagement and a clear communications strategy is needed at the earliest possible stage

State/Council Support

- We require upfront investment to begin our service – agreed by way of a business case.
- State/council support is paramount to the success of the programme
- Political and strategic ownership ensured through the Health and Wellbeing Board
- Further investment will be determined by strategic board made up of all key stakeholder including the CCG, IWC, IWNHS trust and voluntary and private sector.

Financial Barriers

- Some examples of pooled budgets in place – some tensions as ASC agendas lost in health agendas. Spends and budgets could not be attributed equitably. The end vision is what we talk about now - not budget as this stopped progression.
- We endeavour to use a Section 75 to enable us to pool our budgets.

Workforce

- Trusted assessors and joint commissioners and provision roles being developed as new vacancies and opportunities arise. These will be joint appointments going forward
- Greater buy-in from HR across the organisations required

Leadership and Relationships

- Relationships, behaviours and cultural change will enable this to work
- Closing acute services and transferring funding to primary/community care is difficult and we are considering mechanisms for doing this such as different payment methods focussing on outcomes rather than payment per episode of illness

Annex B to Wiltshire CCG Governing Body paper Adult Community Health Services in Wiltshire – Procurement Options

Integrated Care Value Case

Torbay, England[9]

About Torbay

- Torbay and Southern Devon Health and Care NHS Trust serves a population of 250,000 on the south coast of Devon
- Joint work between health and social care began in earnest in 2002, covering the population of Torbay (135,000) and led to the legal establishment of a Care Trust in December 2005
- Torbay has a significantly higher than average number of residents over retirement age, and it was clear a decade ago that the major service question was how best to meet the needs of the rapidly growing number of people with a complex mix of health and social care needs
- The Care Trust is an NHS body, from which Torbay Council commissions its adult social care services
- The service model is based on integrated multi-disciplinary teams, which work closely with primary care, and specialist health services to manage the care of the populations they serve
- There is a strong emphasis on speed of response, the promotion of independence, and providing services in people's own homes

[9]

Outcomes evidenced by Torbay:
What difference does it make?

User Experience

- Use of Direct Payments is one of the best in the region
- 95% of care packages available within 28 days & 99% of equipment available within 7 days

Frontline staff experience

- Annual staff survey showed an increase in staff satisfaction, with 28 of 36 indicators above the national average satisfaction
- Reduction in staff sickness and absenteeism
- Reduction in staff reporting abuse

Impact on institutional care

- Average number of occupied beds fell from 750 in 1998/99 to 502 in 2009/10
- Emergency bed day use in in the 65+ population was 1,920 per 1,000 population in 2009/10 (compared with an average of 2,698 nationally)
- Lowest non-elective LOS in the South West and 4th lowest in the country

Impact on cost

- The creation of the Torbay Care Trust saved approximately £250,000 in management costs in its first year
- Significant additional savings were made to the system as a whole (e.g. through reduced hospital admissions)

Productivity

- Delayed transfers of care have been reduced to a negligible number

What we did: integrated care design

Focus on Mrs Smith

- The experiences of a fictitious Mrs Smith, an 80-year old user of fragmented service, was used to focus energies around integration, and to explain the approach from a users perspective

Crisis Assessment & Rapid Response for the Elderly

- In place before the Torbay Care Trust, CARRIE was a key multi-disciplinary service
- The identification of a need for stronger social care support was a driver for integration

Aligned social services

- Staff teams were aligned to clusters of GP practices based on GP registration rather than home address. These ‘zones’ became facilitators of integration
- Health and social care coordinator role introduced

Risk stratification and case management

- The ‘Kaiser Triangle’ was used to focus services on patients with the most complex needs
- Case management was used with these patients to maximise impact

Zone working

- A single point of contact in each zone, co-ordinating health and social care.
- Multidisciplinary working across zones
- A whole system approach, with hospitals, primary care and community services encouraged to be in partnerships with the zones

Who we did it for and why

Users and carers

- There was a strong focus on the needs of the most complex, vulnerable older people
- Wanted to ensure the user experience was a smooth and co-ordinated with provision of responsive services

Clinical Commissioners

- Reduce the number of patients staying in hospital unnecessarily
- Fulfil need to achieve low rates of unplanned admissions, shorter lengths of stay, and no delayed discharges

Social Services

- Improve performance of adult social care in Torbay Council
- Increase provision of domiciliary care, and significantly reduce the use of residential and nursing home care

Community

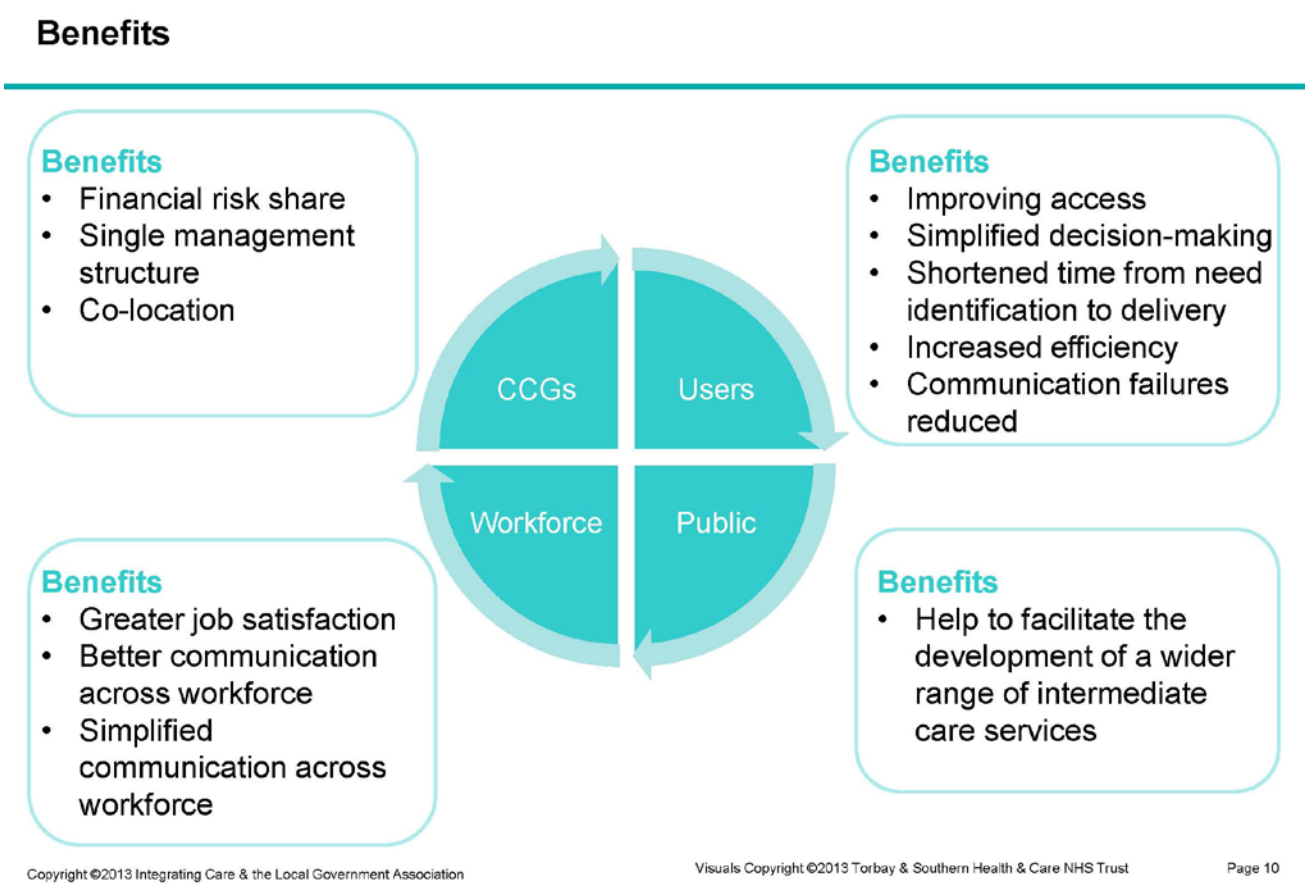
- Improve the provision and quality of services within the community

National politicians

- An early and sustained example of the service user and economic benefits of the full integration of health and social care

Acute providers

- Giving the ability to work closely with a single provider of community services, creating reduction in avoidable admissions, significant improvements to discharge processes, and fewer readmissions



Lessons learned

User-centred services

- Continue to base any strategy on the vision for and benefits being sought for service users/patients (Mrs Smith) to create a compelling narrative
- Specify these in advance, communicate them constantly, invest in improving them, and monitor improvement

GP registration

- Integrate support services from the bottom up around GP registration to simplify access and make co-ordination easier

Organisational development

- With the right change management, cultural, political, organisational and financial risks do not need to be deal breakers – they can be overcome. The evidence base is useful.

Integrated management

- Engage senior and middle management from the start, and avoid separate management arrangements for different professions (including social care)

Care at home

- Prioritise continuity of care at home, with immediate care provision and hospital discharge processes in place to support it

Leadership

- Change relied on leadership across health and social care providers, with commissioners having a lesser role
- Need committed leadership team and political commitment

Annex C to Wiltshire CCG Governing Body paper Adult Community Health Services in Wiltshire – Procurement Options

Integrated Care Value Case

North West London, England[10]

About integrated care in North West London

Context

- North West London (NWL) covers eight boroughs and two million people. Its work is based on genuine partnership between health, social care, third sector and patient and user-led organisations.
- Rising healthcare demand, changing patient expectations and limited resources have led to ambitious plans to move care out of hospital settings to create a high-quality and sustainable health economy. This underpins *Shaping a healthier future*, NWL's programme of service reconfiguration.

Vision for integrated care in NWL

1. People and their carers and families will be empowered to exercise choice and control, to manage their own health and wellbeing and to receive the care they need in their own homes or in their local community.
2. GPs will be at the centre of organising and coordinating people's care.
3. Their systems will enable and not hinder the provision of integrated care.

Progress to date

- NWL has a significant track record as early leaders of integrated care, taking forward ambitious and innovative integration programmes.
- Two **integrated care pilots** (ICPs) already manage the care of the highest risk, most vulnerable patients.
- The Tri-borough (Westminster, Kensington & Chelsea and Hammersmith & Fulham) was as one of the first wave **Community Budget Pilot** sites, working in partnership with central government to improve the experience for the service user and reduce cost through closer integration of health and social care.

Next steps

- Building on the success and lessons of the two ICPs, NWL are now developing towards whole systems integrated care (WSIC). The WSIC programme involved all eight CCGs,

[10]

local authorities and partner providers, and will work with service users to co-design a new model of care.

About the North West London integrated care pilots

- The integrated care pilots (ICPs) are a provider-led initiatives serving NWL's entire population of 2 million.

- There are two ICPs in NWL: Inner (covering the boroughs of Westminster, Kensington & Chelsea, Hammersmith & Fulham and Hounslow) established in July 2011 and Outer (covering the boroughs of Brent, Ealing, Harrow and Hillingdon) mobilised from summer 2012.

- The aim of the ICPs is to improve outcomes for patients, create access to better, more integrated care outside hospital, reduce unnecessary hospital admissions and enable effective working of professionals across provider boundaries.

- At the core of the ICPs is having multi-disciplinary groups (MDG) involving professionals from community health, mental health, primary care, secondary care, social care, community pharmacy and specialist nursing coming together with patients and carers to realise a shared vision of high quality services.

- Multi-disciplinary groups (MDGs) meet monthly as case conferences with the aim of improving the care of these individuals.

- To date, the combined ICPs have produced over 36,731 care plans and are currently holding 42 MDGs each month.

- It is this successful track record that is being developed in WSIC.

Outcomes evidenced by NWL ICP:

What difference does it make?

User experience

- 88% of users reported improved access to NHS services
- 98% of users with ICP care plans felt more involved in the decision making
- 80% of users with ICP care plans had a better relationship with their GP and other care providers
- 96% of patients think that having the care planning discussion has helped improve how they manage their health problem

Frontline staff experience

- 90% of staff involved either agreed or strongly agreed that the case conferences were a very good learning experience
- Over 60% reported that the advice they offered or received at the case conference would enable them to reduce at least1 emergency admission

Health & wellbeing outcomes

- **Consistent screening for common problems**. In the elderly patient cohort, 77% of patients were screened for their risk of falls and 69% were screened for cognitive decline.
- **Detection and management of previously unknown clinical or social problems**. For example, 20% of patients were diagnosed with a new clinical condition and 12% initiated a significant change to their social situation
- **Proactive discussion about how to manage health in the future.** 88% of patients discussed their health related goals for the future and developed an action plan to reach these

Impact on institutional care

- 15% reduction of non-elective admissions in >75s in 2011–2012.
- Emergency activity for the targeted patient groups has seen a decrease of 14% in Inner NWL alone

Productivity

- 81% of users reported reduction in time to book appointments
- 80% users reported that less time was spent of revisiting past medical history on GP appointments as a result of ICP care plans, leaving more time for discussing presenting complaint

What we did: integrated care design

Understanding Population

- Created a patient registry that covered the population and used associated data from all settings of care.
- Initially diabetic and elderly care pathways were rolled out at inception of the pilot; COPD, and cardiac pathways were then developed.
- Currently the ICP focuses on segmenting individual patients by risk, enabling the planning of proactive care.
- The Outer ICP covers a potential population base of 1.2m registered patients, covering 223 GP practices; approximately 140,000 fall within the current criteria for receiving integrated care.

Clinical Protocols and Care Packages

- Clinical protocols and care packages (including activity and resource requirements) were developed for each group, ensuring standardisation of best practice

Care Plans

- Care plans are developed in one-to-one meetings between clinicians and patients allowing for better doctor-patient relationship, and greater patient involvement in decision making.
- These care plans are delivered by multi-professional groups through an integrated approach.
- The patient has one contact point in the delivery of their care plan.
- Across NWL, over 33,000 patients now have a care plan.

Case Conferences

- The most complex cases are discussed at a case conference in an MDT session.
- At these conferences, root cause analysis of NEL admissions is presented for shared learning
- Across NWL, 220 case conferences have been held, and over 1,600 patients discussed.

Who we did it for and why

Users and carers

- Quality of care lagged behind national indicators in some areas, with clinicians describing care as ‘reactive and uncoordinated’.
- Service user satisfaction was variable

Commissioners

- Commissioners in NWL are facing a combined £1bn funding gap in 2014/15, at the same time as healthcare demand is increasing by 4% a year.
- A siloed approach to the provision of complex services and the differential entitlement to receiving them – free at the point of delivery for health and means tested social care – had created perverse and costly incentives for providers, therefore needing an integrated approach.

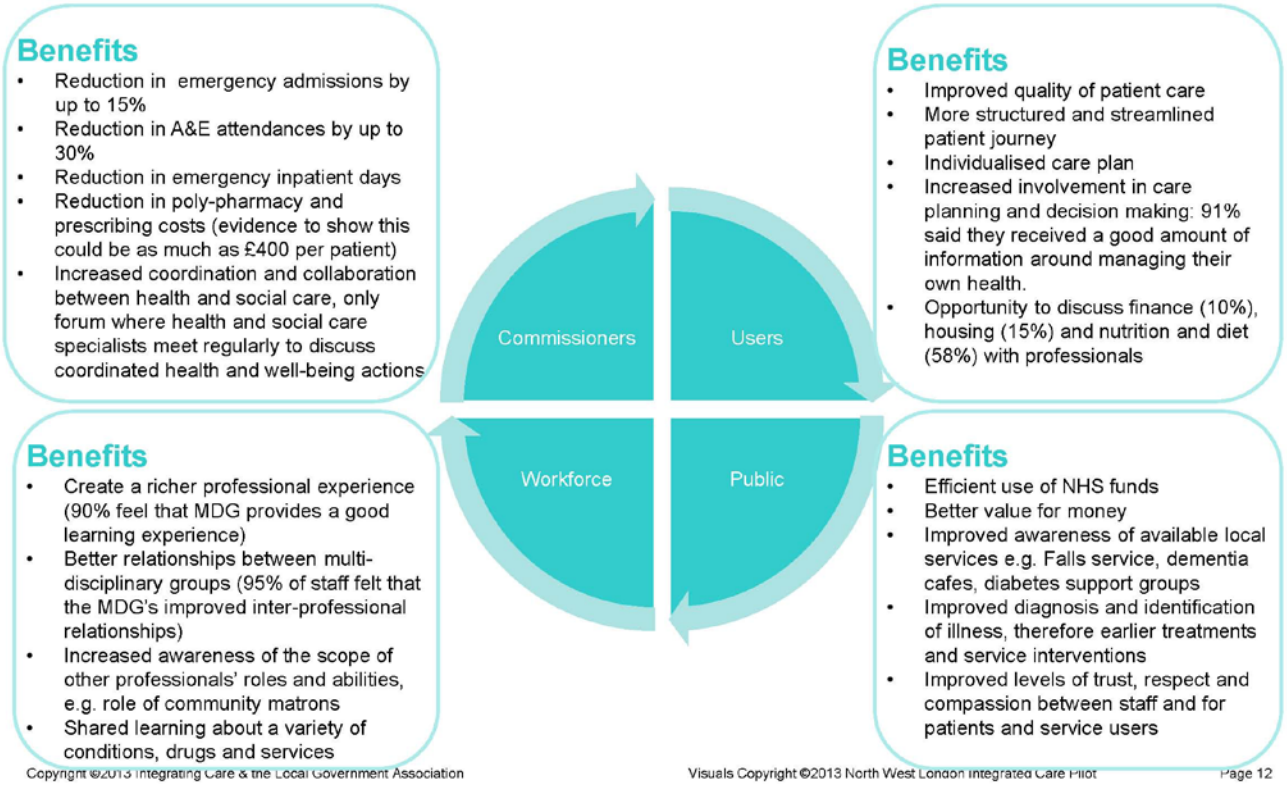
Workforce

- Siloed working meant that there was limited awareness of all services that were provided, and poor professional working relationships. The ICP model served as a platform for bringing all these professionals together to achieve a shared outcome.
- Central to this was a shift from a reactive to a pro-active culture.

Providers

- NWL had misaligned organisational boundaries preventing coordinated decision making, and creating slow and incomplete information exchange between providers.

Anticipated benefits



Lessons learned

Outcomes

- Be realistic about targets and dependencies:
    - E.g. reduction in NEL admissions: Analysis suggests that up to 50% of ICP benefits are dependent on the availability of effective out-of-hospital services
    - E.g. Wanted to reduce the 3620m annual cost of services for diabetic and older service users by 24%: Initial evaluations of programme success showed negligible improvements in outcomes and service user/costs – however international evidence suggests a minimum of three to five years before there is an impact on activity, patient experience and outcomes

IT System

- IT system for care planning was slower and more complicated than first anticipated – IT system implementation timelines must accommodate considerable leeway for refinement and unexpected complexity

Workforce

- There will always be late-adopters to any change programme, but continuous and consistent engagement, together with proven benefits will change their views
- Volunteers in the pilot experienced higher workloads – dedicated and co-located support staff may improve this.

Ways of Working

The ICP developed leaders that successfully engaged with the workforce and enabled them to work together towards achieving positive programme outcomes. The learning from the successes of this programme will form the building blocks in the move towards the ambitious next stage of whole systems integrated care:

- **Strong clinical leadership**, in particular that of the GP, played a central part in ensuring effective participation and engagement of other clinicians with the ICP programme..
- Significant investment in **senior management leadership** and **dedicated programme support** has also played a major role in driving the ICP's success , along with the active involvement of patients including large-scale simulation events run by patients for professionals

Annex D to Wiltshire CCG Governing Body paper Adult Community Health Services in Wiltshire – Procurement Options

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Key points arising in NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (the "2013 Regulations")

1. **Outline of procurement obligations**

1.1 The 2013 Regulations require commissioners to consider certain procurement objectives when commissioning health care services for the purposes of the NHS. These are to act with a view to: securing the needs of the people who use the services; improving the quality of the services; and improving efficiency in the provision of the services (the "**Procurement Objectives**")[11].

1.2 Commissioners should also act in a transparent and proportionate manner and treat providers equally and in a non-discriminatory way. They should procure the services from one or more providers that:

(a) are most capable of delivering the Procurement Objectives referred to in regulation 2 in relation to the services; and

(b) provide best value for money in doing so.[12]

1.3 In complying with their duties to act with a view to improving quality and efficiency in the provision of the services commissioners must consider appropriate means of making such improvements through:

(a) integration (including with other health and social care services, health related services, or social care services);

(b) enabling providers to compete to provide the services; and

(c) allowing patients a choice of providers.

1.4 The 2013 Regulations permit the direct award of a contract for the provision of health care services for the purposes of the NHS to a single NHS provider without advertisement in one circumstance. That is where the commissioner is satisfied that the services to which the contract relates "are capable of being provided only by that provider" (Regulation 5). For instance where local needs and requirements mean that a service must be provided at a particular location and there is only one provider who can provide it at that location.

[11] Regulation 2
[12] Regulation 3

(a) Monitor has indicated in its guidance[13] on the 2013 Regulations that it is 'ultimately for commissioners to decide what services to procure and how best to secure them in the interests of health care service users. The 2013 Regulations do not therefore require tendering, however, commissioners must still satisfy the duties conferred upon them under the Regulations.

1.5 If commissioners choose not to conduct a tender process under the 2013 Regulations (for example, they choose to integrate or follow an AQP process), they will need to ensure that they have a record of their decision making as they are required in the 2013 Regulations to maintain records setting out how the award of contracts complies with their duties regarding the Procurement Objectives.

1.6 Finally, Regulation 10 provides an additional obligation on commissioners not to engage in anti-competitive behaviour unless to do so would be in the interests of people who use NHS services. This brings into play competition law and tests such as market dominance or loss of competition and the importance of drawing a geographical area for the purposes of analysing these impacts.

1.7 In addition, commissioners must also comply with the Public Contracts Regulations 2006 ("**PCR 2006"**) and EU procurement law, which may in turn require advertisement and competitive tendering even if the 2013 Regulations do not. To some extent the 2013 Regulations mirror the PCR 2006.

1.8 Where a competitive process is required (and no exception applies), there is a certain amount of flexibility to commissioners in designing and implementing a process for part B services (e.g. clinical services), as long as it is transparent, proportionate and treats all providers equally. Again, this flexibility is reiterated in Monitor's guidance.

2. Consequence of non-compliance with the 2013 Regulations

2.1 Without clear and justifiable reasons or exceptions, a failure to appropriately advertise and tender healthcare services may trigger a challenge from a disgruntled provider for breach of the Public Contracts Regulations or the 2013 Regulations.

2.2 Breach of the 2013 Regulations permits Monitor to investigate (Regulation 13). Monitor has power to compel information in relation to the investigation and where the breach of the 2013 Regulations is held to be sufficiently serious, Monitor can declare the contract or part of the contract ineffective (i.e. void) (Regulation 14).

2.3 Regulation 15 provides Monitor with wide powers to mitigate against the breach of the 2013 Regulations. These powers include the power to vary the contractual arrangements entered into.

2.4 A potential supplier could choose to bring an action under the Public Contracts Regulations 2006 instead of the 2013 Regulations. This would be dealt with in the usual manner by the courts but would prohibit any action under the 2013 Regulations (Regulation 17).

3. Exceptions to tendering

3.1 Although there is no express requirement to competitively tender, commissioners will need to satisfy their duties above if a competitive tender is not undertaken when awarding a new contract (which could also include extensions of a current contract).

[13] Substantive Guidance on the Procurement, Patient Choice and Competition Regulations 2013 (May 2013 – still in consultation) ("Monitor's Guidance").

The 2013 Regulations permit a direct award to a single provider and that is where that provider is the one capable provider.

3.2 There is an equivalent concept which has been examined by case law in relation to the Public Contracts Regulations 2006. This case law has shown this exception to be construed narrowly by the Courts.

3.3 In the past, possible reasons for reaching a justification that a provider is the only capable provider have included:

(a) that provider is the only provider with the skills or capability to deliver the services;

(b) that provider is, for reasons of patient safety, the only provider capable of delivering that service; and

(c) following a reconfiguration, services are required to be provided in a particular location by a particular provider.

3.4 Generally the CCG will need to consider the requirements in the 2013 Regulations and build those in to its decision making process i.e.by determining whether:

(a) extending the contract will mean you are procuring services from a provider that is **most capable of securing the needs of health care service users** and **improving the quality and efficiency of services** and which **provides the best value for money** in doing so (Regulation 3(3));

(b) you have considered all **appropriate means of improving services** including through enabling providers to **compete to provide services** and allowing patients a **choice of provider** (Regulation 3(4)) and you still come up with the best option being to extend the current contract;

(c) you can show evidence that you have an open dialogue with the providers on the market and no provider is being excluded by your actions and they are enabled to express an interest in providing any services (Regulation 4(4));

(d) you can show evidence that you are acting proportionately (Regulation 3(2)) e.g. to run a procurement process would cost disproportionate amounts and be a waste of money (e.g. because there is no provider that can provide it other than the current provider);

(e) you can show evidence that you have acted transparently and have not discriminated between providers (Regulation 3(2))

(f) in each case your reasoning and criteria are clear and objective and decision making is free of conflicts of interests

4. **Circumstances** which may be relevant when considering whether tendering is or is not the most appropriate way to let or extend a contract, include (these are provided for illustration only below and should not be used as “tests” without full consideration of all factors on a case by case basis):

(a) You can show your thought process and evidence transparently in the CCGs commissioning intentions which in turn reflect the Health and Wellbeing Board’s Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS), that a decision to proceed with an extension of a

contract has been made in order to help you / give you time to consider if those services can be improved by delivering them in a more integrated way. The fact that greater integration across community health and care services is at the heart of the CCG's commissioning intentions will be a key part of the CCG's mitigation and decision making. Clear timescales should be indicated for when any particular configurations or bundles of services are proposed to be tendered / integrated.

(b) You can show evidence, eg from a soft market testing exercise pre-procurement which establishes that all capable providers will not be interested in tendering for the services at the time, and others do not have the capability or capacity to provide the services in the manner or scale proposed (provided your criteria for making this decision are very clear and transparent and linked to the specific service specification, and/or location and/or scale of the services, does not discriminate and it is contained in the written audit trail) this may indicate an extension of a current contract may be appropriate pending a clearly articulated timescale and plan to tender the services or bundles of them in a more locally inclusive and integrated manner in the future which would give all providers in the area a chance to consider or bid for the provision of the services.

(c) That you are preparing to undertake consultation around a service reconfiguration to allow the services to be provided differently or more efficiently or more in line with patient need and benefit (i.e. your Procurement Objectives), but you do not have time to do so robustly or completely prior to the services in the contract terminating. An extension to allow you to complete the consultation and then to run the subsequent process in order to award the contract (or contracts) to the best placed provider(s) may be justified in these circumstances (provided not for an unduly long period).

(d) Where for patient safety or service continuation purposes (which ultimately are in the patients' benefit) it is desirable to continue a contract beyond its end date.

(e) Where this decision fits in with the clear and reasoned commissioning intentions of the CCG, which sets out a transparent intention and process/path for the services in question (e.g. that they will be tendered in due course), which in turn reflects the local Health and Wellbeing Board's JSNA and JHWS.

(f) Where for specific local needs e.g. geographical, it is necessary to continue services in a particular location.

4.2 When considering a contract extension without further procurement it should not be for longer than necessary to effect the decision or action it was extended for.