NHS
Wiltshire
Clinical Commissioning Group

Report to:	Governing Body	**Agenda item:**	GOV/14/11/09
Date of meeting:	25 November 2014		

Title of report:	Adult Community Services Procurement – update & decisions required in advance of formal procurement
Governing Body Sponsor:	Ted Wilson, Group Director NEW and Programme Director for Optimising Community Teams
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Appendices:	

1. Summary of issues (including link to objectives)

As part of the Optimising Community Team programme, agreed as one of the CCG's priorities, is the Adult Community Services procurement. A contract with Great Western Community Hospitals NHS Foundation Trust (GWH) has been in place since 2010. This contract, which is overseen by the NEW group in the CCG has been extended and work has been underway to procure a new community service. This service is due to begin in July 2016 following the recent extension of the current contract which has been agreed with GWH in response to the market engagement event held on 24 September

This paper provides an update on progress and sets out the proposed procurement timetable and arrangements for the development of service specifications. It describes the process for the development of outcomes and for public and stakeholder engagement. It asks the governing body to make the decisions below.

2. Recommendations (note, approve, discuss etc)

The Governing Body is are asked to make six decisions:

1. Endorse the use of Outcomes as the basis for commissioning
2. Confirm the preferred contracting model
3. Agreement on the length of contract including any extension period
4. Ratify progression to formal procurement
5. Agree to delegate decision making authority to the Clinical Executive to support the lead in to formal procurement (ie prior to PQQ) and in so doing identifies that no individuals have a known or potential conflict of interest associated with the procurement of ACS; and where individuals are conflicted it is accepted that they will become excluded from information, discussions and decisions associated with this procurement.
6. Agree approach to communication, engagement and consultation for the

ACS

The Governing Body is also asked to note:

A. The approach to the development of the To Be service specifications and the advice that these are suitably firm at the start of the procurement process so that providers are able to submit proposals for how they will be delivered from July 2016, thus enabling the CCG to commission the best possible services for patients.
B. The timetable including the inherent impact that this priority work will have on the capacity of staff and clinical leaders
C. The requirement for active participation by empowered staff and members in the procurement stages
D. The approach that the organisation must take to ensure a fair and transparent process throughout the procurement

3.	Link to CCG Strategic Objectives

In its five year plan the CCG has indicated the importance of its community services which through this procurement process will be expected to meet the challenges faced by the local health economy in meeting the growing demands of patients and aging population and by supporting the CCG in delivering its out of hospital care model

4.	Legal / Regulatory implications

The CCG has a duty to conduct its business in an open and transparent manner. It is also bound by the procurement legislation and is committed to delivering high quality services for patients by engaging with the market in fair and open competition.

Through the procurement the CCG wants to ensure that the successful bidder is expected to work closely with Social Care in order to fulfil the requirements of the Care Act which is due to be implemented in April 2015. There will need to be options for merging and aligning contracts in the future. As the evaluation process is developed there will be a strong weighting towards the bidders ability to provide integrated care.

5.	Risk (threats or opportunities link to risk on register etc)

The procurement of Adult Community services poses risk to the CCG in the following ways:

1. There are insufficient providers engaged or able to meet the ambitions of the CCG that are intended to be delivered through this procurement or within the available resources.
2. The CCG could be open to challenge on the grounds of anticompetitive behaviour if it provides undue consideration or engages differently (to others) with the current service provider.
3. There are also potential risks associated with legal challenge resulting from

conflicts of interest through the inherent structure of the CCG with its GP providers as members and leaders. These risks will be mitigated through careful consideration of those involved. An example of how this was managed can be evidenced from the market event on 24 September 2014.

4. There are risks associated with delays to stages as set out in the procurement timetable. These can be mitigated by timely action and decision making with resources prioritised by line managers accordingly.
5. There are risks inherent in the competitive dialogue process which the CCG has sought to mitigate through the description of commissioning principles (see Annex A) which will be included in the Memorandum of Information and any contracts. These risk5 will be further mitigated through the identification of conditions which restrict the business activities of the providers. These will be clearly articulated to providers.
6. The available resources are insufficient to meet the requirements of the GP membership or public necessitating a prioritisation of requirements by the CCG which adversely affects engagement and reputation. This could have a negative impact on other aspects of CCG business.
7. The staff and clinical leadership capacity is presently stretched and once the formal procurement process begins this pressure will increase further. This will necessitate the identification of key personnel to act on behalf of the organisation and its membership.
8. Any significant change adversely affecting the public and requiring formal public consultation, whilst not anticipated, would affect the timetable.
9. Service delivery of the existing contract may be adversely affected if provider staff are not appropriately engaged and seek alternative employment during the course of the procurement.

6.	Resources implications (financial / staffing)
The resources for the current adult community services contract is the financial envelope available for the procurement. The project will require significant staff and clinical leadership capacity as it is an organisational priority.	

7.	Equality and Diversity
Refer to Equality Impact Assessment at the end of this document	

8.	Communications (Presentational)
The paper contains a communications and engagement plan and outlines the approach the CCG is taking to public consultation.	

9.	References to previous reports
GOVp/14/09/10 Adult Community Services Procurement - Update	

10.	Freedom of Information

There are no exemptions

Adult Community Services Procurement – update & decisions required in advance of formal procurement

1 ISSUE

The CCG is in the pre-procurement stage of procuring community services for adults. The Governing Body has been involved and has made decisions about the procurement approach including that there will be a single contract in place for the provision of commissioned services. The Governing Body has also been sighted through the Integrated Performance Report on progress. The CCG has indicated that it wishes to move to an Outcome Based Commissioning approach as part of the competitive dialogue approach to procuring new community services.

As the procurement work nears a critical phase this paper provides the Governing Body with an update, sets out the approach that is being taken to the development of service specifications including outcomes, includes a timetable for the procurement and identifies matters about which the Governing Body is required to make decisions.

2 TIMING

Priority. The timetable for the procurement project is tight and prompt decisions are required to enable the project to move to the formal procurement stage which is due to begin in early January. There is no Governing Body scheduled in December 2014.

3 RECOMMENDATION

The Governing body is recommended to take the decisions articulated in section 7 which are summarised here as:

1. Endorse the use of Outcomes as the basis for commissioning
2. Confirm preferred contracting model
3. Agreement on the length of contract including any extension periods
4. Ratify progression to formal procurement
5. Agree to delegate decision making authority to the Clinical Executive to support the lead in to formal procurement (ie prior to PQQ) and in so doing identifies that no individuals have a known or potential conflict of interest associated with the procurement of ACS; and where individuals are conflicted it is accepted that they will become excluded from information, discussions and decisions associated with this procurement.
6. Agree approach to communication, engagement and consultation for the ACS

4 BACKGROUND

The CCG has previously agreed a programme structure and allocated a priority to each programmes and a lead Director. One such programme is Optimising

Community Teams and Ted Wilson is the Programme Director. The Programme splits into two projects:

- Optimising Community Teams Development, and;
- Optimised Community Teams Procurement

For clarity, the following descriptions are included at the outset.

OCT Development project

The OCT Development project involves the set up of the 3 Demonstrator sites by December 2014 in Bradford on Avon, Calne and Salisbury City and also the wider establishment of the remaining 17 Integrated Teams, which are also progressing. The result will be that the CCG as commissioner, in partnership with GWH (the current service provider), Primary Care providers, AWP and Wiltshire Council Social Care has a model of care that fits with its out of hospital model described in its five year strategy. It will also work closely with local community and wider voluntary sector groups and agencies. Through this project the Outcomes for community service provision will be developed. These will impact on the wider community service provision that is to be procured. This paper is not concerned with this project.

ACS Procurement project

The ACS Procurement project will, through the competitive dialogue process, agreed by the CCG Governing Body in July 2014 will ensure that there is a single contract in place which provides the following services for patients:, Community Beds (inc Step up), Community Geriatrician/Frail Elderly Service, Stroke Therapies Neurology Stroke, Speech and Language Therapy (SALT), MIU, Continence, CTPLD, Hearing Therapies, Tissue Viability Lymphedema, Diabetes, Dietetics, Podiatry, Community Outpatient Musculoskeletal (MSK) Physiotherapy & Extended Scope Physiotherapy (ESP), Orthotics, Wheelchairs, Cardiac (PACE) & Respiratory Services (COPD), Core Community Teams (inc Care Co-ordinators) Outpatient Department services, and Fracture Clinic.

Re-procurement of Community Children's Health Services

Re-procurement of children's services is out of scope and therefore not part of either of the above projects which relate to adult services once provided by Wiltshire Community Health Services and previously contracted to GWH through the Transforming Community Services programme in 2010. It should however be noted that the timings of the projects are similar and providers who choose to respond to the tendering process will be required to divert resource to support the bids. The CCG will also have to provide resources to support this project as will the CSU working under SLA to the CCG.

5 CURRENT POSITION OF THE ACS PROCUREMENT PROJECT

5.1 Service specifications

The procurement exercise will require a description of each service. These can be broken down into the following categories, which at the outset of this document it is important to note:

- As is – which describes the current commissioned service, and;

- To be – a description of the service that is required from 1 July 2016. This will be made up of the As Is service specification (where it exists) that must be delivered as a minimum from the start of the contract plus agreed aspirations that will have been included in 15/16 contract plus outcomes for each service (and some outputs) and a description of future aspirations that the provider must have a plan to implement. Where applicable and agreed, through the competitive dialogue process, outcomes will also commence from the start of the new contract or must have a clear plan for phased introduction through the life of the contract. In addition the "to be" specification will also contain the CCG;'s future aspirations for service delivery (i.e. post July 2016).

Through the programme structure service specifications are being developed. Most will fall into the 'as is' category. However, there are some to be specifications which are being produced without a separate definition of the current as is service. Of course, a full analysis of the current 'as is' service has been considered during the development. Table 1 below provides a summary and the services have been grouped into categories.

Table 1 – summary of services for which specifications are being produced

Category	**Specification**	**Specification required**
Integrated Teams	Core Community Teams (inc Care Co-ordinators)	To Be only
Bed-based Care	Community Beds (inc Step up)	To Be only
Specialist Support	Community Geriatrician/Frail Elderly Service	To Be only
Specialist Support	Stroke Therapies Neurology Stroke	As Is & To Be
Specialist Support	Speech and Language Therapy (Salt)	As Is & To Be
Diagnostic & Ambulatory Care	MIU	As Is & To Be
Specialist Support	Continence	As Is & To Be
Specialist Support	CTPLD	As Is & To Be
Specialist Support	Hearing Therapies	As Is & To Be
Specialist Support	Tissue Viability Lymphedema	As Is & To Be
Specialist Support	Diabetes	As Is & To Be
Specialist Support	Dietetics	As Is & To Be
Specialist Support	Podiatry	As Is & To Be
Specialist Support	Community Outpatient MSK Physio & ESP	As Is & To Be
Specialist Support	Orthotics	As Is & To Be

Category	Specification	Specification required
Specialist Support	Wheelchairs	As Is & To Be
Specialist Support	Cardiac (PACE) & Respiratory Services (COPD)	As Is & To Be
Diagnostic & Ambulatory Care	Outpatient Department services	As Is & To Be
Diagnostic & Ambulatory Care	Fracture Clinic	As Is & To Be

Separately to development of the 'as is' service specifications commissioning leads in the CCG continue to manage the performance of the community contract. The NEW Group leads on the management of this contract. It is important that patients receive high quality services which provide value. It is also important that the CCG is provided with services which perform in line with the current contract and from which the future service models resulting from the procurement can be built. All performance issues are being addressed now to inform the future contracting of services.

Producing To Be specifications which clearly articulate CCG requirements of future providers is important as these will assist providers to develop outline proposals and subsequently detailed proposals which inform the outcome of competitive dialogue process. During the competitive dialogue process providers must focus their responses on describing how they will deliver the services that the CCG requires within the confines of the financial envelope, as well as any staff that TUPE across and any equipment, IT infrastructure and facilities that transfer to a new contract provider (should this be the case).

5.2 Development and agreement of the As Is service specifications

The As Is specifications were developed through the use of existing documentation dating from the Transforming Community Services programme in 2010, best practice research, stakeholder analysis, and in some cases workshops with stakeholders. The specifications have received input from colleagues in the Quality and Patient Safety directorate and thereafter approval from the Group Executive meetings. Feedback has also being requested from GP colleagues to assist with the production of the As Is and To Be specifications through the identification of known gaps and/or aspirant improvements in services for patients. It is important to note that our aspirations for service improvement must also be balanced against the financial envelope which will be in line with the current contract for Adult Community Services.

It is intended that the As Is specifications for the 15 Adult Community Services, including draft To Be specifications for the three services (Core Community Teams, Community Beds, and Community Geriatrician/Frail Elderly Service) are approved by the Clinical Executive on 25 November. Once approved the documents will be shared with providers to maintain interest and stimulate planning by the providers. The provision of this information will also assist the CCG demonstrate fairness by

enabling as large a number of providers as possible to be engaged in advance of the PQQ stage of the process. The CCG will want to ensure that it has a sufficient number of providers interested at the outset in order theat the best community service possible can be procured when the formal process begins.

Included in the release of information to the market following agreement by Clinical Executive will also be a description of the aspirations for community services that will be reflected in the To Be specifications as well as outcomes that have been developed and a description of the envisaged system of community service operation.

The As Is specifications are produced using the current NHS Standard Contract template and includes:

- National and local context
- Outcomes – this is a reflection of the national outcomes framework and a statement about an current locally defined outcomes
- Scope – this includes the aims and objectives of the service, service description/ care pathway, population covered, acceptance and exclusion criteria and any interdependencies with other services
- Applicable service standards – these will reflect NICE and national guidance and best practice
- Applicable quality and CQUIN goals – currently these are not populated
- Location of provider premises – these cover DDA compliance, waiting areas, washrooms etc

5.3 Engagement with Providers – update on the market event held on 24/9/14

The CCG launched its intention to undertake a competitive dialogue process for the re-procurement of community services identified above. From this event questions have been generated and responded to. To maintain engagement the CCG has also furnished providers who attended the market event with contact details of each other in order that alliances can be developed so that when the procurement process formally begins provider organisations are in a position to respond. This information is referred to as the Capability Matrix and this document will be maintained by the project team and details of voluntary agencies are being added to the list.

Although a second pre-procurement market event was deemed unnecessary; it is proposed to provide a further opportunity for potential providers to meet with the CCG in early January i.e. once the procurement is formally launched. This will be to provide potential providers the opportunity to clarify any points they may have on the procurement that will assist in the production of their PQQ submission. This will assist with decision making by providers about their interest in the tender which will again assist the CCG demonstrate its commitment to a fair and transparent procurement process with a wide market. It will at the same time allow the CCG to make an assessment of the viability of delivery by providers of the CCG requirements.

5.4 Principles of commissioning a refreshed community services

The CCG's Governing Body approved a number of principles about the new service model; these were then presented at the Market Event on 24th September with an explicit message that these were to be adhered across the life of the contract. The principles, which can be found at Annex A, will need to be factored into the new contract and consideration will need to be given as to how they are best articulated within specific service specifications and the evaluation process.

5.5 Limitations and controls on providers within Outcome based Commissioning and Competitive dialogue

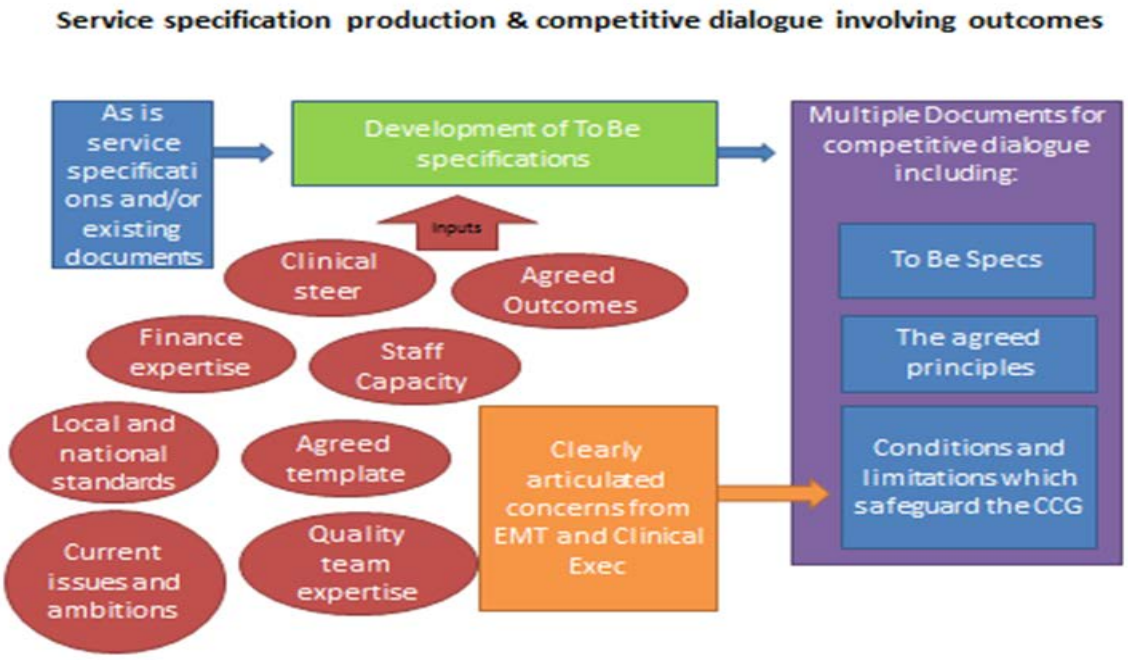
Outcome-based commissioning offers the opportunity for services to be commissioned and contracted in such a way that providers are rewarded for achieving determined outcomes for patients rather than just rewarding levels of activity. It enables the rewarding of the "value-added" aspects of service provision and should, as a result, change the way in which care is offered to patients. Overall, an outcomes based approach aims to shift the emphasis from what services a provider will offer to what outcomes they will achieve.

Outcome based commissioning means putting in place a set of arrangements whereby a service is defined and paid for on the basis of agreed outcomes. It means shifting the basis on which services are purchased and measured from units of service provision (hours, days, appointments etc) to what is needed to ensure that the outcomes desired by service users are met.

The focus on delivery of outcomes does not negate the requirement to ensure the safety and quality of services, and still requires there to be clear systems and processes in situ to enable the delivery of appropriate clinical outcomes. An outcomes based approach depends on establishing and developing partnership working with future providers in a truly collaborative way. This approach, which is in stark contrast to the traditional commissioner provider relationship, requires the development of a relationship with providers based on mutual trust and mutual benefits.

This approach does not mean however that the commissioners need to surrender to the market as safeguards can and must be built in to any contract to prevent changes being made that are outside of the expectations of the commissioners. It is envisaged that through the suite of information shared with providers through the competitive dialogue process providers are made aware of any limitations and conditions which must be adhered to. These may relate to quality standards or the ability to make authorised changes to locations or workforce structure. Figure 1 below depicts how this will work in practice

Figure 1:



5.6 Applying an outcome based commissioning approach to ACS procurement

The Joint Commissioning Board, involving the CCG and Wiltshire Council, agreed in principle in October that outcomes based commissioning will be introduced across the range of services to be procured. These are to be strengthened with patient engagement and progress is being made with this task. The outcomes are included for reference in Annex B. The outcomes, currently broken down into 3 categories (Ultimate, Intermediate and Immediate) were produced predominantly for use in the Integrated Teams development project. However, they are to be applied, where possible across all ACS with staff working closely with clinicians to produce specific outcomes for each service.

As part of the development of the As Is service specifications, CCG staff with stakeholders have started to identify how a more outcomes focused approach can be taken. For some services, there is still a requirement to focus on the systems and processes in place to ensure that a safe and quality focused service can be delivered, and that there is a consistency across the county of Wiltshire. Attention needs to turn to finalising the To Be specifications.

It should be noted that it is unlikely that all CCG outcomes will be relevant to every service and there will be a need to reflect this in any procurement documentation. However, where they are required the timeframe for moving to an outcome based approach will be discussed with the bidders and incorporated as part of their tender submission.

5.7 Designing the To Be specifications within resources available

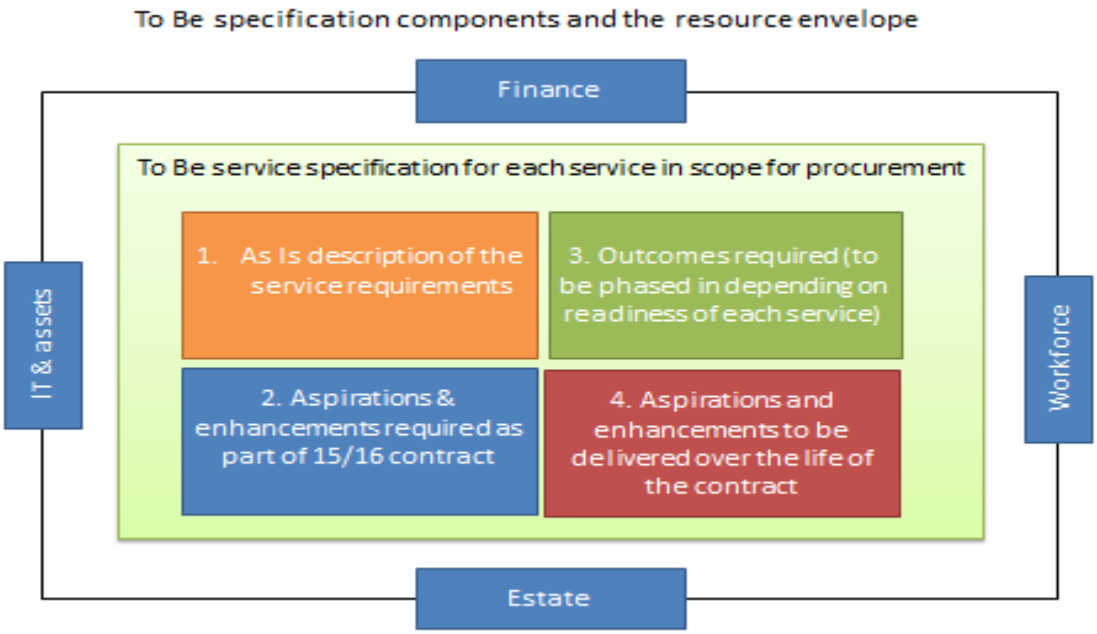
To Be specifications will form part of a standard NHS contract once commissioned and to will be produced on the standards service schedule template. Each will include a description of desired outcomes and where appropriate outputs. Also included will be national standards, quality indicators and other 'must do's' as well as measurements for use in contract performance management.

To be specifications will comprise a description of the service that is required from 1 July 2016. This will be made up of the As Is service specification (where it exists) plus agreed aspirations that have been included in 15/16 contract.

Where applicable and agreed, through the competitive dialogue process, outcomes will also commence from the start of the new contract or must have a clear plan for phased introduction through the life of the contract. Similarly, with the CCG's future aspiration for service development., the provider must have a clear plan for phased introduction

Through stakeholder engagement the aspirations for service provision will have been articulated. It should be noted that a balance must be managed between which aspirations are included in the To Be service specifications and the resources available to any provider to deliver. There must be a clearly identifiable benefit to justify inclusion. Figure 2 depicts the interrelationship between the To Be specifications and the available resources.

Figure 2:



5.8 Participation in the procurement exercise

The procurement exercise is already proving to be resource intensive and it will continue to be so. To ensure that the CCG obtains the best quality and value for patients and the local health economy it will need to have active participation by clinical leaders and managers in the various stages, an indicative list of which is provided below:

- Development and agreement of the Memorandum of Information (see below)
- Agreement of To Be specifications including outcomes and which aspirations and enhancements are actually included for delivery within resources
- Design of the Pre-Qualification Questionnaire – This is important as it acts as a filter to ensure the CCG is having competitive dialogue with providers who have demonstrated capability and capacity to deliver the required service model for community services.
- Involvement in and potential decision making during the competitive dialogue phases – During these phases providers will be developing their outline, and then their detailed proposals on how they propose to deliver the services required. During these stages the CCG will need to field colleagues who can provide clear, authoritative and timely feedback to bidders queries and proposals. There may also be the requirement to reduce, through selection, the number of providers involved before detailed proposals are submitted. This selection will require evaluation and feedback to providers it will also involve significant reading, moderation and discussion with providers.
- Final selection of the provider – using evaluation criteria designed at the beginning of the formal procurement process a panel will need to make a selection. The decision will be for ratification by the Governing Body

For the procurement to flow efficiently there is a need for timely decision making which potentially presents a challenge to the CCG with its structure and governance arrangements. Of course the CCG will operate within its agreed Scheme of Delegation, but it is recommended that consideration is given to a lead GP member being involved and able to speak on behalf of a group and its localities. GP leaders are already engaged in other activities, have limited capacity and yet must feature prominently in the fast paced procurement.

For those identified to participate in the procurement, attendance at relevant training to ensure consistency and fairness of process will be required. It is anticipated that participants will be identified during November 2014.

5.9 Ensuring fair competition and managing conflicts of interest throughout the re-procurement of Adult Community Health Services

The participation of stakeholders in the procurement process will be subject to them having no conflicts of interest as the CCG is committed to there being a fair and transparent process for the procurement of Adult Community Health Services (ACS). Set out below are arrangements that the CCG (a membership organisation as de-

scribed in its Constitution) will have in place and some principles by which it will abide within the current text.

5.9.1 The current context

The CCG has a contract for the provision of ACS with Great Western Hospitals NHS Foundation Trust (GWH). This contract has been in place since 2010 and GWH have indicated to the CCG a willingness to extend the contract until the end of June 2016 to accommodate a longer mobilisation period. Responsibility for managing the contract and the relationship with GWH falls to the NEW Group of the CCG. Dialogue with the provider takes place as part of this contractual relationship.

The CCG has also published its 5 year strategy and stated its aim of developing an out of hospital model of care which requires community service provision to be developed. Some of the development will result through contract performance enhancement and also through the ACS re-procurement exercise. Some development will result from the CCG's current investment in community services and particularly the Integrated Team element resulting from the business case agreed in summer 2014. The aforementioned inter-relationship between commissioner and provider necessitates dialogue and the sharing of information. Although this may be perceived as anti-competitive the CCG is keen that this is not the case. The CCG is committed to the principles of Good Governance, as stated in section 1.16 of its constitution. which states that the CCG will observe:
'the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business.'

Through the procurement process which will include good governance the CCG wants to achieve:

1. a new model of service delivery that does not favour the incumbent or unfairly restrict anybody else from becoming a provider
2. that professional input has been taken on board from a range of sources in order to get the best possible outcome and
3. In-depth discussions with GWH about the future ("to be") model are either not held (outside of the procurement) or are opened up to others.

5.9.2 The Constitution & the Standards of Business Conduct Policy

To assist the CCG membership and management teams with transacting its business in a fair and transparent way the CCG has agreed a policy on the Standards of Business Conduct. This document is contained in the CCG Constitution[1] and is publically available at:

[1] The Constitution is currently under review and once agreed will be published. This will include a revised Standards of Business Conduct Policy which was approved in July 2014 by the Audit and Assurance Committee.

http://www.wiltshireccg.nhs.uk/wp-content/uploads/2013/03/NHS-Wiltshire-CCG-constitution.pdf
This policy will continue to be used by the CCG during its procurement of ACS.

5.9.3 Principles to be adopted throughout the re-procurement

The CCG will:

- Continue to manage its contractual relationships with its providers in order that patients continue to receive quality services, delivered in a timely manner.
- Engage with stakeholders, including its membership, in a manner which enables a transparent, fair and equal procurement process and recognises and minimises potential conflicts of interest.

Through the information released to the market via the official web based portal that will be operated by the CSU procurement team, bidders will be reminded that the CCG is a commissioning organisation whose membership comprises GP providers with whom bidders may have or develop relationships. Bidders should not base their bids on information taken from the membership without reference to the corporate view which will be made available via the portal.

5.9.4 How will the CCG fulfil its obligations?

Fairness and transparency throughout the process will be delivered in line with CCG policies and with support from procurement expertise provided by Central Southern Commissioning Support Unit, augmented where required by legal advice. The CCG will:

1. Continue to ensure conflicts of interest are identified (through declarations), managed and the register is maintained.
2. Undertake regular review of the conflict of interest register in light of potential alliances forming during the procurement exercise between stakeholders including member GPs and other healthcare providers/management organisations.
3. Ensure that those involved in the re-procurement of ACS are aware of declared interests so that inappropriate sharing of information can be avoided.
4. Not hold meetings with organisations in connection with ACS pre-procurement activity without making the same opportunity available to others or sharing the content of the meetings
5. Ensure that information relevant to the procurement process and design of ACS is shared widely with the market[2]
6. Ensure that the 'competitive dialogue' process is facilitated in accordance with the principles of transparency, fairness, equal treatment and proportional-

[2] The Market is defined as interested parties (service providers) who maintain their engagement in the procurement process

ity, but in doing so is also mindful of the sensitivity of commercial information and also Freedom of Information requirements.

7. Maintain a list of information shared with the market.
8. Develop a system which provides regular updates to the public Governing Body on the re-procurement thus enabling scrutiny of proceedings

5.10 Communication with stakeholders including Patient and public engagement

The CCG remains committed to engaging with and informing its stakeholders, including GPs, partner organisations, patients and the public in its development of services. The stakeholder engagement plan identified at Annex C describes how this will happen throughout the procurement exercise.

Information will be shared at three levels:

Progress and updates – will be shared via the CCG Communications team using their networks. Information will be supplied to them by the project team which can then be moulded alongside the communications departments of other organisations including GWH and Wiltshire Council to ensure consistency of message. Staff employed by GWH are an important audience as it will be this body that is potentially unsettled during the procurement process while at the same time being required to deliver services during 15/16. It is intended that all messages broadcast by the Communications Team via this route give the opportunity for the receiver to comment via the existing arrangements administrated by the Communication Team.

Engagement in developments – As part of the process to develop the To Be specifications the CCG will develop desired outcomes for each service. GPs are already being engaged in the development of these outcomes and this will continue. The public via the existing contacts known to the Communications Team will be engaged to comment on the proposed outcomes which will drive the development by providers of the service delivery model. This is in keeping with the current work required by the JCB for the outcomes that will shape the service provide by the Integrated Teams (and specifically in relation to the ACS procurement, the Core Community Team element). It is proposed that the CCG Lay Member for patient and public involvement is included in the competitive dialogue and also the evaluation which leads to contract award to the successful provider at the end of the process. Potential providers are also to be provided with the opportunity to comment and make suggestions on the specifications to assist with their development

Consultation – The CCG is seeking to enhance services that are in scope during this procurement. It is not currently envisaged that significant change to services which will adversely affect patients and the public will result. Public consultation is not therefore considered necessary at this stage. It should be noted that through the CCG's attendance at recent Area Boards the intention to develop community services has been well articulated. The CCG is clear that should the need arise,

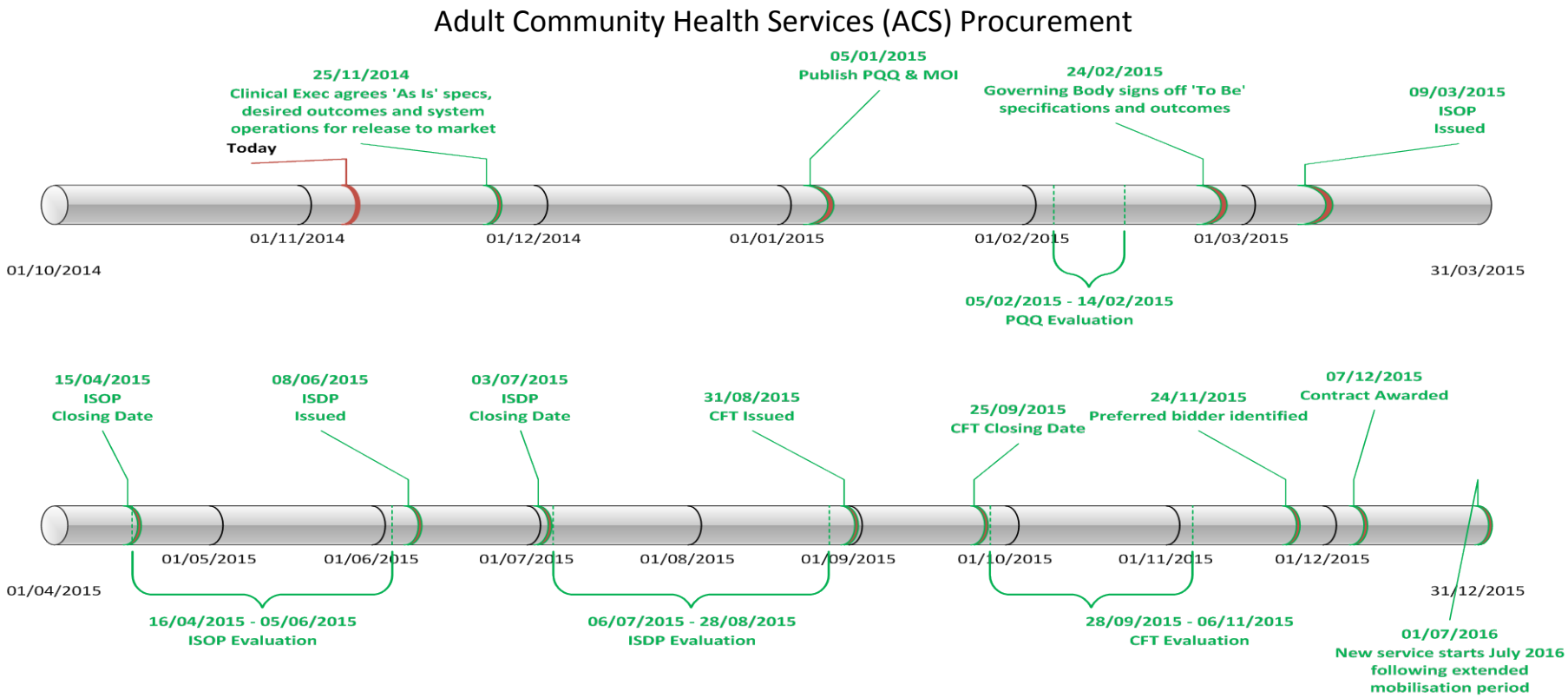
during the competitive dialogue, for there to be public consultation about significant changes proposed to services, it will ensure that the required elements are timetabled and completed.

It is intended that the CCG will share its stakeholder engagement plan with the Overview and Scrutiny Committee and seek endorsement of the approach outlined above

6 THE PROCUREMENT TIMETABLE

This section sets out the high level procurement timetable and indicates decisions required and resource requirements

The pipleline below summarises the key stages of the procurement. Details about the stages including elaboration on the acronyms are included at Annex D



For the procurement to progress in line with the tight timetable agreement by the governing body is required on the following matters.

7 DECSIONS REQUIRED BY THE GOVERNING BODY

The ACS procurement will lead to a high profile, high value contract and the CCG governing body will be required to take a number of key decisions. With reference to information presented already this section outlines the decisions required by the Governing Body for the procurement to progress against plan. Further detail is included beneath each section to support the decision

To date, three key decisions have been taken: to re-procure ACS, to use a procurement process called “competitive dialogue” and for the new service(s) to be operational by April 2016. Following feedback from the market that the proposed 3 month mobilisation period was to short, it has been agreed that the current contract will be extended and thus the new contract will not begin until July 2016.

Decisions required:

1. Endorse the use of Outcomes as the basis for commissioning
2. Confirmation of preferred contracting model
3. Agreement on the length of contract including any extension periods
4. Ratify progression to formal procurement
5. Agree that the Clinical Executive becomes the decision making body to support the formal procurement and in so doing identifies that no individuals have a known or potential conflict of interest associated with the procurement of ACS; and where individuals are conflicted it is accepted that they will become excluded from information, discussions and decisions associated with this procurement.
6. Agree approach to communication, engagement and consultation for the ACS

Each item is explained more fully below

DECISION 1: Endorse the use of outcomes as the basis for commissioning

Throughout the work to date to prepare for procurement there has been a slant towards future commissioning of services for patients by outcome rather than the traditional method of activity or output. This approach continues but with any changes there are anxieties and risks. These will be expressed and captured in procurement and contracting arrangements.

Not all the services in scope for procurement will be easily able to shift to this model of outcome based commissioning so there will need to be a phased approach that will be agreed with the providers throughout the procurement exercise.

The Governing Body is asked to endorse the use of outcomes based commissioning as a key feature of the formal procurement and in doing so recognises that this switch in approach will need to be phased and that conditions to safeguard the CCG's interest will need to be articulated as part of the procurement and contract arrangements

DECISION 2: Confirmation of the preferred contracting model for ACS

There is already an agreement within the CCG that was made by the Governing Body in July 2014 that there will be a single contract for the provision of all of the services within the ACS contract, however, the final contracting model has yet to be determined. At the Governing Body meeting on 23rd September a number of principles were agreed, these are included at Annex A and will be captured in any procurement documentation so all providers are aware.

Feedback has been received from those attending the Market Event on 24th September, and this has helped to shape the CCG's thinking about the possible contracting routes that could be deployed for the new ACS contract. Feedback from providers also lead to the mobilisation period for the new contract increasing.

Competitive dialogue will be used to further scope and shape the final delivery model which will be captured in one contract with a single 'body' – a prime provider.

The prime provider can take several forms, e.g. a single entity or consortium of organisations). The contract allocates risk and reward between the commissioner and the prime provider. If and as required the prime provider then sub-contracts specific roles and responsibilities (and allocates risk associated with their performance) to other providers. The prime provider remains responsible to the commissioner for the delivery of the entire service, and for the co-ordination of its 'supply chain' (i.e. its sub-contractor providers) in order to ensure that it can and does deliver that entire service. The prime provider may be a provider of clinical services itself, but it could sub-contract all but the co-ordination(integrator) role.

The governance and structure of this 'body' will be a matter for the market to determine and there are many models. Permitting sufficient models gives the market the best opportunity to respond to the CCGs requirements.

A summary of the models is listed below with an appraisal and some considerations shown in Annex E

No.	Contracting Model
1	**Lead Provider - Prime Contractor (PC)** A single provider is responsible for managing an entire care pathway[s] and sub-contracts with other providers for part of the care pathway[s]. The prime contractor may not be the largest provider but the role is focused on management of the care pathway[s]
2	**Lead Provider - Principal Provider (PP)** The commissioner commissions a main provider to provide a pathway[s] or service[s]. This provider then subcontracts part of the pathway[s], where needed. This provider will be providing the major part [or all] of the care pathway[s]
3	**Joint Venture (JV)** Providers enter into a partnership/consortium arrangement to deliver services as a single entity, with integrated management/reporting etc.
4	**Lead Organisation (contracting) (LOc)** Contract holder manages all service providers, but does not provide any services itself. Lead organisation determines pathways and enters into contracts with its chosen service providers.
5	**Lead Organisation (non-contracting) (LOn)** Contract holder manages all service providers, but does not provide any services itself. CCG commissions actual services/maintains existing contracts with service providers. Lead organisation's role is just to promote, facilitate and ensure integration.
6	**Alliance (separate contracts)** Separate contracts with individual providers but with shared objectives. Equal, but separate, parties who work together collaboratively to deliver elements of a care pathway[s] or service[s]
7	**Alliance (one contract)** Commissioners enter into a single contract with a number of providers, who share a common performance framework with collective measures… In this approach there is collective accountability for services delivered, with providers judged on performance as a whole rather than as individual components

It is recommended that the Governing Body agree options 1 – 4 listed in the table above as acceptable potential forms of prime supplier for the ACS contract.

This decision will be communicated to the market via the advert at the start of January when the formal procurement process begins.

DECISION 3: Agree length of contract including any extension period

The procurement and onward provision of the adult community services has been developed with a longer term strategic view of the CCG working in a partnership arrangement with the future provider, and requiring sustained improvements across the life of the contract. To this end, it would be prudent and appropriate to consider a suitable length of contract that allows sufficient time to achieve the objectives and outcomes desired for the population of Wiltshire. The procurement process will be resource intensive for all parties involved, and as such the length of contract should recognise the amount of investment both the CCG and potential future providers will have made into the procurement process. As such a contract of 5 years with a potential to extend by a further 2 years would seem an appropriate recommendation for the Governing Body to agree. The length of the contract will naturally be influenced by satisfactory performance and mutual agreement.

The Governing Body is asked to agree the contract length as five years with an option to extend for a further two years

This decision will be communicated to the market via the advert at the start of January when the formal procurement process begins.

DECISION 4: Ratify progression to formal procurement

Having considered the information presented in this paper which describes the process for the development of To Be service specifications that are required along with the outcomes for delivery within existing resource envelope, the Governing Body is asked to agree that procurement of ACS can move to the formal procurement stage and commence in January 2015

The Governing Body is asked to agree that procurement of ACS can move to the formal procurement stage and commence in January 2015

The CSU will support the formal procurement process, helping to ensure that all the required documentation is in situ to enable bidders to make a complete and comprehensive bid. Prior to the start of the formal stages draft information about the services will be released to the market following agreement by the Clinical Executive in November. The Governing Body will be asked to approve the final To Be service specifications in public in February 2015.

DECISION 5: Agree to delegate decision making authority to the Clinical Executive to support the lead in to formal procurement (ie prior to PQQ) and in so doing identifies that no individuals have a known or potential conflict of interest associated with the procurement of ACS; and where individuals are conflicted it is accepted that they will become excluded from information, discussions and decisions associated with this procurement

By the first week in January the CCG will have to have prepared:

- An advert which summarises the contract opportunity, describes the commissioners key requirements, the procurement route to be followed and which aims to attract appropriate bidders.
- A Memorandum of Information will also be released which includes high level information about the tender including the available financial envelope (the current contract value), a summary of total workforce information sourced from GWH along with a position and vision for estate. There will be a reminder about the 12 principles agreed for use throughout the procurement and a description of the process that the CCG will then be required to follow.
- A Pre-Qualification Questionnaire must also be released (for potential providers) which must include the evaluation criteria that will be applied to assess the suitability of providers to progress to the next stage which involves being invited to submit an outline proposal (ISOP stage) in early March 2015.

A. Section 5.8 identified how the procurement exercise is already resource intensive and will require active participation by colleagues from across the CCG. The CCG must also ensure fair competition and manage conflicts of interest (refer to section 5.9). To enable the CCG to run the procurement process and meet its obligations a body of non-conflicted decision makers must be identified. The Clinical Executive provides appropriate individuals as it includes group representation, executives and non executives. Acknowledging this group as the decision making body that can agree information for release to the market and provide the corporate view throughout the procurement will facilitate planning, delivery against deadlines, and training. It will also enable the CCG to mitigate risks associated with challenges relating to anti-competitive behaviour.

B. If the clinical Executive, members of which also attend the Governing Body, is to perform the role identified above then the Governing Body must assure itself that Clinical Executive members have no known or potential for conflict of interest.

The Governing Body is asked to:

i. Agree to delegate decision making authority to the Clinical Executive to support the lead in to formal procurement (as identified in paragraph A above)

ii. Identify at this meeting whether any members of the Clinical Executive have a known or potential conflict of interest relating to any part of the procurement of Adult Community Services and exclude conflicted individuals from receipt of information, participation in discussions and decision making at the Clinical Executive meetings which they would normally attend.

It should be noted that the structure of the Clinical Executive meetings and associated administration of meetings may have to change as a result of the above. Work will continue to identify individuals who will participate in the competitive dialogue during the formal procurement to ensure that providers receive the corporate view as the model of delivery is developed.

DECISION 6: Agree approach to communication, engagement and consultation for the ACS procurement.

As part of the ACS programme, the CCG needs to ensure that it has suitably engaged and involved all stakeholders including patients and the public. The plan is included for reference at Annex C and was summarised in section 5.10

It includes the following elements of information sharing and engagement:

Progress and updates – shared via the CCG Communications team using their networks and with stakeholders invited to respond with comments.

Engagement in developments – As part of the process to develop the To Be specifications the CCG will develop desired outcomes for each service with input from patient groups and providers.

Consultation – The CCG is seeking to enhance services that are in scope during this procurement. It is not currently envisaged that significant change to services which will adversely affect patients and the public will result thus the need for public consultation is not anticipated.

It is intended that the CCG will share its stakeholder engagement plan with the Overview and Scrutiny Committee (OSC) and seek endorsement of the approach outlined above.

The Governing Body is asked to agree the approach to communication, engagement and consultation for the ACS procurement and the current plan, including the intention to consult with OSC

8 INFORMATION TO BE NOTED BY THE GOVERNING BODY

As well as the decision that the Governing Body is asked to make, it is also asked to note:

A. The approach to the development of the To Be service specifications and the advice that these are suitably firm at the start of the procurement process so that providers are able to submit proposals for how they will be delivered thus enabling the CCG to receive the best possible services for patients.
B. The timetable including the inherent impact that this priority work will have on the capacity of staff and clinical leaders
C. The requirement for active participation by empowered staff and members in the procurement stages
D. The approach that the organisation must take to ensure fair and transparent market engagement

9 CCG Strategic Objectives/Priorities

The CCG in its 5 year strategic described its intent to commission an out of hospital model of care which would provide high quality and affordable services to patients which were local, patient centred and which were shaped through close working with Primary Care and other stakeholders. Delivery of the OCT procurement project will assist the CCG fulfil this strategic objective.

The CCG must also comply with contracting requirements and, having previously extended the contract for adult community services with the current provider, it must now offer the opportunity of provision to the healthcare market.

10 Options

The CCG has confirmed its desire to enter into a competitive dialogue process involving for the re-procurement of community services. There are no options presented in this paper for consideration. The CCG, through the authority vested in those involved in the competitive dialogue will ensure that the right services are designed for the Governing Body to award the contract in November 2015.

11 Risks

The following risks are flagged:

1. There are insufficient providers engaged or able to meet the ambitions of the CCG that are intended to be delivered through this procurement or within the available resources.
2. The CCG could be open to challenge on the grounds of anticompetitive behaviour as a result of the engagement with the current service provider.
3. There are also potential risks associated with legal challenge resulting from conflicts of interest through the inherent structure of the CCG with its GP providers as members and leaders. These risks will be mitigated through careful consideration of those involved. An example of how this was managed can be evidenced from the market event on 24 September 2014.
4. There are risks associated with delays to stages as set out in the procurement timetable. These can be mitigated by timely action and decision making with resources prioritised by line managers accordingly.

5. There are risks inherent in the competitive dialogue process which the CCG has sought to mitigate through the description of commissioning principles (see Annex A) which will be included in the Memorandum of Information and any contracts. These risk5 will be further mitigated through the identification of conditions which restrict the business activities of the providers. These will be clearly articulated to providers.
6. The available resources are insufficient to meet the requirements of the GP membership or public necessitating a prioritisation of requirements by the CCG which adversely affects engagement and reputation. This could have a negative impact on other aspects of CCG business.
7. The staff and clinical leadership capacity is presently stretched and once the formal procurement process begins this pressure will increase further. This may necessitate the identification of key personnel to act on behalf of the organisation and its membership.
8. Significant change adversely affecting the public is not anticipated but were such change to be proposed so it would necessitate public consultation which would affect the timetable.
9. Service delivery of the existing contract may be adversely affected if provider staff are not appropriately engaged and seek alternative employment during the course of the procurement.

12 Quality issues

Commissioning quality outcomes is a key aspect of the CCG strategy. Not only is the provision of quality services important for patients it is also a mechanism for driving efficiency. To ensure that quality services are commissioned therefore, members of the Quality and Patient Safety Directorate will be fully involved in the development of the services that are being procured and the subsequent competitive dialogue

13 Partnership issues

Throughout the Optimising Community Teams Programme in which the ACS procurement is a project there has been collaborative working with stakeholders including Wiltshire Council. The intention is that this arrangement continues. The CCG is also engaged with the current adult community service provider, GWH, and this client contractor relationship will continue for the remainder of the contract and include developments that are required in FY 15/16. The requirements will be shared with the market as part of the To Be specs.

The CCG will continue to be mindful and cautious to ensure that it behaves in a fair and transparent manner so as not to disadvantage providers not currently contracted. The CCG will therefore continue to exclude the current provider from discussions which provide an unfair advantage. Where this is not possible the CCG will share relevant information with the market. The CCG's approach to ensuring fair competition and managing conflicts of interest is articulated in section 5.9

14 Estate/Infrastructure

As part of the procurement process the estate which is currently in use as part of the community services will available for use by the successful bidder. The CCG will expect the successful provider to make use of the estate in line with the service specifications and the CCG will work with the successful provider on developments associated with estate in line with the providers agreed service provision. The estate will be identified during the formal procurement and at this time the CCG will articulate its vision which will be in line with its strategy which is being led by the Chief Finance Officer.

15 Procurement Issues

The CSU will support procurement by the CCG of the community services. This support is already being received. Throughout the procurement it will be vital that conflicts of interest are managed. This will be paramount to mitigate risk associated with legal challenge.

The timetable for re-procurement is challenging and will need to be adhered to. This will consume significant staff resource

The Governing Body is to make a decision on the contract length and the preferred model of service delivery. These have been identified in section 7 and Annex E. The contract length is recommended as five years plus two years extension to fit with strategic intent of the CCG.

16 Equality and Diversity

Refer to Equality Impact Assessment at the end of this document

ANNEX A Agreed Principles

The following principles were shared at the market engagement event on 24/9/14.

1. Patient centred care with existing General Practice at the centre of all community provision.
2. The community provider functions in a genuinely community focused way
3. Local integrated teams work in a way such that they function as a single team with primary care
4. We anticipate the devolution of significant levels of clinical governance to the 20 integrated team areas
5. Specialist support services will work with the integrated/primary care teams, in a way that is supportive and focused on the community style of working. These will work with the integrated/primary care teams with appropriate links to secondary care but is in general not an extension of secondary care.
6. Integrated team will work increasingly with social care and mental health
7. Utilisation of the simple point of access, which is able to link primary, community, community specialist support, social care etc. especially for complex cases.
8. Rehabilitation in the community will be developed
9. Full consideration will need to be given to bed based care in the community
10. The new provider will work continuously with the CCG, other local providers and the voluntary sector to allow and encourage a progressive approach to developing and improving the delivery of community care
11. We expect future providers to develop partnerships with local providers, including the voluntary sector, to enhance care of the individual in the local community area.
12. The future provider will ensure patient and public involvement throughout the length of the contract.

Annex B - Outcomes to be commissioned through OCT procurement – template for use to support development of To Be Specifications

The outcomes below are currently for Integrated Teams and through the design of the To Be service specifications for all services these will be assessed for suitability and where necessary changes including additions will be made

Reference	Outcomes	Applicable to service Y/N	If yes, suggested means of measurement; or if no, brief rationale
Ult category	**ULTIMATE outcomes**		
Ult 1	Effectiveness of primary and community care is maximised		
Ult 2	Delayed Transfers of Care from hospital are reduced		
Ult 3	Non elective admissions which can be influenced by effective collaboration across the health and care system are reduced		
Ult 4	More people feel able and supported to manage their (long term) condition(s).		
Ult 5	Permanent admissions of older people (aged 65 and over) to residential and nursing homes is reduced		
ULT 6	People die in their preferred place of care		

Reference	Outcomes	Applicable to service Y/N	If yes, suggested means of measurement; or if no, brief rationale
INT cate-gory	**INTERMEDIATE outcomes**		
Int 1	Wiltshire Community Health and Social Care Services are able to support the care of more people in or closer to their own home		
Int 2	Patients are encouraged and supported in prevention and self-management		
Int 3	Quality of patient care is improved		
Int 4	Access to and speed of response of care is improved		
Int 5	The customers/patients express satisfaction with the health and care services they re-ceive		
Int 6	People with mental health issues are seen and treated with the same priority as other		

Reference	Outcomes	Applicable to service Y/N	If yes, suggested means of measurement; or if no, brief rationale
	long term conditions		
Int 7	Communication Process and collaborative ways of working are in place and delivering effective holistic coordinated care		
Int 8	Patients/customers are ideally getting one assessment (that meets the requirements of all agencies involved in the care of the person)		
Imm category	**IMMEDIATE**		
Imm 1	Community Teams and primary care are working collaboratively and in partnership to deliver care		
Imm 2	Appropriate patient information is being shared effectively within the teams to support quality care		

Reference	Outcomes	Applicable to service Y/N	If yes, suggested means of measurement; or if no, brief rationale
Imm 3	Patients are ideally getting one assessment (that meets the requirements of all agencies involved in the care of the patient) and have a care plan that they have been involved in creating.		
Imm 4	Improved use of community resources will be made		
Imm 5	Family and/or carers are supported appro-priately		
Imm 6	Each Team is proactively managing the health and social care needs of the residents of Care Homes within their population		
Imm 7	Each Team is proactively working with sec-ondary care providers to support the timely discharge of medically stable people		
SS catego-	**SERVICE SPECIFIC OUTCOMES**		

Reference	Outcomes	Applicable to service Y/N	If yes, suggested means of measurement; or if no, brief rationale
ry			
SS1		Yes	
SS2		Yes	
SS3		Yes	
SS 4			
SS5			
SS6			
SS7			
SS8			
SS9			
Op category	**SERVICE SPECIFIC OUTPUTS including national and local standards which must be**	Yes	Describe outputs below including means of measurement

Reference	Outcomes	Applicable to service Y/N	If yes, suggested means of measurement; or if no, brief rationale
	adhered to		
Op1		Yes	
Op2		Yes	
Op3			
Op 4			
Op 5			
Op 6			
Ind category	**OUTCOMES for individuals – the patients/people**		
Ind 1	My care is planned with people who are working together to understand my needs and those of my carers		

Reference	Outcomes	Applicable to service Y/N	If yes, suggested means of measurement; or if no, brief rationale
Ind 2	I am involved in all decisions about me and my care		
Ind 3	I am always kept informed and always know who to contact if the need arises		
Ind 4	I don't have to keep repeating myself to lots of different professionals		
Ind 5	I have a named person to go to when I need them		
Ind 6	I understand my condition and how it will affect me		
Ind 7	I have a plan to help me cope If things get worse		
Ind 8	I have good advice and sufficient information so I know how to look after myself and stay well		
Ind 9	I have a local support network around me		

Reference	Outcomes	Applicable to service Y/N	If yes, suggested means of measurement; or if no, brief rationale
	that meets my wider (holistic) needs		
Ind 10	I am clear about what personal responsibility I hold for managing my ongoing health and wellbeing		
Ind 11	I know that the needs of my family, carers and friends will also be taken into account		
Sta category	**SERVICE SPECIFIC OUTPUTS including national and local standards which must be adhered to**	Yes	Describe outputs below including means of measurement
Sta 1	I work as part of a team which has enough shared resources (staff and equipment) to carry out the tasks required of it		
Sta 2	I understand my role the roles of those within my Team and how my role fits within the team		
Sta 3	I know who to go to for a response if I have		

Reference	Outcomes	Applicable to service Y/N	If yes, suggested means of measurement; or if no, brief rationale
	questions or am concerned about an individual patient or customer		
Sta 4	I have the right information or know where to get it to be able to provide the right support and care		
Sta 5	I have the right skills to meet my patient's needs and a plan to develop my skills where necessary		
Sta 6	I am part of a team that is well led, well managed and well supported at all levels		
Sta 7	I am part of a team that works in a collaborative way to put the patient at the centre of all of its decisions		
Sta 8	I am part of a team that has been empowered to take responsibility for its decisions and actions relating to its patients		
Sta 9	I am part of a team that has devolved re-		

Reference	Outcomes	Applicable to service Y/N	If yes, suggested means of measurement; or if no, brief rationale
	sponsibility and accountability for appropri-ate commissioning (and in time budgetary) decisions		
Sta 10	I am part of a team that is encouraged and supported to think innovatively about the care it provides		
Sta 11	I am encouraged and supported to talk to patients and their carers about how they share and take personal responsibility for their healthcare and wellbeing		
Sta 12	I know that the right relationships are in place above me to ensure that I can function as part of a team in the health and social care system		

ANNEX C

Stakeholder Engagement & Involvement Plan for Adult Community Services

To be agreed by the Governing Body of the CCG at its November 2014 meeting held in public

Context

The CCG remains committed to engaging with and informing its stakeholders, including GPs, partner organisations, patients and the public in its development of services. It aims to continue in a similar vein of transparency demonstrated in its recent collaboration with Wiltshire Council to jointly attend and present the Better Care Plan to the public of Wiltshire at Area Boards. The CCGs ambitions to procure Adult Community Health Services (ACS) have been shared at the following Area Board meetings:

- Chippenham Area Board
- Malmesbury Area Board
- Pewsey Area Board
- Pewsey Vale School
- Bradford on Avon Area Board
- Salisbury Area Board
- Tidworth Area Board
- Royal Wootton Bassett and Cricklade Area Board
- Marlborough Area Board
- Amesbury Area Board
- Calne Area Board
- South West Wiltshire Area Board
- Westbury Area Board
- Southern Wiltshire Area Board
- Melksham Area Board
- Trowbridge Area Board
- Warminster Area Board
- Corsham Area Board
- Devizes Area Board

There is also an obvious need to ensure that providers are engaged so that there is a satisfactory response to the tender, enabling the CCG to obtain the best services available for the public in Wiltshire.

Through the procurement process the CCG and the market must be mindful of the impact that proposed change may have on staff working in provider organisations. A provider's workforce is key to the delivery of services for patients. This is most definitely the case for the Great Western Hospitals NHS Foundation Trust (GWH) which is the current adult community service provider. GWH is also involved in the Community Child Health service procurement and was recently involved in the maternity services retender.

There will need to be careful handling of messages to the right audiences. For this to happen there is a very large responsibility placed on the CCG Communications department to work closely with other organisations to construct and agree suitable messages which respect the sensitivities of the situation.

As stated in the CCG Constitution the Governing Body of the organisation, the ultimate decision making forum, has amongst is membership a Lay Member with responsibility for Patient and Public Involvement. This same forum also has 7 GPs in attendance each of whom has a close attachment to the patients and on whose behalf decisions are made.

The approach to lawful engagement throughout the ACS procurement

The CCG will fulfil its legal obligations under Section 242 (1B of the NHS Act 2006, as amended by the Local Government and Public Involvement in Health Act 2007 to 'make arrangements, as respects health services, for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information or in other ways) in –

a. The planning of the provision of those services
b. The development and considerations of proposals for changes in the way those services are provided
c. Decisions to be made by that Body affecting the operation of those services.'

The CCG also has a duty to consult with Local Authority Overview and Scrutiny Committees on proposals for substantial changes

Involvement and Information sharing will take place on three levels:

1 Consultation – The CCG is seeking to enhance services that are in scope during this procurement. It is not currently envisaged that significant change to services which will adversely affect patients and the public will result. Public consultation is not therefore considered necessary at this stage. It should be noted that through the CCG's attendance at recent Area Boards the intention to develop community services has been well articulated. The CCG is clear that should the need arise, during the competitive dialogue, for there to be public consultation about significant changes proposed to services, it will ensure that the required elements are timetabled and completed as part of the procurement exercise. Future changes to services which necessitate public consultation that are to take place once the procurement exercise is completed will follow due process and the CCG will support the provider in ensuring that this happens.

2 Engagement in developments – As part of the process to develop the To Be specifications, the CCG will develop desired outcomes for each service. GPs are already being engaged in the development of these outcomes and this will continue. The public, via the existing contacts known to the Communications Team will be engaged to comment on the proposed outcomes which will drive the development by providers of the service delivery model. This is in keeping with the current work required by the JCB for the outcomes that will shape the service provide by the

Integrated Teams (and specifically in relation to the ACS procurement, the Core Community Team element). It is proposed that the CCG Lay Member for patient and public involvement is included in the competitive dialogue and also the evaluation which leads to contract award to the successful provider at the end of the process. It is proposed that as the evaluation process is finalised at a later date in the project stakeholders including the public will feature in the evaluation process. Their input is likely to influence the decision making panel at the end of the process.

3 Progress and updates – will be shared via the CCG Communications team using their networks. Information will be supplied to them by the project team which can then be moulded alongside the communications departments of other organisations including GWH and Wiltshire Council to ensure consistency of message. Staff employed by GWH are an important audience as it will be this body that is potentially unsettled during the procurement process while at the same time being required to deliver services during 15/16. It is intended that all messages broadcast by the Communications Team via this route give the opportunity for the receiver to comment via the existing arrangements administrated by the Communication Team.

It is intended that the CCG will share its stakeholder engagement plan with the **Overview and Scrutiny Committee** and seek endorsement of this approach.

In the table below the CCG sets out how it will engage and inform various stakeholder groups.

PATIENTS & PUBLIC

ACTION	LEAD	ACTION/NOTES	DATE/TIME	COMPLETE
Completion of the CCG participation in the Area Boards to share details of the 5 year strategy including intention to procure ACS	HRG/Executives	Collaboration with Wiltshire Council to engage the Public in the Better Care Plan for Wiltshire in which the CCG has a major stake	December 2014	
Patient involvement meetings using established networks to provide feedback on the proposed outcomes to feature in the To Be service	Project managers/ RH/HRG	This will ensure that the CCG commissions outcomes for patients. Similar engagement has already taken place for the outcomes for use in the Integrated Team development	By End of Jan for sign off by Clinical Exec	
Distribution of regular updates via the Communication department using established routes/media	Project managers/ RH/HRG	To ensure the public remain abreast of progress and are given the opportunity to comment	Ongoing	
Feedback on updates from the public to the Communications Team	Comms Team	To enable a feedback mechanism to those leading the procurement process	Ongoing	
Participation by Lay Member for Patient and Public Involvement in the evaluation of providers involved in the procurement process	TW/RH	Likely to be a member of the evaluation panel as well as present throughout the process of competitive dialogue. The process for evaluation has yet to be finalised	Ongoing	

ACTION	LEAD	ACTION/NOTES	DATE/TIME	COMPLETE
Participation of selected individuals in the evaluation of providers involved in the procurement process	TW/RH	The process for evaluation has yet to be finalised	Ongoing	
Various opportunities to address the public	Chair/Executives	To maintain the dialogue with the public the CCG will continue to maintain a visible presence at meetings across Wiltshire	Ongoing	
Papers relating to ACS will be produced for the public Governing Body				

CCG MEMBERSHIP & CLINICAL LEADERS

ACTION	LEAD	ACTION/NOTES	DATE/TIME	COMPLETE
Involvement of GPs in the Optimising Community Team Programme	TW	The OCT programme is the home of the ACS procurement project and there are GPs involved on the Strategy Board and Steering Group.	Ongoing	
Presentation and discussion with CCG Clinical Executive in respect of procurement route and contracting model, and the preferred service delivery aspirations	TW & JS	Preference from Clinical Executive will inform the CCG's decision making process at Governing Body re: contracting route to be procured	Clinical Exec mtgs 12/08, 26/08 and 09/09	Complete
Clinical Executive to be involved in the Market Event on 24th September 2014	SB, TW & JS	Clinical leadership of process clearly visible and articulated	24/09/14	Complete

ACTION	LEAD	ACTION/NOTES	DATE/TIME	COMPLETE
Involvement of GPs in the sign off of the As Is Service Specifications	RH/Group Directors	Identification of omissions to these specifications which form the baseline for the development of the To Be specifications	7 November	
Identification by GPs on Group Executive bodies in the identification of Outcomes for consideration in the To Be specifications.	RH/Group Directors/Project managers	To ensure GPs, who are close to patients, are able to articulate desired outcomes for commissioning.	End Jan 2015	
Review of final To Be Specifications by Clinical Executive prior to Governing Body approval in Feb 2015	TW/RH	To ensure that the services that are to be commissioned are accurate and fit within the resource envelope ahead of competitive dialogue.	Feb 2015	
Involvement of selected GPs representing Groups and individual specialist services in the design and use of the evaluation criteria.	RH	The process for evaluation has yet to be finalised		
Involvement of CCG Quality Team members in the review of the service specifications prior to ratification	RH/Project managers and Quality leads	Ensure the Quality Team have sight of the service specifications as they are developed to ensure quality assurance components are captured	End Jan	
Involvement of CCG non executive members in the evaluation process including Registered Nurse and Secondary Care Doctor		The process for evaluation has yet to be finalised		

PROVIDER ENGAGEMENT

ACTION	LEAD	ACTION/NOTES	DATE/TIME	COMPLETE
Current provider service leads involved in the As Is service specification development	CCG service leads	To ensure that there is a baseline understanding of the services currently commissioned. This information will be used to shape the To Be service specifications by the CCG and without the involvement of the current provider.	Service specification workshops arranged for each specification	Complete
Market event on 24th September 2014	TW & JS	Involvement of providers within the market event to open up discussion about CCG's aspirations and the openness of providers to enter into the competitive dialogue process	24/09/14	Complete
Feedback on answers to questions raised by providers to market event	RH			Complete
Invitation to join and circulation of Capability matrix of providers including voluntary organisations	RH	To ensure the market is well connected and able to forge the right relationships across provider organisations to respond to the CCG tender	Ongoing	Version 1 circulated in October 2014
Circulation to market of As Is specs and supporting information	RH	To engage the market early and enable development by providers of their planning	November 2015	
Release of PQQ, memorandum of Information and description of process	TW/RH/CSU	To ensure that providers are clear on process and able to make decisions about whether to enter into formal procurement process	Jan 2015	
Second market event	TW	Details to be confirmed but intended to assist providers with PQQ and answer questions ahead of ISOP stage and the release of the To Be specs.	Jan 2015	

ACTION	LEAD	ACTION/NOTES	DATE/TIME	COMPLETE
Competitive dialogue approach to procurement	TW, JS & CSU	Iterative process with potential providers as part of the competitive dialogue	From March 2015	
Support information share about ACS procurement progress	Comms Team	Working with GWH Comms to ensure that the current provider workforce is engaged and anxieties associated with potential change are mitigated	Ongoing	

OTHER STAKEHOLDER ENGAGEMENT

ACTION	LEAD	ACTION/NOTES	DATE/TIME	COMPLETE
CCG staff to be kept aware of the ACS project through the 14 days email bulletin and team meetings	RH/HRG/Directors	To ensure staff engagement and prioritisation of resources to deliver on time.	Ongoing	
Involvement of Wiltshire Council on OCT Strategy Board	TW		Ongoing	
Involvement of Wiltshire Council in the evaluation process	TW	The process for evaluation has yet to be finalised		
Involvement of Wiltshire Council within the development of service specifications where there are close interfaces and inter-dependencies between health and social care provision	Project manager/RH		End Jan 2015	
Pre-meet with Chair of Overview and Scrutiny Committee	Chief Officer	To present approach and to understand OSC requirements	TBC	

ACTION	LEAD	ACTION/NOTES	DATE/TIME	COMPLETE
Consultation with the with Overview and Scrutiny Committee	TW	Discussion and support from OSC will provide openness and transparency to approach being taken,	TBC plus updates as required Other dates	
Participation of Healthwatch in the evaluation of providers involved in the procurement process	TW/RH	The process for evaluation has yet to be finalised	Ongoing	
Regular update to Healthwatch on progress	TW			

The information below is included to demonstrate an approach to Formal Public Consultation that the CCG may take if the need arises. At this stage this is not anticipated as being necessary.

FORMAL PUBLIC CONSULTATION – included as indication of process.

ACTION	LEAD	ACTION/NOTES	DATE/TIME	COMPLETE
Agreement of period of formal public consultation to be undertaken				
Identification of dates for formal public consultation				
Development of consultation documentation				
Publication of consultation documentation in multiple formats inc easy read, and web-based				

ACTION	LEAD	ACTION/NOTES	DATE/TIME	COMPLETE
Public consultation events to be booked and published				
Public consultation events to have strong evident clinical leadership and endorsement				
Comments and responses from events to be captured and published during the period of consultation				
Feedback mechanisms on consultation to be developed		Web-based e.g. Survey Monkey Feedback form as part of public consultation document FAQs		
Formal report and recommendations at end of consultation to inform the “to be” service specifications and service model used in the procurement process				

Annex D Key Dates for Wiltshire CCG ACS Programme

Date	Action and explanation
End October 2014	"As is" specifications to be written and in process of being shared with GP leads for service lines
October – November 2014	Continued engagement with Clinical Exec around progress and feeding in information ahead of GB meeting on 25/11/14 Development of the 'to be' specs is underway
November 2014	Discussion with Overview and Scrutiny re CCG plans – details to be confirmed
7 November 2014	Completion of GP engagement to review As Is Service Specifications and seek desired inputs to To Be specs.
17 November 2014	EMT approves : 1. As Is Service specifications 2. Information collected from GP engagement on outcomes to be considered for use in To Be service specifications

25 November 2014	Governing Body to: • Endorse the use of Outcomes as the basis for commissioning • Confirm the preferred contracting model • Agreement on the length of contract including any extension period • Ratify progression to formal procurement • Agree that the Clinical Executive becomes the decision making body to support the formal procurement • Agree approach to communication, engagement and consultation for the ACS
25 November 2014	Clinical Executive agrees: 1. As Is service specifications 2. Information collected from GP engagement on outcomes to be included in To Be service specifications 3. Description of Community Service system operation

26 November 2014	Circulation to the market of: A. Agreed As Is Service specifications B. Description of Community Service Aspirations C. The 12 principles – as a reminder D. Updated capability matrix This information is being released to stimulate the market and enable providers to ready themselves for the formal procurement stages.
November 2014 - January 2015	15/16 contract negotiations – information from spec development to be used to start to address gaps / performance issues. This is not part of the procurement project
December 2014 – Mid January 2015	"To be" specifications to be finalised • Progression of outcomes to be expressed • Aspirations & Stretch targets
December 2014	Identification of staff to be involved in competitive dialogue process and evaluations
January 2015	Training on to support individuals participating in formal procurement process including evaluation and FOI. Training provided by CSU.
January 2015	Commence formal procurement process

w/b 5 January 2015	**Publish PQQ and Memorandum of Information** The advert is a summary of the contract opportunity to be published on the pan-Government contracts finder web-site and via the Official Journal of the European Union, describing the commissioners key requirements and aiming to attract appropriate Bidders. The memorandum of Information is a supplementary document that provides additional background information to that in the adverts, including service data and a more detailed explanation of the process to be followed including evaluation criteria. It is intended that this will include the agreed principles and any conditions/limitations that have been identified by commissioners.
Early January	Second market event – possibly a workshop, Q&A session with the purpose of: 1. Assist the market with its response to the PQQ stage 2. To provide any further information about the service requirements, including any updates arising from en-gagement.
27 January 2015	Governing Body receives Update on ACS procurement
w/b 2 February 2015	PQQ submission closing date
9 February – 27 February 2015	PQQ Evaluation The CCG will appoint a panel of expert evaluators to assess all PQQ responses received from potential providers, scoring each question in a fair and transparent manner, according to evaluation criteria published alongside the PQQ. From this the CCG will shortlist the highest-scoring providers to take through to the next stage. Evaluation is due to be completed by the week commencing 2nd March
2 February 2015	EMT approves To Be Specifications including outcomes

10 February 2015	Clinical Executive approves To Be service specifications and outcomes
24 February 2015	Governing Body signs off all 'To be' Service specifications In a specially arranged Governing Body session the CCG will sign off the services specifications that will be used in the ISOP which is the first stage of the competitive dialogue process.
w/b 9 March 2015	Invitation to Submit Outline Proposal (ISOP) • Will include the "to be" specifications The CCG will provide shortlisted bidders with comprehensive information about the requirements of the contracts, including service specifications, finance data, transferring workforce information, Estates and IT strategies, and provider to provider contracts. Bidders will be asked to respond to a series of questions about how they would deliver these requirements forming an outline proposal.
Noon on Wednesday 15 April 2015	**ISOP Closing Date** Bidders will be required to submit their outline proposals via the NHS sourcing e-tendering portal. Any bidders that do not submit proposals by this deadline will be rejected
16 April - Friday 5 June 2015	**ISOP Evaluation** Bidders will submit their outline proposals by the closing date above. The evaluation panel will the assess the proposed delivery models and shortlist bidders for the next stage. This will include holding a dialogue meeting with each bidder to discuss the proposed model. Feedback will be provided that will help shortlisted providers improve their proposals and rejected providers understand the panel's decision

w/b 8 June 2015	**Invitation to Submit a Detailed Proposal (ISDP) Issued** Following the ISOP stage, shortlisted bidders will be invited to submit a detailed proposal taking into account the evaluation panel's feedback
w/b 29 June 2015	**ISDP Closing Date** Bidders will be required to submit their detailed proposals via the NHS Sourcing e-tendering portal. Any bidders that do not submit proposals by this deadline will be rejected.
6 July – **28 August 2015**	**ISDP Evaluation** Bidders will submit their detailed proposals by the closing date above. The evaluation panel will the assess the proposed delivery models and shortlist bidders for the next stage. This will include holding a dialogue meeting with each bidder to discuss the proposed model. Feedback will be provided that will help shortlisted providers improve their proposals and rejected providers understand the panel's decision
w/b 31 August 2015	**CFT Issued and Competitive Dialogue process closes** Following the ISDP stage the competitive dialogue process will be formally closed and shortlisted bidders will be invited to submit a final version of their service delivery proposal, taking into account the evaluation panel's feed-back.
25 September 2015	**CFT Closing Date** Bidders will be required to submit the final version of their service delivery proposal via the NHS Sourcing e-tendering portal – any bidders that do not submit proposals by the deadline will be rejected.

28 September - 6 November	**CFT Evaluation** Bidders will submit their final proposals by the closing date above. The evaluation panel will then assess the proposed delivery models and a preferred bidder will be identified
10 November 2015	Clinical Exec to agree decision to go to Governing Body
24 November 2015	Governing Body to ratify the contract award Once the preferred provider has been identified, the decision will be ratified by the CCG Governing Body and all bidders notified of the outcome. Feedback will be provided to rejected providers in order to help them understand the panel's decision. Thereafter a ten day 'standstill' period will be observed before the contract is awarded. Service mobilisation (including TUPE consultation etc) will begin as soon as the standstill period ends
w/b 7 December	**Contract Awarded**
July 2016	**New service starts** The current Service Provider has agreed that the current contract can be extended by a further 3 months to allow increase time for mobilisation in response to comments received at the market event on 24 September 2014

Annex E

NHS Wiltshire CCG Adult Community Services Procurement
Analysis of potential contracting/provider models

The Governing Body has considered a briefing paper at its meeting on 22nd July 2014. Taking this paper and other NHS publications into consideration, the following assumptions have been made:

1) Competitive Dialogue is the preferred procurement route
2) All contracting models will require significant trust & effective partnering
3) All contracting models will require significant resource and time to implement
4) Lead provider/alliance contracting models offer greater scope for reduced inefficiency and improved pathway co-ordination ("The NHS Standard Contract: A guide for clinical commissioners")
5) Lead provider models have limited proof of concept in the NHS
6) Alliance contracting models have very limited proof of concept

The following table sets out the key features of different lead provider/alliance contracting models:

No.	Contracting Model	Potential Benefits	Considerations (also see Monitor guidance below)
1	**Lead Provider - Prime Contractor (PC)** A single provider is responsible for managing an entire care pathway[s] and subcontracts with other providers for part of the care pathway[s]. The prime contractor may not be the largest provider but the role is focused on management of the care pathway[s]	• One contract for CCG to manage • PC is focused on integration and management • PC takes on operational accountability for service delivery	• Would need assurance that they could effectively manage (potentially larger) supply chain partners • CCG retains overall accountability, but is reliant on PC holding sub-contractors to account
2	**Lead Provider - Principal Provider (PP)** The commissioner commissions a main provider to provide a pathway[s] or service[s]. This provider then subcontracts part of the pathway[s], where needed. This provider will be providing the major part [or all] of the care pathway[s]	• One contract for CCG to manage • PP directly controls majority of service provision • PP potentially has more "clout" over supply chain • PP takes on operational accountability for service delivery	• Potential risk of inward focus • Potential risk of protectionism towards their own services • CCG retains overall accountability, but is reliant on PP holding (any) sub-contractors to account
3	**Joint Venture (JV)** Providers enter into a partnership/consortium arrangement to deliver services as a single entity, with integrated management/reporting etc.	• One contract for CCG to manage • May incentivise providers as they are party to the main contract • Flexibility for providers	• Requires providers to develop a formal governance arrangement • Reliant on providers maintaining strong management structure

		when formulating arrangements	• CCG therefore has higher exposure to risk of failure • Need for separate provider registration/licence?
4	**Lead Organisation (contracting) (LOc)** Contract holder manages all service providers, but does not provide any services itself. Lead organisation determines pathways and enters into contracts with its chosen service providers.	• One contract for CCG to manage • Focused on integration and management • Potentially much wider pool of providers	• Lead organisation could have less clinical focus than in other models • LOc does not have direct management of any services
5	**Lead Organisation (non-contracting) (LOn)** Contract holder manages all service providers, but does not provide any services itself. CCG commissions actual services/maintains existing contracts with service providers. Lead organisation's role is just to promote, facilitate and ensure integration.	• Maintains greater CCG oversight of supply chain	• Lead organisation could have less clinical focus than in other models • Much greater resource requirement from CCG • CCG would have to commission supply chain separately • Would inhibit influence of LOn • Replaces one layer of contract management with another
6	**Alliance (separate contracts)** Separate contracts with individual providers but with shared objectives. Equal, but separate, parties who work together collaboratively to deliver elements of a care pathway[s] or service[s]	• Collective accountability for services delivered, with providers judged on performance as a whole rather than as individual components, thereby incentivising cooperation to drive successful delivery of services	• Multiple contracts to manage • Need to be clear where responsibility lies for delivery • Likely to work better where relationships are less mature • Not currently possible using NHS Standard Contract
7	**Alliance (one contract)** Commissioners enter into a single contract with a number of providers, who share a common performance framework with collective measures… In this approach there is collective accountability for services delivered, with providers judged on performance as a whole rather than as individual components	• Collective accountability for services delivered, with providers judged on performance as a whole rather than as individual components, thereby incentivising cooperation to drive successful delivery of services	• Reliant on strong working relationship between providers • Likely to work better where relationships are less mature • Not currently possible using NHS Standard Contract

Monitor guidance:

"Commissioners may decide to award a contract for a set of related health care services to a "lead" or "prime" provider that is responsible for delivering some of the services itself and arranging for other providers to provide the remaining services. Providers may also independently decide to sub-contract the delivery of certain services to other providers.

NHS
Wiltshire
Clinical Commissioning Group

Equality Impact Analysis – the EIA form

Title of the paper or Scheme: Adult Community Services procurement

For the record	
Name of person leading this EIA: Rob Hayday	Date completed: 10 November 2014
Names of people involved in consideration of impact: Not applicable	
Name of director signing EIA: Ted Wilson	Date signed

What is the proposal? What outcomes/benefits are you hoping to achieve?

As part of the Optimising Community Team programme, agreed as one of the CCG's priorities, is the Adult Community Services procurement. A contract with Great Western Community Hospitals NHS Foundation Trust (GWH) has been in place since 2010. The CCG will procure a new contract for adult Community Services. The formal procurement will begin in January 20-15 and the new contract will be in place in July 2016. In line with the CCG's five year strategy, the aim of the procurement is to seek an enhanced adult community healthcare service

Who's it for?

The new contract will be for services commissioned in line with the current portfolio of services provided by GWH in the community and will be for adults served by the commissioning responsibilities of Wiltshire CCG. Broadly this means those living within the county of Wiltshire and those whose GP practice is a member of Wiltshire CCG

How will this proposal meet the equality duties?

The CCG will ensure that through the procurement it is mindful at all times and compliant with the responsibility that the CCG has under the Public Sector Equality Duty.

What are the barriers to meeting this potential?

The procurement will be complex due to the size of the current contract and the arrangements in place across Wiltshire with the current provider. However, at the heart of the procurement are service descriptions which are currently commissioned for patients. These have been reviewed and patients have been involved in this process. To secure the right future services the CCG will describe outcomes that are required and these will be proposed to patients/groups to ensure engagement. The resource envelope of the CCG will need to be considered when commissioning the new services.

2 Who's using it? Refer to equality groups

What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)?

The CCG will procure services for the people of Wiltshire in line with those in operation under the contract with the existing provider. Commissioning of these services is influenced by the Joint Health & Wellbeing Strategy produced by Wiltshire Council Public Health available at: http://www.wiltshire.gov.uk/healthandsocialcare/jointhealthandwellbeingstrategy.htm

How can you involve your customers in developing the proposal?

Patients/Groups will be engaged in the review of desired outcomes that are to be commissioned as

part of the procurement.

Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary)
At this stage it is not anticipated that the procurement needs to be paused

3 Impact Refer to dimensions of equality and equality groups

Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation
and if appropriate: financial economic status, homelessness, political view
Using the information in parts 1 & 2 does the proposal:

a) Create an adverse impact which may affect some groups or individuals. Is it clear what this is?
How can this be mitigated or justified?
The CCG intends that the procurement delivers an enhanced community health service for adults during the 5 year contract period. During this time, where changes to service delivery are identified the CCG and its provider will ensure that it meets any obligations for formal consultation with the public and associated involvement of the Overview and Scrutiny Committee (OSC) of Wiltshire Council

What can be done to change this impact?
At this stage there is anticipated adverse impact though as part of the CCG's commitment to engage with the public the CCG will share its plans with the OSC

b) Create benefit for a particular group. Is it clear what this is? Can you maximise the benefits for other groups?
Not applicable

Does further consultation need to be done? How will assumptions made in this Analysis be tested?
No, not at this stage.

4 So what? Link to business planning process

What changes have you made in the course of this EIA?
None required.

What will you do now and what will be included in future planning?
The need for formal consultation, should it become necessary, is already flagged as part of the Stakeholder Engagement Plan which supports the ACS procurement

When will this be reviewed?
Throughout the procurement process during 2015 and thereafter during the contract

How will success be measured?
Wiltshire CCG will, through contract management, expect to see the community services provider deliver good outcomes for patients