Meeting:	**Social Care, Health and Housing Overview and Scrutiny Committee**
Date:	**15 December 2014**
Subject:	**Commissioning care closer to home**
Report of:	**Thomas Wilson, Director of Contracting & Performance for Bedfordshire CCG** **Dr Gail Newmarch, Executive Member for Bedfordshire CCG**
Summary:	This paper sets out the care closer to home commissioning principles BCCG will adopt in light of the feedback received from the Healthcare Review, for discussion with stakeholders.

Advising Officer:	Thomas Wilson, Director of Contracting & Performance for Bedfordshire CCG
Public/Exempt:	Public
Wards Affected:	All
Function of:	Council

CORPORATE IMPLICATIONS

Council Priorities:

1. This summary report sets about how Bedfordshire CCG (BCCG) will approach the commissioning of care closer to home that will contribute to the promotion of health and wellbeing and protecting the vulnerable.

Financial:

2. Effective commissioning of care closer to home will help to deliver financial sustainability across the health & social care economy. However, this paper provides details on the approach and principles of commissioning care closer to home and is not a costed business case.

Legal:

4. No legal implication

Risk Management:

5. The risk registers of the BCCG Strategy & Redesign Directorate and Contracting & Performance Directorate are being updated to reflect risks associated with the commissioning principles laid out in this paper. If adopted, a formal project team will be created and the risks associated with this work will be captured there and escalated as necessary to the BCCG Corporate Risk Register.

Staffing (including Trades Unions):

6. Not Applicable.

Equalities/Human Rights:

7. Impact on equality will form part of a project plan if this approach is adopted.

Public Health

8.. Taking this approach to commissioning care closer to home has the potential to make a greater contribution to population health.

Community Safety:

09. Not Applicable

Sustainability:

10. Not Applicable.

Procurement:

11. This paper outlines how the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 should be adhered to in order to effectively commission care close to home for the benefit of patients in Bedfordshire.

RECOMMENDATION(S):

The Committee is asked to:-

1. Note the work commissioning principles BCCG will adopt in light of the feedback received from the Healthcare Review, for discussion with stakeholders.

Background

12. The Bedfordshire & Milton Keynes Healthcare Review has given a clear steer that we need to be delivering more care closer to home. It has confirmed that BCCG must develop more integrated, joined up health services in Bedfordshire if we are to ensure we have affordable, clinically sustainable services for local people.

13. The Bedfordshire & Milton Keynes Healthcare Review used the term “Care Closer to Home” to encompass those current and future services that could be delivered to patients outside of a hospital setting; it expressly includes services which may be led by a consultant grade doctor and employed by a hospital but whose delivery of care to patients does not rely on the complex physical infrastructure of a hospital such as an inpatient ward, operating theatres and access to certain diagnostics. It obviously includes those services currently provided by General Practitioners and community service providers (predominantly but by no means exclusively in Bedfordshire delivered by South Essex Partnership NHS Foundation Trust (SEPT)). The terms “community services” and “primary care” are used interchangeably with “care closer to home” to describe this range of services.

14. How care closer to home is commissioned is fundamental to how care in a hospital setting is commissioned. One provides the foundation of support for the other – it is not possible to think about the configuration of hospital services without planning for how services out of hospital are delivered.

15. This paper sets out the commissioning principles on which Bedfordshire Clinical Commissioning Group proposes to engage with stakeholders and the public on commissioning care closer to home.

Our approach

16. Our approach can be summarised as having four principles:
    - The focus of health services and the way they are paid for and monitored must move from being activity based (the amount of something done) to being outcome based (what benefit did the patient receive?) Our proposal is to achieve this by seeking to move away from activity based payment mechanisms and move to one where an increasing proportion of money a provider receives for delivering care is dependent directly on the improved outcomes experienced by patients.
    - A strong culture of collaboration and formal integration of services and the organisations that provide those services is the means by which patients will experience a single joined up National Health Service. Our proposal is to achieve this by developing an alliance contracting approach to provide a strong framework within which all partners operate and to "vertically integrate" community services into both hospital organisations and potentially into emerging GP federations. This may or may not require a separate provider of community services.
    - Ensure that we effectively use the rules regarding procurement (formally the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013) to help us achieve principles 1 and 2 above. Our proposal to achieve this is to ensure we do not run formal procurements for services where, as allowed by the regulations, it is not necessary to do so: procurement exercises are a tool we will choose to use where it will deliver greater patient benefit than not running a procurement.
    - Acknowledge that whilst we have an overall obligation to reduce health inequalities across Bedfordshire in localising services there may be times when it is justifiable to offer different service models recognising that we cover two hospital catchment areas (Bedford Hospital NHS Trust and Luton & Dunstable University Hospital NHS Foundation Trust) and two local authorities (Bedford Borough Council and Central Bedfordshire Council) each with their own specific issues. Our proposal is to achieve this by considering the development of two alliance contracts to reflect the different partners who will make up the alliance.

17. However, this approach is not without its risks and has major implications for the capacity, capability and culture of both commissioning and provider organisations across the Bedfordshire health and social care economy.

Outcomes Based Commissioning

18. As a health system we need to stop commissioning for activity and processes – where providers are paid for how much they do – and move to a commissioning system where the focus is on what they achieve.

19. There are three broad areas of outcomes that can be developed. Firstly, an outcome of financial sustainability for the Bedfordshire health economy. Our allocation is £440 million and there can be no more money in that year: all the health needs of the population must be met for that sum. Secondly, we should aim for a commissioning model that encourages integration so that patients' experience of the NHS is as far as possible that of a single entity.

20. The main focus however needs to be on patient measured health outcomes. BCCG has started to develop outcome based specifications with its work in musculo-skeletal conditions, dermatology and mental health. By collaborating with and learning from organisations such as COBIC (Capitated Outcomes Based Incentivised Commissioning), and ICHOM (International Consortium for Health Outcomes Measurement) amongst others; benchmarking against other CCGs who have adopted a similar approach such as Cambridgeshire and Peterborough CCG's Older Persons Programme (see http://www.cambridgeshireandpeterboroughccg.nhs.uk/older-peoples-programme.htm) we will develop a set of measurable patient centred outcomes that will form the core of our performance measurement and increasingly over time be related to the financial system of paying for care. This will move us away from counting the number of district nurses available to support General Practice and hospital services to measuring how many people are helped to remain independent in their homes safely.

Collaboration and Integration

21. The consistent feedback from the Bedfordshire & Milton Keynes Healthcare Review was that patients and public want to experience a single NHS – they do not wish to continually have to recount their story, to have the same test undertaken by a different clinician because they have been referred and they do not wish to fall between the referral and acceptance criteria of different organisations looking after their care. We believe that frequently this happens as a direct result of different organisations operating under different contractual terms, with different payment mechanism and different performance measures.

22. We aim to tackle this by developing alliance contracting structures. The alliance contract is a legally binding mechanism that enables partners to align services and financial resources within a single contractual framework, with joint standards and performance indicators agreed for all parties. It also provides a vehicle to implement different payment regimes and facilitate financial risk and benefit sharing. It will allow us to move away from one partner being paid for the amount of something they do whilst another has a historical fixed sum irrespective of rising demand whilst another has a fixed sum based on the size of population served both of whom manage the same patient for the same condition on the same clinical pathway.

23. Alliance contracts are still reasonably new within the NHS, though more widespread in many other industries, They are being developed in Greater Manchester – Salford and Tameside & Glossop health economies; the Tri Borough Partnership in London adopts very similar principles in their integrated care plans to name but a few. Internationally the King's Fund has reviewed this approach to commissioning in Canterbury, New Zealand[1] and puts forward that it was collective leadership of the health economy accompanied by the structure of the alliance contract and new payment mechanisms that turned Canterbury from a failing health economy to one where services are starting to deliver improved outcomes for patients.

24. The King's Fund paper does not suggest that everything is now perfect and nor does it suggest there is a direct causal link between the new structures and the turnaround but it does note that change started happening as the mantra of "one system one budget" became embedded throughout the culture of the Canterbury health system. What it does show is that for collaboration to work it takes positive decision of the leaders of the local health and social care economy to make it work.

25. The current advanced work that has been developed under the Better Care Fund initiative with Central Bedfordshire Council could be simply subsumed into the alliance contract. The plans, which have been extensively discussed with all stakeholders across the Bedfordshire health and social care economy, broadly covers:
    - Empowering Patients Families and Carers for independent living
    - Care Planning/Tele-health
    - Extra supported living
    - Integrated wheelchair/equipment
    - Occupational Therapy
    - Supported Discharge

26. We start from the acknowledgement that we have two local authorities, mirrored to a large extent by two health economies centred around our two major hospital providers in Bedford and Luton & Dunstable, and this is reflected in the different approaches and emphasises of the two Better Care Fund plans. In localising our service delivery we recognise that there will be times when it is justifiable to commission differing services to meet the needs of the relevant populations whilst not losing the economies of scale that a county wide service can often bring.

27. Vertical integration is the term used when services that operate in a different level in a patient's care pathway are brought together – so for example a GP, district nurse, community matron, hospital nurses and hospital consultant working together under a single contracted arrangement to manage the care of frail elderly people with a single point of contact would be an example of vertical integration.

28. It is possible that community services, currently under separate contracts from primary care and from hospital based services, could be vertically integrated with those services. One potential model is shown below – this is for illustrative purposes it is not a proposed way of integration which would follow in detailed work but shows how the vertical integration of community services might work.

29. Primary care through GP federations keeping people out of hospital
    - Community nursing including community matrons, rapid intervention teams etc.
    - Step up beds or intermediate care services
    - Support for independent living such as health coaching

30. Hospital services that see people in hospital and facilitate their discharge
    - Integrated urgent care system including 111 and residual GP out of hours
    - Hospital at Home services
    - Rehabilitation beds
    - Specialist nursing clinically supervised by the Consultant for conditions such as Stroke, neurological diseases, diabetes, COPD and cancer

31. The new provider(s) of mental health services, currently being procured, will need to be appropriately incorporated throughout this model. Community services can be provided either by hospital services or GP federations or by those organisations working in collaboration with a separate community provider such as SEPT.

Procurement

32. It is a popular urban myth that the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 oblige CCGs to run formal tendering opportunities every time a new contract is awarded. This is simply not true.

33. The regulations **do not** insist on procurement but do place a specific obligation on commissioners when awarding contracts to "secure the needs of patients who use the services and to improve the quality and efficiency of the services, including through the services being provided in an integrated way (including with other health care services, health-related services or social care services)." (Regulation 2).

34. Regulation 3 covers a general requirement:
- to act transparently and proportionately, and to treat providers equally and in a non-discriminatory way;
- to procure services from one or more providers that are most capable of delivering commissioners' overall objective and that provide best value for money;
- to consider ways of improving services (including through services being provided in a more integrated way, enabling providers to compete and allowing patients to choose their provider); and
- to maintain a record of how each contract awarded complies with commissioners' duties to exercise their functions effectively, efficiently and economically, and with a view to improving services and delivering more integrated care.

35. Probably the clearest and easiest way to discharge obligations under Regulation 3 is to undertake a formal procurement exercise but this is not always necessary. Monitor's guidance[2] states that "where the commissioner carries out a review of service provision in a particular area to understand how those services can be improved and, as part of that review, identifies with reasonable certainty the most capable provider or providers of those services it may be appropriate to negotiate directly with the provider(s) in question rather than run a formal procurement exercise."

36. This can be seen in the contrasting approaches of Oxfordshire CCG and Cambridgeshire & Peterborough CCG in commissioning their outcomes based programmes for older people's services. Oxfordshire ultimately decided to not move down an open procurement route but to adopt a Most Capable Provider Assessment approach which involves finding a negotiated route with all partners – part of the reason for this was that the "financial situation in the health and social care economy requires an urgent whole system collaboration and the delay involved in open market procurement would prevent optimal progress".[3] It must be noted that OCCG reserved the right to implement a full market procurement if the negotiations did not deliver what was required. Cambridgeshire & Peterborough CCG on the other hand adopted a full open market procurement, eventually awarding the contract to a consortium of local NHS Trusts.

37. To arrive at the conclusion that current providers are the best placed to deliver services it will be necessary to conduct an open, fair and transparent review engaging providers and stakeholders and document this conclusion. The CCG can then make a fully informed decision, in line with its legal advisers, as to whether and if necessary what kind of procurement it needs to run to achieve its commissioning objectives.

Specific Services

38. The approach outlined above is considering those community services that broadly align to helping manage people with long term conditions management and the care of elderly people. However there are some services that can be aligned with care closer to home that would not necessarily fit with the wider alliance arrangements described.

39. These services are covered below.

- Phlebotomy and anti-coagulation services

  A strong message coming through all the patient engagement work we carried out for the Healthcare Review is that people want these services closer to home: they cannot understand why they have to travel into hospital, pay for parking etc. to get a blood test while their friends and family a few miles down the road can get the same service at their GP surgery. BCCG has reviewed the current provision for phlebotomy (taking blood for tests) and anti-coagulation services (warfarin) and will be embarking on a procurement exercise for both services within the next three months.

- End of Life

  We will redefine the specification for end of life services and introduce a revised model of care based on a partnership between acute hospitals, hospices and primary care federations, ensuring emergency ambulance pathways are clearly defined. This will involve procurement of a lead provider/prime vendor commencing Q2 2015/16

References

1. http://www.kingsfund.org.uk/publications/quest-integrated-health-and-social-care
2. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf p39
3. http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2014/01/Paper-14.10-Outcomes-based-contracting-next-steps-.pdf