Health and Wellbeing SUFFOLK

Agenda Item 10

Suffolk Health and Wellbeing Board

A committee of Suffolk County Council

Report Title:	Update on Suffolk NHS Community Services procurement
Meeting Date:	26 January 2016
Chairman:	Councillor Tony Goldson
Board Member Lead(s):	Ed Garratt, Chief Officer Ipswich & East Suffolk Clinical Commissioning Group (CCG) and West Suffolk CCG
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What is the role of the Health and Wellbeing Board in relation to this paper?

1. To note current position and agree recommendation to progress to detailed negotiations.

Key question for discussion:

2. The key question for discussion is: does the Board support the actions taken and proposed with regard to the procurement of community services in Ipswich and East and West Suffolk?

What actions or decisions is the Board being asked to take?

3. The Board is asked:

   a) to note the current position with regard to the procurement of community services in Ipswich and East and West Suffolk;

   b) and to note the following recommendation:

   The progression of the alliances through gateway 1 to start detailed negotiations around vision, service delivery and contracts; which will culminate in a mutually agreed delivery plan; innovation plan and an agreed service contract which once ratified can be moved towards signature.

Brief summary of report

4. The Community Services contract currently held by West Suffolk NHS Foundation Trust is due to end on 31 October 2017.

5. In Suffolk, we have completed a number of strategic programmes that all require care to be integrated and these are underpinned by the Suffolk Health and Care review that defines a new way of working based around 13 localities in Suffolk.

6. The Ipswich & East Suffolk and West Suffolk Clinical Commissioning Groups (CCGs) agreed that the community contract would be an excellent catalyst for delivering the Suffolk health and care review.

Main body of report

Background

7. The CCGs agreed (September 2016) to undertake a Most Capable Provider process with existing system providers, as permitted under the Procurement Patient Choice and Competition (No. 2) Regulations 2013. The Most Capable Provider (MCP) process was designed to understand whether an alliance of existing system providers would able to offer a unique set of opportunities which could not be delivered by any other group(s) of providers.

8. The Commissioners did not prescribe the providers needed. The providers came together and agreed the organisations to be involved in the process were as follows:

    - The Ipswich Hospital NHS Trust
    - West Suffolk NHS Foundation Trust
    - Norfolk and Suffolk NHS Foundation Trust
    - Suffolk County Council
    - Suffolk GP Federation

9. The commissioners committed to a long term contract (estimated 8-10 years) to ensure continuity and time for providers to succeed.

The Most Capable Provider Process (MCP*)*

10. The MCP process involves two distinct stages, constructive dialogue through to Gateway 1 and detailed work-up and mobilisation through to Gateway 2.

11. The MCP process drew on a traditional procurement process to ensure that the appropriate suite of indicators were used to assess the capability, capacity and desire of the alliances to deliver the vision for services outlined within the Health and Care Review and the Proactive, Reactive and Children's specifications which had been jointly worked up with system partners.

12. Stage 1 reassurance gateway (current point in process). This stage is the most critical point within the process. This is the point at which the CCGs will decide whether to progress with the structured dialogue and most capable provider process, or whether to divert into an open market procurement process. The CCGs will need to have received enough reassurance to be able to evidence that the provider is the most capable provider of the service(s) under scrutiny and that negotiations should continue through to stage 2. If the assurance has not been received then the CCGs reserve the right to commence an open market procurement process in order to secure a provider for the service(s).

13. Stage 2 reassurance gateway. Assuming negotiations continue through the stage 1 reassurance gateway the provider(s) and the CCGs will progress onto stage 2 which will include detailed negotiations around vision, service delivery and contracts. The stage 2 reassurance gateway will need to detail a mutually agreed delivery plan; innovation plan and an agreed service contract which once ratified can be moved towards signature.

14. The commissioners worked through procurement best practice and developed the domains and criteria in which to assess the providers against:

Alliance Commitment & Integration	Vision and innovation
	Commitment to working as a system with partners and no blame ethos
	Commitment to working with wider system strategies
Service Management	Organisational structure, leadership and management structure
	Organisational structure, outline governance structure
	Locality approach
	Review of existing performance and improvement areas
	Patient involvement and engagement
	Quality management
	Development of outcomes framework
Service Delivery	Service integration (adults and children)
	Service delivery (adults and children)
	Agreement to System Outcomes (OC's) and Process Performance Indicators (PPIs)
	Delivery operating models – children
	Delivery operating models – adults
	Expected results/outcomes (adults and children)
Human Resources	Staff supervision; clinical and non-clinical
	Recruitment, training and continuous development
	Staff involvement and feedback
	Professional Registration
	TUPE
Governance	Risk management
	Clinical Governance
	Patient safety and clinical quality
	Infection prevention and control
	Safeguarding
	Equality and Diversity
	Audit
IT	IM&T Operating Model
	Analytics, reporting and information
	Information Governance
Mobilisation	Regulators – NHSI and others
	Care Quality Commission
	Heads of terms
	Contract form and sub-contracting
Cost	Open book accounting and commitment to accounting openness
	Cost of delivery
	Risk share agreements

15. Each of the sections included a number of questions and these were scored using the following methodology:

CCGs are assured - no further amendments to proposals required
CCGs are partially assured - aspects of response which require further revision to provide assurance
CCGs are not assured of proposals put forward - sections require material reworking to provide assurance

16. Unlike a traditional procurement the MCP process involved five constructive dialogue sessions which addressed the criteria above. Providers where expected to provide a presentation, then hold extended questions/dialogue around the subjects under review in that session. To underpin the structured dialogue sessions the alliances were asked to submit a written response at the end of the process which was then evaluated by a group of representatives from the CCGs.

17. A panel of representatives from the CCGs was present at each of the structured dialogue sessions and evaluated the final written submission.

18. In order to assure the Commissioners that the above process was robust, legal advice was provided.

19. A notice was published to the market notifying the open market of our process and required outcomes.

Process Outputs

20. The process to date has culminated in receiving a final written portfolio of evidence from the alliances which outlines why they believe they are uniquely placed to deliver these services and deliver the level of integration and collaboration required of the system to deliver the Suffolk health and care review vision.

21. The provider alliances submitted their written submission on 30 November 2016, the documents provided were:

    a) Constructive dialogue session Slides
    b) Joint Suffolk alliance narrative pack
    c) Joint Suffolk alliance evidence log

22. A moderating panel met on 12 December 2016 and agreed their collective recommendations.

Alliance Provider Commitments

23. The CCGs' Accountable Officer received a signed letter of commitment from the Chief Executives in the alliance. It stated how committed they are to delivering services in an integrated way breaking down organisational barriers.

24. Within the documents outlined above, the Alliance has agreed to:

    a) "West Suffolk and East Suffolk providers, including Suffolk County Council, Norfolk & Suffolk Foundation Trust, Suffolk GP Federation, The Ipswich Hospital NHS Trust, and West Suffolk Foundation Trust (including community services), have formed two alliances and have developed an evidence log and narrative pack to outline the way we will develop new and innovative care models that deliver the high level of integration required by the Health and Care Review and 'Family 2020.'"

    b) "The alliances will work independently, but have recognised the need to continue to work together where appropriate. This includes some services that require a pan-Suffolk focus, or where services require the critical mass of a larger population. The existing strong relationships and providers that currently span the whole county will enable this to happen."

25. In order for us to establish that we can get 'more' from the alliance then Commissioners can achieve through open market procurement for isolated services the following unique points were provided as justification:

a) "The strength and maturity of relationships across alliance members from the leadership to the front-line and across the clinical and non-clinical workforce provides an excellent platform for accelerated partnership working. We believe this would take time for another provider to develop and delay benefits achieved for our communities."

b) "All organisations within the two alliance footprints are signed up to the STP vision and approach. This includes financial risk management as a system and agreement on integrated locality care models, which is broader than just community services."

c) "The alliances have already initiated new collaborative programmes of work, such as the Delayed Transfer of Care (DTOC) Taskforce in the East, and the Connect teams in the West, which demonstrate the value of greater integration and which we will enhance through an alliance framework."

d) "Working with the alliances will accelerate change and improvement as we can initiate our integrated locality teams immediately, rather than wait for a lengthy procurement exercise and contract award to commence mobilisation."

e) "We believe working with the alliances will motivate staff and secure commitment of staff that have already been through significant change. This will allow them to focus on delivering high quality care and the change required for integration and transformation."

Process Gateway 1 - Evaluation

26. Overall the panel felt partly assured by the information and evidence received at the constructive dialogue sessions and within the evidence log submitted. Below outlines the individual areas and the outcome of the evaluation.

27. Overall the panel were partly assured that the alliances would be able to deliver the vision for the community services. Part assurance at this stage in the process means that the panel felt the alliances should progress through gateway 1 and that they are in a unique position to deliver the vision.

28. There was one area which the panel were not assured by, and this was around the Children's Services. The panel felt that a lot of work had already been undertaken to address issues around children's services, and that this work had not been referenced or built upon; which was a missed opportunity.

29. Part assurance should not be considered with negative connotations; the alliances are at the start of a relationship and wide ranging transformation program, and as a lot of these developments will evolve then they are not in a position to provide all the answers at this point; however the evidence provided has demonstrated that they are capable and uniquely placed, with the capacity and the desire to undertake this work in conjunction with the CCGs.

30. The next stage of the MCP process will develop a mutually agreed delivery plan; innovation plan and an agreed service contract, which should include the detail and therefore provide the assurance required.

31. There were themes within the submission which the panel feel will need to be addressed early within the next stage of the process if the transformation is to be successful; these are as follows:

    a) Organisational cultures appear to still dominate, and an alliance identity needs to be developed to reflect the integration of services.

b) The integration and alliances need to be driven by leaders with community and integration experience.

c) The role of the commissioner within the alliances as the 'system integrator'.

d) There needs to be assurance that the right operational delivery capability will be in place to move the services forward into successful delivery.

e) The CCGs would like to understand how conflict will be resolved within the alliances.

32. An area which the panel felt will need to be developed is an offer from the CCGs for their involvement in the transformation development and implementation. This is a transformation opportunity for all involved in the health and social care system and the CCGs should be more involved in the developments, working jointly with the providers to realise the wider benefits to the system. This will mean a commitment by the CCGs to undertake more of a facilitation role, and commit to field individuals to fulfil this role.

Patient and Public Engagement

33. There has been considerable patient and public engagement throughout the work up of the Health and Care Review and the subsequent development of the Proactive, Reactive and Children's specifications. So far the MCP process has not had involvement from parties outside of the CCGs or the alliance providers; however, if the process moves into the detailed development and mobilisation stage then there will be a requirement on the alliance providers to undertake the development in partnership with patients and the public.

34. Discussions have already been held on how this wide ranging transformation could be effectively handled and widened to include patients and the public. These discussions will need to be progressed if the CCGs decide to progress with the MCP process past gateway 1. Ideas which were discussed included specific focus groups where ideas could be taken by the alliances, such as pathway groups, or patient experts being involved in the workup of specific services.

Actions/decisions recommended

35. The Health and Wellbeing Board is asked to note the following recommendations:

    The progression of the alliances through gateway 1 to start detailed negotiations around vision, service delivery and contracts; which will culminate in a mutually agreed delivery plan; innovation plan and an agreed service contract which once ratified can be moved towards signature.

Why this action/decision is recommended

36. The new approach to the procurement of the community contract will make a significant contribution to the integration of care in Suffolk, one of the cross-cutting themes of the Board's Joint Health and Wellbeing Strategy, underpinned by the Suffolk Health and Care review.

Alternative options (if appropriate)

37. None proposed.

Who will be affected by this action/decision?

38. Users of Community Services, their families, Board and Partnership organisations.

Sources of further information

Integrated Health and Care in Suffolk:
http://www.healthysuffolk.org.uk/health-and-wellbeing-board/integrated-health-and-care-in-suffolk/

Suffolk Joint Health and Wellbeing Strategy (refreshed January 2016)

https://www.suffolk.gov.uk/assets/council-and-democracy/the-council-and-its-committees/health-wellbeing-board/JHW-Refreshed-Strategy-for-Suffolk.pdf