Derby City Council

Health and Wellbeing Board
11 September 2014

ITEM 6

Report of the Chief Officer, Southern Derbyshire Clinical Commissioning Group and Strategic Director for Adults, Health and Housing

Collaborative Commissioning in Southern Derbyshire

SUMMARY

1.1 Derby City Health and Wellbeing Board has agreed a draft vision for the future of services in Southern Derbyshire. This was set out in the Better Care Fund submission and has been endorsed by the Southern Derbyshire Leadership Group (which includes commissioners and providers working within the Southern Derbyshire geography).

1.2 Although originally focussed on meeting the needs of the frail and elderly population, it is now intended to cover all aspects of care, including health and social care, physical and mental health, adult and children's services, and planned and unplanned care. The articulation of our strategy for organising the delivery of services to achieve the vision is summarised via the 'wedge' diagram (See section 4.3)

1.3 There has been significant progress in moving towards implementing the ideas articulated through the “wedge”. However, it has also become clear that there is a pressing need to reach agreement on the future focus and structure of community-based services. Developing community-based services is crucial to delivering the strategic aims of health and social care and will also help define the future role of both secondary care and general practice.

1.4 To make progress ‘at scale and pace’ commissioners have developed a Statement of Intent which actively invites providers to work collaboratively with each other and with the commissioners to agree a radically different approach to the provision of community-based services in order to achieve a step change in the next two years.

RECOMMENDATION

2.1 To support the Collaborative Commissioning initiative and the direction of travel set out in the Statement of Intent

2.2 To recognise the need for a leadership development programme across all the organisations involved in order to develop a shared understanding of the implications of the initiative and the behavioural changes that need to be encouraged.

2.3 To receive regular reports on progress at the Health and Wellbeing Board

REASONS FOR RECOMMENDATION

3.1 Local Authorities and the NHS are facing unprecedented financial pressures. Demand for services, particularly from an increasingly elderly population, are increasing each year at the same time as resources, in real terms, are falling. Rapid evolution of integrated services offers the potential to deliver better services to more people at a similar cost

3.2 The strategic aim for services in five years' time is to support more people to remain living independently in their own homes and own communities. At present the incentives in the system are not aligned to achieve this goal and need to be significantly changed – based on the outcomes to be achieved rather than the activity undertaken

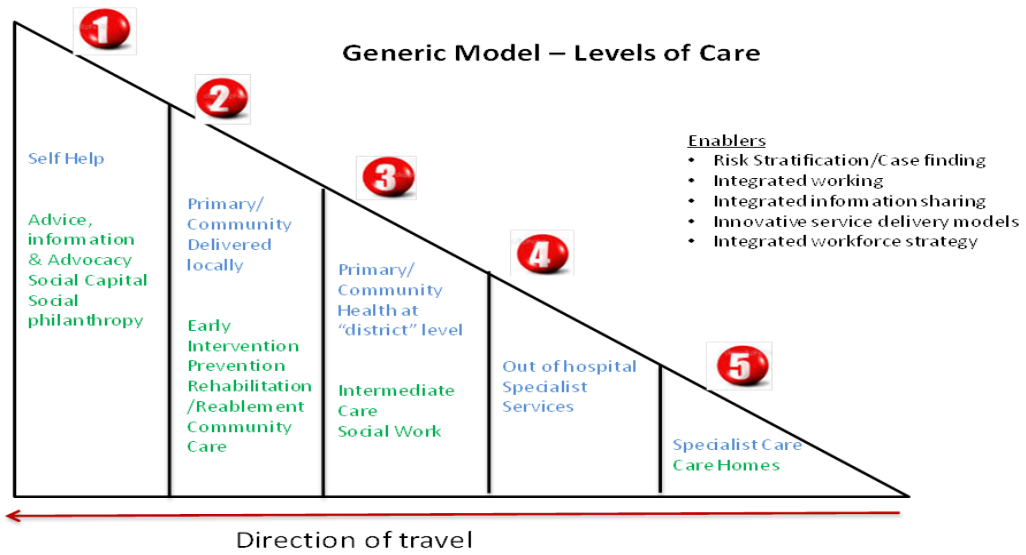
SUPPORTING INFORMATION

4 Introduction

4.1 Health and social care services face a challenging future as needs rise at the same time as reducing public expenditure. The size of the financial challenge to the NHS in southern Derbyshire is £25m-£30m per year for the next five years. Adult social care is facing an underlying budget pressure of £6m with an annual pressure of £2.5-£4.6m with a spike of £7.8m in 2016/17 due to the introduction of the care cap. The system, as it is currently configured, is unsustainable.

4.2 Derby's Health and Well-being Board has agreed a vision for the future which was set out in the Better Care Fund submission and is articulated through a diagram referred to as the "Care Wedge" as set out in the paragraph below.

4.3



4.4 A key part of achieving a strategic shift in how services are delivered involves meeting a greater number of people's needs in the community. This has brought into focus the need to rapidly transform these services that are currently provided by a range of providers but include Derby Hospital Foundation Trust, Derbyshire Healthcare Foundation Trust, Derbyshire Community Services Trust and the two local authorities.

4.5 Section 75 of the Health and Social Care Act 2012 allows competition in the NHS. It does not prohibit collaboration where it can be shown that this benefits patients, achieves high quality services and delivers best value. It is with this in mind that the commissioners, that is Southern Derbyshire Clinical Commissioning Group and Derby City Council, has issued a statement of intent that actively encourages and challenges the providers to transform local services through collaborative endeavour.

The Leadership Challenge

4.6 If a collaborative approach is to be successful then leaders need to work together to secure wider systems value through sharing and collaborating. We need to better understand the dynamics of collaborative working between organisations and the role leaders play in setting the tone and behaviours that underpin critical relationships. By "leaders" we mean leaders at every level in our organisations and citizen leaders too.

4.7 *"Collaboration is not just another strategy or tactic for addressing public concerns. It is a means of building social capital, sustaining a democratic society, and transforming the civic culture of a community or region".*
David Chrislip *(The Collaborative Leadership Fieldbook)*

We need to not only consider the role of collaboration between organisations but between organisations and the communities we service. By engaging, building and supporting community-based collaborative activities we are also increasing the opportunity to unleash the ideas and creativity of our citizens in helping shape the future. We therefore suggest to the Health and Well-being Board that officers develop proposals for a Leadership Development Programme that also includes citizen leaders as part of it.

OTHER OPTIONS CONSIDERED

5.1 For the NHS, the alternative approach is for services, either individually or in combination, to be subject to competitive tender. For the reasons set out in the Statement of Intent, this would be an expensive and time consuming process, and would not necessarily lead to changes in incentives in the system that are needed to achieve a significant shift from acute to community delivery

This report has been approved by the following officers:

Legal officer	Robin Constable
Financial officer	Toni Nash
Human Resources officer	Not relevant
Estates/Property officer	Not relevant
Service Director(s)	Perveez Sadiq
Other(s)	

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Background papers:	None
List of appendices:	Appendix 1 – Implications Appendix 2 – Statement of Intent

Appendix 1

IMPLICATIONS

Financial and Value for Money

1.1 None at this stage. However, the move towards greater integration of the delivery of health and social care is explicitly intended to ensure that the best value is achieved from the combined resources of the NHS and Local Authorities

Legal

2.1 There is a risk that the Collaborative Commissioning initiative will be considered anti-competitive within the NHS, which is subject to European regulation on procurement and competition. Partners will need to demonstrate that foregoing a competitive procurement is in the best interests of the public. SDCCG are working closely with Monitor, the NHS regulator that has responsibility for ensuring compliance with legislation.

Personnel

3.1 The Collaborative Commissioning proposal involves different health and social care organisations working closely together but does not believe, at this stage, that there is any value in organisational change.

IT

4.1 Not applicable yet. However, local partners have recently bid for national NHS funding to develop data sharing between organisations. This is an important supporting programme in developing integrated working between health and social care and between primary and secondary care providers

Equalities Impact

5.1 Services across Southern Derbyshire have evolved over many years and reflect many different initiatives and priorities. The movement towards collaborative commissioning will be based around achieving consistent outcomes for people across the geography, rather than being based upon service inputs. These will aim to support people being able to remain independent in their own homes and within their own communities. The ‘offer’ from health and social care is intended to be more consistent than is the case at present, but also be sensitive to the needs of different communities.

Health and Safety

6.1 N/A

Environmental Sustainability

7.1 N/A

Property and Asset Management

8.1 N/A

Risk Management

9.1 That the initiative will be deemed anti-competitive. SDCCG is working with Monitor to ensure that this can be resolved

9.2 The work proposed is difficult and with relatively few national precedents. Commissioners will need to define the outcomes to be achieved, the nature of the contract between commissioners and providers, and the financial arrangements. Providers will need to ensure that they can work together, and develop risk sharing agreements to ensure that organisations are not destabilised

Corporate objectives and priorities for change

10.1 The Corporate Plan includes a commitment to promote the health and well-being of people in Derby.

Appendix 2: Statement of Intent

Southern Derbyshire Clinical Commissioning Group

Commissioning Community services – A Statement of Intent

Background

Derby City Health and Wellbeing Board has agreed a draft Vision for the future of services in Southern Derbyshire. This was set out in the Better Care Fund submission and has been endorsed by the Southern Derbyshire Leadership Group (which includes commissioners and providers working within the Southern Derbyshire geography).

Although originally focussed on meeting the needs of the frail and elderly population, it is now intended to cover all aspects of care, including health and social care, physical and mental health, adult and children's services, and planned and unplanned care.

The articulation of our strategy for organising the delivery of services to achieve the vision is summarised via the 'wedge' diagram.

There has been significant progress in moving towards the “wedge”. However, it has also become clear that there is a pressing need to reach agreement on the future focus and structure of community services. Developing community services is crucial to delivering the strategic aims of health and social care and will also help to define the future role of both secondary care and general practice.

To make progress ‘at scale and pace’ commissioners have developed a Statement of Intent which invites providers to work collaboratively with each other and with the commissioners to agree a radically different approach to the provision of community services in order to achieve a step change in the next two years.

The vision for the future of services in Southern Derbyshire

In five years’ time we will have empowered citizens, able to access helpful information on a range of subjects that promote their independence and enable them to manage their long term condition/ risk to independence. They will be supported in this through a good network of family, friends and engaged community – perhaps with the help of a peer educator too. The amount of social capital in our communities will have increased through the facilitation of the Local Area Co-ordinators and our voluntary, community and faith sector. Social philanthropy will have increased and contributors will be able to make informed decisions about donating through the *Vital Signs* philanthropic guide. Increased volunteering will make a valuable contribution to tackling social isolation and increasing informal forms of support. Every older person aged 85+ will be offered the opportunity to have an individualised “winter plan”.

A more effective involvement of carers at each level will contribute to meeting identified outcomes. Informal carers will be supported to continue their caring role for as long as they feel able or wish to. They will receive a carers assessment and from this support mechanisms to prevent carer breakdown. Increased investment in the carer emergency plan will reduce the 'cared for' being admitted to hospital or institutional care following a carer crisis. Clear pathways of support for the carer will reduce carer stress and the requirement for more dependent funded support from health or local authority.

There will also be an agreement to continue the support to carers who support people with dementia by securing current provision.

The Community Support Teams (created through integrating social work, primary and community health services) will be at the heart of our community offer and will cover both physical and mental ill-health. They will have a close professional relationship with the Local Area Co-ordinators. They will be effectively reducing planned and unplanned admissions to hospital and care homes through rapid action to support frequent attenders and through proactive preventative work with people with long term conditions/ risks to their independence. Working with peer educators and citizen leaders will be a key part of this work as will the maximum usage of health and social care personal budgets. There will be close working between Community Support Teams and Care Homes for any individual who does need a short stay in a care environment.

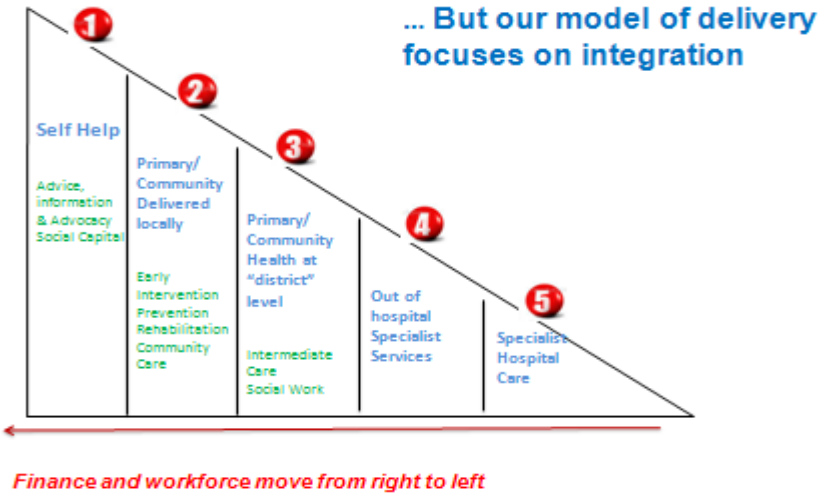
General practice will be an integral part of Community Support Teams and provide clinical leadership. Practices will be working collaboratively to provide a wider range of services within each geographical area than is currently the case.

These teams will be complemented by a rapid response service obtained through a single point of access that GPs have confidence in because it guarantees it will see someone within 2 hours of referral and has a comprehensive spectrum of services it can call upon to support people at risk of an admission. The work of the service is ably supported by geriatricians who will spend a significant proportion of their practice time in the community. Health and social care support staff will work together to provide a single source of care for patients.

Recovery capacity and expertise will have increased across physical and mental ill health services. Rather than go to day centres, people with a mental health problem will go to Recovery College to gain the skills and confidence they need to overcome their illness. Rather than people be assessed in hospital to facilitate discharge, the default position will be to discharge people home to assess, ably supported with intensive support and night sitting if required in the first few days. Only by exception will people receive rehabilitation in a community hospital bed with greater use of care home capacity and people's own beds with peripatetic therapy support and care workers acting as agents of therapy. It is likely that we will need fewer buildings as services will be delivered in people's own homes.

The acute hospital will be free to focus on its core purpose and, as a result of the effectiveness of admission avoidance and supported discharge, will no longer need to expand its capacity to meet demand and may, in fact, be more compact than at present. Community staff will reach in to hospital to provide continuity of care and facilitate discharge; and acute clinicians will provide expert advice and support to community teams and primary care. There will be regular circulation of staff between acute and community settings.

Definition of the wedge

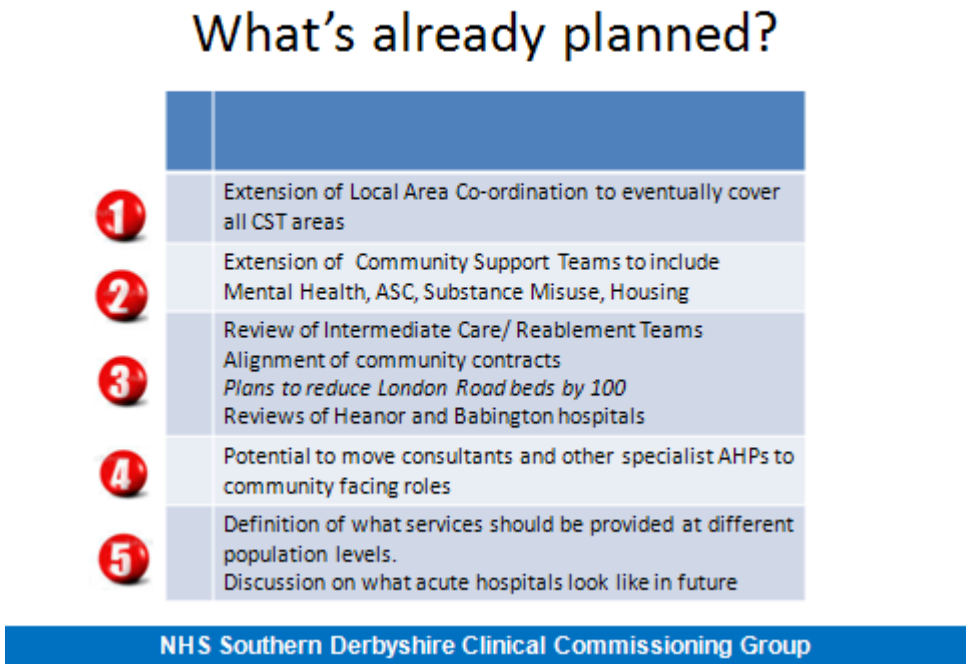


We want to engineer a step change in the following:

1. Increase the number of people who avoid formal care and support because they have their needs met through natural community support
2. Decrease the number of people with a long term condition(s) living without an informal network of support
3. Increase the role of peer support and educators to help people manage their condition and recover
4. Significantly reduce the number of unplanned admissions to hospital and care homes through effective admission avoidance interventions
5. Increase recovery outcomes across all client groups through increased and improved recovery services
6. Significantly reduce the number of people going into long term care from a hospital bed
7. Reduce delayed discharges through increased community-based services and effective care pathways
8. Timely and effective support to carers

Progress in implementing the wedge

Future plans for implementing the wedge



The current apportionment of funding to each level

(SDCCG funding only)

	Level 1	Level 2	Level 3	Level 4	Level 5
£592.2m	0.0	96.4	73.0	70.1	352.7

Moving towards a collaborative approach

As commissioners, there are two potential avenues open to achieve the necessary transformation of community services - either through a contractual route (which will require developing the specification of what services are required) or by working with providers to reach a consensual agreement, but without going through formal procurement.

The risk with the first approach is that undertaking a procurement that brings together community services across Southern Derbyshire, together with mental health and social care, will be very complex, take considerable time and depends in part on commissioners developing a clear specification for what is required. Experience in, for example, Oxfordshire and Cambridgeshire shows how difficult this can be.

The risk of the second approach is that provider efforts do not achieve the radical changes which must be achieved and raises a number of key issues to resolve, particularly around risk management between organisations, activity currencies and workforce. An agreement that simply bolts together existing services and rearranges the management structures isn't going to solve the major challenges facing the whole system.

The view from a number of observers is that, given the level of collaborative working that already exists in Derbyshire and the shared Vision already agreed with the CCG's main providers, there is a real opportunity that the second approach could be made to work. Providers are keen to have the opportunity to work together in this way because they believe that currently they are being constrained from developing services because of uncertainty as to whether they will be required to behave collaboratively or competitively.

For the commissioners, this would have a number of implications:

- Health and social care commissioners would work together to agree a Statement of Intent setting out the desired outcomes, impact, metrics, and timetable for achievements
- Health and social care providers across Southern Derbyshire would work together to provide an initial response to the Statement of Intent
- The CCG would suspend the reprocurement of community services in the City (TCS). The CCG will need to understand any legal implications of this
- The reprocurement of those children's services for which the CCG has responsibility (TCS) will continue
- The CCG and providers will agree the governance arrangements for this work.
- Commissioners would reserve the right to revert to a contractual framework if sufficient progress isn't evident

At a meeting of the CCG's Clinical Commissioning Committee on 9th May, the following recommendations were approved:

That the Clinical Commissioning Committee:

1) Approves the proposal to move towards a collaborative approach to the commissioning of community services instead of a competitive procurement, providing that:
    a. This is guided by a joint health and social care Statement of Intent from commissioners
    b. The CCG reserves the right to move back to a competitive approach if sufficient progress isn't being made by providers
2) Agrees to delay the reprocurement of community services in the City, providing that sufficient progress is made by providers and that there are no legal restrictions
3) Receives a further report in June setting out the full implications of following the collaborative approach.

Towards a Statement of Intent

The Statement of Intent will have the following:

a) A set of guiding principles for how we envisage the collaborative approach could work in practice
b) What we believe will be the key characteristics of a transformed system
c) A statement on the desired **impact on flows/ pathways** we hope will be achieved
d) A statement on the desired impact on **people's experience** of transformed services
e) A statement on the desired **impact on the cost and efficiency** of community services

In return, we want providers to set out their preliminary thinking on the above. We believe that the collaborative commissioning approach will require on-going, dialogue and the testing out of ideas between commissioners and providers which will eventually formulate into worked up plans with milestone and metrics to track progress.

Guiding principles:

- The Vision. All proposals from providers will need to be consistent with the Vision set out above. Commissioners are effectively asking providers to define the service delivery within level 3 and 4 of the wedge. There should be clear links with levels 1 (self-care), level2 (general practice) and level 5 (secondary care)
- As commissioners we commit to open and honest dialogue with providers.
- We will be explicit about our "non-negotiables"
- We will give a timely response when a steer is requested
- We will take a fair approach to risk sharing and risk reward
- We expect compassion and quality to remain paramount in any service transformation or change

Key characteristics of a transformed system

Community delivery. Commissioners want to see a shift in the delivery of services from secondary care to community settings, in line with the vision. However, this will need to be supported by clear business cases that identify both the clinical and financial benefits. Shifting delivery without changes to the model of service are unlikely to be effective

Workforce. Commissioners want to see significant changes to the current workforce and the way in which it is used to deliver services in future.
These include:

- A significant shift in the workforce from working in secondary care to working in the community
- The development of generic workers who are able to work across physical and mental health and across health and social care
- Ensuring that practitioners are working 'at the top of their licence' and that they are supported by a range of less specialist support workers.

Flexibility. Needs and services inevitably change over time. Flexibility and adaptability will be essential components of future service design

Impact on flows/ pathways

- More people will be able to remain living in their own home for longer in greater control of their health and well-being
- Less people go into long term care because there is a greater level of support available to help people recover
- More people able to access 'a good death' at home, or in a community setting if preferred.
- Less people being admitted to Acute Services where this can be avoided
- A smaller proportion of people being discharged from an acute hospital directly to long term care

Impact on people's experience of care

- They will have an improved experience of using community-based services as our integrated approach means that:
    - They only have to tell their story once
    - The service offer is consistent across all the days of the week
    - They know the name of the person they need to contact if they need help
- They have an increased sense of security because they know they can get help quickly – whether it be for social, physical or mental health reasons
- More people are in direct control of their support because of increased take up of Health and Care Personal budgets.

Impact on cost and efficiency

- Productivity. Commissioners are working within fixed or declining resource limits. Significant productivity improvements need to be achieved across the health and care system. Providers will need to be clear how changes in any income redistribution between organisations are also reflected in cost reductions. Estate rationalisation will need to be considered.

- Variations in practice. There is good evidence that more efficiencies can be achieved through the standardisation of existing practice than through changes in the settings in which care are delivered. Proposals will need to address this in both secondary care and community settings

Governance

There will be a need to develop clear governance arrangements between both commissioners and providers, and between providers themselves. These will be critical in both the design and development of the system and in risk management at the different levels.