your care your way

Outline Business Case

Phase Two

November 2015

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Bath & North East Somerset Council

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1. Executive Summary

Over the past ten months Bath & North East Somerset Council and Bath and North East Somerset Clinical Commissioning Group (BaNES CCG) have been listening to the views of local people and organisations delivering services. We have been working together to review and develop proposals to improve the delivery of integrated community health and care services to the people and communities of Bath and North East Somerset. As a result of this work commissioners have developed this Outline Business Case (OBC) describing proposals for achieving a local model of integrated health and care that improves outcomes and system sustainability both now and in the future.

The proposals detailed within this document recognise that not all aspects of community services may need to change, and acknowledge the need to build on the successes of the current system and the achievements of providers and staff. This gives us a sound foundation on which to build and to ensure that community services are ready, flexible, and resilient enough for the future – not only to respond to the challenges of constrained resources but also to drive lasting and sustainable improvements in outcomes for our population.

The CCG and the Council published the "Making Plans" consultation document in September 2015 to offer a vision and set of proposals in the context of addressing these challenges. The strategies detailed within this OBC should be read in conjunction with this document as well as the following key publications available www.yourcareyourway.org;

- Case for Change - Phase One : Commissioning Approach
- Getting Started Overview - Phase One : Commissioning Blueprint
- The Story So Far - Phase One : Engagement Report
- Options and Choices - Phase Two : Engagement and Consultation Report

The ***your care, your way*** programme is also aligned to support the delivery of local strategic priorities including those set out in the Health & Wellbeing Strategy, Better Care Plan, Council vision and priorities, and the CCG's five year strategy.

What have we learnt from public consultation?

We have undertaken an extensive engagement programme in order to inform future commissioning intentions set out in this Outline Business Case. The ***your care, your way*** consultation has reached over 2,000 individuals during this phase and we gathered feedback from service users, patients, carers and members of the public who may be service users in the future as well as from those people delivering and commissioning services.

The Phase Two consultation document, 'Making Plans' set out;

- Our vision for community services
- Four potential models for service delivery
- Fourteen priorities to support transformational change

We have a **vision** for delivering real lasting change for local people. Ultimately the key to any successful transformation of services rests with the strength and maturity of the relationships between us all – between individuals, services, commissioners and providers. During Phase Two of the review we set out our vision for community services which has been further developed based on what we have learnt from the consultation process to ensure that recognition is given to encouraging a culture of continuous quality improvement, whilst delivering better outcomes for people in ways which deliver best value for money.

Each **model** was recognised as having its own attributes and although the results of the consultation showed no clear preference towards one particular model there was general support for a locality-based model that would harness the strengths and assets of local communities whilst ensuring that people can continue to access the specialist support they need when required. In response, and to support a new model of outcomes-based commissioning, delivering improved person-centred and integrated care and support, we will seek to adopt a locality-based approach often referred to as asset-based community development.

When it came to the **priorities**, our stakeholders gave us a clear indication that joining up people's care and support is their number one priority for this review. This will require a technical solution that enables everyone to work from a single care plan with a simultaneous investment in the culture, skills and resources of the work force to ensure that services provide holistic, person-centred care and support rather than focussing on specific conditions. There is also strong support for placing greater emphasis on prevention, ensuring that the right support is available to people before they reach crisis point, require hospital admission or develop a long-term condition.

What have providers told us?

Running concurrently with the consultation process, commissioners also embarked on further engagement with providers of services in order to explore the opportunities and challenges around our proposals.

We heard during the engagement process a consistent understanding of the need for change, particularly due to increasing demographic pressures and the knowledge that "things can't continue as they are". However, we recognise there are some anxieties around how any contract would be set to respond to a commissioning approach incorporating a locality-based model. Relationships between providers are also mixed. Many providers welcomed the positive outcomes being brought out through the engagement process, but also they acknowledged the time it takes to get to a level of trust and reach agreement on governance structures in order to realise successful collaboration.

Although a more collaborative and integrated approach is welcomed by providers, the implications of outcomes based commissioning are not fully understood. There are significant

differences between providers in their perceptions of what the commissioners' role should be. For some, it is to free up providers from siloed contracts and budgets, giving them more rein to lead and adapt delivery systems to improve outcomes. For others, it is that the commissioners' role is to lead and, indeed, to tighten the reins when necessary. Clarity on what collaborative commissioning means in practice, and articulation of what a more collaborative approach between commissioners and providers looks like, will assist all stakeholders in their roles and responsibilities in the next phase.

Groups of providers are starting to discuss how they can best react and respond to the increasing pressures they face, and a locality-based approach appears to offer the greatest benefit in readying the health and care economy. The commissioner's leadership of this process should continue to become more visible, working with providers to help articulate how the opportunities within this review could lead to improved service models.

We should consider the production of a comprehensive organisational development programme for commissioners early in the next stage of work. This should include, for example, consideration of how commissioners will work together in a future outcomes based commissioning scenario, what the transition period would mean for commissioning teams and contract managers, and how commissioners should prepare and adapt for the proposed future service model.

The provider engagement carried out thus far has demonstrated the need to undertake further, more detailed work with provider stakeholders across the spectrum of the proposed contract scope. In particular, there is a strong demand for further work to support primary care engagement and development which will need to be taken forward into Phase 3.

What is the financial context?

Commissioners and providers are facing a significant challenge in ensuring that high-quality, affordable, community health and care services can be delivered in the face of reductions in funding allocations and increasing demands. Service transformation will be required in order that B&NES community services remain at the heart of a sustainable health and care system into the future. The funding available indicates a considerable gap, i.e. a 7% reduction to net budgets over a four year period.

This will require care and support provided in a community setting to demonstrate efficiency and productivity savings in the context of the cost reduction required of the whole health and care community.

In order that we achieve and maintain local system sustainability, the following strategic principles apply:

- There will be a further shift of investment from acute and specialist health services to support investment in community-focused provision;

- This shift of investment will be focused on those areas where there is robust evidence that this will achieve improved value from the available resource and deliver wider financial benefits to the health and care system;

- Alternative sources of funding and income will be proactively sought by providers and commissioners working in collaboration;

- Providers and commissioners will explore new approaches to sharing resources, including knowledge and expertise, where there are demonstrable benefits in doing so;

- Any proposed shift of resource and/or service change will be impact-assessed to ensure that the proposed change will not adversely affect whole system sustainability.

How will we deliver transformational change?

The proposals set out in this document will take time to achieve and must be continually nurtured by those commissioning and delivering services and by the people who use them. We want to build – together - a model which will provide trusted, compassionate and responsive services that people recognise as truly personalised in its approach to meeting people's needs.

We recognise the huge contribution our providers make to the health and care of our local population. Our challenge is that our health and care services are not affordable in their current form in the longer term. We need to work together with providers to transform local services so that we can maintain and improve the quality of services, changing them to meet the developing needs of our population, and do this within a challenging financial environment.

To establish a new commissioning framework for B&NES, we will need to develop a new contract (or set of contracts) with collaborating providers as opposed to the current model where we act as commissioners of individual providers. The scale of the transformation means it is unlikely that an individual provider will be able to deliver this contract independently. Therefore, the preferred "Prime" contractual form needs to incentivise and facilitate collaboration amongst providers to jointly deliver services for the chosen population. Under this arrangement it is expected that commissioners could also determine the proportion, within a range, of the overall contractual value that continues to be provided by third sector and Small and Medium sized Enterprises (SMEs) in order to maintain a diverse and thriving local market.

Once the Prime Contractual form is established commissioners will commence the market testing process in order to identify the most capable provider(s) of services. Commissioners have ruled outany routes to market test that cannot be deemed legally compliant. However it is recognised that regulations permit a "light touch" regime which does provide a mechanism that can mirror and deliver this aim, provided it meets EU Treaty principles.

Based on our assessment of the available processes set out in above and the core requirement to develop a solution with the provider the recommendation is to follow a regulated procurement approach. The assessment process would involve the placing of a formal OJEU advert and iterative stages of bidding. However, the commissioner would use the flexibility afforded to them through their respective legal frameworks to minimise the burden on both commissioners and bidders by optimising the scale of the process and rapidly but safely identifying the most capable provider.

2. Introduction

This OBC builds on the Case for Change published in November 2014 and describes both the strategic and economic cases for the development of integrated community health and care services for people living in B&NES. It sets out our proposals for the future of community health and care services beyond April 2017 and our approach to achieving the required outcomes for the people and communities of B&NES.

The OBC has drawn on a wide range of external expertise and support so that it is informed by best practice and learning from successful service reconfigurations that have been undertaken in other areas. This includes: Attain, the Consultation Institute, Ashford's LLP (solicitors), South West and Central Commissioning Support Unit and NHS England as well as a wide range of stakeholders. The purpose of the OBC is to:

- Enable the respective commissioning organisations to understand the key outcomes from the Phase Two consultation and earlier engagement and make an informed decision about how these will shape the project into Phase Three: Service Model Development;

- Outline the financial principles in order to assess how to invest most effectively in the collective health and care resources to improve outcomes for the local population, taking account of funding constraints and demographic challenges; and

- Outline proposals for the market testing arrangements and commercial model to deliver the transformational change required in the future.

3. Public Consultation…shaping our strategy

Summary

This section sets out what we have learnt from the public consultation process and describes how this has informed future commissioning intentions.

Key points

- We reached over 2000 people during this phase of the review, 545 people responded to our consultation survey
- Our vision has been updated to ensure that recognition is given to innovation, quality and affordability.
- There was no clear preference towards one particular model, however there was general support for a locality-based model that would harness the strengths and assets of local communities
- There was clear indication that joining up people's care and support is their number one priority for this review. There is also strong support for placing greater emphasis on prevention

Recommendations

- More work is needed in phase three to ensure the views of under 18's and over 75's are factored into our developments
- We plan to adopt a co-production approach for Phase Three based around smaller focus groups. These groups will provide a space for informed debate and scrutiny of the plans being put forward by providers.

The team working on ***your care, your way*** communications has worked hard to ensure the successful implementation of the communications and engagement strategy to enable continuous discussion and involvement of the local population and key stakeholders throughout the process. The face-to-face and digital-led approach has seen us working closely with all stakeholders to ensure that information about the review was widely circulated and we have provided as many people as possible with the opportunity to contribute to the review in a cost-effective manner.

We have placed great emphasis on hearing the views of seldom heard groups and providing suitable opportunities for them to participate in the review. This has included tailored presentations to existing groups, round table discussions, role play exercises, outreach events, sign language invitations and subtitled presentations for people with sensory impairments. In total, we have participated in over 50 separate events during this phase of the review.

We reached over 2000 people during this phase of the review and the formal consultation received 545 responses from across all our stakeholder groups with an even distribution of service users, carers, commissioners and providers of community health and care services.

We explore in the following section how learning from this phase has shaped our commissioning strategy.

3.1 Our Vision

During Phase Two of the review we set out our vision for community services which has been further developed based on what we have learnt from the consultation process;

- Bath and North East Somerset will be a connected area ready to create an extraordinary legacy for future generations - a place with a strong social purpose and a spirit of wellbeing, where everyone is invited to think big.

- We will have health and care services in the community that empower children, young people and adults to live happier and healthier lives.

- Our services will provide timely intervention and support to stem ill health, prevent social isolation and tackle inequalities. By placing people at the heart of services, they will receive the right support at the right time to meet their needs and conditions.

- Dedicated to supporting greater levels of prevention and to help people self-manage their conditions, community services will ensure that clear routes to good health and wellbeing are available.

- Supporting people to access services when they are needed in as seamless a way as possible, navigators will assist individuals to access pathways of care and support.

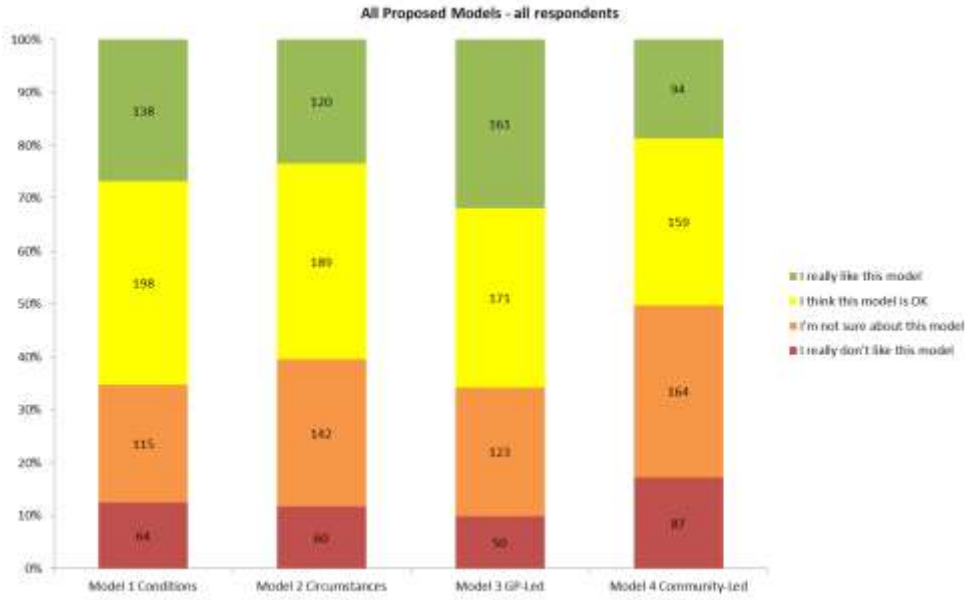
- Services will be easy to access and will connect and integrate across acute, primary care, mental health and community service boundaries.

- Services will reward excellence and innovation, encouraging a culture of continuous quality improvement, whilst delivering better outcomes for people in ways which deliver best value for money.

3.2 A locality based, community development approach

The Phase Two consultation document, ‘Making Plans’ set out four potential models for delivering community services in the future. The first two models were based on a pathway approach, with services organised around specific conditions or the nine functions of community services set out in our first publication, “Getting Started”. The other two models were based on a locality or asset-based approach, with services coordinated within local communities by a GP-led Wellbeing Hub or a Community-led Neighbourhood Team.

Each model was recognised as having its own attributes but each would also require a differing level of transformation from the existing arrangements to achieve the best outcomes for our population.



Although the results of the consultation showed no clear preference towards one particular model there was general support for a locality-based model that would harness the strengths and assets of local communities whilst ensuring that people can continue to access the specialist support they need when required. In response, and to support a new model of outcomes-based commissioning delivering improved person-centred and integrated care and support, we will seek to adopt a locality-based approach often referred to as asset-based community development.

By taking this approach we want to facilitate people and communities to come together to achieve positive change using their own knowledge, skills and lived experience of the issues they encounter in their own lives. We recognise that positive health and social outcomes will not be achieved by maintaining a 'doing to' culture and believe that meaningful change will only occur when people and communities have the opportunities and infrastructure to control and manage their own futures. In community development terms, asset-based approaches value the capacity, skills, knowledge, connections and potential in a local community, and see people and communities as active co-producers of health and well-being, rather than passive recipients of care.

3.2.1 Locality options

There are a number of potential options for taking a locality approach, or in other words, segmenting B&NES across geographical boundaries. The imperative for our provider base to work together also implies that co-operation must be at the heart of how we procure services in the context of a new community services contract.

We are currently working with three potential options that will be further explored and evaluated in Phase 3. These are as follows:

- Option 1 – A single locality
- Option 2 – Multiple localities designed around groups of GP Practices (Clusters)
- Option 3 – Multiple localities designed around neighbourhoods

3.2.2 Service User Flows

The development of geographical localities must be supported by high level analysis of service user flows. At a locality level, some service-user flows are less easy to track and therefore analyse, and during the next phase we will need to further consider how geographical localities can be defined in a way that best supports easy, effective access to services. Many community service providers currently operate on a B&NES-wide basis and, again, we will need to consider how best to achieve transition to a locality-based model.

We do recognise that there will be further risks and challenges in establishing geographical localities that will need to be considered in the next phase and appropriately managed. For example:

- Whilst we expect to deliver one Prime Contract for the entire B&NES locality we need to consider how we establish geographical boundaries within the commercial model.

- There may be some patient/service-user flows across geographical and/or B&NES Council boundaries, which will need to be managed. Contracts would, therefore, need to make provisions for people accessing services outside of their locality.

- We need to consider how we maintain high levels of quality across multiple localities – particularly for more specialist services and small teams without sufficient scale to have a constant presence in multiple localities.

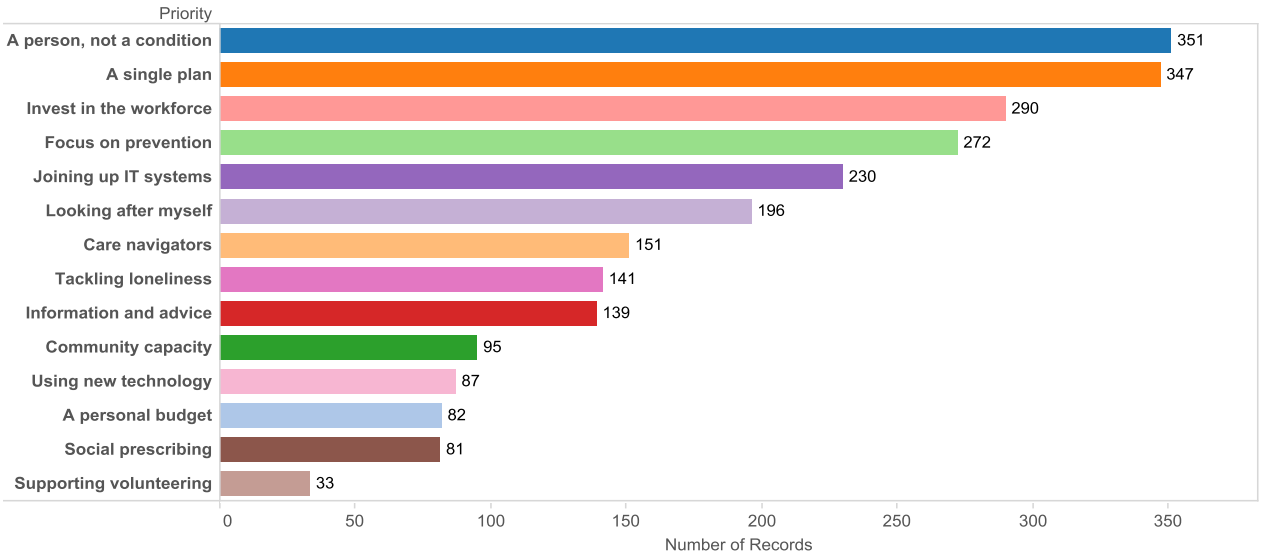
- We need to consider how GPs can be fully engaged in a locality-based model of community services.

- We need to determine funding arrangements for each locality that ensures the appropriate level of local control and flexibility whilst also ensuring equitable distribution between localities; the most effective utilisation of the overall resource; and robust governance and oversight of public funds.

3.3 What are our priorities?

Our consultation document, ‘Making Plans’ set out 14 priorities that we aim to address through this review. These priorities were developed as a direct response to the nine themes that emerged from Phase One of the review.

A key part of the formal consultation was to test whether we had identified the right priorities and how important they were to our stakeholders. The results are summarised in the graph below and explored in more detail in our consultation report; *Options and Choices – Phase Two Consultation Report*.



Our stakeholders have given us a clear indication that joining up people's care and support is the number one priority for this review. This will require two key changes:

a) A technical solution that enables individuals and the people involved in their care and support (be they professionals, friends or family) to work from a single care plan.

b) A simultaneous investment in the culture and skill set of our work force to ensure that services provide holistic, person-centred care and support rather than focussing on specific conditions.

There is also strong support for placing greater emphasis on prevention, ensuring that the right support is available to people before they reach crisis point, require hospital admission or develop a long-term condition.

We remain committed to addressing all of the priorities identified during the earlier phases of this review but, in response to the feedback received, we will ensure that there is a greater emphasis on person-centred approaches and single care plans, joined up care and support, integration of health and care and investing in the capability and capacity of the workforce.

These priorities will be reflected in the revised commissioning intentions and new frameworks for commissioning of services which are outlined in further detail below.

3.3.1 Our commitment to personalisation

A key aim for this review is to bring about a fundamental shift in the way we see, and work with, people who need care and support. Personalisation means seeing the whole person, not just their diagnoses, illnesses and disabilities, but their strengths, interests, abilities and networks. It means working with the person in the context of their lives, building support around their preferences and choices and helping them to help themselves.

We want community health and social care support to be enabling people to live their lives, not just doing things for them. We are committing to work this way because it's what the community have told us they want. During our engagement, people have clearly told us they wanted support to consider the whole person, provide more joined up care and support, reduce social isolation and build community capacity. Working in a personalised way fully supports this.

3.4 How will we measure success?

To ensure that the ***your care, your way*** review delivers real lasting change for local people, the Council and the CCG will be measuring the success of community health and care services using a set of physical and emotional outcomes based around the nine themes developed during Phase One of our review as shown in Section 3.2.

The most important outcomes are the ones that make sense and are important to everyone who uses community health and care services and their carers. These will be the priorities for us to embed across all health and care services. Some are built into services already as part of previous and ongoing public engagement but we recognise there is always more that can be done to establish measures that enable us to monitor and evaluate outcomes including the quality, effectiveness and value for money of all services.

All services will contribute to the population outcomes which have been prioritised by the B&NES Health and Wellbeing Board and which are reflected in the Children and Young People's Plan.

Ultimately the key to any successful transformation of services rests with the strength and maturity of the relationships between us all – between individuals, services, commissioners and providers. The proposals set out in this document will take time to achieve and must be continually nurtured by those commissioning and delivering services and by the people who use them. We want to build – together - a model which will provide trusted, compassionate and responsive services that people recognise as truly personalised in its approach to meeting people's needs.

3.5 Commissioning Intentions

Commissioners recognise there are systems and levers which can be used to deliver more effective and efficient services and we must plan to use these to the best effect. We also need to be imaginative and adopt an approach that gets the best for our local communities. This means using the levers but also looking beyond them to the people, processes, systems and outcomes that will deliver high impact and sustainable change.

In such a major programme of development we have a prime opportunity to transform the experiences and outcomes for individuals, the model of care and support, and the working of the system in relation to community services.

We recognise that we need a radically different approach to the commissioning and delivery of community services, and to develop new ways of working with people accessing services as well as providers of services. In common with many areas we have traditionally commissioned on the basis of measuring and funding for activity, with a focus on processes, individual organisations and single inputs of care. This approach has often inadvertently helped sustain a fragmented approach to the way care and support is delivered, acting as a barrier to the development of more integrated services and models.

We believe that the way forward is to establish new models of commissioning based on outcomes, which will not only provide more person-centred care and support for people but also help to address the financial and demographic challenges facing the health and care economy.

3.6 What is Outcomes-based Commissioning?

Outcomes-based commissioning is a way of specifying for health and care services based on rewarding the outcomes that are important to the people using them. This typically involves the use of a fixed budget for the care of a particular population group, with aligned incentives for providers to work together to deliver services which meet the specified outcomes.

The system incentivises interventions that add most value for individuals, shifting resources to community services, a focus on keeping people healthy and in their own homes, and co-ordinated care and support across settings and regions. It also encourages a focus on the experience of people using the services, and achieving the outcomes that matter to them through more integrated and person-centred services.

We will make the best use of contractual models and levers that will both enable service development and set the foundations for more advanced and innovative approaches in the longer term. We have been examining the models that most closely align to what we aim to

achieve. We will also work with all partners to understand the opportunities for workforce development to underpin the future model of delivery. In order to succeed, there is a need for a coherent framework that demonstrates what good will look like and how the outcomes and principles will be measured, monitored and reported on.

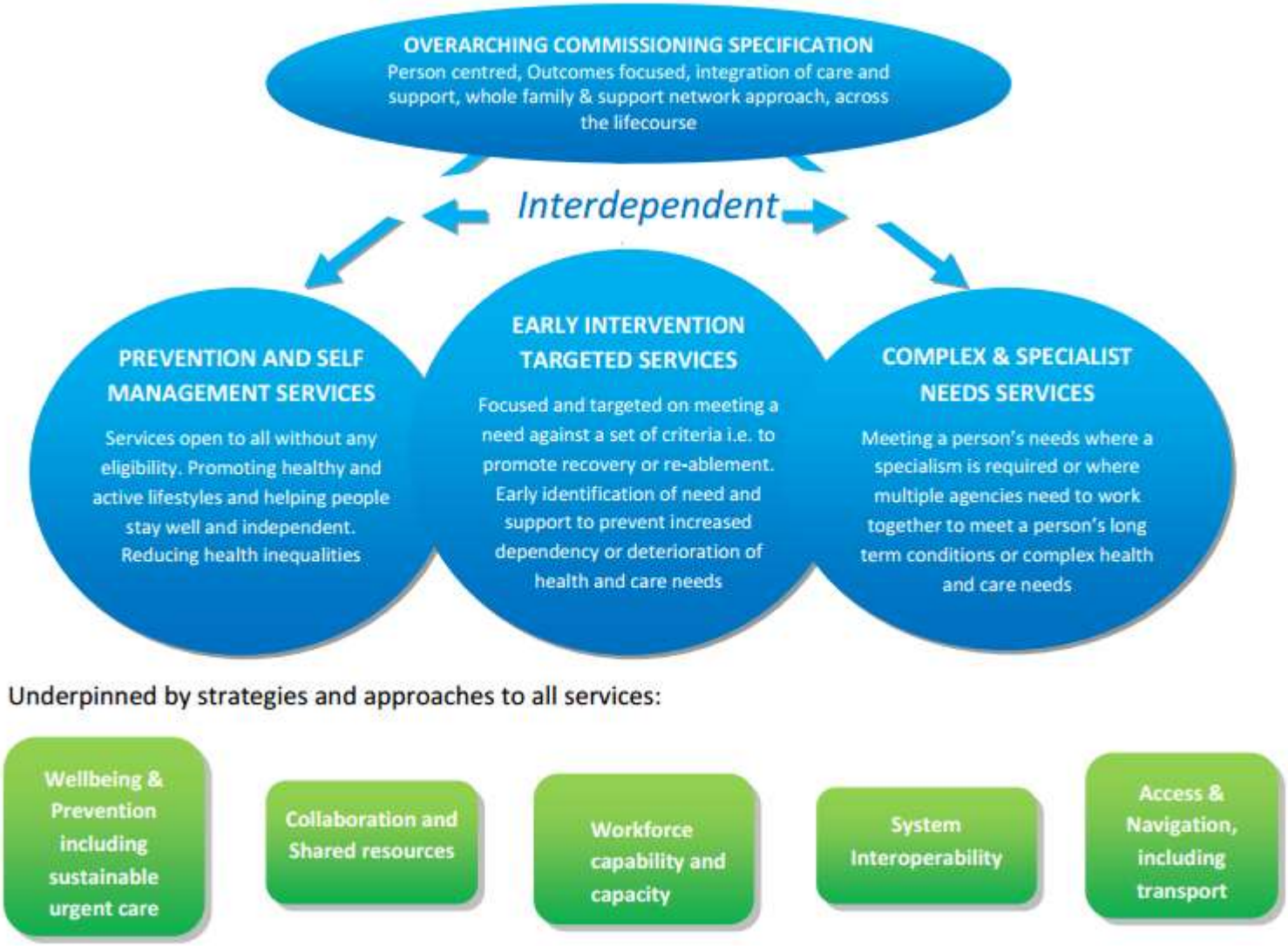
In the strategic planning stage of the review process we must ensure that in preparation for our chosen market testing approach we have a clearly defined strategy and set of priorities before confirming future delivery arrangements. These are described in further detail below.

3.7 A new commissioning framework

We know that there are over 400 community health and care services currently operating in B&NES, provided by over 60 different organisations and commissioned by a number of different commissioners working across the Council and the CCG. We have heard that this can lead to fractured and disjointed service delivery and that people and organisations find our current system confusing, often not knowing who does what, with people having to tell their story numerous times. We have also heard that people find it very frustrating that services don't appear to 'talk to each other' and do not always work collaboratively in individuals' best interests. It is also clear that our current model is based on commissioning multiple providers independently of each other and often not with common outcomes to work towards together.

To address many of the issues that have been raised during the engagement stage of our review, and to respond to the feedback we have received and the learning that has resulted from this, we are proposing a new framework for aligning the commissioning and delivery of future community health and care services, illustrated in the diagram shown in Figure 5 below;

Figure 5: Specification Architecture



3.8 Valuing the workforce

Our vision for community services in B&NES requires a new approach which is able to accommodate the growing demand for access and coordinate care and support around people, families, carers and communities. Workforce development and education and training strategies must be aligned to the emerging and future service delivery models.

We are convinced that approaches to workforce planning along with education and training strategies should be based on achieving population health outcomes. The exact nature and make-up of the workforce will need to be tailored according to localised population needs and circumstances; the health, care and support needs in Chew Valley, for example, are not the same as those in the centre of Bath. We need to ensure we are able to define the workforce requirements locally, aggregating them across the localities where appropriate and using this information to better inform what and how providers train the health and care workforce.

The development of a workforce strategy for B&NES must be based upon an assessment of local need, taking into account emerging service models, defined population needs and outcomes, a focus on appropriate capabilities to enhance population outcomes, and the workforce skill-mix required to improve population outcomes and reduce inequalities. The workforce strategy will also incorporate the training and development needs of those commissioning services to ensure that they also have the necessary capabilities.

3.9 Meeting the needs, wishes and aspirations of our community

The overarching commissioning specification will articulate the underpinning values, principles, priorities and objectives that all services will be governed by, and should be aligned to each service specification for individual contracts.

Under each of the three headings of Prevention and Self-management; Early Intervention; and Complex and Specialist; services will be commissioned in line with clear commissioning specifications that will encourage and incentivise providers to work collaboratively and where appropriate, in formal partnerships with each other through new contracting mechanisms.

New commissioning arrangements will ensure that providers who deliver services to the same cohort of people or with a similar purpose are supported to harness their collective strengths and capabilities to ensure that people can access the right services at the right time as simply as possible, with the minimum bureaucracy, and in new ways of working that achieve the Values outlined in Section 3.4

It is the aspiration of this review that over time all services are jointly commissioned between the Council and the CCG in an integrated commissioning structure, and in a manner that maximises the potential for individuals to exercise choice and control over the services they receive.

New specifications for services will be based on a model of integrated health and care delivering person-centred services to individuals and local communities at different levels of provision.

Effective integration of services overcomes many of the negative consequences of a fragmented system from the user's perspective, such as the need for multiple assessments and visits to different providers, and in turn improves the experience of care. Conversely fragmented and disjointed care and support can have a negative impact on individual experience, result in missed opportunities to intervene early, and consequently can lead to poorer outcomes. Poor alignment of different types of care and support also risks duplication and increasing inefficiency within the system

Integrated care and support has also been shown to lead to improved clinical outcomes, including a reduction in the use of acute and emergency care through better co-ordination with primary and community services, and to support individuals to remain within their communities and to counter threats to their independence.

Successful integration of services is dependent on having a shared purpose and a clear vision of what integrated care and support will achieve. Clarity about the outcomes that integrated care and support is designed to achieve will therefore be an important consideration in developing any new arrangements.

3.10 Continued Engagement

We plan to adopt a co-production approach for Phase Three based around smaller focus groups. These groups will provide a space for informed debate and scrutiny of the plans being put forward by providers. The format for the focus groups is still in development but they will include representatives from all our key stakeholder groups who will receive appropriate training and support to fulfil this role effectively.

4. Scope of the Contract

Summary

This section sets out the current scope of the community services contract.

Key points

- services currently provided as a specific, delegated function of the Council or CCG will need further consideration about appropriate commissioning and delivery arrangements in any future model
- The service scope had informed the baseline financial envelope set out in Section 5.

In the future, community services will need to adapt and thrive in the face of the significant challenges ahead. The age demographic and associated complexity of need, coupled with increasing quality requirements and financial austerity all signal the need for change. Community services will need to become a driving force for the important shift in emphasis towards health and wellbeing and the delivery of new models of care and support at or close to home.

To support the transformation of services for the whole population of B&NES, there needs to be an understanding of the 'scope' of services that providers will be required to deliver under the terms of the contract. Our process for identifying these services has been to first understand our current landscape of health and care commissioning. This has allowed us to determine current spend on services and, therefore, set out the baseline financial envelope for those community health and care services within scope (set out in Section 5).

Whilst we recognise that future service models may be very different to the services that exist under the current system, an understanding of the resources that could be available to shape these models is helpful because it allows future providers to:

- Understand the budgets and contracts they are inheriting, and
- Identify the current service areas being provided that they will need to continue to work with, deliver or transition from.

It is also important to note that while the current contracts and budgets have been used to determine and agree the financial envelope, an outcomes-based specification will contain only a high level outline of the envisaged service model rather than a detailed specification. The focus on outcomes will require providers to innovate with new integrated models of care and support, joining services around the needs of the person, and moving away from previous organisational silos.

4.1 Services In Scope

The health and care landscape of B&NES is complex and a range of services are currently commissioned. However, with the all ages approach to provision and a fundamental aim to integrate care and support, our starting point has been to consider the broadest set of services within scope.

Therefore, our working assumption is to include all services currently commissioned within the scope of a new contractual framework, only removing services from our scope by exception. Even then, it is our ambition that exempt services may be bought into scope over the life of the contract. The table below provides a summary of all in scope services;

Table 1: In Scope Services

Prevention, self-management and support services	
• Wellbeing College • exercise on referral • sexual health services • telehealth support • health visiting • school nursing • community transport	• community resource centres • social prescribing • lifestyle education and campaigns • stop smoking service • healthy weight support • food and health service • advocacy and information services • village agents
Early intervention and targeted services	
• dementia services • early intervention • recovery teams • Talking Therapies Service • district nursing • specialist nursing • health visitors • specialist foot care, • speech and language therapy • rehabilitation	• floating support • child and adolescent mental health services • creative link services • specialist equipment services • social work • independent living services • homelessness support • occupational therapy
Complex and specialist needs services	
• specialist care and support • drug and alcohol support • substance misuse	• sexual health service • specialist clinical services for diabetes, stroke, tissue viability etc

It should be noted that whilst commissioners have categorised services into specific categories of care we recognise that many services span all levels of provision.

4.2 Services Out of Scope

We have, however, identified a number of services that will be excluded from our scope, at least initially.

Potential grounds for excluding certain services include:

1. Relevancy of coordination - One of the key benefits of outcomes-based commissioning for B&NES is how it will stimulate integration and coordination across provider groups. If a particular service operates in a natural silo, then it may not be worthwhile including it in scope.

2. Specialty of service - There may be some specialist services which are delivered in small volumes but at very high costs and, as such, carry a higher risk to the budget holder and this may be grounds to consider a service out of scope.

3. Specialist Commissioning - Some services may be more difficult to include within scope, either because of current contracting arrangements or because they are commissioned centrally for example by NHS England.

4. Services that are not intended or able to be delivered in community settings, for example in-patient beds including mental health

At this stage, our working assumption is to consider the following out of scope:

- **Children's social work services**
  These are currently delivered in house by the Council and are not regarded as appropriate for consideration under this review.

- **Core, national and local enhanced primary care services**
  These services are commissioned by either NHS England or the CCG and as such fall outside the scope of the contract. While we recognise that core primary care is central to pathway management, as co-commissioning of primary care with NHS England develops, we will continue to explore opportunities to align out of scope services with this contract.

- **Secondary care services**
  Secondary care services that are necessarily delivered in a hospital setting such as medical and surgical treatments, accident and emergency services

- **Specialist commissioning**
  Similarly, some elements of specialist commissioning fall outside the scope of the contract precisely because they are commissioned externally. In addition, there are grounds to exclude some of these services on the 'specialty of services' test described above.

- **Registered Care and Nursing Home provision**
  These services are modelled on a person living under a license arrangement having been placed with the provider through a contracting mechanism with a commissioning authority, or as a self- funded placement. Placements are made following an assessment which has determined that the person is no longer able to live independently and has care or nursing needs which can only be met through the provision of registered care home placement.

In addition, services currently provided as a specific, delegated function of the Council or CCG will need further consideration about appropriate commissioning and delivery arrangements in any future model.

In defining the services in scope it is recognised that nationally the emerging direction of travel is to move towards outcomes based commissioning approaches across whole populations and capitated budgets. Over time there may be potential to extend the scope of services included under this framework (subject to provider agreement) to include a broader range of services to maximise the benefits of this approach.

5. Financial Planning and Payment Mechanisms

Summary

This section sets out the financial context for community services and the strategic principles that will apply to maintaining local system sustainability.

Key points

- The funding available indicates a considerable gap, i.e. a 7% reduction to net budgets over a four year period.
- Service transformation will be required in order that B&NES community services remain at the heart of a sustainable health and care system into the future.

Recommendations

- The future funding envelope will need to be aligned to both the CCG financial planning requirements and the Council's proposals as they are agreed over the next four years as part of the 2016/17-2019/20 budget setting and longer-term financial planning process.
- Consideration will need to be given in phase three to the full range of payment mechanisms

5.1 Financial Planning

Both the Council and CCG are facing considerable financial challenges. Since the national and local elections in May 2015 the Government has not provided any information on local government funding beyond 31 March 2016, although the Chancellor announced an Emergency Budget Statement on 8 July 2015. This will be followed by a Spending Review leading to the Financial Settlement for Local Government around Christmas 2015.

This means we cannot be certain about the funding available for our community services from 2016/17 onwards, although we can expect the financial challenge facing the public sector to continue throughout the period of the next parliament from 2016/17 to 2019/20.

5.1.1 B&NES Council Planning assumptions:

Whilst the scale and speed of funding reductions are not yet clear, there are a number of factors which we can identify that will impact on our funding going forwards:

- Continuing reductions in the national allocation of local government funding – we assume this will be around 40% over the next four years with an element of "front loading" these reductions in the first two years.
- A significant increase in employer's national insurance contributions to fund the new national pension arrangements
- The ongoing impact of new legislation including the Care Act 2014 and the rising cost of providing adult social care as a consequence of demographic change.
- The need to provide for future pay inflation.
- The potential impact of changes to interest rates and the revenue cost of meeting the Council's full borrowing requirement.
- The level of inflationary and demographic cost pressures.

5.1.2 BaNES CCG Planning assumptions

Financial planning for 2016/17, subject to national planning guidance and information on allocations and tariff yet to be published, is based on the following assumptions:

- The NHS will continue to receive a level of real terms growth. However, BaNES CCG will receive less than average as the CCG is marginally above target allocation based on the national funding formula. This is expected to reduce the growth to the CCG by £1 million over 3 years.
- Priority expenditure will be on existing recurrent commitments based on 2015/16 outturn, nationally mandated new commitments and unavoidable cost pressures. Should funding remain available after these have been met, any new expenditure will be on the basis of sound evidence of its contribution to improving the value of services and supporting the financial sustainability of the system.
- National guidance, where provided, will be followed in respect of provider inflation and efficiency; CCG financial planning obligations; specific financial contractual rules; and availability and application of CQUIN funding.
- Demographic growth will be at least in line with ONS projections and together with non-demographic demand increases will create a high level of financial as well as operational challenge.
- Cost reductions for reinvestment are expected to be at the level of at least three per cent of the CCG's allocation and will require sustained commissioner and provider commitment to the delivery of schemes at the scale and pace necessary to support financial stability.
- Any transfers or delegations of commissioning responsibility from NHS England will be accompanied by a flow of funds which creates a neutral impact for all parties.

5.2 Council Funding

Taking these challenges into account the Council has undertaken a Strategic Review that considers spending across the Council to ensure efficiency savings and income

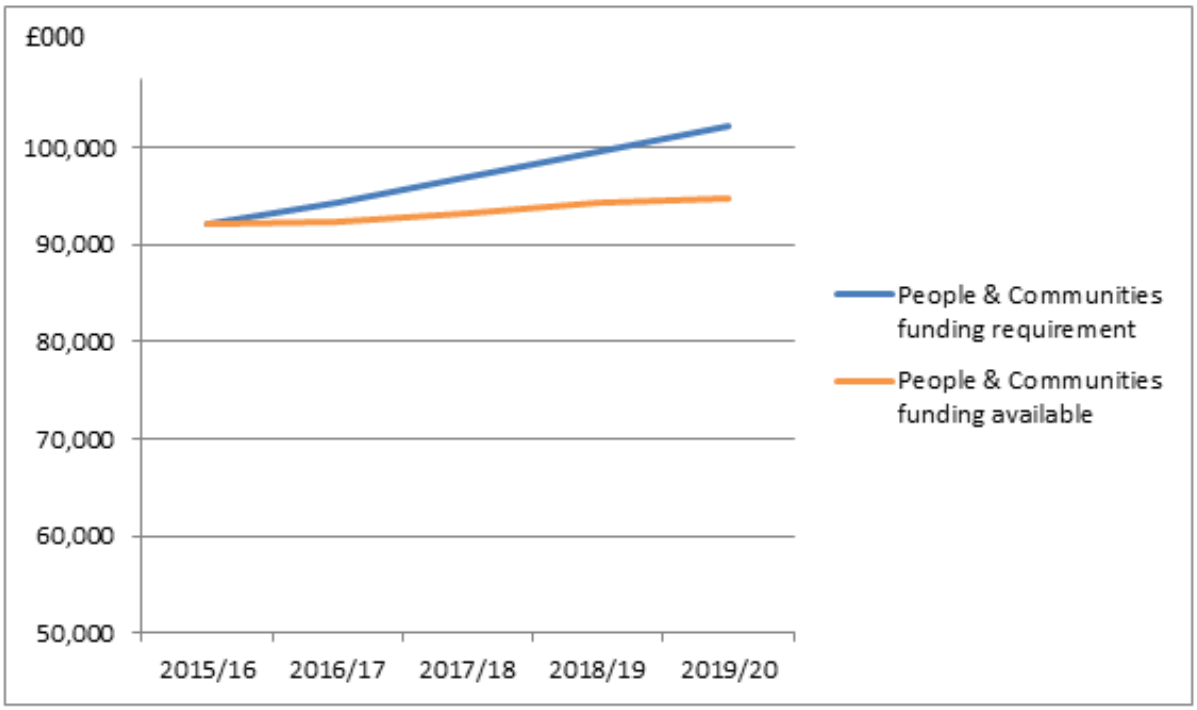
generation opportunities are maximised; thus limiting any necessary service reductions, whether those services are provided directly by the Council or by other organisations commissioned by the Council.

The review has the following four strategic priorities:

- A strong economy and growth
- A focus on prevention
- A new relationship with customers and the community
- An effective business

The Council's community services are commissioned through the People and Communities Directorate as part of the integrated commissioning arrangements with the CCG. The graph below illustrates the Directorate's annual net budget funding requirement with indicative growth and savings proposals that will be subject to formal approval.

Graph 1: Council Annual Net Budget Funding



The funding available indicates a considerable gap, this equates to a 7% reduction to net budgets over a four year period. Savings will need to be achieved through delivery of the Strategic Review proposals to help fund the year on year pressures across health and care, including those arising from demographic change.

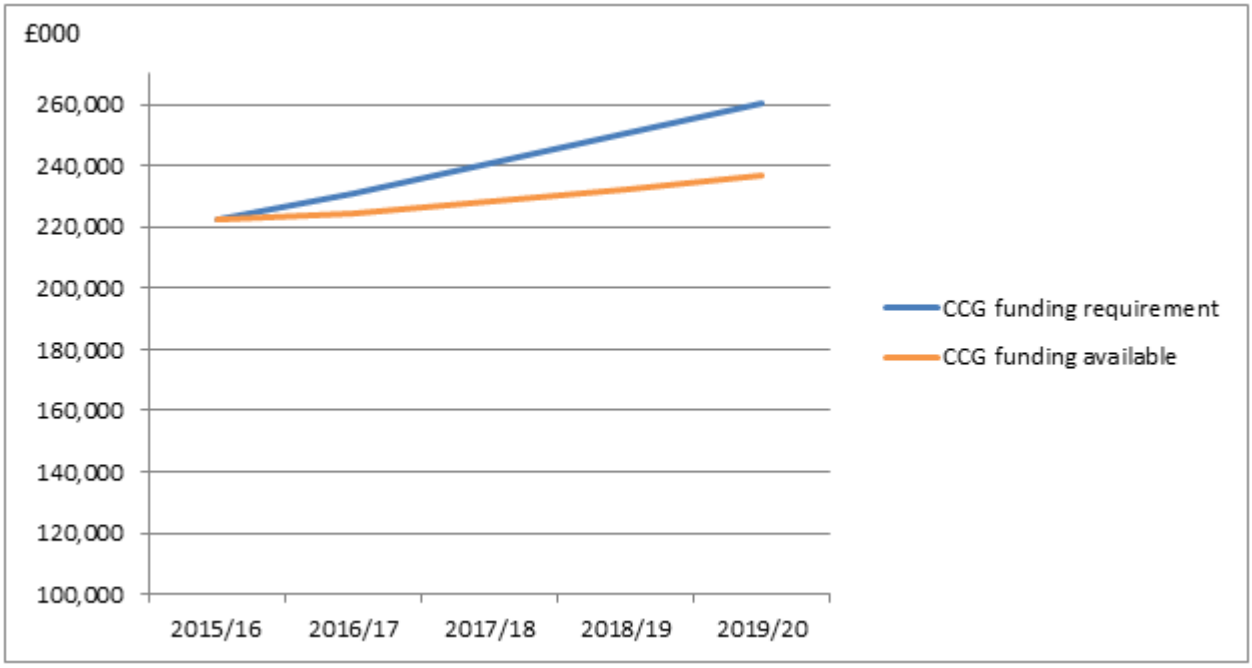
Whilst the detailed proposals for how the funding gap will be delivered will be subject to further consultation and the development of full business cases the indicative recurring savings target for the People and Communities Directorate 2016/17 – 2019/20 is £7.6m.

5.3 BaNES CCG Funding

The CCG has produced a first cut medium term plan based on current expenditure levels, adjusted for demographic growth and expected cost pressures. Planning guidance will be shared nationally in early 2016 and the financial plan will be refreshed at this point although the likely value of savings is assumed to be broadly consistent as those within the current model.

The graph below illustrates the CCG's annual funding requirement at current levels, compared to expected funding, highlighting a significant challenge to deliver an affordable plan.

Graph 2: CCG Annual Net Budget Funding



Based on the current planning assumptions, the CCG is expecting to deliver recurring savings of between £6 million and £7 million per year over the next four years. Over the four years this is a recurring savings target of £24 million and 10% efficiency saving requirement. Savings will be delivered through targeted schemes based on benchmarking analysis, aligned to the CCG strategic objectives. Savings figures exclude those that providers must deliver; these are planned for by providers in line with national pricing assumptions.

The CCG are in the process of developing a number of schemes that are being quantified to assess the level of potential savings. The focus of savings will be via service redesign

and improved efficiency to ensure costs are removed from the local health economy to enable a level of reinvestment by the CCG.

5.4 The Funding Envelope

The services that have been defined as in-scope for the review are made up of 68 providers who provide a range of community health and care services commissioned by the CCG and Council. Table 2 below shows the number of providers across a range of contract values.

Table 2: Provider analysis by contract value

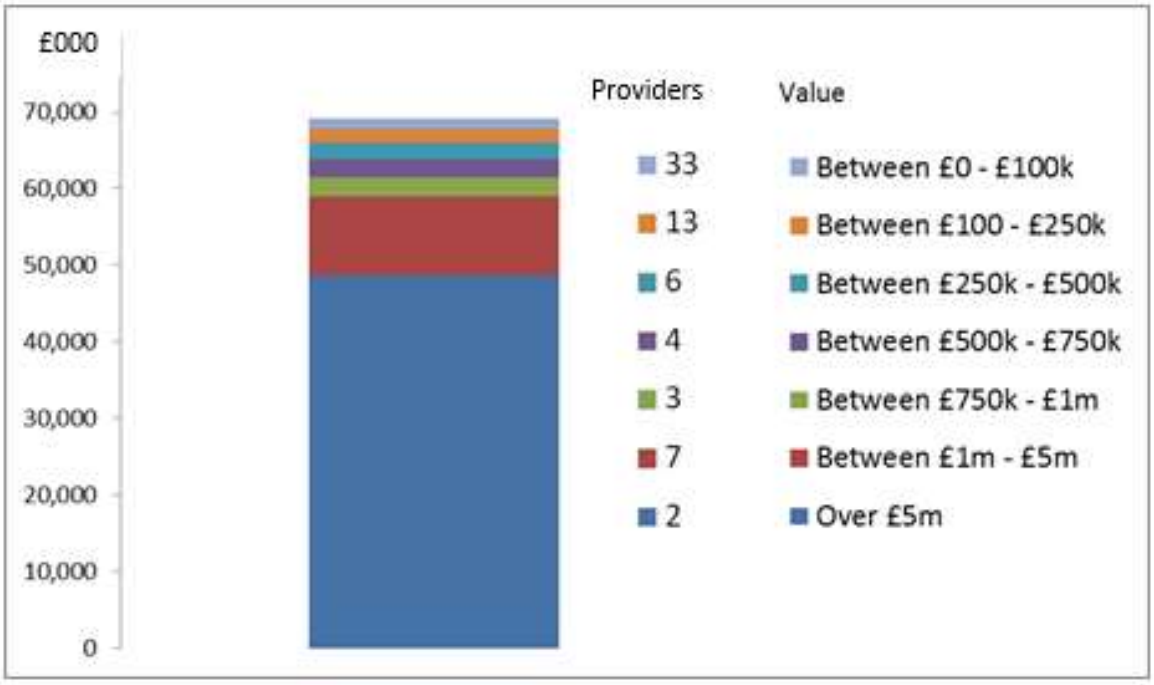


Table 3 below shows the current funding envelope of £69.2m for the in-scope services based on 2015/16 expenditure. Across the CCG and Council this is made up of a range of community health and care providers across the three broad categories illustrated below.

Table 3: Current Funding Envelope

	CCG	Council	
Category	**Current commissioner spend £000**	**Current commissioner spend £000**	**Total £000**
Complex & Specialist	20,567	14,296	**34,863**
Early Intervention	2,714	23,120	**25,834**
Prevention and Self-Management	5,067	3,472	**8,539**
TOTAL SPEND	**28,348**	**40,888**	**69,236**

The future funding envelope will need to be aligned to both the CCG financial planning requirements and the Council's proposals as they are agreed over the next four years as part of the 2016/17-2019/20 budget setting and longer-term financial planning process.

These funding reductions are underpinned by the following assumptions:

- The funding envelope will be adjusted from the 2016/17 baseline to align with Council and CCG reductions in health and care funding arising from both organisations' financial planning and annual budget-setting processes.
- Identified areas for cash-releasing efficiency savings or improving value will need to align to new commissioning & provider delivery models.
- Demographic change pressures will need to be managed within available resources.
- New investment requests will reviewed on an individual basis and require sound quantitative and qualitative evidence of system benefits.
- Commissioners and providers will continue to work in partnership to jointly identify areas of opportunity including back office efficiencies.

Taking into account the funding challenges the key messages for consideration are:

Commissioners and providers are facing a significant challenge in ensuring that high-quality, affordable, community health and care services can be delivered in the face of reductions in funding allocations and increasing demands. Service transformation will be required in order that B&NES community services remain at the heart of a sustainable health and care system into the future.

This will require care and support provided in a community setting to demonstrate efficiency and productivity savings in the context of the cost reduction required of the whole health and care community.

In order that we achieve and maintain local system sustainability, the following strategic principles apply:

- There will be a further shift of investment from acute and specialist health services to support investment in community-focused provision;

- This shift of investment will be focused on those areas where there is robust evidence that this will achieve improved value from the available resource and deliver wider financial benefits to the health and care system;

- Alternative sources of funding and income will be proactively sought by providers and commissioners working in collaboration;

- Providers and commissioners will explore new approaches to sharing resources, including knowledge and expertise, where there are demonstrable benefits in doing so;

- Any proposed shift of resource and/or service change will be impact-assessed to ensure that the proposed change will not adversely affect whole system sustainability.

5.5 Payment Mechanisms

The current payment mechanism for the majority of community service providers is through block contract arrangements, which do not generally vary with levels of activity. Block contract arrangements can be the most effective form of payment for a standard, fixed, service offer. They may not, however, be the most effective payment mechanism for supporting integrated, personalised care and support.

During the next phase of the review, consideration will be given to the full range of payment mechanisms and how utilisation of these payment mechanisms can act as enablers for the provision of integrated, personalised care and support whilst also being consistent with the principle of efficiency and affordability. One example of an alternative payment mechanism is “capitation”. Capitation means paying a provider or group of providers for care and support to a specified population across different care settings. The provider(s) is paid as a lump sum per person in the target population group, which could be, for example, the population of people aged over 85 years and/or all those living within a geographical location.

A range of payment mechanisms will be considered including:

- Capitation
- Block contracts
- Year of care or episodic payment
- Multilateral gain/loss sharing

Appendix A gives a short overview of methods and information on proposed payment mechanisms found at:
https://www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models

6. Provider Engagement

Summary

This section sets out our findings from phase two provider engagement and how this has informed our commissioning process during the remaining phases of the review.

Key points

- There is a consistent understanding of the need for change
- Relationships between providers are mixed but a more collaborative and integrated approach is welcomed by providers
- The locality-based approach seems to be providing the greatest benefit in readying the health and care economy.
- There were consistently strong preferences for a longer term contract of at least seven years, ideally ten.

Recommendations

- We should consider the production of a comprehensive organisational development programme for commissioners and providers early in the next stage of work.
- We must ensure providers, in particular the Third Sector, have time and support to establish sufficient resilience and capacity to play a meaningful part in any redesign process.

In order to undertake a full assessment of the potential provider market in B&NES, a programme of engagement with a range of providers was undertaken between May and October 2015. Phase 2 of the ***your care, your way*** review was launched with a Planning Day, further engagement took place with both incumbent and non-incumbent providers through a series of workshops and on a 1:1 level with providers ranging from telephone to presentations at provider forums and board meetings.

6.1.1 Key themes

Key themes from the engagement programme are summarised below:

a) Opportunities and challenges around service model delivery

We heard during the engagement process a consistent understanding of the need for change, particularly due to increasing demographic pressures and the knowledge that “things can’t continue as they are”. However, there are some anxieties around how any contract would be set up geographically.

Any response to a commissioning approach incorporating a locality-based model needs to show how providers can enable delivery of health and social care service that is localised and meets the needs of the local population.

The implications of moving to more outcomes-based commissioning through a locality model presents challenges to the existing provider landscape, and relationships within it. Relationships between providers are mixed. Many providers welcomed the positive outcomes being brought out through the engagement process, but also acknowledged the time it takes to get to a level of trust and agreements in governance structures in order to realise successful collaboration.

There is strong consensus that primary care should form the basis of a population-based, preventative approach to health and care and should, therefore, be engaged, at the very earliest stage in preventative approaches.

Whilst our proposals were, on the whole, welcomed by providers, many expressed frustration and concern regarding the resource to both commit to and develop this further as well as potential to align the pace of change to existing changes underway. There was also recognition of the commissioning organisations maintaining ‘business as usual’ at an operational level which led to questioning of the seriousness of commissioners in taking a radical new approach. This was articulated in terms of recent procurements or service reviews. In the next phase, as commissioners we need to set out how their activity will align with a shift to new models of care and support and demonstrate where work underway will either potentially stop or reduce in order to release resource across the system, or have a clear rationale where work is required to continue in line with current plans.

The B&NES health and care economy has already achieved some integration of service models. The high level system-wide case for change has been articulated clearly and is understood amongst providers. Less clear are the specific options and impacts on providers – and teams within providers. Some providers welcome the new freedoms that new models of care and support would give them to redesign and collaborate in order to reduce inefficiencies and improve effectiveness. Others, however, feel that such an approach is the responsibility of commissioners and their ‘strong hand’ is required to steer the system.

The scale of potential transformation was welcomed but clearer guidance on how this may be phased or implemented is required. Groups of providers are starting to discuss how they can best react and respond to the increasing pressures on each other, and this locality-based approach seems to be providing the greatest benefit in readying the health and care economy. There does however, need to be some initial investment in supporting the provider response and freeing resource.

b) Views on potential contracting mechanisms

There were consistently strong preferences for a longer term contract of at least seven years, ideally ten, in order to drive the necessary change and promote the right behaviours by providers in managing population health and moving to a more preventative focus.

Third sector providers would welcome the move to a more outcomes based commissioning approach but consistently expressed the need for time and help to establish sufficient resilience and capacity to play a meaningful part in any redesign process. They were nervous that a procurement process might inadvertently lose the important relationships and joint working already existing locally.

There was consistent feedback that existing mechanisms for integration haven't always worked due to different financial incentives across organisation types and an understanding that this would be addressed under the new contractual arrangement.

There was less certainty about the contractual form, such as risk share/gain share arrangements – used to underpin the budget and particular concern that the risk for primary care was carefully considered in the development of any type of new contractual form.

Most providers discussed the need for an integrated IT system; some were looking into options for achieving this locally and all identified this would be a critical success factor requiring finance and planning.

6.1.2 Analysis

The following are the key points arising from the engagement with providers across sectors:

- Although a more collaborative and integrated approach is welcomed by providers, the implications of outcomes based commissioning are not fully understood.
- There are significant differences between providers in their perceptions of what the commissioners' role should be. For some, it is to free up providers from siloed contracts and budgets, giving them more rein to lead and adapt delivery systems to improve outcomes. For others, it is that the commissioner's role is to lead and, indeed, to tighten the reins when necessary. Clarity on what collaborative commissioning means in practice, and articulation of what a more collaborative approach between commissioning and providers looks like, will assist all stakeholders in their roles and responsibilities in the next phase.

- Positive relationships are being developed between providers in localities as reported by each provider organisation.
- Continued engagement with General Practice around the implications of new models of care and support. This engagement also needs to consider the funding implications given the proposed increased role in a more proactive system that is based around population health management and preventative care and support.
- The commissioners' leadership of this process should continue to become more visible, working with providers to help articulate how the opportunities within this review could lead to improved service models.
- The commissioners should then expect providers to be encouraging front line staff to redesign care and support in conjunction with service users.
- We should consider the production of a comprehensive organisational development programme for commissioners early in the next stage of work. This should include, for example, consideration of how commissioners will work together in a future outcomes based commissioning scenario, what the transition period would mean for commissioning teams and contract managers, and how commissioners should prepare and adapt for the proposed future service model.
- The provider engagement carried out thus far has demonstrated the need to undertake further, more detailed work with provider stakeholders across the spectrum of the proposed contract scope. In particular, there is a strong demand for further work to support primary care engagement and development which will need to be taken forward into Phase 3.

7. Provider Contracting Model

Summary

This section sets out the proposed methodology for establishing a new commissioning contractual framework for B&NES.

Key points

- The scale of the transformation means it is unlikely that an individual provider will be able to deliver this contract independently.
- The preferred “Prime” contractual form needs to incentivise and facilitate collaboration amongst providers to jointly deliver services for the chosen population.
- Commissioners will determine the proportion, within a range, of the overall contractual value that continues to be provided by third sector and Small and Medium sized Enterprises (SMEs)
- More “dynamic” contractual arrangements will be developed for lower value, lower complexity services.

Recommendations

- Prime Contractor route is the preferred approach to pursue during phase three of the review
- Dynamic Purchasing Systems will be established for the sub-contracting of lower value, lower complexity services.

The provider contracting model is the vehicle through which a provider or coordinating group of providers come together to deliver the outcomes expected of them in the contract.

To establish a new commissioning framework for B&NES, we will need to develop a new contract (or set of contracts) with collaborating providers as opposed to the current model where we act as commissioners of individual providers. A number of contracting options can be considered to help us achieve our aim to deliver new models of care and support and outcomes that matter.

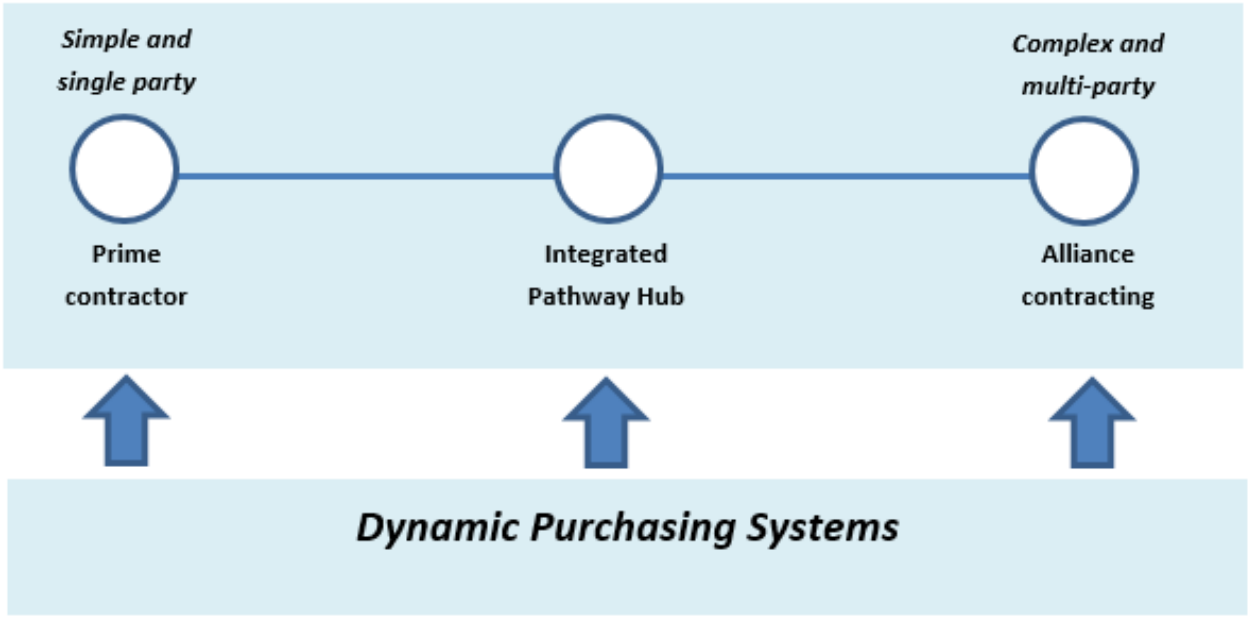
The scale of the transformation means it is unlikely that an individual provider will be able to deliver this contract independently. Therefore, the chosen contractual form needs to incentivise and facilitate collaboration amongst providers to jointly deliver services for the chosen population. Achieving the aim of delivering joined-up, person centred care and support will require more collaborative working.

Delivery options for a new commissioning contract include:

- Prime contracting
- Integrated Pathway Hub
- Alliance contracting
- Dynamic Purchasing System

These models span the range of potential contracting models, as illustrated in figure 6 below.

Figure 6: Potential Contracting Models

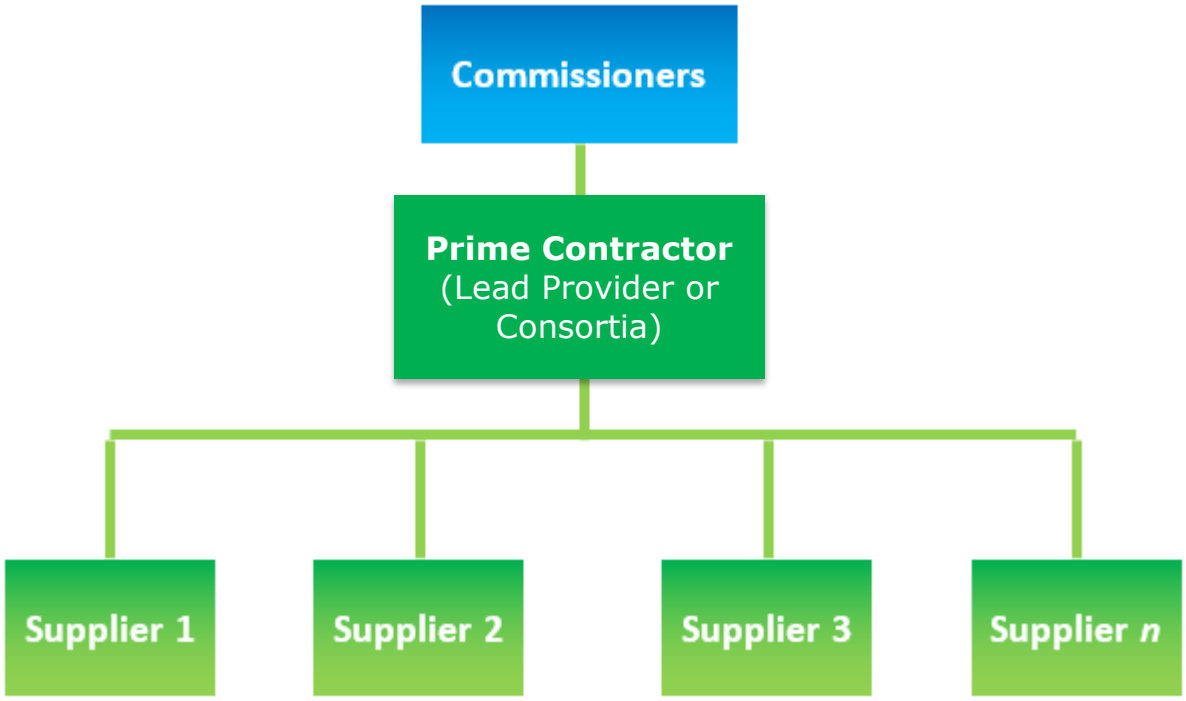


The following sections provide a high level overview of the key characteristics of each delivery model that were used to inform decisions by both commissioners around our preferred contractual design model. We do however recognise that whilst we have set out a preferred approach this should be evolved in discussion with the providers who are better placed to determine which model will allow them to deliver the specified outcomes. The final decision will be presented to Governing Bodies as part of the Full Business Case with full justification, allowing us to ensure that key requirements are met.

7.1 Contracting Model Options

This section provides a high level overview of the key characteristics of each delivery model to help inform decisions by both commissioners and providers. It should be noted that although we may recommend a preferred contractual design model, we recognise that further market engagement will be required in order to determine which model (or combination thereof) will allow them to deliver the contracted services.

Model 1 - Prime Contractor



Under this model, the commissioners enter into a contract with a Prime contractor (or consortia of providers as may be the case).

The contract allocates risk and reward between the commissioner and the Prime contractor. Dependent on the make-up on the Prime contractor (i.e. whether it is a single organisation or a consortia of organisations), the Prime contractor may choose to form itself in any of the following manners:

- With a single organisation as 'lead provider', sub-contracting any elements within the scope of the Prime contractor specification allows the commissioners to achieve best of breed and the inclusion of third sector providers and Small and Medium sized Enterprises (SMEs).

- With a group of organisations jointly forming a new business (a Special Purpose Vehicle) that are jointly accountable and liable for the provision of services.

The commissioners could choose to require a Prime contractor to form a Special Purpose Vehicle as part of the market testing process, but in doing so would need to be conscious of the additional regulatory and corporate burden on bidders and the commissioners of mandating the establishment of a new legal entity.

The Prime Contractor would remain accountable to the commissioners for the delivery of the entire service, and for the co-ordination of its 'supply chain' (i.e. its sub-contractors) in order to ensure that it can and does deliver the entire service. The Prime Contractor is likely to be a provider of services itself, but it could sub-contract any elements of service excluding the co-ordination role.

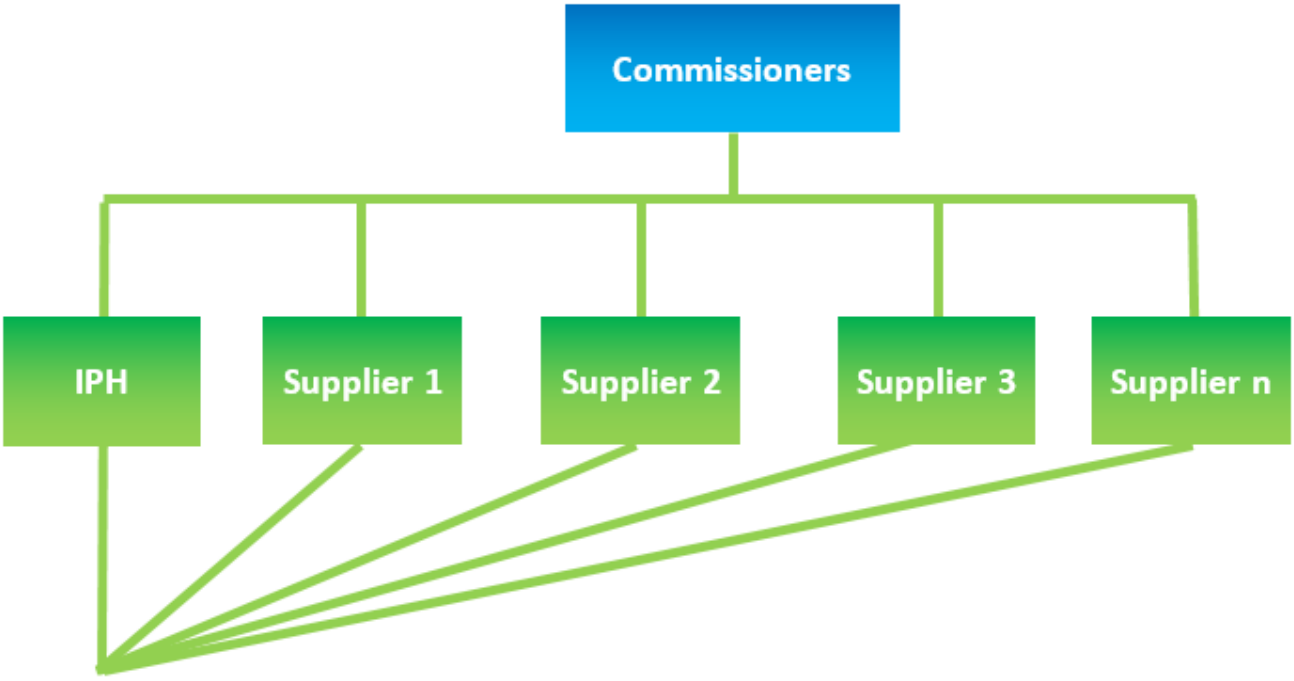
Prime Contract - Key Risks:

- Provides less ability for commissioners to influence the behaviour of individual subcontractors.
- Relies on the strength of the Prime contractor in managing the services.
- Requires some scrutiny of how the Prime contractor engages and manages their supply chain.
- Careful contractual arrangements would be required to set out clearly what is expected of the lead provider and subcontracted organisations.
- Identifying one provider as the Prime contractor may disengage other providers who consider they may be more appropriate for that role.
- May take longer to put in place if the commissioners first need to engage with a Prime contractor before engaging with sub-contractors.

Prime Contract - Key Benefits:

- Enables commissioners to transfer the responsibility and risk for the delivery of services to a single provider.
- Gives a single point of contact for the commissioner and vice-versa.
- Allows appropriate emphasis on contracting for outcomes.
- Provides a single leadership structure and clear accountability for integrated working.
- Providers can directly work together, supported by the contracts between them, to ensure the pathway is as efficient and effective as possible.
- Sufficiently flexible to accommodate a range of payment mechanisms and incentives.
- The Prime contractor would normally directly employ a multi-disciplinary/multi-agency management team and provide the IT solution for all key participants to be able to deliver the objective.

Model 2 – Integrated Pathway Hub



Under this model separate contracts are awarded to a number of providers, all of whom contribute to the delivery of an integrated service. One of the awarded providers acts as an Integrated Pathway Hub (IPH) provider, and they are additionally commissioned to coordinate and manage the integrated service. The IPH provider assumes responsibility for the co-ordination and management of the integrated service and risks and rewards are allocated between the commissioner and the IPH provider in relation to that integration and management function. The IPH provider may be a provider of clinical services, or alternatively may just take a clinical coordination and management role. No one provider is responsible for the delivery of the entire integrated pathway. It should be noted that in the IPH model, the commissioner retains individual contracts with each and every provider, and so each provider remains accountable to the commissioner, rather than to the IPH. A separate collaboration agreement will be required between the IPH and each provider to enable end-to-end service provision.

Integrated Pathway Hub - Key Risks:

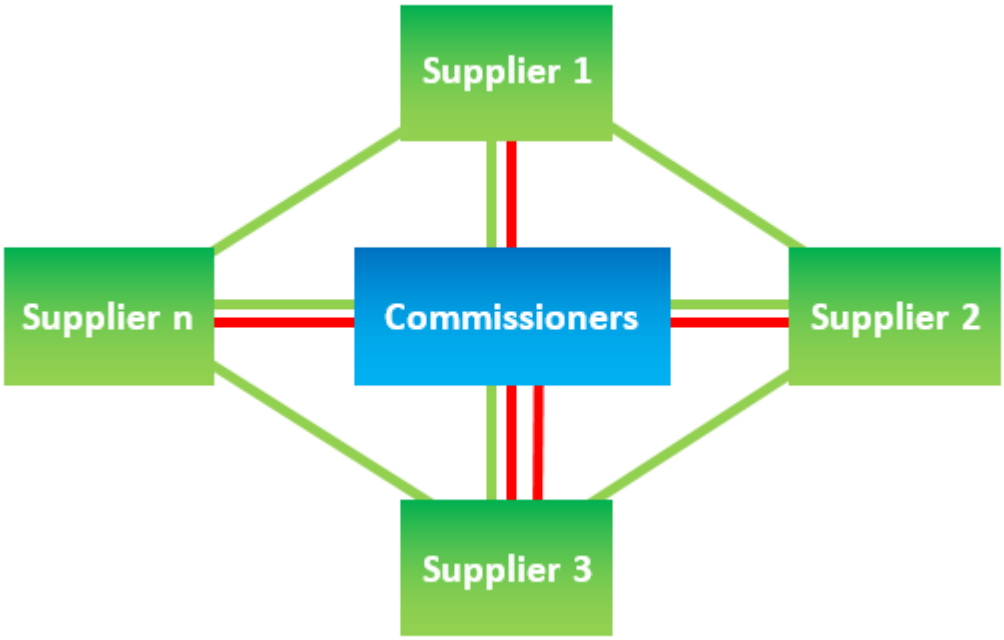
- No single provider is responsible for the delivery of the entire integrated pathway.
- The IPH provider, if a non-service deliverer, could become detached from service delivery. This could cause tension between care delivery and contract management.
- If a single contract approach is being adopted then the commissioner would need to ensure that a single contract could cover all the relevant services.

- All of the supply chain will need to be engaged and to agree the terms of any flow down of the contract – there is a risk of the IPH provider enforcing down a position to protect its bid position and margin. This could destabilise the supply chain.
- The IPH provider is responsible for the whole system, but not accountable for the whole system.
- Significant risk of the duplication of commissioning resource, where the commissioners are paying the IPH provider to act 'like a commissioner', but also retaining the costs of commissioning in-house as well.
- Providers become confused who they are accountable to – whether it is the commissioner or the IPH provider.
- Without adequate incentivisation for the delivery of an end-to-end service the providers may lapse into a siloed approach to service delivery.

Integrated Pathway Hub - Key Benefits:

- Providers are incentivised to reduce waste and deliver high quality care and support
- Supports the provision of subcontracting.
- Shared decision making and supports self-care as a means of delivering optimal care and support for specific individuals in the right setting to demonstrate best value for money.
- If not delivering any services, the IPH provider's sole objective is to manage the contract. They have no vested interest in how the sub-contract payments are proportionally distributed. Therefore they can be very focused and targeted on providing more focused contract management as there is no distraction by service delivery pressures.
- A reduction in the need for management resources for the commissioner.
- The providers are mutually dependent and must collaborate to achieve end-to-end service levels.

Model 3 – Alliance Contract



The commissioner holds individual contracts with a number of providers. In addition to each individual contract, an Alliance Contract is created that all the providers are party to, and contained in which is a common performance framework with collective measures. Although each provider maintains their own internal control and accountability for delivering their contracted services, providers are additionally judged on performance as a whole rather through the Alliance Contract.

This model is typically a commissioner-led contracting mechanism which aims to incentivise collaboration between two or more providers, who co-operate to deliver a particular service or services.

Alliance Contract – Key Risks

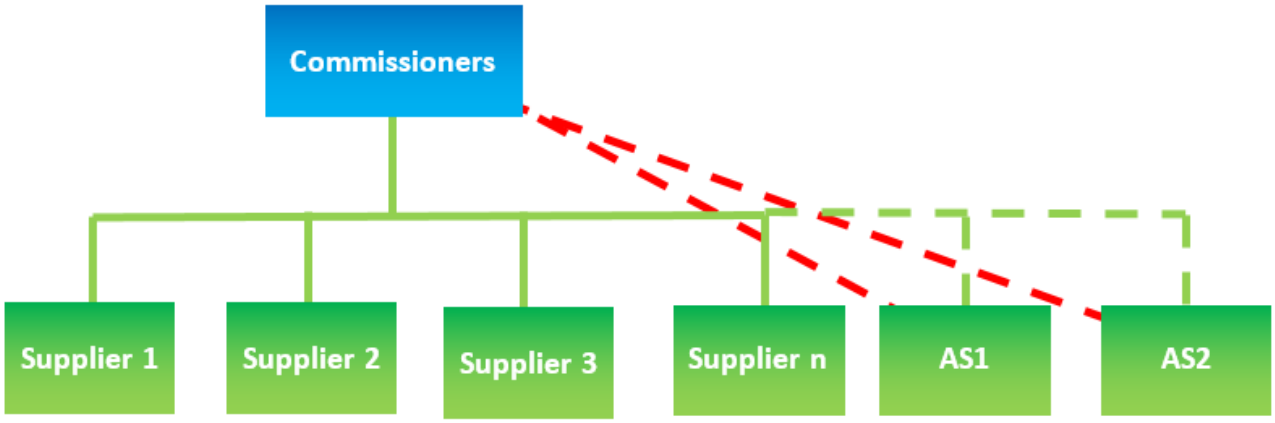
- There is no single agreed form of alliance arrangement in an NHS setting at present. This would therefore be a complex approach where the time and cost required for legally compliant documentation and management should not be underestimated.
- Creating the balance between partnership working and individual organisational interests.
- Sufficient provider engagement is required to make the contract work and develop inclusive provider partnerships.
- Need to design the systems of risk and reward around the NHS standard contract
- Complexity when a contract variation is required.

- Alliance contracting works better with a manageable number of partners; the greater the number, that greater the complexity and management issues.

Alliance Contract – Key Benefits

- Collaborative environment without the need for new organisational forms.
- Collective ownership of opportunities and responsibilities; any ‘gain’ or ‘pain’ is linked to performance overall.
- Supports a focus on outcomes and incentivises.
- Joint leadership is incentivised through an outcomes-based payments structure. This reduces the risk inherent in the lead provider model that the lead provider may be able to make changes not in line with commissioners’ objectives.

Model 4 – Dynamic Purchasing System



A Dynamic Purchasing System (DPS) is a form of framework agreement. DPS’s are traditionally used for well-defined goods or services where there are multiple potential providers, with the key difference between a DPS and a framework being that providers can enter or leave the DPS throughout its life. By contrast a traditional framework arrangement does not allow additional providers to be admitted once it has been let and have a limited contract duration. A DPS (or set of DPSs) would not be the only form of contractual arrangement, and could be let in conjunction with one or more of the other contractual models for lower value, lower complexity services.

For example, DPSs would be let for specific pathways or conditions, and contracts for each would be held either by the commissioner or directly by the Prime Contractor (if used in conjunction with the aforementioned Prime Contractor model).

Dynamic Purchasing System – Key Risks

- The open nature of DPSs could create an additional contract management burden on the commissioner.
- The number of available providers under a DPS could cause confusion if not clearly communicated to professional and public stakeholders.
- The zero-volume nature of DPS contracts does not offer providers any guarantees of payment, so their use for any particular condition or pathway must always be carefully considered.

Dynamic Purchasing System – Key Benefits

- Aligned with choice agenda.
- Does not disadvantage small or third sector organisations.
- Flexible in a way that other contracting mechanisms are not – with the ability to gain and lose providers throughout the life of the DPS.
- Allows specialisation to flourish by not requiring organisations to provide aggregated or homogenised services.
- DPS as a contracting mechanism is increasingly being used in B&NES, so commissioners and providers may have existing knowledge of the process.

7.2 Assessment Approach

Given the above contracting model options, a legal workshop was established as part of the decision-making process. The workshop had representation from the Council and CCG, as well as an independent legal advisor. The purpose of the workshop was to discuss the options, and form a recommendation to take forward with regard to both contracting model and market testing.

The group were led through the different contractual models, discussing the relative merits of each option and combinations thereof. An assessment of each model was made based on the following key considerations:

- **Does the proposed model support the delivery of outcomes based commissioning?**

  All contracting options can be used in the delivery of outcomes based services.

- **Does the proposed model encourage and facilitate collaboration between providers?**

  Alliance contracts formalise collaboration amongst providers. However, the success of these models also hinges on strong working relationships between providers. In a Prime contracting model, the prime contractor takes an integrator role and is responsible for achieving collaboration.

- **How does the model allocate risk between providers?**

  A Prime contract transfers the majority of risk to the prime contractor. On the other hand, the service integration risk in an Alliance contract is retained by the commissioner. It should be noted that the Prime contract can be a formed consortium which would in turn share risk.

- **How much involvement of commissioners is required in the proposed model?**

  Under each model, commissioners have a key point of contact. With a Prime contractor model, however, the commissioners' role is primarily limited to governance. In a Prime contractor model, the commissioners are able to deal with a single service provider (assuming the services are let through a single contract). The other models all require multiple contractual relationships, with a higher degree of commissioner involvement in contractual governance.

- **How will the dual role of the Council as commissioners and providers of service be managed?**

  The Council acts as a provider of some services and as a commissioner of others; within all of the contract structures, differing arrangements and terms need to be considered in order to manage this dual role.

- **How will the contract model support the continued sustainable provision of services delivered by the third sector as well as SMEs?**

  A Prime contract enables the co-commissioning of these contracts via a "dynamic purchasing system" further explored in Section 7.1. Under Alliance and IPH models commissioners would continue to be contractually accountable for these providers. It should be noted that third sector suppliers will participate in all contractual models as independent contracting bodies. However, there is more scope for simplified contractual arrangements to be developed between a Prime contractor and a third or voluntary sector supplier working in collaboration as part of a consortium.

  Commissioners could also determine the proportion, within a range, of the overall contractual value that continues to be provided by third sector and SMEs in order to maintain a diverse and thriving local market.

  Although the ultimate contracting model established within B&NES will be determined jointly with providers, the commissioner will need to set out the core principles which we expect to base market testing and to consider these principles in the final evaluation of contracting options. A fundamental decision needs to be made as to how to restructure the role of commissioners to support delivery of the new contractual model.

7.3 Recommended Approach

Prime Contractor route is the preferred approach, aligned to the establishment of Dynamic Purchasing Systems for the sub-contracting option. The following core principles are recommended for commissioners to pursue during Phase Three:

I. The ability to first commission that Prime Contractor, and to then subsequently commission the DPS arrangements.
II. It is expected that the commissioner will specify the DPS processes and specifications in conjunction with the Prime Contractor and will be party to the appointment of DPS providers alongside the Prime Contractor.
III. In this model, it would be the Prime Contractor who would hold the DPS contracts and be accountable for this functioning.
IV. Within the combined model where a Prime Contractor is sought who then themselves establishes a number of DPS's, there is a potential risk that the commissioner loses an element of control over those DPS contracts, including in the initial formation of them. To ensure this is not the case, the process for appointing DPS providers will need to be clearly and contractually laid out at the onset of the process to seek the Prime Contractor, and that the commissioner would have to mandate that they be party to the process of seeking DPS providers.
V. The commissioner will need to carefully specify the ongoing system management arrangements such as a Partnership Board that would be chaired by the Prime Contractor, and that would take membership from the commissioner and the DPS providers.
VI. In the case where the Prime Contractor is made up of more than one organisation consideration must be given to how the Prime Contractor chooses to organise itself. The commissioner may require a Prime Contractor made up of a consortia of organisations to create a new legal entity (a Special Purpose Vehicle). Alternatively, the commissioner could accept that a consortia bid for the role of Prime Contractor would be led by a single lead provider, who would then hold a contract with the commissioner and would hold sub-contracts with their delivery partners. The group recognised that it was ultimately not for the commissioner to decide how a Prime Contractor chooses to organise itself structurally.

8. Approach to Market Testing

Summary

This section provides and options appraisal of the compliant market testing processes and sets out the recommended approach to identifying the most capable provider(s) of services.

Key points

- Commissioners have ruled out any routes to market test that cannot be deemed legally compliant.
- Regulations permit a “light touch” regime which does provide a mechanism that can mirror and deliver this aim, provided it meets EU Treaty principles

Recommendations

- Based on our assessment of the available processes and the core requirement to develop a solution with the provider(s) the recommendation is to follow a regulated negotiated procurement approach.

It is important to recognise that as commissioners, the CCG and the Council are governed by EU procurement law and governed by the Public Contract Regulations 2015. The CCG is further bound by the Procurement, Patient Choice and Competition Regulations 2013. The regulations permit a number of ways in which services can be commissioned, but in each case they require the publication of a call for competition and the conduct of a fair and transparent process prior to the award of the contract. Any decision to award a contract must also be publicly notified.

The requirements for conducting a fair and transparent process can be achieved by:

- ***open tendering***, under which all those interested may respond to the published advertisement by submitting a tender for the contract;
- ***restricted tendering***, under which the commissioners invite qualified suppliers to submit a tender for the contract.
- ***a choice of negotiated procedures*****,** under which qualified suppliers are invited to develop a solution in consultation with the commissioners.

It is plausible under these regulations that commissioners can develop a locally derived process that follows best practice elements of the methods above but ensures delivery against a core set of local principle:

- **Stability:** Ensure the stability of the current system for the whole population;

- **Competition:** Maintain an element of competition to encourage innovation and value for money;

- **Market:** Retain the ability for new parties to enter into the local health and social care economy;

- **Accountability:** Require providers to become accountable for transformation and innovation and the delivery of outcomes for the whole population;

- **Choice:** Maintain choice and competition within the delivery of services – both through this process and in future delivery;

- **Benefits:** Deliver in-year system benefits (outcomes and financial); and

- **Constraints:** Recognise fixed points, such as existing estate, within the system that will need to be maintained and utilised.

8.1 Options for market testing

Commissioners have ruled out any routes to market test that cannot be deemed legally compliant. However it is recognised that regulations permit a "light touch" regime which does provide a mechanism that can mirror and deliver this aim, provided it meets EU Treaty principles.

Based on our assessment of the available processes set out above and the core requirement to develop a solution with the provider the recommendation is to follow a regulated procurement approach. This can be defined as:

"An assessment process using a transparent approach that complies with the regulations which seeks to identify the most capable provider(s) to deliver the service by means of a light-touch, front-loaded process. The assessment would seek to make an early identification of the preferred bidder(s). The assessment process would involve the placing of a formal OJEU advert and iterative stages of bidding. However, the commissioner would use the flexibility afforded to them through their respective legal frameworks to minimise the burden on both commissioners and bidders by optimising the scale of the process and rapidly but safely identifying the most capable provider."

The key merits to this approach are;

- Provides a specific framework within which decisions are made objectively and transparently.
- Assures legal and regulatory compliance.
- Allows the commissioners to prove value for money over the life of the contract.
- If properly designed, allows the commissioners to take a flexible and iterative approach to contracting.
- Makes the contracting process significantly simpler through pre-completion and pre-confirmation of acceptance of core terms from bidders.

- Allows the commissioners to rapidly progress to discussions with a focused group of most capable providers, reducing burden on both the commissioner and providers.

8.2 Recommended Approach

Having assessed the current market and legally complaint market testing options available, the recommendation is to pursue the regulated procurement approach.

Given the very significant value of the services over their lifetime, a formal “call for competition” for the services was deemed mandatory. It is proposed this is issued in the form of an OJEU advert.

This would be subject to safeguards for both the commissioner and providers including that:

- Any approach to a regulated procurement must be proportionate (not overly burdensome);
- The procurement process would as rapidly as reasonable reduce the number of bidders involved in the process; and
- The process would recognise the need to involve and support the broad provider base within B&NES.

Given the regulatory flexibility afforded to the CCG and Council due to the type of services being commissioned (health and care services), the regulated procurement was considered the most viable option. This is because of its simultaneous legal compliance and level of flexibility.

As part of the assessment process the commissioner would commit to a number of principles:

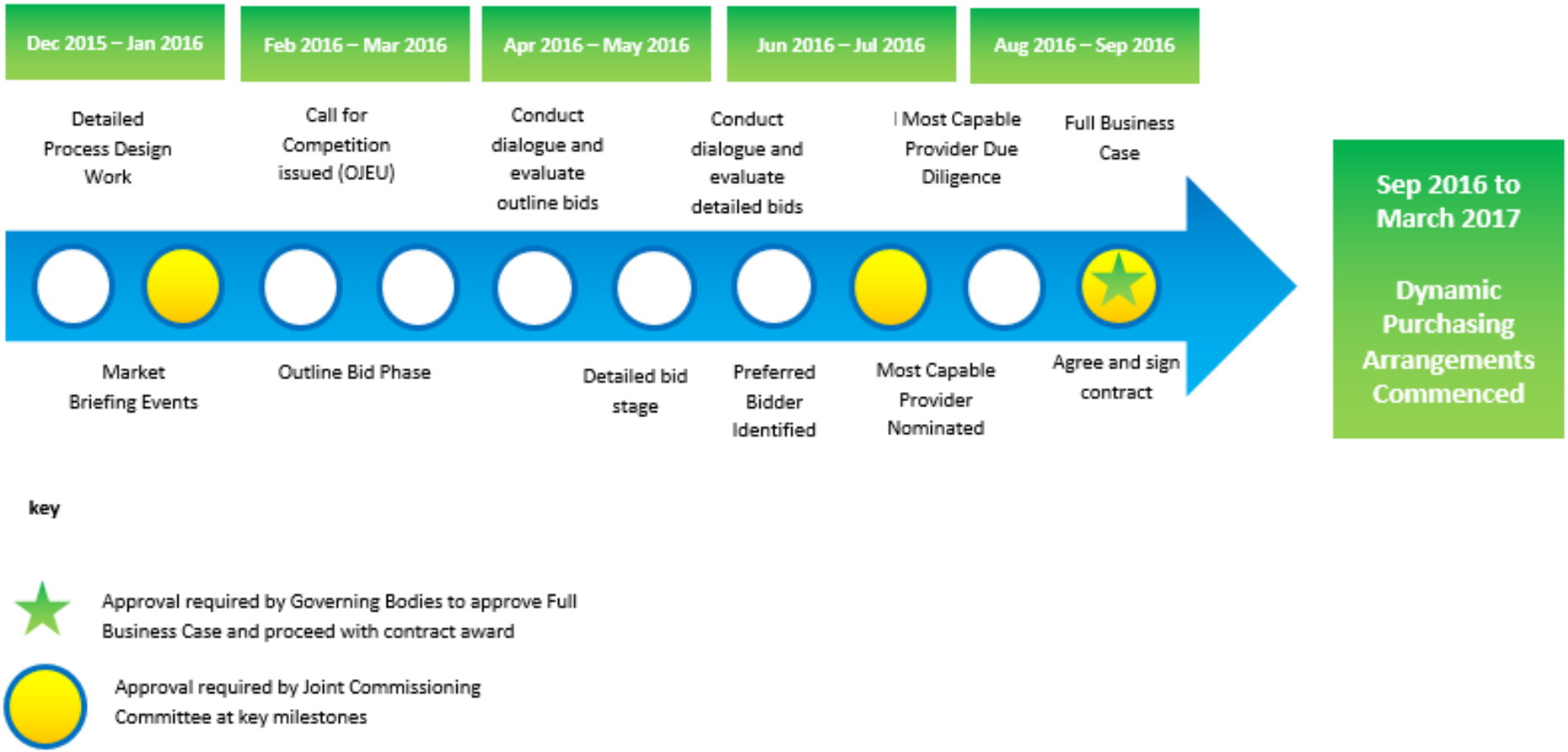
- Minimise the burden on the commissioners and bidders through the asking of primarily strategic, rather than operational, questions.
- Minimise the overall number of questions asked through the formal process (i.e. 10 or 15 overall questions).
- Limit the number of proposed iterative stages and the number of bidders to be taken through to those stages in order to quickly identify a single preferred bidder (or consortia thereof).
- Front-load the process (pre-procurement) to ensure full readiness and understanding on all key issues from both the commissioners and potential providers.

Considering the above principles, we have stated a preference to pursue a regulated procurement approach to identifying a Prime Contractor.

Given the previous recommendation to also commission a series of Dynamic Purchasing Systems to work under the Prime Contractor, ***it is further recommended that the Prime Contractor should be sought first, with the DPS providers then being sought afterward***. They will be formally commissioned by, and accountable to, the Prime Contractor, but with support from the commissioner in terms of regulatory and legal compliance.

An overview of the regulated procurement process is illustrated in figure 7 below;

Figure 7: Regulated Process Timeline



8.3 Areas for further consideration

In order to support the recommendations made above, a number of further pieces of work need to be carried out.

- **Extension of existing contracts** – given the recommendation to first seek a Prime Contractor, and to then seek DPS providers, it may be that all of the DPSs are not in place by April 2017. Existing in-scope contracts will be audited in order to understand where any need to be extended past April 2017, and the date to which they need to be extended.

- **Market engagement work to inform and ready the provider base** – To ensure a smooth and effective market testing (and eventual contracting) process, it is imperative that the provider base is aware and supportive of the commissioner's plans.

- **Careful consideration of the DPS design** – The design of the DPS process requires careful consideration as part of the Prime Contractor process. This is to ensure that the commissioners retain a level of engagement and control over the subsequent appointment of DPSs by the Prime Contractor.

- **Detailed process design** – the Most Capable Provider assessment process will be designed in detail with the above principles as critical success factors.

- **Contract duration** – the duration of a contract is central to facilitating the delivery of transformational care and providing an opportunity to realise the agreed outcomes and gain a return on any investment. The length of the contract needs careful consideration: the longer the contract the more opportunity a provider has to develop, implement and refine new models that will realise the full benefits of integrated outcomes based care and support

- **Geographical structure** - whilst the expectation is to develop one Prime Contract for the entire B&NES locality the structure is key to supporting delivery of locality based contracts and ensuring issues in terms of equity of provision are addressed.

9. Governance

The preparation of this Outline Business Case was directed and monitored through existing governance arrangements:

a. Formal consideration by the CCG Board
b. Formal consideration by the Council Cabinet
c. Consideration and oversight by Joint Commissioning Committee
d. Consideration by and regular updates to the Health and Wellbeing Board
e. Consideration by NHS England
f. The CCG's Executive Team
g. The Council's Strategic Management Team
h. Consideration by the Health and Wellbeing Select Committee

A number of workstreams were established during project initiation, which have contributed to various aspects of the business case. External support to the workstreams was provided by Attain Consultancy, Ashfords Legal Services and South Central and Western Commissioning Support Unit

The resulting Outline Business Case is presented for formal acceptance to the following authorities:

- Bath and North East Somerset Council Cabinet (2nd December 2015)
- NHS BaNES CCG Board (3rd December 2015)

10. Summary of Recommendations

Before commissioners can progress to developing the service delivery model during the next phase, there are a number of key outcomes that form the body of this report and will need to be considered and approved by Governing Bodies, which are the Council Cabinet and the CCG Board:

i) The analysis of consultation findings that set out what our community has told us about the plans detailed in the September Cabinet report "*Proposals to Review Community Services Consultation Document".*

ii) The findings of our market engagement with providers and our proposed methodology to market test and contract in order to develop a process to identify the most capable providers for future service delivery.

iii) The outline financial planning process that will set out the factors that will impact funding going forwards and the principles against which the funding envelope will be derived.

In consideration of the rationale outlined in this report, Governing Bodies are asked to:

i) Note the findings of the consultation as set out in Section 3 and approve progression to the next phase.

ii) Approve the financial planning process as set out in Section 5.

iii) Approve the pursuit of a Prime contractor approach supported by a regulated market testing process as set out in Sections 7 and 8.

Appendices:

Appendix A - Payment Mechanisms

The current payment mechanism for the majority of Community Service providers is though block contracting arrangements. Through the next phase of the review consideration will need to be given to alternative payment mechanisms. As we move to more integrated models of care and support we need to consider how to align to the 'Five Year Forward View' and Integrated Personal Commissioning (IPC) programme with payment mechanisms that will give the best outcomes for service users.

In line with our strategic vision, our longer-term approach is to align contractual and financial incentives across the system to deliver care and support in the most effective and best value setting. We will develop our preferred approach of contracting and payment mechanisms which best support our plans for effectively streamlined and integrated care and support within the overall affordability envelope for the health and social care community, and which both limit and fairly share the impact of risks across partners. Our approach will seek to use innovative commissioning and contracting models which incentivise delivery of our desired wellbeing outcomes across our population and, where appropriate, across targeted segments of our population. We expect our providers to work together to develop provider contractual models which best equip them to respond to our commissioning requirements.

In parallel to the development of contractual approaches, we expect to move towards payment mechanisms which also incentivise delivery of our desired outcomes, including effective co-operation between providers and system cost reduction in support of meeting our population's care and support needs in a sustainable and affordable way. Capitated, year of care, pathway and network-based payments would be examples of this. We will also examine our commissioning finance mechanisms for opportunities to extend demonstrably effective arrangements such as the use of pooled budgets.

The current contract payment mechanisms being considered as part of the review are:

a) Capitation

Capitation means paying a provider or group of providers for care and support to a specified population across different settings. The provider(s) is paid as a lump sum per patient in the target population group. This allows providers to plan and deliver care and support in a way that can be tailored to individual and local population needs, while also incentivising early intervention, prevention and recovery.

Different capitated payment approaches may be appropriate depending on local factors, including:

- the vision for the local health economy and the degree of coordination between relevant services, including social care and housing
- the accuracy and availability of data to inform the capitated budget.

All capitated payment approaches should include a component linked to quality and outcomes to ensure that providers have financial incentives to maintain access to services elsewhere under cost pressure. In addition it may be desirable to include a mechanism that allows for some sharing of financial gains or losses between commissioners and providers, to facilitate changes in demand and data quality.

Developing this payment approach locally
When developing local capitated payment models, the CCG and the capitated budget holder (e.g. Prime contractor) must agree the scope of services and how payment will be calculated. If the budget holder is not the provider of all services, it will also need to agree payment arrangements with any sub-contracted providers of care and support. This could include NHS and community providers and the voluntary sector.

b) Block contracts

Block contracts do not vary with levels of activity. These are the most common type of local contract identified for existing community services in B&NES, and covered the largest volume of services. The contract values for long standing contract arrangements are historic and future year values are aligned to the Council and NHS planning processes incorporating contract deflator / inflator where applicable. Changes to services within the block are incorporated through a contract variation process that gives the contract mechanism to alter values and service specifications.

c) Year of care or episodic payment

A year of care or episodic payment approach means payment based on a price for each unit of activity. For community services this would mean linking payment to specified areas of activity that can be measured. This approach can make it easier for patients to choose their provider for an episode of treatment.

This payment approach can draw on existing data flows, provided existing data is of sufficient quality. This approach is based on work that has been undertaken in developing a Payment by Results Tariff system for Mental Health. Introducing a year of care or episodic approach to payment builds on what is already being implemented or shadowed in many areas: payment based on mental health cluster currencies. Quality and outcome measures should also be agreed, along with agreement on data reporting, and how agreed quality and outcomes measures will be linked to payment. Caps and collars and risk sharing could be used to aid transition to this payment approach, particularly where untested assumptions have been made about demand or expected costs.

Developing this payment approach locally

Commissioners and providers should carry out a bottom up costing exercise to look at how much NICE compliant care actually costs to deliver. This should include an appropriate focus on prevention and early intervention to ensure that good quality outcomes are delivered, and that resources are used in the most efficient and effective way.

e) Multilateral gain/loss sharing

Designing the right payment mechanism relies on the wider process of moving to a new care and support model. This starts with developing a common vision for the local care economy, it is an essential step since getting the financial incentives right is crucial to supporting the delivery of high quality, good value care and support. Multilateral gain/loss sharing combined with an underlying payment model – such as capitation – defines the overall payment approach.

The two key components of a multilateral gain/loss sharing mechanism are:

- it covers multiple providers and one or more commissioners

- financial gains/losses are identified and distributed based on system financial performance and/or other metrics, such as performance on quality and outcomes.

The gain/loss sharing mechanism works by comparing the expected commissioner spend (associated with delivering care and support) with the actual outturn. The difference between the expected spend and actual outturn forms the gains/losses pool. This pool is then distributed between the commissioners and providers. For instance, a reduction in non-elective admissions may lead to an overall reduction in spend across the board. This reduction would form a gains pool that could then be shared among the participants, including the provider that has seen a reduction in its activity and the providers in the community that helped achieve this outcome. The gain/loss sharing mechanism therefore helps:

- align individual organisations' and the system's financial incentives

- allocate financial risk associated with service change appropriately

By bringing together payment for multiple providers, the gain/loss sharing mechanism allows individual organisations' financial incentives to be realigned to achieve outcomes for the whole system. It allows organisations to benefit from individual actions that generate benefits for other parts of the system, and similarly feel the impact of costs their individual actions impose on others in the system. It also enables commissioners and providers to contribute to system-wide change with some protection from a sudden loss in revenue and unfunded fixed costs, or from an unpaid increase in activity. In doing so it supports the successful transition towards new care and support model.