NHS
Brent
Clinical Commissioning Group

Report to: Brent Health Partnerships Overview and Scrutiny Committee (OSC)
Brent CCG Equalities, Diversity, and Engagement (EDEN) Committee

Report from: NHS Brent CCG

Date of meeting: 8th October 2013

Re: **Wave 2 Outpatient Procurement Commissioning Briefing**

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1. Purpose of the Report

1.1 This report sets out the background to NHS Brent CCG's commissioning intention to commission outpatient specialities, the general procurement and consultation plans with respect to the specialities that will be commissioned as part of Wave 2 and the rationale which supports the decision to re-commission these services.

1.2 The report further outlines next steps and draft timescales with regard to this procurement and identifies the points at which there will be further updates on progress to the Health Partnerships OSC.

2. Background

2.1 The CCG's intention to commission new pathways for outpatient specialities originates from the PCTs Commissioning Strategy Plan (2009-14), which was subject to extensive consultation and engagement at the time of development, articulated the rationale for reviewing the way in which certain outpatient specialities were commissioned. The Commissioning Strategy Plan (CSP) 2009-14 highlighted that there were variable referral rates to acute care in some specialities, community pathways for elective care are under developed and that some pathways for elective outpatient care are fragmented across providers resulting duplication.

2.2 Subsequently, working in shadow form with GP Clinical Commissioners (following white paper on NHS Reforms[1]), NHS Brent PCT published a refreshed CSP, which reconfirmed GP Clinical Commissioning's intentions to review the way in which outpatient elective care is commissioned. This publication proposed a phased programme of change to implement and ambitious and innovative approach to the establishment of care pathways for identified specialities for elective care which:

- Supports care provided within general practice without the need for onward referral
- Transforms community provision including a multi-disciplinary team approach
- Reduces the need for onward referral to acute settings and decommissions consultations which do not currently add clinical value for patients.

2.3 This intention was re-emphasised by the Brent Shadow CCG Governing Body when it approved its corporate objectives in 2012-13. Corporate objective 3 – QIPP delivery

[1] Liberating the NHS white paper, Department of Health (July, 2010)

clearly defined the intention to re-commission 13 specialities in 'waves' with associated timescales for doing so.

2.4 As part of the authorisation process for CCG's to be established as statutory successors of PCT commissioning responsibilities, the CCG was required to produce an Integrated Plan (finance and commissioning intentions) which set out the CCG's commissioning intentions for 2013-14. This was subject to patient and public engagement with CCG representatives visiting several forums and holding a public event (14th November 2012) to consult on the integrated plan and commissioning intentions.

2.5 As the successor statutory organisation to NHS Brent PCT, the CCG inherits the assets, liabilities and commissioning plans that were developed by the PCT, jointly with clinical commissioners and in discussion with patients and the public that participated in the extensive consultation that supported the development of our commissioning plans to date.

3. Case for Change

3.1 NHS Brent CCG has emphasised that its mission is to:

- Commission services that improve the health and wellbeing of all patients registered with its member practices and those who are unregistered but are resident in the London Borough of Brent.
- Secure sustainable care that enables Brent patients to receive modern, responsive, high quality yet cost effective care
- Ensure that these services are effectively commissioned within the CCG's financial resource limits. NHS Brent CCG's mission is based on an aspiration to reduce health inequalities within the communities that make up Brent's diverse population.

3.2 There are three main challenges for Brent that mean how health care in the borough is delivered needs to change:

- The residents of Brent have changing health needs, as people live longer and live with more chronic and lifestyle diseases – putting pressure on social and community care.
- Under our current model of care, we cannot afford to meet future demand. We need to have more planned care, provided earlier to our population in settings outside of hospital. This should provide better outcomes for patients, at lower cost
- However, this needs a transformation of primary, community and social care. Currently there is variation in both quality and access and standards must improve.

3.3 In order to achieve this and meet the needs of our population, it is not possible to maintain the current duplication and fragmentation which drains resources and does not offer high quality and cost effective care. There is much evidence from around the country that shows that we can commission outpatients services in the country at less cost and achieve better clinical outcomes.

3.4 The CCGs Out of Hospital (OOH) Strategy is a key enabler for the Shaping a Healthier Future (SaHF) programme. The success of SaHF is predicated on having substantial capacity in the community to meet population health needs, as described within Brent CCG's OOH Strategy. This is a fact that is well recognised by Brent Council in their

submission to the Independent Review Panel on Shaping a Healthier future (August 2013), which states that:

"SaHF makes it clear that changes to out of hospital care are essential if it is to deliver the planned changes to acute care. The general principle of transferring services from acute to community locations with investment in primary and community care, where appropriate, is welcomed. People should not have to travel to hospitals for routine care or to manage a long term condition."

3.5 Brent Council further express anxiety about failure to deliver CCG OOH strategies "*could have a knock on effect on neighbouring CCGs, particularly if it affects demand on shared acute care services".* The submission further expresses concern that the Council has not seen any evidence of investment into out of hospital care.

3.6 NHS Brent CCG's Out of Hospital Strategy describes two key initiatives designed to improve how planned elective care is delivered; move some elective procedures from secondary to primary care and move a proportion of outpatient services to community settings. This is a key element of our OOH Strategy underpinning investment in community services and will determine the success of SaHF. Specifically, we anticipate that these initiatives will:

- Improve current quality of services
- Allow services to be provided in an integrated way, e.g. multi-disciplinary one stop shop
- Release funds for reinvestment into the increasing healthcare demands that the wider population are facing
- Allow us to develop innovative service models

3.7 The anticipated reduction in costs of commissioning these services is estimated in the table below. This will allow the CCG scope to reinvestment in healthcare that meets the growing demand of the wider public.

Wave 2

Outpatient Speciality	Gross full year efficiencies	Re-provision Costs in Community Services	Net Efficiencies
Musculoskeletal Services	MSK as a speciality along is unlikely to achieve any efficiencies; the purpose of procurement is to enable an integrated service with trauma, orthopaedics and rheumatology to improve quality of care and improved outcomes.		
Trauma & Orthopaedics	1,110	687	423
Rheumatology	480	336	144
Gynaecology	930	279	651
Totals	2,520	1,302	1,218

4. Approach to Procurement

4.1 In addition to these major strategic drivers for change, Brent CCG has a statutory duty to commission services for its population that:

- Continuously improves
- Ensures that expenditure does not exceed the allocated budget
- Are integrated and offer high quality care

4.2 To achieve the CCG's mission and fulfil its statutory obligations, the CCG has agreed to apply competitive procurement for services where there is:

- Poor provider performance
- Opportunity to commission more innovative models of care
- Opportunity to bring care closer to home in line with our vision and strategies
- Improve quality of care for patients
- Potential to achieve better value for money

4.3 In the case of wave two specialities, a combination of factors have resulted in a decision to re-commission these specialities. For rheumatology services there are no issues relating to poor provider performance but primary care have raised concerns about poor integration of MSK services. There is evidence nationally that more integrated MSK services which combine rheumatology, trauma and orthopaedics have improved clinical outcomes and achieve better value for money. This is a model that is being commissioned by many CCG's given its evidence base.

4.4 With respect to other specialities within wave 2, e.g. gynaecology there are comparatively lower rates of satisfaction with outpatients with the current provider and there is concern about the provider's ability to meet demand in view of recent breaches to the 18 weeks RTT NHS Constitution performance measure.

5. Procurement Process

5.1 The approach that CCG's can use to secure services is clearly defined as:

- through the contracts with existing providers that they have inherited from PCTs and through future variations in those contracts;

- through enabling patients, when they are referred for a particular service, to choose from Any Qualified Provider (AQP) that wishes to provide the service;

- through tendering for a new or replacement service, i.e. identifying the single exclusive provider or group of providers that will be chosen to provide that service

5.2 The CCG is also required to comply with European legislation on procurement and section 75 of the Health and Social Care Act 2012, relating to procurement, patient choice and competition. Therefore as a statutory body, the CCG will need to adhere to legislation that governs the award of contracts by public bodies, including the Public Contracts Regulations 2006, and will need to satisfy the obligations of transparency, equal treatment and non-discrimination set out in the regulations. Section 75 of the Health and Social Care Act 2012 also makes it mandatory for CCG's to:

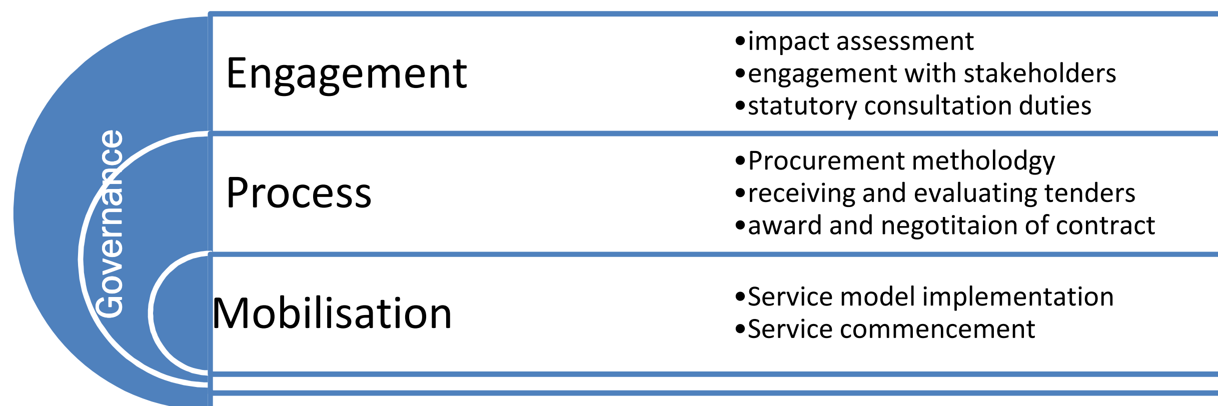
- adhere to good practice in relation to procurement
- do not engage in anti-competitive behaviour
- and protect and promote the right of patients to make choices about their healthcare

5.3 Decommissioning notices which need to be served either 6 or 12 months in advance of any effect or impact, serve as a signal to the provider that commissioners wish to see a change in service. Therefore the serving of a decommissioning notice will not always result in a service being decommissioned. Providers treat decommissioning notices as an indication that a change is required.

5.4 Under the new regulations, NHS money can only be legally spent through one of the two permitted competitive markets, AQP or competitive tendering, and any other way to

arrange services is now illegal (except for the contract renewals permitted for previously tendered contracts).

5.5 The procurement process encompasses a number of key components which are described in the diagram below. The governance function is in place for entire process and is the mechanism by which the Governing Body and/or Executive (depending on contract value) assure and maintain oversight of the procurement process.



6. Next Steps

6.1 Wave 2 procurement is in the commencement phase and is currently in the process of securing a provider to undertake an independent impact assessment and statutory consultation with respect to wave 2 procurement specialities. The specification for this work seeks a provider with expertise to undertake an Integrated Impact Assessment to cover the following areas:

- Health outcomes;
- Statutory and demographic specific equality groups (equality assessment);
- Health inequalities;
- Travel and access; and
- A financial and clinical independency impact assessment to their main providers; North West London Hospitals NHS Trust and Imperial College NHS Healthcare Trust.

6.2 We are seeking a three stage approach to our work; a pre-consultation, mid consultation and a post consultation impact assessment. The impact assessments will be used to inform and provide assurance for the engagement phase of this procurement.

6.3 The specification further sets out that NHS Brent CCG are seeking a provider with ability and proven track record of undertaking the public consultation and stakeholder engagement. This includes engagement with Brent Healthwatch and the general public, voluntary community organisations and specific patient groups in the borough.

6.4 NHS Brent has four desired outcomes from the proposed patient and public consultation:

- That key patients and stakeholder groups are informed about the proposed procurement and the process by which it will take place.

- An understanding of the impact of the procurement on patient and stakeholder groups by NHS Brent in a medium that allows the development of effective management strategies.

- Clear input into the service specification from patients and key stakeholders including desired benefits defined and prioritised.

- Evidence of meeting the statutory duties in respect of patient and public engagement and equality.

6.5 For wave 2, the procurement will be performed through a competitive dialogue process and the scope of service change will be decided through active patient engagement and discussions with prospective providers. Patient engagement supporting the procurement will be a two stage process. Firstly giving patients the chance to input into the service specification and secondly, the chance to comment on the service specification. Following any changes to service models there will be a further piece of engagement from the existing and any new provider to ensure that there is a seamless transition for patients and that any clinical risks are minimised.

6.6 Once we have selected a provider to undertake the impact assessment and consultation the CCG will engage with its EDEN Committee and the Health Partnerships OSC with regard to the plan to confirm that the plan is robust.

6.7 An outline timescales for wave 2 procurement is set out below. These are draft until we have confirmed with the provider undertaking the impact assessment the feasibility of these timescales given the scale of the assessment and formal consultation requirements.

Timescale	Activity
October 2013	• Commission integrated impact assessment and formal consultation and engagement • Agree timescales with providers for each component of the impact assessment
November 2013	• Engage with HOSC and EDEN Committee on the impact assessment and consultation plans agreed with the provider
Dec 13 to Jan 14	• Shortlisted potential providers identified
Jan to Mar 2014	• Integrated impact assessment starts
Jan to May 2014	• Formal consultation and engagement starts with providers, patients, the public and partners
Feb to May 2014	• Procurement process via competitive dialogue starts • Discussing with potential providers services that could be provided in the community that would provide high quality outcomes for patients, enable integrated services and encourages effective partnership with patients and their GPs
April 2014	• Consultation on draft specification with patients, partners and public
May 2014	• Successful bidders selected
June to Sept 2014	• Mobilisation phase which includes: • working with the new provider on establishing the new service • informing patients about the new arrangements • ensuring safe and seamless transfer of care