Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 04"' September 2017**

From: Andrea Green, Chief Officer - Coventry and Rugby CCG

Title: Out of Hospital

1 Purpose

This report is to provide an update on the Out of Hospital transformation programme which aims to achieve truly integrated community services based on the changing population needs, by using an outcome based commissioning approach.

The work programme is underpinned by extensive public, patient and stakeholder engagement and seeks to address the structural, cultural and professional barriers to delivering person centred care.

2 Recommendations

Members are asked to receive the report for information.

3 Information/Background

The three CCGs in Coventry and Warwickshire commenced a programme of work (known as the Out of Hospital (OoH) Programme) during 2015 with the aim of improving the integration of community services to deliver a more personal-centered offer. The programme represents a significant component of our CCG strategy and in 2016 was bought into the Coventry and Warwickshire Better Care, Better Health, Better Value Plan as part of the Proactive and Preventative Care workstream.

The early work during 2015/16 was the preparation phase, where Commissioners worked with patients, the public, clinicians and key stakeholders including Local Authority representatives, to shape and define a set of outcomes and objectives that a future clinical model of care would need to deliver.

At the heart of the OoH Programme is the ambition to meet the changing needs of patients, making better use of technology, capitalising on new treatments, and to unleash system efficiencies more widely. To that end, commissioners agreed a number of objectives for the OoH Hospital Programme,

- To reduce the health and wellbeing inequalities;
- To address the care and quality gap by ensuring more services use evidence based best practice;
- Identify those in most need and co-ordinate their care more effectively, by commissioning and ensuring interdisciplinary working;
- To work within tight financial parameters by developing and delivering services around the needs of patients and carers, and reduce duplication and waste of resources.

In April 2017 CCG Governing Bodies formally adopted the Clinical Model presented to Commissioners by Providers. The OoH Programme Board then undertook a process to identify the type of contract(s) and way of awarding the contract(s) that will facilitate collaboration and deliver the outcomes that are important to our local population.

Delivering the transformation required to make our system truly integrated will require sustained effort over a number of years by Commissioners and Providers. The contract in itself, is not the solution, the change will be driven by effective collaboration; cultural shifts within the workforce; and, a more effective relationship with the people receiving the service.

The clinical model and outcomes commissioned will be consistent across Coventry and Warwickshire but the underpinning contracts will be based on geographies that people identify with as 'places' i.e. Coventry. The rationale of this approach is that the lead providers will be able to tailor the operational delivery of the clinical model to the place and allow them to redistribute their resource (human and financial) in a way that reflects the different health needs of each population; different service provision and different historical levels of resourcing. Contracts at place level will provide the CCGs and their populations with a higher degree of transparency than a single contract when reviewing how the lead provider is redistributing resource, and how effective it is in delivering the outcomes.

4 Options Considered and future governance of the programme

In July 2017, the Governing Body of NHS Coventry and Rugby CCG, considered a range of commissioning and contracting options and made the decision to make a direct award to CWPT for Coventry residents, and South Warwickshire Foundation Trust for Warwickshire residents. The CCG Contracting teams are now working as part of the Programme Board through the next stage of contract development with the Provider, with a view to operating the new type of contract from April 2018.

The 3 CCGs and Coventry City Council and Warwickshire County Council commissioners will use the Collaborative Commissioning Board established across Coventry and Warwickshire as the future governance arrangement for the programme.

Report Author(s): Andrea Green

Name and Job Title: Chief Officer Coventry and Rugby CCG

Directorate: NHS Coventry and Rugby CCG

Telephone and E-mail Contact: c/o Samantha.checklin@warwickshirenorthccg.nhs.uk

Enquiries should be directed to the above person.

Appendix 1 Overview of the programme and process

Background

The Coventry and Warwickshire Better Care, Better Health, Better Value Plan

In December 2015, the National Health Service (NHS) was asked to take a new approach to help ensure that health and care services are built on the evidence about the needs of local populations. Every health and care system in England was tasked to produce a five-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable. The aim is to deliver a vision of better health, better patient care and improved NHS efficiency.

Health and Social Care leaders within Coventry and Warwickshire agreed that the already established Out Of Hospital transformation Programme (OOH) was critical for both the sustainability and development of the local health and care system and therefore agreed that it should form part of the overall plan.

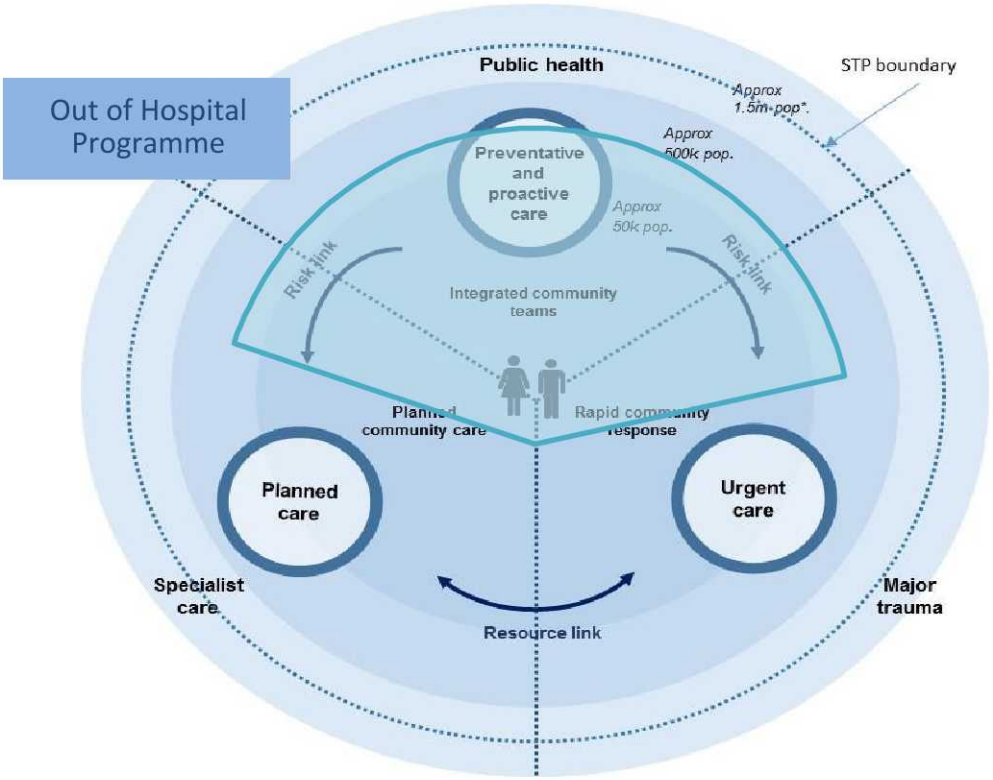


Figure 1 Better Care, Better Health, Better Value

The Coventry and Warwickshire OOH Programme is part of the Sustainability and Transformation Plan and sits within the larger Proactive and Preventative Care Programme. This is illustrated in the diagram above.

Process

The OOH hospital programme has had three distinct but related steps as the diagram below demonstrates.

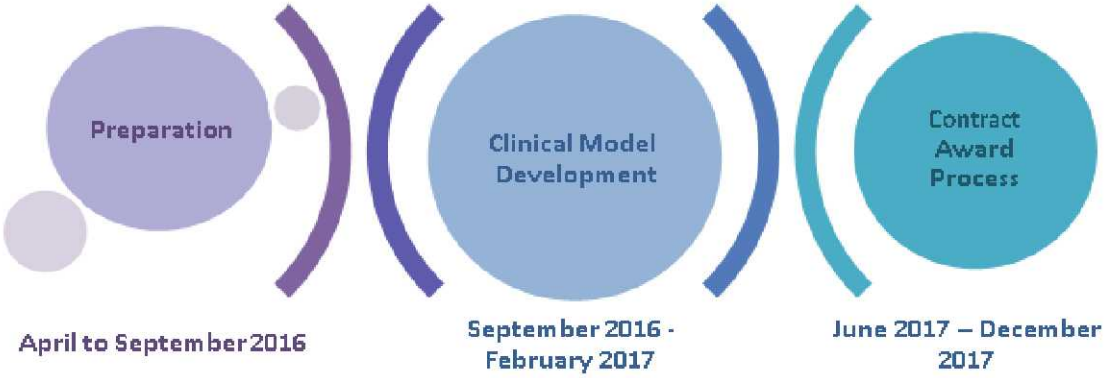
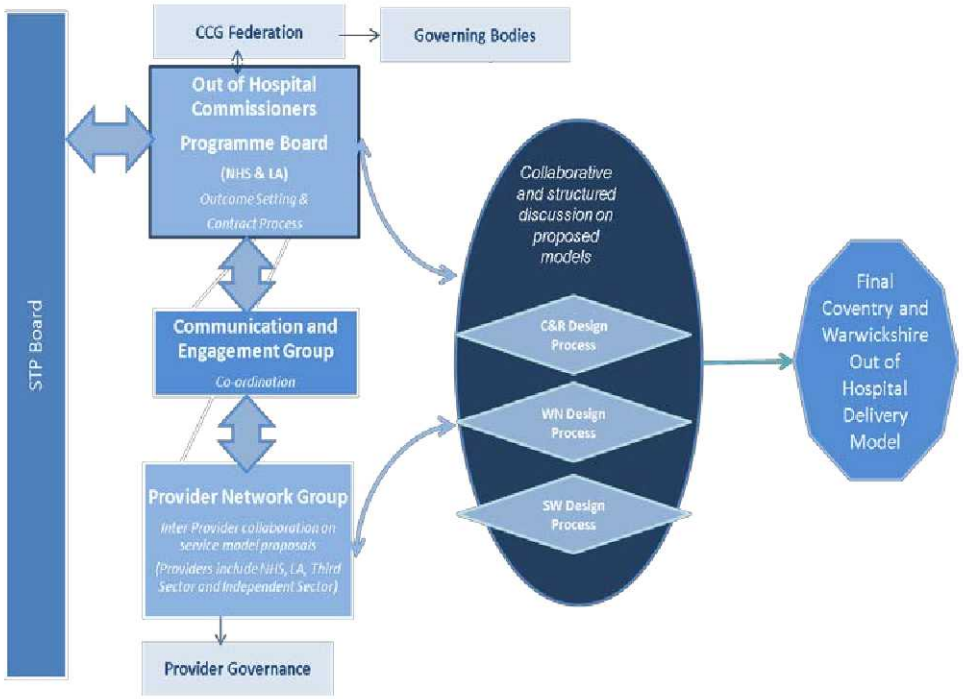


Figure 2 Out of Hospital Processes

The CCG governing bodies' took a decision on making a direct award of a contract in July 2017, and are currently progressing the contract award process, phase 3 above.

Governance Structure

The OOH Commissioners' Programme Board has overseen this process to date and its membership has included senior representatives from the CCGs and commissioning partners from Warwickshire County Council and Coventry City Council, collectively the "Commissioners".



Throughout the process the commissioners have ensured that this programme is a priority; with senior directors responsible for the programme in each CCG and local authorities.

Leads met regularly and progress calls were scheduled for every week. Meetings and workshops were organised to include wider representation as required to ensure a holistic and informed approach to decision making. The commissioners have worked very closely to ensure the most advantageous outcome for their localities whilst ensuring a whole system approach.

As commissioners commence the contract process they will focus the governance arrangements, designed to ensure that as commissioners they continue to work together, with accountability routed through the Coventry and Warwickshire Collaborative Commissioning Board (CWCC Board).

Future Governance Structure (Collaborative Commissioning Arrangements)

The commissioners across Coventry and Warwickshire support a collaborative working arrangement between the three CCGs and the two Local Authorities via the recently established CWCC Board. The details of the working arrangement are being finalised and will be captured in a formal agreement; this will detail how the working arrangements between commissioners will function including budgetary commitments and give potential early insight into delivery risks which can then be monitored and / or mitigated.

The CWCC Board will be responsible for the next phase of development and on-going management of the contract. To support the Board, a dedicated Virtual Commissioning Team is being formed, with the most appropriate staff, from the five commissioning organisations, with the required breadth of skills to manage all the relevant contracts, performance, quality, transitions and the management responsibility of the relevant commissioning budgets. They will have the expertise to develop whole system commissioning which reflects the diverse population needs and changing demands.

The Case for Change

Delivering the Triple Aim

The NHS was founded on a commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. Whilst “our values haven’t changed, our world has” and so the NHS needs to adapt to new trends which are emerging in both health and social care. These trends are presenting new challenges in society that have led to three gaps in the provision of healthcare across the country. Closing these emerging gaps is known as the ‘Triple Aim’.

The Triple Aim is the term used to describe the three emerging gaps in the provision of healthcare across England which are being driven by a range of factors including changing population, trends in society and our economic situation, workforce challenges, sustainability of health and care organisations, and the ways in which organisations work.

Figure 4 – The Triple Aim

The reasons for the need to close such gaps are:

- **The health and wellbeing gap:** if prevention does not become more widespread, then recent progress in healthy life expectancies will stop, health inequalities will widen, and the ability to pay for beneficial new treatments will be put aside by the need to spend billions of pounds on avoidable illness.
- **The care and quality gap:** unless there is change to the way in which care is delivered; make better use technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in health outcomes will persist.
- **The funding and efficiency gap**: if the systems fail to innovate how they deliver care and do more for patients within our existing tight financial parameters, the result will be worse services, fewer staff, and restrictions on new treatments.

Responding to Local Issues

The Commissioners serve diverse populations and the diversity will continue to grow. Commissioners recognise the need to commission services for local populations that are flexible and can respond to the diversity and the changing needs of the population, with more services, where appropriate, provided closer to the patients' homes. Commissioners remain committed to tackling the challenges that come with diverse populations including an ageing population and to improving the quality of life for those with long term conditions.

It is acknowledged that significant change is needed to deliver the Commissioners' vision of integrated care in the context of the following issues:

- The population of Coventry and Warwickshire is expected to continue to grow between now and 2021, with the greatest percentage growth to be seen in Coventry (15%), closely followed by Rugby Borough (11.1%) and Stratford upon Avon District (9.5%);
- In Warwickshire, the population is ageing and more people are living for longer with long term medical conditions. The county currently has approximately 13,356 people aged over 85, and by 2021 this group is expected to grow by 42%;

- Overall there is a mix of urban and rural populations; Warwickshire's rural population is generally older than in the urban areas. The proportion of people aged 65 or over in rural areas is 21%, whilst in urban areas it is 17%;
- In Coventry, there is a high ethnically diverse population, with 33% of the city's residents coming from minority ethnic communities compared to 20% for England as a whole;
- The combination of a growing and ageing population means increasing pressure on health and social care services;
- It is estimated that more people are likely to suffer from long term physical and mental health problems such as heart disease, high blood pressure and dementia;
- People living with multiple health conditions will become the norm, if people continue on the present trajectory. This trend brings with it poorer quality of life, higher hospital admissions and increased mortality.

There are a number of wider current service issues in parts of the system including pressure on emergency departments, high occupancy in hospital beds, delayed transfers of care, and pressure on limited resources in community and primary care services which makes the need to pursue a whole system approach to the development and implementation of OOH services.

Some of the pressures can be significantly improved though better organised, better integrated and better targeted care. From the evidence, the key factors that will improve care include:

- Preventing ill health and improving the quality of life for people with long term conditions;
- Effective management and early intervention to reduce the impact of long term conditions including diabetes, heart disease, stroke, heart attack and lung disease is key to improving the physical and mental health and wellbeing;
- Identifying people at risk of ill health or hospital admission or who are 'frail';
- Identifying risk factors for people with increasing frailty, avoidable harm and avoidable hospital admissions, can improve their health and social outcomes;
- Coordinating the care of people with complex problems and supporting them to live in the community where possible;
- Coordinating the care of people with complex problems via joined up hospital and community services can avoid sometimes lengthy hospital admissions and increase the chance of ongoing independent living. Integrated care is key to achieving better co-ordinated care for individuals and their carers / families;
- Setting specific outcomes targets by which to measure and manage performance is a key step in achieving effective transformation of joined-up, patient centred care;
- The outcomes framework describes evidence based outcome measures, the achievement /delivery of which would improve the quality of life of people;
- Using Joint Strategic Needs Assessments (JSNAs): The purpose of a JSNA is to bring together information to inform how cross-sector partners and local communities can best work together to prevent ill health and improve services.

Outcome Based Commissioning

Commissioning Approach

At the heart of the OOH Programme is the ambition to meet the changing needs of patients, making better use of technology, capitalising on new treatments, and to unleash system efficiencies more widely. To that end, commissioners agreed a number of objectives for the OOH Hospital Programme, in line with the Triple Aim:

- To reduce the health and wellbeing inequalities;
- To address the care and quality gap by ensuring more services use evidence based best practice;
- Identify those in most need and co-ordinate their care more effectively, by commissioning and ensuring interdisciplinary working;
- To work within tight financial parameters by developing and delivering services around the needs of patients and carers, and reduce duplication and waste of resources.

The Commissioners recognised that in order for change to occur at the front line they need to change their commissioning approach to support provider organisations and their staff make the changes that need to be made without the constraints of the existing contracting and payment mechanisms. Health and Social Care commissioners therefore came together to develop a unified commissioning approach to the OOH contract.

The Commissioners agreed that giving providers a budget to cover the health care needs of a defined population given specific health outcomes for the population that they are responsible for would be the most effective commissioning approach. In essence, outcome based commissioning. This will enable the provider to balance the risks they are expected to take on with the level of control and influence they have on outcomes.

In order to implement outcomes based commissioning, the Commissioners had to develop a set of outcomes. These were done in collaboration with providers, stakeholders' clinicians, patients, carers, and the public to achieve a clear and informed understanding of the requirements for OOH services. Each outcome sits within a domain, and providers will be managed against the delivery of the outcomes associated with each of the following domains:

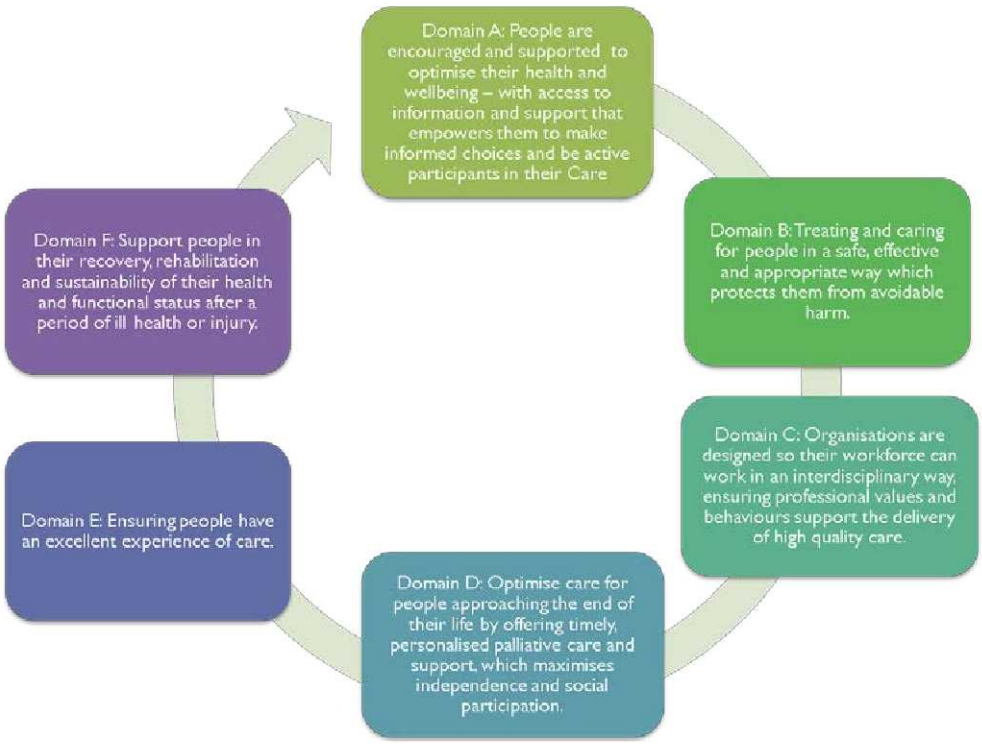


Figure 5– The Outcomes Framework agreed 6 Domains

By taking this approach the Commissioners were seeking to identify a clinical modedl of care that delivered the following principles:

- A population health and care model focused on proactive and preventative care tailored around the needs of the individual;
- Empowering patients and local people to support each other and themselves in their health and care;
- Multi-disciplinary health care professionals working within a system that has accountability for the delivery of health and care services for their population;
- Contracting and payment systems that incentivise and enable the delivery of services for the population health.

Maintaining independence and preventing unnecessary admission into hospital will be one of the fundamental goals of delivering effective care out of hospital. This will not only be more convenient for patients, but will reduce the current unnecessary pressure on hospitals.

Delivering this programme is the first of many steps in transforming our system and our initial focus will be on those individuals who have the most need. Those with:

- Long Term Conditions;
- Young adults with complex disabilities;
- People with high complex needs including physical and / or mental health illness;
- People approaching the end of their life last 12 months;
- High users of health and social care services;
- People at risk of requiring health and social care services;
- People who are housebound.

By adopting this approach the Commissioners will be addressing the following Triple Aims:

Addressing the Health and Wellbeing Gap through:

- Supporting people to care for their own health and well-being by promoting independence, empowering them to care for themselves;
- Ensuring health and care resources are shared to improve outcomes for communities;
- Streamline service delivery, simplifying care model and supporting people to get to the right support to meet their needs;
- Investment in the workforces and empower them to focus on well-designed, personalised high-quality care regardless of which organisation they work for.

Addressing the Care and Quality Gap by:

- Enabling better and more sustainable primary care services;
- Ensuring community services are proactive, responsive and integrated;
- Breaking down boundaries between organisations to maximise the people, buildings and financial resources across the whole footprint;
- Reducing health inequalities by providing consistent, high quality access across the community.

Addressing the Funding and Efficiency Gap by:

- Using existing resources more effectively, by integrating contracts and encouraging the health and care system to work together;
- Encouraging Investment in technology, organisational development and cultural change to ensure more people are cared for in their own home, to proactively plan care for people rather than reacting to unplanned crises;
- Using staff with a wide range of skills, teaming up specialist and generalists to deliver more care in the community.

Financial Arrangements and Principles

The Commissioners continue to face significant financial challenges and expect this level of challenge to continue for the foreseeable future. It is recognised that some of the efficiency savings have already been achieved and the financial challenges ahead will require a more transformational approach. In order to realise the benefits of outcome based commissioning then the payment mechanisms utilised by the Commissioners need to change.

The expectation is that the lead providers will need to interface with other providers, the local authorities, GPs and primary care (this list is not exclusive) to deliver the clinical model and the agreed outcomes.

To move from the present contractual model to the proposed outcomes based model it has been necessary to define the scope of services, the current spend and the interdependencies. If the proposed clinical model of care and the Outcomes Framework are to be delivered then the right scope of services is pivotal in developing and delivering future care models.

The clinical model of care scope included in the OOH service for Coventry and Warwickshire has been refined as part of the process. The discussions with providers included any service changes in progress, pilots in process and services which would impact on the delivery which are not included in the actual scope of services and the financial envelope.

Substantial work has been completed by the Commissioners to date to ensure the accuracy of the financial envelope and the corresponding scope of services.

Whilst the intention is to ensure that the appropriate range of services is in scope, for a number of services where challenges have been identified, to overcome these, the commissioners may consider a phased approach to their inclusion within the contract(s).

In recent years, it has been possible to address this funding challenge by means of realising process efficiencies in areas such as; prescribing and reduction in outpatient activity. Going forwards, savings must come from more effective service models.

The opportunity to implement innovative models of care and more effective contractual arrangements with provider organisations now provides the infrastructure by which the commissioners can take this step and meet in part the financial challenge in a new way.

Overview of financial arrangements in the contract

In addition to creating integrated person-centred care; another objective is to ensure that the Providers deliver improved outcomes as set out in the Outcomes Framework for people, within the agreed financial envelope. It is expected that the totality of the spend within the whole system per head of population will reduce over time; the onus will be on the Providers to manage down demand by taking proactive steps to ensure care is developed in the most appropriate settings and reflects the patients' needs.

It is anticipated that all the required service development will be completed during the first two years of the contract and agreed milestones will be delivered.

The payment mechanism for OOH services will have two components:

- **Fixed element -** a regular payment for the delivery of services paid to the providers.
- **Performance - related element - a regular payment based on the delivery** of specified outcome / performance indicators paid to the provider. In year one this will be linked to the achievement of agreed transformation milestones and by Year 3 will be linked to delivery of improved outcomes. This component will also need to cover nationally prescribed clinical quality (CQUIN) initiatives.

Current expenditure on Out of Hospital Services in scope

The commissioners' current expenditure on the in-scope services is £57m. A breakdown of this by service is provided in the tables below:

In Scope Services (CCGs)	Value 17/18 £m
South Warwickshire	21,715,000
Coventry	21,700,479
Rugby	5,313,621
Warwickshire North	8,698,920
Total in scope	**57,428,020**

Table 1: Value of Scope of Services

The opportunity to implement a wider scope of services will be subject to an agreed programme of work being completed and agreed in year 1 and 2 and to appropriate contract variations being agreed.

Process for setting the Base Annual Contract Value

The basis for the calculation of the Base Annual Contract Value (BACV) will be set at the level of the previous year's BACV.

Performance Incentive Payment

As described previously, one of the key drivers is to improve the integration of services and to incentivise enhanced performance through payment for performance. As such, the commissioners have decided to allocate a percentage of the overall payment as a performance based incentive payment. The outcome / performance indicators and anticipated performance levels along with the methodology for assessing and making the Performance Incentive Payment will form part of the contract.

The Performance Incentive Payment is the contract value set to be awarded if all outcome / performance indicators are met. A proportion of the Performance Incentive Payment will be paid where only some of the outcome / performance indicators are met.

The Performance Incentive Payment will be linked to the Outcomes Framework on the basis of an agreed formula.

All other changes to the contract value that may be required from time to time will be subject to negotiation and supported where relevant by a business case.

An Overview of the Adopted Clinical Model

In April 2017 commissioners made the decision to adopt the CLINICAL MODEL OF CARE that had been developed by providers to deliver the Outcomes Framework and scope of services.

The process undertaken to develop the clinical model consisted of the following steps:

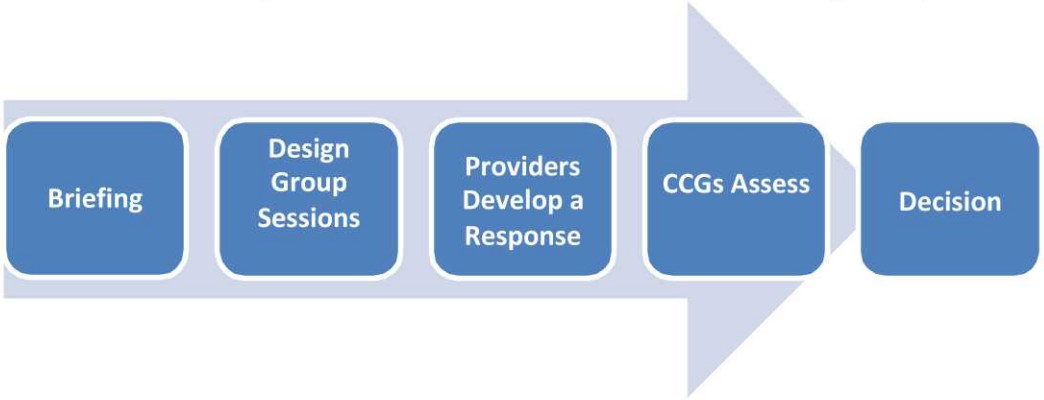


Figure 6 Overview of CLINICAL MODEL OF CARE process

This process took place over a period of 3 months and involved clinical and managerial teams from both commissioners and providers. Patients and wider stakeholder groups were engaged via public events and two large engagement sessions were held.

The Model Vision and Objectives

The vision and objective of the clinical model is to deliver OOH services in Coventry and Warwickshire that will improve care, integrate teams, deliver a sustainable future for services, and reduce demand on acute health and mental health services:

- The providers stated that their "vision is to reconfigure both the provision of services and the culture of care to enable our population to live safe, happy and healthy lives at home for as long as possible";
- A key focus of the development of the model was on the holistic needs of local people to improve the patient and carer experience;
- Providers explored how they could organise their collective resources across the health and social care systems more effectively, to empower people to take control of their own health and wellbeing, thus creating a more efficient system;
- Providers have committed to deliver the outcomes that matter to people in the communities that they live in and as part of the process inputted in the draft outcomes.

Key Characteristics of the Model

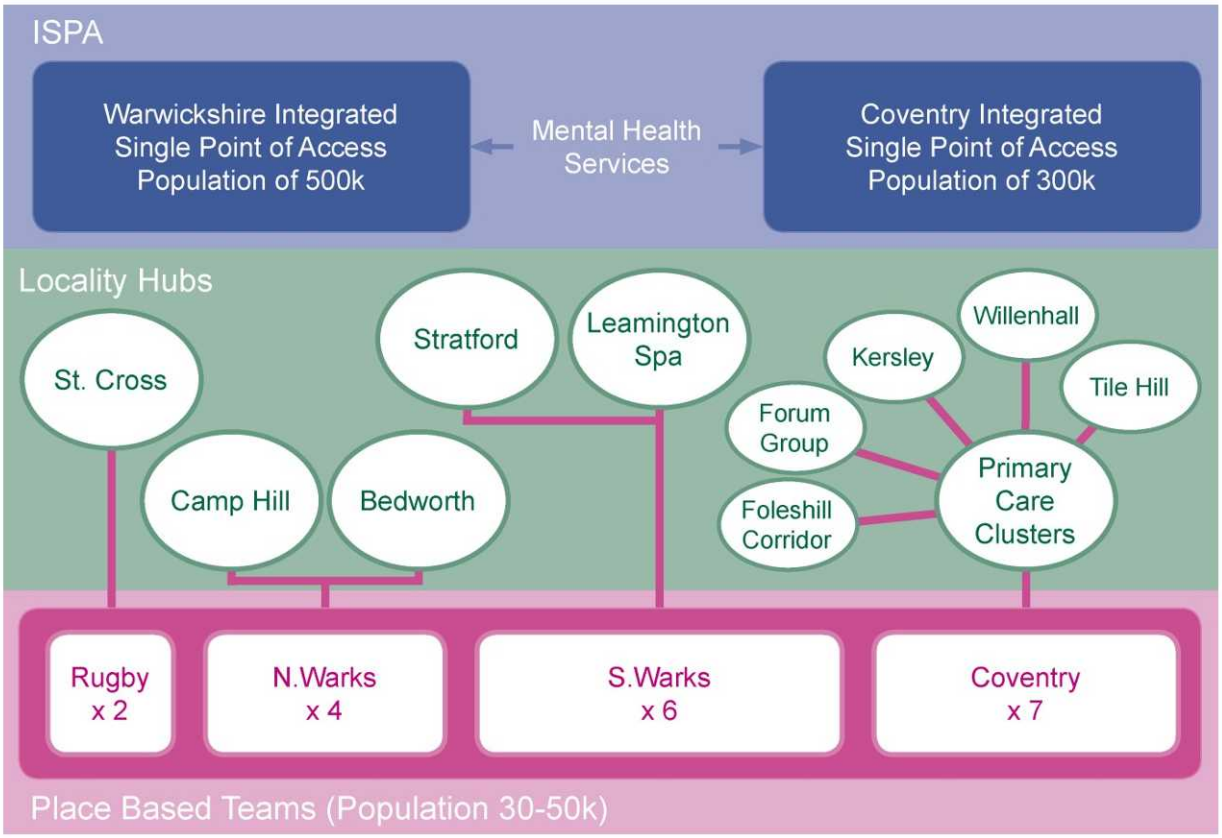


Figure 7: Overview of the proposed single point of access & the proposed locality hubs alignment.

The Intergrated Single Point of Access (ISPA) will be the point of central co-ordination for people across the system and will have an emphasis of improving the outcomes for patients; to achieve these providers will continue to work together to ensure a systematic approach across Coventry and Warwickshire. The ISPA will:

- Be the front door for referrals into the OOH service;
- Co-ordinate care responses to OOH service referrals at a system level;
- Co-ordinate urgent responses to OOH service referrals within a defined timescale allocating teams from across the system, including the Place Based Teams;
- Manage telehealth services available to people including health coaching as part of the prevention agenda;
- Provide educational and continued professional development opportunities to clinicians and other patient facing members of staff;
- Provide data management and analysis, as well as providing a central repository for information (population health system);
- Co-ordinate and disseminate longer term public health information and plans;
- Signpost patients, carers and clinicians to the most appropriate OOH resource;
- Provide links back to acute care where appropriate.

The Locality Hubs are designed to be linked into planned care. Working with larger groups of people than the Place Based Teams, they provide a hub for professionals who the MDT may wish to access, but for whom it is not realistic to have one per team:

- The Locality Hubs will be used as the operational delivery mechanism for training and development;
- Training will then be delivered at the Locality Hub level, to give economies of scale, and will ensure that their local clinical teams understand the range of services available to them, and that they are appropriately using the clinical pathways that will be developed;
- Working at a greater population level will allow services currently delivered in secondary care to be delivered in the community, because of the economies of scale. This is particularly true of specialisms where the PBT would be too small a population group to offer services.

The Place Based Teams (PBTs) are the on-the-ground delivery mechanism for the OOH service. Although exact locations will be determined as part of the ongoing design work, it is anticipated that there will be one team for every 30,000-50,000 people. Other key factors include:

- All staff delivering physical healthcare interventions trained to identify and support individuals improve their own mental health;
- The Multi Disciplinary Team (MDT) will liaise closely with patients, relatives and carers to give them more control over the co-ordination of their own care;
- Within the MDT there will be a deep and evolving knowledge of local services, including those outside of traditional healthcare settings. This will be formalised in the Directory of Services, which is kept up to date with any changes;
- Care co-ordinators will ensure that the MDT generates and delivers a multi-agency care packages tailored to individuals on a case by case basis;
- Care Navigators will also play an important role at the PBTs. They will be responsible for raising awareness of the variety of health and wellbeing options available to access, and navigating people (patients and carers) and professionals within the localities to the right type of care for them;
- Care Navigators will be a key point of patient facing contact within the teams and hence they will have a positive impact on patient experience.

Reasons for Adopting the Model

Overall the assessors recognised the significant amount of work undertaken by the providers and acknowledged the need going forward for a huge shift in organisations' cultures. The submission made clear links on how the proposed model could deliver the commissioners' Outcomes Framework and in doing so gave commissioners confidence that the model was capable of delivering the commissioners objectives and the potential for seamless care.

Commissioning Options Assessment

In developing this process, the commissioners have been mindful of the competition guidance, procurement regulations and consultation requirements.

Legal Context

In 2015, the public procurement regime changed with the introduction of the Public Contracts Regulations 2015 (the "PCR 2015"). The new Light Touch Regime (LTR) is a specific set of rules for certain service contracts that tend to be of lower interest to cross-border competition. The list of services to which the LTR applies is set out in Schedule 3 to the PCR 2015, and includes certain health and social services. The Commissioners will apply the LTR to this contract award.

The advantage of procuring using the LTR is that there are fewer mandatory process requirements with which commissioners will need to comply and follow in order to legitimately award a contract compliant with the PCR 2015. The key express mandatory requirements of which the commissioners will need to be aware, and satisfy, are:

- PCR 2015 Subject to any exemption, advertise the contract in the Official Journal of the European Union (OJEU), using a contract notice or prior information notice ("PIN"):
    - Publish a contract award notice ("CAN") following each individual procurement or, if preferred, group such notices on a quarterly basis;
    - Determine and follow an award procedure sufficient to comply with transparency and equal treatment of providers;
    - Apply "relevant considerations" to the decision to award – flexibility to decide on what these are, including "accessibility" and "flexibility".

In the context of the Light Touch Regime, Commissioners will need to undertake the following steps, regardless of their decision:

- OJEU notice;
- Execution of commissioning contracts in accordance with NHS England standard forms and guidance; and
- Execution of a Memorandum of Understanding (MoU).

LTR rules are flexible on the types of award criteria that may be used, but make clear that certain considerations can be taken into account, including:

- The need to ensure quality, continuity, accessibility, affordability availability and comprehensiveness of the services;
- The specific needs of different categories of users, including disadvantaged and vulnerable groups;
- The involvement and empowerment of people;
- To share down-side risk rather than additional payments.

The applicable National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 requirements are to:

- Act in a transparent and proportionate way;
- Treat providers equally and in a non-discriminatory way;
- Procure services from one or more providers that are most capable of securing patient needs, and improving quality and efficiency of services;
- Consider whether integration and patient choice will improve quality of, and efficiency in, provision of services.

Overview of the process

The options assessment process was designed to ensure openness and transparency and to enable the commissioners to have a common approach, whilst balancing the needs of their localities and the whole system. The options review was carried out between late April and May 2017.

The assessment options process was designed to enable the commissioners to run a robust and transparent process which provides assurance to the Governing Bodies and NHS England.

Throughout this process the objectives have been to ensure that whatever process route and contract mechanism becomes the preferred option the assessment incorporates a full exploration of the benefits and risks of the options to ensure at each stage they are fit for purpose, viable, robust and capable of producing the best sustainable solution for the future services with the whole Coventry and Warwickshire footprint.

To ensure a transparent, robust and comprehensive appraisal of all the options available to the CCGs the following process steps were developed.

Steps	Description	Due
1	Identification and Alignment of the options for the procurement routes & contracting mechanisms	April 17
2	Finalise the scope for the future services	May 17
3	Determine preferred contracting mechanism(s) • Assess & Evaluation of preferred options, • Impact Review of Contract Model	June 17
4	Determine the preferred process option(s)	June 17
5	Commissioner approval of preferred Contract Model option and process	July 17

The processes outlined were supported by an assessment plan, a summary of the contract mechanisms and procurement options and the assessment guidance which was developed by the programme leads.

South Warwickshire created one assessment panel and Warwickshire North and Coventry and Rugby a second, these assessment panels formed a consensus of their preferred option(s) and their recommendations as set out in the assessment report June 2017.

The process was designed to support a fair and open assessment process of the contract mechanisms taking into consideration the driving factors and the needs of the local health economy.

The assessment panels undertook an extensive discussion of the options before reaching their conclusions. These discussions considered the impact of the options and the potential risks in the context of their locality areas.

In carrying out the discussions the commissioners considered the potential impacts summarised below:

- The risk of destabilisation and its impact on patient care in all or parts of the health and social care economy;
- Existing service development gaps management to minimise risk to patients;
- How changes in providers could impacts directly on patients;
- Risk that the incentives developed may not robust or significant enough to drive the process and changes;
- That the model may fail to address the key issues including the unwarranted variations;
- The benefits the contracts are expected to achieve for care quality and sustainability and how will they be achieved;
- The benefits that can be achieved for patients and the local health economy.

Commissioners were clear that whichever process they decided on it must include ensuring transparency and equal treatment of providers.

Procurement Route Outcome

The commissioners determined the process route which best met their objectives and the needs of the population they serve, by which they will award the contract(s) for the providers for the future OOH services.

As the OOH service is deemed a complex service where the commissioners and the local authorities are seeking service development, improvements and integrated working it has been crucial to work with providers to develop a CLINICAL MODEL OF CARE across a range of services and organisations. Having agreed the model, the commissioners then considered their procurement options as listed below:

- Do Nothing – maintain the current arrangement with a collaborative overlay [apply procurement rules to a competitive process via:]
- Procurement process;
- Procurement – Competitive dialogue;
- Direct Award.

The commissioners having weighted up all the options and the likely impacts have decided to recommend a Direct Award of the OOH contract to the incumbent providers in line with the requirements of the LTR.

The regulations support the commissioners in directly contracting with service providers without an extensive competitive process; however, the commissioners in making this recommendation have considered the options, reached their conclusions and evidenced their rationale that the incumbent providers are deemed the most capable of delivering the clinical model.

Contract Mechanism Outcome

The contract mechanisms options considered are listed below:

- Do Nothing – collaboration agreement;
- Alliance;
- Lead Provider.

The potential contract mechanism which emerged was Lead Provider utilising the Standard NHS Contract. Within the CLINICAL MODEL OF CARE submission it is clear that SWFT and CWPT see themselves as a collaborative working together to achieve the aims of the proposed model and it is the intention of both parties that this collaboration is continued and strengthened. It is not the subject of this process to determine as yet whether the collaboration arrangement is continued as a formal or informal agreement. A formal arrangement could be where parties enter into an agreement to work cooperatively to ensure a whole system approach to delivering outcome indicators.

The commissioners, after serious deliberation weighting the benefits and risks, concluded that Lead Provider contracts were the most appropriate mechanism to realise the commissioners' requirements for the future OOH services and the wider health and care economy.

A lead provider is described as an arrangement where commissioners have a single contract with the Lead Provider.

The Lead Provider can then organise other providers along the pathway and be responsible for subcontracting delivery of their services, but cannot decommission "material" subcontracted providers without approval of the Commissioners. For Coventry and Warwickshire, it is the intention to recommend CWPT and SWFT as lead providers.

Conclusion

The commissioners needed to determine the process route by which they would secure provider(s) for out of hospital services. Having explored all the options, the Governing Bodies' determined that the lead provider option is the one most likely to enable the delivery of the contract model and ensure transformation of services is delivered within or sooner than the expected timeframe, and made a decision to make a direct award to CWPT for Coventry and SWFT for Warwickshire.

Next Steps

Indicative timeline

The following milestone table is an indicative high-level timeline in which to conduct a process. This timetable remains high-level until the recommendations to proceed with the options is finalised. Once agreed a detailed project plan, timetable and dates for all necessary meetings with be implemented.

	Milestones	DATES
1	Issue OJEU	19 /20 July 17
2	Commence Contract discussions with providers	July 17
3	Contract Signature	November 17
4	Contract commencement	April 18