NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE - INFORMAL MEETING

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 20 April 2017 from 1.30 pm

Membership

Present	Absent
Councillor Jim Armstrong	Councillor Merlita Bryan
Councillor Ilyas Aziz	Councillor Corall Jenkins
Councillor Patience Uloma Ifediora	Councillor Dave Liversidge
Councillor Carole-Ann Jones	
Councillor Ginny Klein	
Councillor Anne Peach (Chair)	
Councillor Chris Tansley	

Colleagues, partners and others in attendance:

Kathryn Brown	-	Contracts Manager – Community Services, Nottingham City Clinical Commissioning Group
Dave Miles	-	Integrated Care Team, Nottingham City Council/ Nottingham City Clinical Commissioning Group
Maria Principe	-	Director of Cluster Development and Performance, Nottingham City Clinical Commissioning Group
Jane Garrard	-	Senior Governance Officer

1 NEXT PHASE ADULT INTEGRATED CARE

Dave Miles, Integrated Care Team, gave a presentation about the next phase of integration for adult integrated care. He highlighted the following information:

(a) Key achievements of integration so far have included Care Delivery Groups bringing services together; the introduction of new Care Co-ordinator roles supporting Care Delivery Groups; multi-disciplinary meetings now taking place in GP practices; continued expansion and integration of assistive technology; piloting of a range of self-care initiatives including social prescribing in Bulwell; and integration of the Nottingham Health and Care Point.

(b) Objectives for the next phase of integration include ensuring care is delivered in the right place by the right people with the appropriate skill mix; ensuring care is delivered at home or in the community where possible; focusing on prevention and ways in which individuals and resilient communities can best support themselves; building medium and long term sustainability in response to rising demand and constrained resource.

(c) Priorities for the next phase of integration are managing risk; prevention and self care; developing the third sector; workforce and culture; parity of esteem

between physical and mental health; responsiveness; achieving outcomes; and technology enabled care.

(d) The key areas for integration activity will be developing an advanced community offer to promote self care and independence; developing an integrated health and social care response to citizens' changing needs and circumstances; and improving access and navigation.

(e) The recently published Next Steps Five Year Forward View refers to development of new models for care, including Multispecialty Community Providers (MCP). Consideration is also being given to alignment with the Greater Notts Delivery Plan and proposals to develop a Greater Notts Accountable Care System (ACS). This would be a care model wrapped around Nottingham University Hospitals requiring commissioners and providers to work alongside each other with the support of an 'integrator'. Currently contracts are held with individual providers and this means that providers all work to their own individual contracts and not necessarily collaboratively across the system. In an ACS there would be an alliance agreement between commissioners and providers setting out required outcomes across the system. The alliance would monitor how providers are delivering together and the alliance would be overseen by clinical commissioning groups.

In response to questions the following additional information was provided:

(f) The approach to self care was piloted in Bulwell with volunteer navigators to support individuals in supporting themselves. The intention is that this will be rolled out wider and through the Health and Care Point staff will be trained to direct people to support themselves. The volunteer navigators in Bulwell should still be operating. Evaluation of the Bulwell pilot will inform future commissioning.

(g) Commissioners need to get better at joined up commissioning and the ACS should help with this.

(h) Commissioners are under financial pressure. While it is anticipated that prioritising prevention and self care will contribute to a more sustainable health and social care system over the medium and longer term, there are no immediate financial savings to help alleviate current financial pressures.

Commissioners were asked to provide further information about the current and future position of the self care pilot in Bulwell.

2 PROPOSAL TO RE-MODEL THE COMMUNITY SERVICES CONTRACT AND ESTABLISH GOVERNANCE ARRANGEMENTS TO PROCURE AN INTEGRATED OUT OF HOSPITAL SERVICES CONTRACT

Kathryn Brown, Contracts Manager – Community Services, Nottingham City Clinical Commissioning Group, introduced a report outlining a proposal to remodel the Community Services Contract and establish governance arrangements to procure an

integrated Out of Hospital Services Contract. She highlighted the following information:

(a) The current Community Services contract is held by Nottingham CityCare Partnership and due to end in March 2018. This has provided an opportunity to review the contract in terms of what should be included and ways of working and as a result the re-procurement will not be a like-for-like replacement of current provision.

(b) The scope of the new contract is still being determined and the current list of proposed services for inclusion was included with the agenda papers. It is intended that there will be one provider contracted to provide all of the services but that provider will be able to subcontract with other providers. A benefit of this approach is that the Clinical Commissioning Group (CCG) will only have one contract to manage.

(c) The CCG is aiming to ensure that the voluntary and community sector are engaged in service delivery. It is proposed to dedicate a particular percentage of the contract value to be delivered by voluntary and community sector organisations. In the first 12 months of the contract the provider will be asked to review what they want voluntary and sector organisations to deliver, for example self care, carer support.

(d) Some services are integrated with other services commissioned by the local authority for example and the provider will be mandated to continue this.

(e) There is a need to achieve savings and this will be done by only having one contract to manage; reviewing provision to reduce duplication; and creating efficiencies within the contract.

(f) It is a very large contract and the CCG is being supported by procurement experts throughout the procurement process.

(g) It is anticipated that there will be several stages at which public and patient engagement will take place: a review of relevant past engagement findings will be undertaken; assumptions will be tested with population groups; once the provider has been appointed there will be engagement on what the services will be and how they will be provided.

(h) It is intended to develop joint service specifications between the CCG and local authority to maximise opportunities for integration.

(i) The contract going out to tender will not be too specific to encourage innovation.

(j) In addition to the risks included within the agenda papers, the following additional risks have been identified:

i. That patients will experience different services
ii. The re-procurement process may destabilise services

iii. The TUPE process may need to be used to transfer staff to a new provider and this would be a significant amount of work
iv. Better Care Fund guidance isn't yet available but some services are currently funded through the Better Care Fund.
v. Need to recognise the significance of estates
vi. Need to recognise the impact of achieving savings against ensuring that providers bid for the contract and that the contract is deliverable.

In response to questions the following additional information was provided:

(k) The need to ensure that the health needs of new and emerging communities are met is recognised. Each Care Delivery Group area has its own Joint Strategic Needs Assessment and there will be a commissioning manager engaged with each Care Delivery Group area to ensure that the needs of that area are identified and taken into account. This will be different for each Care Delivery Group area.

(l) There will be an expectation that quality of care will be maintained over the 12 month period of the procurement process and current providers would be expected to raise any issues or concerns about this with the CCG.

(m) The workforce is crucial to current and future service delivery and staff will need to be reassured about the process.

It was agreed that the Committee will be kept informed of progress with the procurement process and that updates will come back to future meetings at key points in the process – June 2017; January 2018; and March 2018.