

Monitor

Making the health sector
work for patients

Commissioning better community services for NHS patients



About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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Executive summary

An older man with a leg wound is visited by a district nurse who changes his dressings and bandages and monitors how well the wound is healing. A young person with diabetes has regular appointments with a diabetes nurse in a community centre to receive advice on how to control her condition and maintain a healthy lifestyle. A man recovering from a heart attack attends cardiac rehabilitation classes to undertake supervised exercise and learn how to make changes to his lifestyle.

All of these people are receiving an NHS-funded community service. Services traditionally referred to as 'community services' are an important part of many people's NHS care. Community services are provided outside hospitals in people's homes and in community settings. In 2012/13, the NHS spent about £9.7 billion on these types of services.¹ By one estimate, patients come into contact with community services about 100 million times per year.²

Improving how community services work for patients is critical to making the NHS more effective and efficient. Community services often are not well co-ordinated with other services, causing patients to receive care that is fragmented and of variable quality.³ The NHS 'Five Year Forward View' ('Forward View') envisions new models of care that break down the traditional divides between primary care, community services and hospitals.⁴ The aim is for patients to receive personalised and co-ordinated care from different types of services and clinicians working together.

Commissioners now have an important opportunity to commission community services in a way that will support this shift to more co-ordinated care for patients closer to home. Many of the community services contracts put in place three to five years ago are expiring, giving commissioners an opportunity to:

- move to new ways of working or new models of care that are better for patients
- test which providers are most likely to achieve the changes that commissioners want for patients

¹ 2012/13 Department of Health annual accounts. This figure excludes community learning difficulties, mental illness, maternity services and community hospitals.

² Edwards, N. (2014) *Community services: How they can transform care*. The King's Fund. [Online] Available at: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/community-services-nigel-edwards-feb14.pdf

³ Edwards, N. (2014) *Community services: How they can transform care*. The King's Fund. [Online] Available at: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/community-services-nigel-edwards-feb14.pdf

⁴ NHS England. (2014) *Five Year Forward View*. Available at: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

- move to new contracts that provide greater transparency and accountability for community services provision, as well as greater incentives for providers to improve services for patients.

Monitor has reviewed community services commissioning to understand the extent to which commissioners are seizing this opportunity. This report, written mainly for commissioners, describes how clinical commissioning groups (CCGs) are commissioning community services as their contracts expire. We also discuss why our findings mean that it is especially important for commissioners to engage effectively with patients.

Further, to help commissioners make the best decisions for patients as these contracts expire, we summarise how the ‘Procurement, Patient Choice and Competition Regulations’ (the ‘Regulations’)⁵ apply to some of commissioners’ decisions about commissioning community services. We explain the approach that Monitor will take if we receive a complaint about what commissioners have done at the expiration of their community services contract.⁶

We also offer case studies to show how some commissioners have commissioned community services or models of care that are intended to make services more joined-up and work better for patients.

Many commissioners are reviewing and redesigning community services

Monitor sent a questionnaire to all CCGs seeking information about their community services contracts and how they intend to improve services. We received responses from 147 CCGs.

The responses indicate that most community services are provided under contracts covering a wide range of services with a fixed-sum payment that generally does not vary based on activity or quality of care. These arrangements were first put in place three to five years ago as a result of the Transforming Community Services (TCS) programme.⁷

The responses also indicate that community services providers are most commonly NHS organisations, with one provider typically providing all or most community services in a geographic area.

⁵ National Health Service (‘Procurement, Patient Choice and Competition’) (No. 2) Regulations 2013.

⁶ Monitor’s main function is to protect and promote the interests of patients. Part of our role is to enforce the ‘Procurement, Patient Choice and Competition Regulations’ and advise commissioners how these Regulations apply or might apply to their commissioning decisions.

⁷ The Transforming Community Services programme resulted in primary care trusts transferring provision of community services to providers. It created a purchaser/provider split in community services to mirror that which was already in place in primary, secondary and mental healthcare. See sections 1 and 5 for more background on TCS.

Our research found that in 2014 many commissioners extended or renewed the community services contracts first put in place as part of TCS. Many commissioners said they expect to roll over their contracts with their current provider in 2015 for at least one year.

Close to two-thirds of responding CCGs reported that they are in the process of reviewing and redesigning some or all of the community services provided in their area. Some CCGs said that they rolled over their contracts in 2014 to allow themselves more time to review service lines and clinical evidence, and engage with patients, providers, clinicians, local authorities and others to understand what new ways of providing care will work best for patients. Other commissioners said they are reviewing services to understand whether their current provider is offering quality care and value for money.

How community services are improving for patients

Our research suggests that many commissioners are taking steps to improve how community services work for patients. Typically, they are working with others in their local health economies to:

- identify patients with complex needs and co-ordinate their care through teams involving general practitioners (GPs) and other clinicians drawn from different types of services
- define the outcomes desired for patients and change incentives for providers so that they are more focused on achieving those outcomes
- commission pathways of care or care for certain populations, such as older people, using contracting models that bring different providers together.

Commissioners said their greatest challenge in improving community services is a lack of robust activity, cost and quality data. Recording of data for community services has been poor historically. Because a wide range of community services is paid for with a fixed-sum payment, providers have had little incentive to understand the costs of individual services. Commissioners sometimes find it difficult to know whether providers are delivering value for money. In some cases, commissioners said, a lack of robust activity and cost data has hampered their efforts to determine costs for new pathways of care or for particular populations.

There is a risk that, given these challenges, some commissioners will roll over their community services contracts indefinitely without exploring whether alternative models of care or providers would be better for patients. This would mean patients might not receive the best care possible.

Effective engagement with patients is critical for improving services

People who use community services have an important contribution to make as commissioners assess and redesign the way in which community services are commissioned and delivered.

Our findings suggest that effective engagement with patients is critical to improving community services. For example, because most community services are provided under contracts with an annual fixed-sum payment that does not vary based on activity or quality of services, providers may lack incentives to ensure they are delivering quality care for patients. This means it is particularly important for commissioners to investigate whether community services are working for the people who live in their areas.

We believe commissioners should think creatively about how to engage effectively with people who use community services and their families. For example, commissioners should use techniques and tools that reach diverse groups of people, use patient feedback in their decisions, be clear and honest about changes that may take place, and provide a way for patients to provide ongoing feedback. This is in line with the 2015/16 planning guidance for implementing the Forward View. The planning guidance calls for the NHS to focus on actions to improve how the NHS engages with communities and citizens, including with local Healthwatch.⁸

As contracts expire, commissioners need to consider what options are best for patients

To make good decisions for patients, commissioners will need to consider how to improve services as their current community services contracts expire. This involves assessing patients' needs, thinking through which models of care might work best for patients, and exploring which providers are most likely to deliver the changes that commissioners want for patients.

We observed commissioners taking different approaches when their community services contracts expire. For example, some commissioners said they rolled over their contract because they want to work with their current provider to improve services, while others said they did so as an interim measure while they are reviewing services. Other commissioners said they intend to use a competitive tender process to commission community services.

This report intends to help commissioners consider how the Procurement, Patient Choice and Competition Regulations apply to their approach or intended approach. The Regulations are designed to ensure that commissioners take decisions that are

⁸ *The Forward View into action: planning for 2015/16*, 8. Available at: <http://www.england.nhs.uk/ourwork/forward-view/>

likely to benefit patients. They are intended to promote improved quality and efficiency of services, including innovative models of care.

Some important points for commissioners are:

- As community services contracts expire, commissioners will need to consider how services should improve for patients. They also will need to satisfy themselves that their provider is the most capable of improving the quality and efficiency of services for patients. Generally, rolling over contracts indefinitely without considering these factors is not in the best interests of patients and therefore is not consistent with the Regulations.
- Commissioners will need to think about how they can satisfy themselves that they have selected the best provider. They can go about selecting providers in a number of different ways. Whatever process commissioners use to select a provider should be fair and open. This does not necessarily mean putting contracts out to a full competitive tender, but in some cases a tender process may be the best option. Commissioners should design a process that makes the best possible use of their resources while maximising the potential benefit to patients.
- If Monitor receives a complaint about what a commissioning body has done at the expiration of a community services contract, we will first attempt to understand what steps commissioners took to make their decision. We will primarily look for commissioners to show that they have followed a sensible and thoughtful process to try to identify the best options to improve services for patients. Where commissioners rolled over contracts as an interim measure because they are in the process of reviewing or redesigning services, we will look at several factors, including:
 - whether commissioners are acting in a fair and transparent manner while reviewing services and considering options for redesigning services
 - whether commissioners weighed the possible benefits or drawbacks of considering alternative commissioning approaches, including alternative providers, in the interim period against the possible benefits or drawbacks of waiting until services are redesigned.
- When thinking about contractual arrangements that bring different providers together (commonly referred to as prime or alliance contracts) commissioners should:
 - ensure they start by assessing patients' needs and develop a model of care and contracting arrangement around those needs

- ensure they retain the ability to monitor the quality of care and value for money; commissioners must continue to hold levers to improve care and hold providers accountable
- ensure that patients' right to choice is protected and promoted
- consider whether bringing providers together under a contract might affect their incentives to improve services to attract patients or win contracts and what incentives are needed to ensure providers do their best for patients.

Commissioners can learn from the experiences of other local areas

Commissioners can help themselves to meet challenges by sharing and learning from each other's experiences. Annex 1 of this report includes case studies describing how some commissioners have commissioned community services or an integrated model of care which may involve community services. These case studies include a look at how commissioners have:

- used competitive dialogue to commission services that are delivered in a more integrated way for patients
- developed quality-of-care measures to enable commissioning for patient outcomes
- empowered patients to take part in the process to select the best provider for community services
- worked in partnership with the local authority and agencies to test a model of integrated support for families with complex health and social care needs.

While this report aims to support commissioners to make good decisions for patients, several issues relevant to improving community services are outside of its scope. Monitor is working on some of these issues. For example, we are working with our national partners and local health economies to support development of the new models of care set out in the Forward View, to test and enable payment models, to support local areas implementing integrated care, and to support troubled or distressed local health economies.

1. Introduction

This report looks at what clinical commissioning groups (CCGs) are doing in relation to community services as the contracts first entered into as a result of the Transforming Community Services (TCS) programme expire.

From 2009 to 2011, as part of the Department of Health's TCS programme, primary care trusts (PCTs) transferred their community services provider arms to existing providers or created new providers. In most cases, PCTs awarded a three-year contract to a single provider to provide the entire range of community services in a geographic area.⁹ The contracts mostly featured a fixed-sum annual payment to providers that generally did not vary according to activity levels or provider performance (a block contract).¹⁰

In 2013, CCGs took responsibility for commissioning many community services, including managing most services provided under the contracts entered into as part of TCS.¹¹ Local authorities became responsible for commissioning certain community-based services, such as intermediate care and some public health services, including alcohol and drug use prevention and treatment and sexual health services. NHS England also became responsible for commissioning certain public health services provided in the community, such as immunisations and national screening programmes.

To understand how commissioners are commissioning services as the TCS contracts expire, Monitor sent a questionnaire to all 211 CCGs. We asked about the CCGs' current community services contracts, their intentions for the future, and any challenges or lessons learned in commissioning community services.

We received 147 responses to our questionnaire, accounting for:

- 70% of CCGs
- 70% of the population

⁹ See Department of Health. (2010) *Guidance on the NHS Standard Contract for Community Services 2010/11*. Three years was the default duration of the contracts, although this could be shorter or longer with agreement of the strategic health authorities. We are aware of some providers having had one-year contracts, subject to annual renewal, in place since the time of TCS.

¹⁰ In some cases, some service lines were separated from the main block of community services and awarded to providers who had bid to deliver those services, or staff providing certain services under the PCT elected to form a social enterprise to provide those particular services. While the payment generally did not vary with performance, contracts did include commissioning for quality and innovation (CQUIN) measures that rewarded providers for meeting certain quality measures.

¹¹ In April 2014, the contracts were (or should have been) varied to agree with the terms of the 2014/15 NHS Standard Contract.

- £3.9 billion in community services spending.¹²

We followed up the questionnaires with discussions with 30 stakeholders, including 21 CCGs, some patient representative groups and some community services providers.

This report sets out the results of our research. It describes:

- what services are defined as community services
- how community services are commissioned
- how commissioners intend to improve community services for patients
- challenges related to a lack of robust information about community services
- a need for effective engagement with patients.

In addition, to support commissioners to make good decisions for patients as their community services contracts expire, the report:

- summarises how the 'Procurement, Patient Choice and Competition Regulations' apply to commissioners' decisions about commissioning community services and explains the approach that Monitor will take if we receive a complaint about what commissioners have done at the expiration of their community services contract¹³
- provides case studies showing how some commissioners have commissioned community services or models of care that are intended to make services work better for patients.

Some issues that are important to improving community services fell outside the scope of this project, such as CCGs' capabilities or capacity to move to new models of care, providers' capabilities or capacity to match commissioners' intentions, and workforce recruitment issues. These issues can affect the sector's progress in changing how care is provided. We also recognise that local authorities and NHS England are responsible for commissioning some community-based services or they may jointly commission some services with CCGs. The decisions, capabilities and resources of other commissioning bodies can affect how and what services are commissioned.

¹² Our responses account for less than half of spending on community services because CCGs are not the only type of commissioner to secure and/or fund community services and not all CCGs responded to our questionnaire.

¹³ Monitor's main function is to protect and promote the interests of patients. Part of our role is to enforce the 'Procurement, Patient Choice and Competition Regulations' and advise commissioners how they apply or might apply to their commissioning decisions.

In addition to this project, Monitor is looking at a range of issues and challenges that involve community services. We are working to support development of the new models of care described in the Forward View, to test and enable payment models, to support local areas implementing integrated care, and to support troubled or distressed local health economies.

2. What are community services?

There is no standard definition of community services. Community services are provided outside of hospitals in community settings, including in people's homes and in community clinics. Community services have a number of objectives, including promoting health and healthy behaviours, supporting people to manage long-term conditions, and providing treatment in a person's home or in the community to avoid hospital or residential care where possible.

Commissioners responding to our questionnaire commonly reported that their community services include community matrons, district nursing, continence services, podiatry, physiotherapy, diabetes care, specialist nurses, tissue viability, heart failure services, wheelchair services, rehabilitation services, falls, palliative care, neurology, respiratory and stroke services.¹⁴

Beyond these common services, commissioners varied in what they identified as services commissioned under their community services contracts.¹⁵ Some commissioners listed paediatric services, children's speech and language, learning disabilities, musculoskeletal, pulmonary rehabilitation, infection control, or community case managers. A handful of responding CCGs said their community services include chronic pain management, a central dressing clinic, cancer information, community management of deep vein thrombosis, and services for people with chronic fatigue syndrome.

In addition to variations in which services are defined as community services, commissioners said that the same or similar services often are provided in different ways in different areas.

Because community services are not defined or delivered in a standard way across localities, they can be tailored to meet local needs. The lack of standardisation

¹⁴ Not all CCGs responding to our questionnaire included a list of the services covered in their community services contracts. We compiled this list of most commonly commissioned services by looking at the responses that did include such a list.

¹⁵ We did not seek information about local Any Qualified Provider (AQP) contracts; therefore, most commissioners did not list services covered under those contracts. Services covered by AQP may include musculoskeletal services for back and neck pain, adult hearing, continence, certain diagnostic services, wheelchair services, podiatry, venous leg ulcer and wound healing and primary care psychological therapies. We estimate that a small proportion of community services are commissioned under AQP contracts.

presents difficulties, however, in creating common patient-level currencies¹⁶ against which costs of care can be captured or in benchmarking local services against those of other areas.

3. How are community services commissioned?

Our research provides a picture of how community services commissioning has changed – and how it has not changed – since the TCS programme. Broadly:

- most community services continue to be provided under block contracts covering a wide range of services with a fixed-sum payment
- community services providers are most commonly NHS organisations, with one provider typically providing all or most services in a geographic area
- the bulk of community services contracts now in effect expires in 2015, and many commissioners indicated that they are likely to extend or renew contracts for at least another year
- many commissioners are in the process of reviewing and redesigning community services.

3.1. Most community services continue to be provided under block contracts covering a wide range of services with a fixed-sum payment

In 2008, 90% of community services were funded under block contracts featuring a fixed-sum payment for a wide-range of services.¹⁷ At that time, the Department of Health urged PCTs and providers to move away from block funding to new currencies and better pricing mechanisms.¹⁸ Our research suggests, however, that today most community services are still delivered and funded under block contracts.

The contracts identified in commissioners' responses to our questionnaire cover about £3.9 billion in CCG spending on community services. Our analysis indicates that 93% of this total value of community services contracts is paid for with an annual

¹⁶ Currencies are nationally standardised definitions of a unit of care, which can be discrete activity (eg a home assessment or a diagnostic image) or a bundle of care that forms a treatment for people with similar needs (eg a course of talking therapy).

¹⁷ Department of Health. (2008) *Transforming Community Services: Currency and pricing options for community services*, 4. [Online] Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093008

¹⁸ Department of Health. (2008) *Transforming Community Services: Currency and pricing options for community services*. [Online] Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093008

fixed-sum payment that does not vary based on activity or quality of care.¹⁹ A small proportion of the total contract value is paid for on a cost and volume basis, which is a fixed-sum payment that may be adjusted if activity differs from anticipated levels. And even smaller proportions are paid for using an activity (tariff) or outcomes-based payment mechanism (see Table 1).

Table 1: Current remuneration methods²⁰

Description	Type of payment	%
Percentage of total annual value of contracts in our sample remunerated by:	Fixed-sum payment	93%
	Cost and volume	5%
	Activity	1%
	Outcomes-based	1%
Total		100%

Source: Monitor's analysis of questionnaire responses

Note: AQP contracts, typically remunerated on an activity basis, are not included in the analysis

3.2. Community services providers are most commonly NHS organisations, with one provider typically providing all or most services in a geographic area

NHS organisations accounted for about 87% of the total annual value of community services contracts represented in our questionnaire responses (see Table 2).²¹

In most CCG geographic areas, one provider provides all or most community services for local patients. Of the CCGs responding to the questionnaire, 92% reported that their community services are provided by only one provider or by one provider plus some additional providers with relatively small contracts. For 8% of the CCGs, the total value of their community services contracts is distributed evenly across two or more providers (see Table 3).

This suggests that commissioners may need to consider which services might work better for patients if commissioned separately from the main block of services. Unbundling services might enable smaller specialised providers to deliver innovative care models.

¹⁹ Block contracts may include CQUIN measures, which can provide additional payments to providers for meeting certain quality measures. See section 4.2.2.

²⁰ For about 30 responses, it was not specified whether the payment was a fixed-sum payment or a cost and volume payment. In these cases, we categorised payment based on our best interpretation of the response. When the CCG specified an exact amount for the contract and did not specify that a cost and volume arrangement was in place, we assumed a fixed-sum payment.

²¹ As part of TCS, the provider arms of PCTs were transferred into or transformed into new providers, which were existing NHS acute trusts or NHS mental health trusts or independent providers, or new NHS community trusts or social enterprises (such as community interest corporations).

Table 2: Type of provider²²

Description	Provider			%
Percentage of annual contract value in our sample provided by:	NHS providers	Community trusts	42%	87%
		Acute trusts	18%	
		Mental health trusts	27%	
	Independent providers ²³			7%
	Third sector ²⁴			4%
	Other ²⁵			2%
Total				100%

Source: Monitor's analysis of questionnaire responses; NHS Choices website
Sample size: 145 CCGs;²⁶ AQP contracts are not included in the analysis

Table 3: Number of providers per CCG

Description	Proportion of CCGs
Only one provider for entire block of community services	42%
One provider for large block of community services and one or more provider(s) of service lines with relatively low contract value	50%
Value of community services evenly spread among two or more providers	8%
Total	100%

Source: Monitor's analysis of questionnaire responses
Sample size: 145 CCGs²⁷; AQP contracts are not included in the analysis

²² This analysis includes only services commissioned by CCGs and not by other types of commissioners (eg local authorities and NHS England).

²³ This includes private companies, GP practices and some hospices.

²⁴ This includes charities, community interest corporations, social enterprises and voluntary sector organisations.

²⁵ This includes where CCGs indicated that local councils are responsible for providing services. It also includes some partnerships of NHS and independent providers and cases where the information in the responses was not sufficient to determine the nature of the provider.

²⁶ Two of the CCGs who responded to our questionnaire did not provide enough information to be included in this analysis.

²⁷ Two of the CCGs who responded to our questionnaire did not provide enough information to be included in this analysis.

3.3. The bulk of community services contracts expires in 2015, and many commissioners said they are likely to roll over contracts for at least one year

Our research indicates that many of the contracts first entered into as part of TCS expired in 2014, and that in many cases, commissioners extended or renewed these contracts with their current provider for one, two or three years.²⁸

A few commissioning bodies have run competitive tender processes for their block of community services or specific types of community services. Others have run competitive tenders for certain community services to be delivered as part of integrated care pathways or as part of a bundle of services for a population, such as older people. Others have commissioned new services, or commissioned services in a community setting that were previously provided in an acute setting. And in some cases, commissioners have changed service specifications or other contractual provisions with their current provider.

The responses indicate that most community services contracts now in effect are due to expire in 2015. About 78% of the total value of current community services contracts represented in the responses we received will expire in 2015, 12% in 2016 and 8% in 2017.

The responses also indicate that most community services are now provided under one-year contracts, with about three-quarters of the total annual value of community services contracts represented in our analysis provided under a one-year contract.

Table 4: Contract expiration dates

Description	Expiry	%
Percentage of annual contract value in our sample expiring in:	2015	78%
	2016	12%
	2017	8%
	2018 or after	2%
Total		100%

Source: Monitor's analysis of questionnaire responses

Note: AQP contracts are not included in the analysis

Sixty-one CCGs indicated that they are likely to keep their current provider for at least one of their community services contracts by extending or renewing the contract in 2015. Of these CCGs, 40 said they are likely to extend or renew in 2015 for at least one year and 21 CCGs said their contract is subject to renewal on an annual basis. These planned rollovers account for 61.5% of the total annual value of contracts expiring in 2015 in our analysis. Fourteen CCGs said they intend to competitively tender at least one of their community services contracts, accounting for 6.5% of the total annual value of contracts expiring in 2015. Fifty-seven CCGs

²⁸ Based on our analysis of responses, our conversations with stakeholders and desktop research.

said they have not determined what they will do in 2015 or they did not specify; this accounts for 32% of the total annual value of contracts expiring in 2015.²⁹

Table 5: Plans for contracts expiring in 2015

Description	%
Annual value of contracts to be competitively procured in 2015	6.5%
Annual value of contracts for which commissioners said they will extend or renew with their current provider	61.5%
Annual value of contracts for which commissioners said they do not yet know what they will do when the contract expires or did not specify	32%
Total	100%

Source: Monitor's analysis of questionnaire responses

Note: AQP contracts are not included in the analysis

Some CCGs said that they are likely to continue to work with their current provider to improve services because they see this as the best way to make services more integrated. Several commissioners said they see a competitive tender process as a last resort when their current provider fails to deliver expected improvements.

In section 7, we address some of these considerations and explain how the 'Procurement, Patient Choice and Competition Regulations' may apply to decisions about community services contracts.

3.4. Many commissioners are in the process of reviewing and redesigning community services

Close to two-thirds of CCGs responding to our questionnaire reported that they are in the process of reviewing and redesigning some or all of the community services provided in their area. Some CCGs said that they rolled over their contracts to allow themselves more time to review service lines and clinical evidence, and engage with patients, providers, clinicians, local authorities and others to understand what new ways of providing care will work best for patients. Other commissioners said they are reviewing services to understand whether their current provider is offering quality care and value for money.

Generally, commissioners who have completed or are close to completing a review of community services reported that 9 to 18 months were needed to engage with stakeholders and decide how services should be improved. Some CCGs said they have revised service specifications and are implementing changes with their current provider; others said they are considering using a competitive tender process to select a provider.

²⁹ We received responses to our questionnaire from June through August 2014, so some commissioners may have firmed up plans since the time they responded.

4. How do commissioners intend to improve community services for patients?

We asked commissioners how they intend to improve community services for patients. We asked them to describe, for example, which models of care or ways of remunerating providers they are considering to improve how these services work for patients.

Not surprisingly, most commissioners reported that they are focused on delivering community services in a way that is more integrated with other services, including other community services, primary care, secondary care, mental health, and social care services. The goal is to shift care out of hospital by strengthening the care provided in community. Commissioners commonly cited 'integrated care' and 'care closer to home' as shorthand to describe their intentions.

National policies, as well as information and views gathered during local engagement with patients and other stakeholders, are behind the push to better integrate community services and shift care into homes and community settings. For example, some commissioners said that the Better Care Fund initiative has sparked closer working with local authorities to explore a range of joined-up social and health care provision, which often involves community services.

The Forward View describes new models of care that will need to take root in some local health economies. Among the models for the future, primary care providers would seek to provide different types of services and host clinicians with different specialities to work alongside each other to provide integrated care in communities.

Some of the changes that commissioners have recently put in place, or are trying to put in place for community services, may facilitate the development of these new models of care. Our research suggests many commissioners are focused on:

- identifying patients with complex needs and those at risk and co-ordinating care through teams operating across different types of services and different providers
- defining the outcomes that commissioners want for patients and changing incentives for providers so that they focus more on achieving those outcomes
- using contractual arrangements that involve different providers coming together to deliver care pathways or care for certain populations, such as older people.

4.1. Identifying patients with complex needs and working in teams to support their care

Commissioners have widely adopted tools to help them understand the health characteristics of their local populations and identify people with complex needs.³⁰ These patients are most likely to benefit from greater interventions, such as case management, health coaching or co-ordinated care supported by a multidisciplinary team.

Commissioners and providers are building on models that bring staff from different types of services and different providers together to oversee care for patients with complex needs. Commissioning these models often requires commissioners to rethink how services operate and support providers to share information. Providers involved sometimes enter into memorandums of understanding to facilitate working in teams. Or commissioners might change service specifications to facilitate working in teams.

Wandsworth CCG, for example, have commissioned a new model for community adult health services that is in its first year of implementation. The model places greater emphasis on multidisciplinary working and supports greater opportunities for different types of clinicians, including a patient's own GP, to work together. The CCG has tried to ensure that patients and their carers will be fully involved in their care plan by establishing personalised goals and reviewing them regularly with community staff so care is managed effectively as a patient's needs change. The model also entails community staff working with mental health staff, the voluntary sector and social services to deliver more streamlined services and prevent duplication wherever possible.

In some cases, CCGs are promoting shared access to patient records to support integrated care. Camden CCG, for example, invested in software to create an integrated digital health and social care record. The system can gather patient-level information from different IT systems across different providers, including social care. With a patient's consent, clinicians can view a patient's information from all local providers, including Camden's main community services provider and adult social care provider.³¹

There are a number of resources to support local efforts to strengthen co-ordinated team working for patients with complex needs.³²

³⁰ See Information Governance Task Force. (2014) *Privacy impact assessment – risk stratification*, 9. These tools rely on data from GP practices or GP practices and secondary care.

³¹ See Camden Integrated Digital Record. [Online] Available at: www.camdenccg.nhs.uk/cidr

³² See eg Goodwin, N. et al. (2013) *Co-ordinated care for people with complex chronic conditions*. The King's Fund. [Online] Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf

4.2. Defining outcomes for patients and strengthening providers' incentives to support those outcomes

There is a trend in the NHS towards commissioning for outcomes. NHS England describes an outcome of care or treatment as:

“... the impact [care or treatment] has on a patient – on their symptoms and on their ability to live the life they want to live. An outcomes-based approach means focusing less on what is done for patients, and more on the results of what is done. It means focusing on how well patients feel after treatment and helping them to stay well, whether suffering from physical or mental ill-health.”³³

To commission for outcomes, commissioners first need to understand which outcomes are most important for patients and then develop indicators to measure whether those outcomes are being met. A next step is to strengthen incentives for providers to achieve those outcomes for patients.

4.2.1. Developing outcomes measures

During the TCS programme, the Department of Health developed 43 quality indicators for community services, some of which were intended to be outcomes-based quality measures.³⁴ Commissioners told us that these largely were adopted as key performance indicators (KPIs) in the block community services contracts, along with other KPIs. Contractual KPIs are intended to enable commissioners to measure quality of care, productivity or other aspects of a provider's performance.³⁵

Commissioners said that over time additional KPIs, mostly measuring activity or processes, were added to the contracts resulting in a large number of repetitive or unhelpful indicators. This has made it difficult for commissioners to manage contracts and understand whether patients are getting the best possible outcomes. One CCG, for example, told us that its contract has more than 200 KPIs. The CCG is working to reduce this amount to those most important for patients.

Commissioners and providers are now focused on reducing the number of KPIs and revising them so that they mostly measure patient outcomes instead of activity or processes. Commissioners are using a variety of resources and working with stakeholders to understand what is most important to patients and develop outcomes indicators.³⁶ In Annex 1, we present a case study of how Cambridgeshire and

³³ NHS England. (2014) *Everyone counts: planning guidance for patients 2014/15 to 2018/19*.

³⁴ Department of Health. (2011) *Transforming community services, Demonstrating and measuring achievement: community indicators for quality improvement*. [Online] Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/215624/dh_126111.pdf

³⁵ Most commissioners we spoke to said that their current KPIs were not linked to payment incentives.

³⁶ One source, for example, could be the framework for community services outcomes measures and indicators developed by trusts aspiring to become community foundation trusts. See <http://www.bridgewater.nhs.uk/demonstratingthevalueofcommunityservices/>

Peterborough CCG developed outcomes indicators to be one of the first CCGs to use outcomes-based commissioning on a large scale for pathways involving community services.

4.2.2. Exploring payment incentives

Most commissioners said they want to explore payment-based incentives that will promote better outcomes for patients, including reducing unnecessary and emergency hospitalisations.

More than 60% of CCGs responding to our questionnaire said they are considering payment mechanisms other than the fixed-sum payment now in place in most contracts. Payment mechanisms under consideration include cost and volume payments, capitated payments or community tariffs. Most current block contracts include CQUIN payments, but commissioners indicated that more effective payment incentives are needed.³⁷

To introduce payment incentives, some commissioners are tying a proportion of payment to outcomes-based measures. Cambridgeshire and Peterborough CCG, for example, has tied a proportion of payment to its providers achieving certain outcomes identified in the new contract (see Annex 1). North East Essex CCG, which is running a competitive tender process for community services, has also said it plans to tie a proportion of payment to a set of indicators that measure the experience of care or changes in quality of life for patients.

Other commissioners said they have implemented shadow activity-based tariffs for an interim period to test whether the fixed-sum payment in place reflects the cost of activity.

Generally, however, commissioners said that developing payment incentives is difficult. Poor activity or costing data for community services can hamper efforts to develop currencies and prices.

This is an area where Monitor is already working to support local innovation. For example, Monitor and NHS England recently published examples of alternative payment approaches that local areas can opt to use.³⁸ These examples set out the

³⁷ CQUIN refers to 'commissioning for quality and innovation,' a national framework that ties a certain amount of the total NHS budget for England (2.5% for 2013/14) to the achievement of specified measures. Half a % is tied to nationally set outcomes such as the Friends and Family Test and improvements against the NHS safety thermometer; 2% is linked to local measures related, for example, to reducing non-elective admissions, improving hospital supported self care, and improving health assessments in maternity services. Providers will only receive CQUIN payments if they meet these goals. NHS England sets the national CQUIN measures. Local commissioners set the local CQUIN measures.

³⁸ See Monitor and NHS England. (2014) *Supporting innovation in the NHS with local payment arrangements*. [Online] Available at: [/www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements](http://www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements)

detailed design choices available when considering population-based capitated budgets, and include a payment model that supports community-based comprehensive assessment, self-care support and care co-ordination. Monitor and NHS England will establish and support test sites for new payment approaches that support the new models of care outlined in the Forward View.

4.3. Commissioning using 'prime' or 'alliance' contracts

There is a trend for commissioners to use or consider using contracting arrangements in which one provider leads and manages other providers to deliver services, or in which a number of providers are commissioned separately but bound contractually to work together to deliver services. The goal is for all providers participating in these arrangements to work toward the common objective of improving outcomes for patients.

Commissioners commonly refer to these arrangements as 'prime,' 'lead' or 'alliance' contracts. Most commissioners interested in these arrangements said they are considering commissioning care pathways or services for distinct populations, such as older patients, with a prime provider or alliance contractual arrangement.

These arrangements will vary in how they look and operate. Generally, however, a prime or lead contract involves commissioners contracting with a single provider which will be responsible for providing an entire care pathway or set of services. The prime/lead provider will subcontract with other providers to provide elements of the pathway. These arrangements may feature the prime/lead provider acting only as a co-ordinator or manager of services, or with the prime/lead provider also providing services itself.³⁹

An alliance arrangement generally involves a group of providers entering into an umbrella agreement with commissioners in addition to their individual contracts with commissioners. The agreement will detail how the group of providers is to work together towards desired outcomes for patients, including how they will make decisions and share information. The umbrella agreement or each provider's commissioning contract may set out aligned incentives to encourage providers to work together to achieve the desired outcomes for patients.

Our discussions with commissioners suggested that they are eager to adopt these forms of contracting but are in early stages of thinking about how they will work, and there are several issues that need to be worked through. There is work going on in

³⁹ See Addicott, R. (2014) *Commissioning and contracting for integrated care*. The King's Fund. [Online] Available at: www.kingsfund.org.uk/publications/commissioning-contracting-integrated-care

the sector to evaluate and support commissioners to use different types of contractual arrangements when commissioning services.⁴⁰

In section 7, we discuss some factors for commissioners to take into account under the Regulations when considering these contracting arrangements.

5. A lack of information has slowed progress

Commissioners said a main challenge in redesigning community services is a lack of robust information about activity, costs and quality of care. Data collection related to community services provision has historically been poor, and this can be compounded by contracts that have lacked incentives for providers to track quality and costs. Several commissioners said they have gone through an arduous and time-consuming process to ‘unpick’ community services to try to understand the quality and efficiency of current services.

In some examples, commissioners said they found:

- they were paying for services that they weren’t actually receiving for patients in their area (where services from the same provider were commissioned jointly with other CCGs)
- providers had shifted funds allocated to particular service lines to other services, obscuring spending and costs
- patients were receiving duplication in care; one CCG, for example, said years of layering slightly different nursing and therapy services on top of existing services resulted in confusion and duplication of care for patients
- where PCT community services provider arms were acquired by acute trusts or where separate provider arms were combined into one provider, they sometimes continued to operate as distinct units; for example, in some cases, back office operations were not consolidated.

In some cases, commissioners said unpicking the contract has allowed them to understand service line costs and rebase the contract, redesign service specifications to commission types of care rather than service lines, or strengthen monitoring tools in the contract. However, the process of unpicking the block contract

⁴⁰ See Addicott, R. (2014) *Commissioning and contracting for integrated care*. The King's Fund. [Online] Available at: www.kingsfund.org.uk/publications/commissioning-contracting-integrated-care. NHS England has looked at how commissioners might contract for these different arrangements. The NHS Standard Contract, as is, can be used for a prime or lead contract. NHS England is planning to publish a set of optional provisions which may be added to the NHS Standard Contract to commission an integrated package of primary and secondary care services (whether using a prime/lead arrangement or not). NHS England also will publish a model umbrella agreement to facilitate an alliance-type arrangement. Commissioners may contact the NHS Standard Contract team at nhscontractshelp@nhs.net for more information.

appears to be slowing the pace of change for patients and is hampered by a lack of robust data.

5.1. Data related to community services is not robust

There continues to be a lack of robust data about community services provision. In 2009, the Department of Health acknowledged that there was very little information about activity, costs, or quality of care (including patient outcomes) in community services.⁴¹ At the time, the TCS programme⁴² sought to address this issue by:

- developing practical tools for commissioners and providers to improve their information systems⁴³
- providing support to improve the collection of data^{44, 45}
- developing community indicators for quality improvement⁴⁶
- introducing the Community Information Data Set (CIDS), a nationally developed community services dataset for local use.⁴⁷

The NHS Standard Contract for Community Services, which went into effect when provision of services was transferred from PCTs to providers, also required commissioners and providers to agree to a data quality improvement plan to address the lack of quality data available.⁴⁸

Our research suggests that in some local health economies commissioners and providers have made progress since TCS to improve the data collected and provided

⁴¹ Department of Health. (2009) *Improving information for stakeholders*. [Online] Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109423

⁴² Department of Health. (2008) *NHS Next Stage Review, Our vision for primary care and community care*. [Online] Available at: www.nhshistory.net/dhvisionphc.pdf

⁴³ Department of Health. (2009) *Improving information for stakeholders*. [Online] Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109423

⁴⁴ Department of Health. (2010) *Allied health professional referral to treatment guide*. [Online] Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114871

⁴⁵ Department of Health. (2010) *TCS mobile working readiness framework*. [Online] Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_116846

⁴⁶ Department of Health. (2010) *Transforming community services, Demonstrating and measuring achievement: Community indicators for quality improvement*. [Online] Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126110

⁴⁷ Health and Social Care Information Centre. (2011) *Information Standards Notice – New Standard: Community Information Data Set*. [Online] Available at: www.isb.nhs.uk/documents/isb-1510/amd-25-2010/1510252010isn.pdf

⁴⁸ *Guidance on the NHS Standard Contract for Community Services, 2010/11*, 9. All community services were since moved or made to conform to the NHS Standard Contract.

to commissioners. A number of CCGs told us that they have worked with their provider to obtain information such as activity data, staff numbers and staff location.

Some commissioners say their providers submit data based on the CIDS, regional, or locally developed datasets. Other commissioners and providers use data from the NHS Benchmarking Network, a voluntary network in which members submit certain data. In its work related to community services, the network brings together data from providers of community services which enables benchmarking on measures related to access, activity, use of resources, workforce, costs and quality of care.⁴⁹ In 2014, 56 providers of community services from across the UK contributed data across 10 categories of services.

Despite these strides, almost a quarter of commissioners responding to our questionnaire mentioned a lack of robust data as a barrier to improving how community services work for patients. Commissioners said they find deficiencies in data needed to measure healthcare outcomes for patients, data to benchmark activity and outcomes in their area against other areas, and cost data that would help them evaluate value for money or develop new currencies and payment mechanisms.

Some commissioners and providers said, for example, that the CIDS is not useful because at this time there is no national collection that would allow benchmarking of local CIDS data against other areas.

Commissioners and providers also said there is wide variation in the IT capabilities of community services providers.⁵⁰ This is true across different providers and within single organisations, as some service lines are more equipped than others to capture data. Some providers have digital technology for all or parts of their mobile workforce, while others still rely on paper records to record information.

5.1.1. Why do commissioners need better data?

At a system level, the entire sector needs better data about costs, activity and patient outcomes to enable a shift to new ways of providing care.⁵¹ This includes data that would allow commissioners and providers to see a patient's contacts with all points in the system, including with community services.

⁴⁹ The NHS Benchmarking Network has 135 members from the NHS across the UK, including 76% of acute trusts, 100% of mental health trusts, 76% of community providers, 42% of CCG commissioners.

⁵⁰ See also Foot, C. et al. (2014) *Managing quality in community health care services*, The King's Fund. [Online] Available at: www.kingsfund.org.uk/publications/managing-quality-community-health-care-services

⁵¹ David Bennett. (2014) *How Monitor's strategy supports new models of care*, Future Hospital Journal, Vol. 1, No 2:84-7.

Monitor is publishing a guide to help local areas create person-level linked datasets that will support local health economies to understand the patterns of care and associated costs of their local populations across all settings. The goal is for commissioners to be able to use the datasets to design service requirements, define outcomes for patients, and track costs for groups of people, such as older people or those with multiple long-term conditions.

Commissioners gave a number of reasons why they need better data about community services:

- to understand patients' needs and use of services to enable planning and prioritising
- to manage performance of contracts, for example to understand whether providers are providing quality care that achieves good outcomes for patients and offers value for money
- to develop new currencies or payment mechanisms
- to prepare to use a competitive tender process, and provide information to prospective providers so that they can offer a sound bid.

The types of data that commissioners may need to support these functions will vary, but commissioners said they may include:

- activity data (eg number of contacts specified by service line)
- information on the costs of services provided
- data to measure quality of care, including outcomes and experiences of patients
- staffing information, such as Transfer of Undertaking Protection of Employment (TUPE) lists and other human resource information
- information on the state of premises and facilities
- data to benchmark their own services.

Our research suggests that there is wide variety in the types and quality of data collected. Some commissioners said obtaining data often is difficult for two main reasons outlined below.

First, the provider may not collect the data. This can be because the provider's information technology (IT) systems limit its ability to collect data or because the provider has not put appropriate practices or capacity in place to gather and record robust data. One commissioner told us, for example, that provision of data recently improved when their provider equipped staff with handheld devices for data input.

Another commissioner said that they have introduced more outcomes-focused KPIs to the community services contract, but the provider's IT system is not able to capture all the data needed to measure care against the KPIs. The commissioner has given the provider one year to resolve this issue. In other cases, commissioners told us that a provider's switch to a new IT system has interrupted or delayed the flow of data.

Second, providers may not share certain data with commissioners. Some commissioners said their providers have not been forthcoming with data, and they believe this may be because the provider does not want to provide information that could enable or lead the commissioner to competitively tender the services.

Commissioners and providers said that tender processes have been delayed while commissioners attempted to obtain data from their current provider. Or, in some cases, commissioners have been unable to provide accurate information needed by prospective providers to support their bids. One provider said, for example, that after winning a contract it found that information provided during a competitive tender process about the number of patients waiting for care from the incumbent provider was inaccurate. The new provider was faced with an unexpected backlog of patients when it took over service provision.

5.1.2. Commissioners have addressed the problems with data in a number of ways

A number of commissioners have told us that they continue to work and negotiate with their current provider to try to get the data they want.

South Manchester CCG adopted a template for unpicking its block contract and used it to evaluate each service line provided under the community services contract. The template identified the key pieces of information that were to be collected in the review. This included certain activity data (eg attendance rates, attendances by location, referrals by source); cost information (eg total spend, average cost per unit of activity, staffing costs); some local data benchmarked against national data using community services reference costs; and feedback from patients and stakeholders about the service. The template also required commissioners to set out what they wanted to achieve to improve the service and the recommendations resulting from the review. Using the template helped the CCG to streamline the review process and to systematically review all services.

Another CCG said that it has added additional enforcement options to its contract, including financial penalties that are triggered if the provider doesn't provide the required data.

Other commissioners have looked to strengthen data requirements for the future. For example, commissioners who have tendered contracts said they have made data requirements clearer for their selected provider or providers.

One CCG said that when it tenders its community services contract it will take into account the capacity and capability of providers to collect and provide certain data. In another example, a CCG has allowed its new provider to use the first year of the contract to gather information that was not available during the tender process. This will then be the basis for amending the contract if required.

6. Our findings suggest that effective engagement with patients is critical to improving services

Patients have an important contribution to make as commissioners assess and redesign the way in which community services are commissioned and delivered. Our findings suggest that effective engagement with patients is critical to improving community services. For example, because most services are provided under an annual fixed-sum payment that does not vary based on activity or quality of care, providers may lack incentives to ensure they are delivering quality care for patients. The onus is on commissioners to make sure that community services are working for the people who live in their areas.

Commissioners' engagement with patients can vary in effectiveness. To make the changes necessary to provide better care, we believe commissioners should ensure that their engagement is meaningful and constructive. This is in line with the 2015/16 planning guidance for implementing the Five Year Forward View. The planning guidance calls for the NHS to focus on actions to improve how the NHS engages with communities and citizens, including with local Healthwatch.⁵² Our research and conversations with commissioners and patient groups suggest that some of the characteristics of effective engagement include:⁵³

- investigating who uses different types of services and reaching different types of people where they normally would gather
- engaging local Healthwatch and other patient groups to help identify and reach out to diverse groups of patients
- thinking carefully about patients' concerns and what they mean for services (for example, if patients say they are being visited too often by different care providers who seem unaware of what each other is doing, commissioners will need to think specifically about how they can ensure that services change to address this issue)

⁵² *The Forward View into action: planning for 2015/16*. [Online] Available at: www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf

⁵³ See NHS England. (2013) *Transforming participation in health and care*. [Online] Available at: www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

- exploring whether patients would value having a choice of providers for certain types of community services⁵⁴
- being clear and honest about what commissioners are doing (patients may be sceptical of change; therefore, explaining why services need to change in a clear and honest way is important. Describing ‘visions’ or ‘principles’ may be useful but patients need to know what actually is likely to happen in practice and what it means for them)
- keeping people informed about how commissioners have used their feedback in making decisions
- gathering information and views about how services can meet the whole needs of patients – clinical and wellbeing (patient groups emphasised the need for health and social care services to take account of each individual’s goals or aspirations, and design services that can help them achieve those things that will them happy. This might be as simple as taking measures to help an older person take a walk or visit friends)
- giving the public and patient groups adequate time to absorb plans and understand issues (asking people to provide feedback on short notice is unlikely to yield useful information)
- thinking of innovative ways to involve patients (for example, in Annex 1, we present a case study of how Oldham CCG stepped up the involvement of service users in selecting a provider for community services)
- having a mechanism in place that allows people to share experiences and provide feedback on an on-going basis. Commissioners should consider what they and providers should do to ensure that patients can regularly provide feedback about services.

By using meaningful, effective engagement as community services are reviewed and redesigned, commissioners are more likely to make decisions that are in the best interests of patients.

⁵⁴ A King’s Fund survey found that 75% of respondents said choice was either ‘very important’ or ‘important’ to them when referred to a consultant; older respondents, those with no qualifications, and those from a mixed and non-white background were more likely to value choice. King’s Fund. (2010) *Patient choice: How patients choose and how providers respond*. [Online] Available at www.kingsfund.org.uk/projects/patient-choice-how-patients-choose-and-how-providers-respond. Monitor is looking at how choice is working in adult hearing services in England, including whether patients value having a choice, and is due to publish its findings shortly.

7. How the Procurement, Patient Choice and Competition framework applies to decisions about community services contracts

The 'Procurement, Patient Choice and Competition Regulations' provide a framework for commissioners to make decisions that are in the best interests of patients. The Regulations are intended to promote the quality and efficiency of services, including innovation and integrated care.

The Regulations support commissioners to adopt more integrated models of care. Monitor has previously published information about how integrated care, competition and choice can work together.⁵⁵ Our case studies in Annex 1 include examples of how some commissioners used a competitive tender process to commission services that would be delivered in a more integrated way.

In this section, we describe some of commissioners' obligations as community services contracts expire and explain the enforcement approach that Monitor will take if we receive complaints about what commissioners have done. We also discuss some factors for commissioners to take into account when considering contractual arrangements commonly referred to as prime or alliance contracts.

Commissioners who are uncertain about how the 'Procurement, Patient Choice and Competition Regulations' apply to their specific situations or intentions should contact us for advice. We are always happy to have discussions with commissioners to help ensure they are using the framework of the Regulations to achieve the best outcomes for their local populations.

The issues addressed in this section reflect questions and issues that commissioners most often raised in conversations about community services. Monitor's '[Substantive guidance on the Procurement, Patient Choice and Competition Regulations](#)' describes the full set of obligations and considerations that commissioners need to have in mind when commissioning services, including community services.

7.1. Commissioners are taking different approaches as community services contracts expire

In our research, we observed CCGs taking different approaches when their community services contracts expire. Some CCGs suggested that they intend to renew the contract with their current provider indefinitely and will work with their current providers to improve services. Some commissioners said they see this as the

⁵⁵ See *Complying with Monitor's integrated care requirements*, Section 7. [Online] Available at: [/www.gov.uk/government/publications/integrated-care-how-to-comply-with-monitors-requirements/complying-with-monitors-integrated-care-requirements](http://www.gov.uk/government/publications/integrated-care-how-to-comply-with-monitors-requirements/complying-with-monitors-integrated-care-requirements)

best way to make services more integrated. Several commissioners said they see a competitive tender process as a last resort to procure services when their current provider fails to deliver expected improvements.

Other commissioners said they extended or renewed their contract with their current provider because they are working to review services and decide how they want community services to improve for patients. Some of these commissioners indicated that after they determine what services they want, they will consider options for selecting a provider.

Still other commissioners have engaged with stakeholders and have invited all interested providers to propose ideas and/or to bid to provide community services.

Below, we describe some of commissioners' obligations under the Regulations to help them consider how the Regulations may apply to their approach or intended approach. We focused on those obligations and issues that commissioners commonly had questions about in relation to community services.

7.2. Commissioners' obligations under the 'Procurement, Patient Choice and Competition Regulations'

Commissioners' objectives in buying healthcare services are to secure the needs of patients and improve the quality and efficiency of services.⁵⁶

When procuring services, the Regulations require commissioners to:

- act in a transparent, proportionate and non-discriminatory way (treating all providers equally)
- procure services from the providers that are most capable of securing the needs of patients and improving the quality and efficiency of care, while providing best value for money in doing so
- consider improving the quality and efficiency of services by enabling the services to be provided in a more integrated way, enabling providers to compete to provide services, or offering patients a choice of provider.⁵⁷

These obligations mean that when community services contracts expire, commissioners will need to assess patients' needs, consider how best to meet those needs while improving the quality and efficiency of services, and will need to satisfy themselves that their provider is the most capable of improving services and is offering the best value for money. These obligations must be carried out in a transparent, proportionate, and non-discriminatory way.

⁵⁶ Regulation 2.

⁵⁷ Regulation 3.

What does this mean in practice? Generally, rolling over contracts indefinitely without considering how services need to improve for patients or without considering which provider is best is not in patients' interests or consistent with the Regulations.

As community services contracts expire, commissioners will want to engage with providers, patients and other stakeholders to determine if and how services can be made to work better. Commissioners' current community services providers have an important role to play in providing information that will help commissioners to understand how current services need to change. They may also be well placed to propose how services can work better.

As well as engaging with current providers, to get the best possible result for patients, commissioners will need to be transparent about what they are doing and be open to other proposals. This might mean, for example, announcing their intention to redesign services on their website and inviting other providers and stakeholders to suggest ideas. These steps will help commissioners gather the information they need to get to the best decisions for patients and help commissioners to comply with the Regulations.

Commissioners also will need to consider which providers will be most likely to secure patients' needs and improve the quality and efficiency of services. Whatever process they adopt for selecting providers should be fair and open. A fair and open process for selecting a provider can help commissioners identify and compare the strengths of different providers and determine which are most likely to work best for patients. This does not necessarily mean putting contracts out to a full competitive tender, but in some cases a tender process may be the best option.

There are different ways to go about selecting providers. Some commissioners have started by running engagement events with all interested providers to understand their capabilities and conducting market research to improve their understanding of local circumstances. Others have decided to run a more formal competitive tender process. This might include a competitive dialogue process, in which bidders engage in a back and forth with commissioners to develop proposed solutions, or process in which bidders bid against pre-determined service specifications.

Whatever process commissioners choose, they should be able to show how and why they decided that a particular provider or providers is best for patients.

Commissioners should design their process to make the best use of their resources while maximising the potential benefit to patients. If, for example, it is best from a clinical perspective to deliver a particular set of services in a bundle with others, this could narrow the number of prospective providers that could deliver the services in that way. Engaging directly with this small number of providers might be the best use of resources to identify which of them is most capable.

Alternatively, if a large number of providers appear to be capable of providing services, using a bidding process might be the best use of resources to identify which provider will go furthest to improve services for patients and deliver value for money.

The process of redesigning services can also help inform commissioners' decision about how best to select a provider. By using a transparent process in which commissioners engage with providers and consider a range of options for improving services they may also gather useful information about which providers are most capable of making improvements. For example, through the process of engaging with a range of providers to redesign services, commissioners may identify which provider or providers are most capable of improving services. Or commissioners may determine that there are a number of potentially capable providers and they want to run a separate process to test which one is likely to offer the best services for patients. To avoid complaints of unfairness, commissioners should think from the outset about transparency – what information can be shared from the beginning to make all providers aware of what commissioners are doing and able to participate as appropriate?

7.3. How will Monitor approach complaints about commissioners rolling over community services contracts?

To ensure that commissioning of community services operates in the best interests of patients, Monitor oversees and, where appropriate, enforces the 'Procurement, Patient Choice and Competition Regulations'.

If Monitor receives a complaint that commissioners have rolled over community services contracts without considering the options and what is best for patients, we will first attempt to understand what steps commissioners took to make their decision. We will primarily be looking for commissioners to show that they have followed a sensible and thoughtful process to try to identify the best options to improve services for patients.

It may be that commissioners can show that they extended or renewed a contract as an interim measure because they are in the process of engaging with stakeholders to understand current community services provision and redesign services so that they work better for patients.

Where commissioners are in the middle of a review or redesign process, we will consider:

- whether the commissioners' process for redesigning services is transparent and open
- whether commissioners are taking active steps to move toward implementing improvements for patients

- whether the time taken to extend or renew the contract as an interim measure appears reasonable
- whether commissioners weighed the possible benefits or drawbacks of considering alternative commissioning approaches, including alternative providers, in the interim period against the possible benefits or drawbacks of waiting until services are redesigned. There is a balance to be struck between patients' interests and commissioners' resources in the short term – if commissioners are confident that redesigned services will be in place quickly, say in a year or less, there may not be much to be gained for patients in the interim so it may not be a good use of resources to run a process to consider other providers for that period. On the other hand, patients might benefit from a change of provider in the interim if commissioners are still a fair amount of time away from implementing redesigned services, especially if it is known that services are poor quality or if an alternative provider has expressed interest in providing services that may work better for patients.

7.4. Factors to consider related to contractual arrangements in which different providers come together to deliver care pathways

There is a trend for commissioners to seek arrangements in which different providers come together and agree to deliver a pathway of care or a range of services for a particular population. Every arrangement is different, but commissioners commonly refer to these as prime (or lead) or alliance provider contracts. Because so many commissioners said they hope to commission services including community services using prime or alliance contractual arrangements, we have set out below some factors for commissioners to consider.

The NHS Standard Contract and its supporting technical guidance encourage commissioners to use innovative contracting models, particularly to facilitate integrated care. The guidance encourages commissioners to think carefully about the potential advantages of non-traditional contracting models.

The 'Procurement, Patient Choice and Competition Regulations' support – and do not prevent – the use of models of care or contracting that would bring benefits to patients. The Regulations are meant to ensure that all of a commissioner's decisions and activities are likely to lead to good results for patients, including decisions about which models of care or contracting will best meet the needs of patients.

There are some factors commissioners should consider when thinking about developing prime or alliance provider arrangements, and these flow from patients' best interests as well as some of commissioners' obligations under the Regulations and patients' right to choose providers.

- Commissioners should always start with an assessment of patients' needs and develop the model of care and contracting around those needs. We've heard of

examples where commissioners appear to have chosen prime or alliance contracting arrangements before the work to review services and assess patient needs and potential improvements in the local area has been carried out.

- Commissioners will need to retain the ability to monitor the quality of care and value for money. Introducing a system where a prime provider subcontracts with other providers may have certain advantages (such as putting incentives on a prime provider to improve care integration or value for money), but commissioners need to ensure they still hold levers to improve care and hold providers accountable.
- When providers come together to deliver pathways of care that include services for which patients have a right to choice, commissioners will need to ensure that patients' right to choice is protected and promoted. Where a group of providers works together to provide good care and well-integrated services, patients may be more likely to choose services that are offered within that group; however, patients have many reasons for choosing different providers.
- Commissioners should consider how bringing providers together might affect their incentives to improve services in order to attract patients or win contracts. Competition, which can create incentives for providers to improve services, typically takes place between providers of the same or similar services. Integrated care typically involves the delivery of different services by professionals from different disciplines responsible for elements of a patient's care. Thus, in many circumstances, bringing providers together to deliver a pathway of care will have little or no effect on competition. Nonetheless, for each specific contractual arrangement, commissioners should think through what incentives exist or might be needed to ensure providers do their best for patients.

While prime/lead or alliance contract arrangements are intended to incentivise integrated care, commissioners will need to think carefully before deciding whether these arrangements are right for patients in their local areas.

8. Conclusion

Improving how community services work for patients is critical to making the NHS more effective and efficient. Commissioners have an important opportunity to commission community services in a way that will work better for patients. As community services contracts expire, commissioners will need to consider how to improve services. To make good decisions for patients, commissioners should engage with patients in a meaningful, effective way. Further, they will need to assess patients' needs, think through which models of care might work best for patients, and explore which providers are most likely to deliver the changes that commissioners want for patients.

Annex 1: Case studies

Luton CCG: using competitive dialogue to commission integrated care

In 2014, Luton CCG and its commissioning partners, Luton Borough Council and NHS England, used a competitive dialogue process to commission community services and mental health services.

Learning

Commissioners can:

- draw on information and feedback from providers and service users in a process to select providers to help them design improved service models
- use the process to select providers to test how different providers would deliver care that is more integrated with other services

What were commissioners trying to achieve for patients?

Luton CCG felt there was considerable scope for improvement in the delivery of community services and mental health services. Some patients were not fully satisfied with the services and public engagement showed a need to improve care pathways and patient outcomes. To improve patients' experience and reduce costly service duplications, commissioners wanted to achieve more integrated care with clinicians and staff working in more cohesive teams.

The CCG wanted community service staff to work alongside community mental health staff to ensure that people receive prompt support in the community without resorting to hospital care. Similarly, they wanted services to work better with primary care. The CCG found that a number of referrals to hospital care could have been prevented with an early intervention in the community.

What services were involved?

The original community services and mental health contracts expired in March 2013. The CCG extended the contracts for one year and then for an additional year to run their competitive dialogue process and mobilise the services. They divided the services into four lots and allowed bidders to bid for as many or as few lots as they wanted. The services involved were:

1. Community services (adult and children services)

2. Mental health
3. Children and adolescent mental health services (CAMHS)
4. Intermediate services.

What did commissioners do?

Beginning in 2013, the CCG hosted events to gather the views of patients and inform them of commissioners' plans. To try to engage patients as effectively as possible, they worked with Healthwatch and voluntary sector organisations, and set up various forms of public engagement throughout the process until October 2014.

The CCG also published an invitation for providers to express their interest and respond to four questions, including one about how the provider would unlock key local health and social care system opportunities. Based on the responses, the CCG then met one-to-one with 18 providers to discuss ideas. This engagement enabled them to identify several interested providers potentially capable of introducing innovation and increasing service quality.

The CCG said that through this exercise they became aware of examples of service innovation and best practice elsewhere. For example, they were introduced to information tools, or 'dashboards' that track quality, activity, performance and risks. This allowed them to consider how elements of these dashboards could be incorporated into future contract deliverables.

After engaging with the public and providers, commissioners felt they knew the outcomes they wanted for patients, but did not know the exact solution or exact costs. They therefore chose to run a competitive dialogue process to test a range of possible solutions with bidders rather than defining fixed service specifications and inviting providers to bid on those.

Different stages of the competitive dialogue process

The CCG's competitive dialogue process included three stages: a pre-qualification stage (PQQ), an invitation to participate in dialogue (ITPD), and an invitation to continue dialogue and submit a final tender (ITCD). Because the commissioners were keen to ensure that services would be delivered in a more integrated way, certain questions at each stage of the process focused on how providers would integrate care. For example, at the PQQ stage, they were looking to see if providers shared their vision of integrating services.

At the ITPD stage, qualified providers were involved in conversations and interviews aiming to test their thinking and how they would achieve the series of outcomes specified by the commissioners at the outset of the process. Bidders were invited to propose models of care and demonstrate how they would achieve integration for each pathway of care. This stage was intended to evaluate provider proposals only

from a clinical and commissioning point of view. At the end of this stage, four bidders were shortlisted to continue the dialogue.

At the ITCD stage, the CCG tested the estates, the finances, the IT solutions and mobilisation plans of each qualified provider. This involved gathering evidence of the bidders' practices and included representatives of the CCG, the local authority and Healthwatch visiting the bidders' sites to observe the quality of services and to interact with patients and staff. The CCG said the site visits were useful in rounding out its understanding of providers' services and capabilities.

Results of the process

Through the dialogue process, the CCG developed service specifications for the pathways of care, which are being finalised with the selected providers. They explored incentives for providers to improve and integrate care. They also specified its budget for the services during the selection process and that services would be paid for with a fixed-sum payment. The CCG believes the process will result in improved patient outcomes because the resulting services will have greater integration of multi-disciplinary teams and more outcomes-focused specifications. The approach for providers emphasises close working with primary care and making services more accessible in the community.

What were the challenges?

- The CCG underestimated the time required to obtain the level of detailed information from current providers to supply to bidders at the ITCD stage. The information required about estates and information technology was more complex than anticipated. This meant they needed to stretch the timetable to give bidders more time to use the information and construct their bids.
- Managing a shifting timeline was particularly challenging because of the need to rearrange competitive dialogue activities for everyone involved and to ensure the commissioning partners could engage their governance processes. However, this was mitigated because the steering group for the process included senior level members of the three commissioner bodies. Decision-making processes and timelines were agreed and aligned through that group.

What lessons did commissioners learn?

- Involving patients and carers from the start of the process was invaluable. Two service user groups, one for mental health and one for community services, were established, drawing on people from voluntary sector organisations, Healthwatch and those who attended a public launch meeting. The service user groups were able to influence the content and questions in the dialogue sessions, attend dialogues and compile questions for the

bidders. They also took part in and evaluated the final panel interviews. Healthwatch Luton colleagues worked with the CCG to prepare participants for the work required at each stage of the process. The groups have continued and will now work directly with the incoming preferred providers through the transition and mobilisation phases.

- Although the competitive dialogue process took a long time, it did allow the CCG to explore in detail the trade off between costs of services and desired patient outcomes. Splitting the services into four groups meant the commissioners were able to devote adequate time and attention to each group. They were also able to interact and test with providers how their proposed integrated care solutions would achieve better outcomes for patients and be financially sustainable. The process allowed GP clinical commissioners to engage with providers in the dialogue sessions and take part in the evaluation panels.

Cambridgeshire and Peterborough CCG: developing outcomes for older people

Cambridgeshire and Peterborough CCG commissioned services for older people and adult community services using patient outcomes to incentivise improvement. This case study looks at how they developed indicators to measure patient outcomes.

Learning

Commissioners can:

- take the first step toward new ways of commissioning for outcomes by drawing on providers, patients, clinicians and other experts to help them identify and test the outcomes they want for patients

What were commissioners trying to achieve for patients?

The CCG had identified improving older people's care as a strategic priority. The increasing number of older people, constrained finances and fragmented services led commissioners to believe they needed a radical new approach. They decided to commission older people's pathways and adult community services using patient outcome measures as the main driver of improvement. The aim was to improve health and wellbeing for patients and help them maintain their independence.

What services were involved?

The services included unplanned acute hospital care for older people, community health services for older people and adults, end-of-life care, older people's mental health services and related services. Taken together, these are described locally as Older People and Adult Community Services (OPACs). Commissioners decided not to include planned acute care for older people, certain specific adult community services (such as physiotherapy) and services mainly commissioned by the council (social care, occupational therapy, intermediate and re-ablement services) in the bundle of services.

The CCG decided to run a process to select a provider that would be responsible for organising and integrating care for older people along the pathway, including subcontracting with other providers to provide elements of patients' care. They chose a competitive dialogue process to identify the different ways this might be done and to identify the best provider.

What did commissioners do?

The CCG developed an outcomes framework, including outcomes indicators, through research and engagement with stakeholders. They tested and refined the framework through engagement with bidders during a competitive dialogue process. They then published three iterations of the outcomes framework, with the second version made part of a public consultation process.⁵⁸ The outcomes frameworks are available at: www.cambridgeshireandpeterboroughccg.nhs.uk/older-peoples-programme.htm

The CCG started by reviewing existing measures of patient experience, outcomes and other performance measures across the country, including:

- NHS Outcomes Framework 2013-2014
- Public Health Outcomes Framework 2013-2016
- Social Care Outcomes Framework 2013-2014
- CCG National Outcomes Frameworks 2013-2014
- national datasets for specific populations or specific diseases
- local commissioning health datasets including Secondary Uses Service data

⁵⁸ The outcomes framework is available at www.cambridgeshireandpeterboroughccg.nhs.uk/older-peoples-programme.htm

- measures of patient experience including national reports (eg the National Voices 'Principles of integrated care') and patient-reported outcome measurement tools (Euro-Qual 5Q and SF-36).

The review formed the basis for the first draft of the outcomes framework. The CCG then tested this framework with patient representatives, the voluntary sector, social care and council colleagues, and GPs.

A revised version of the framework, based on this feedback, was used in the second phase of the competitive dialogue process. Through dialogue with bidders, the CCG further refined the outcomes framework. The dialogue enabled bidders to comment on the approach, including the validity and relevance of the indicators and the practicalities and resources associated with collecting data for the indicators.

External national experts and organisations also contributed to the outcomes framework.

The final outcomes framework is structured under seven overarching themes, which are called domains:

- ensure people have an excellent and equitable experience of care and support with care organised around the patients
- treat and care for people in a safe environment and protect them from avoidable harm
- develop an organisational culture of joined-up working, patient-centred care, empowering staff and effective information-sharing
- support older people and individuals with long-term conditions through early interventions and evidence-based care to maintain their health, wellbeing and independence
- support older people and those with a long-term condition with an acute deterioration in health or inability to cope at home, to reduce avoidable admissions and prevent unnecessary hospital stays
- promote recovery, rehabilitation and sustainability of health and functional status after a period of health or injury, with supported discharge and reduced readmissions
- optimise the experience of care of people approaching the end of their lives (and their carers) in all settings and at all times of the day and night.

A number of outcomes sit under each domain. Within each outcome, there are specific indicators. These are a mix focused both on patients' health and wellbeing and on care processes, for example, the extent to which patients are receiving

certain elements of high quality care (such as care plans, screening, assessments or appropriate waiting times).

Some indicators measure how well staff and organisations are working together. For example, one indicator is whether staff report that they collaborate with each other and can share information easily.

Cambridgeshire and Peterborough CCG has concluded its process and selected a lead provider. Some additional outcome indicators won't be decided until after one year into the contract to give the CCG time to see how the service is running first.

The contract is based on a capitated budget (adjusted annually for population change). The CCG believes this payment mechanism will enable the lead provider to shift resources across the pathway, including to work on prevention.

A new payment system links a percentage of the contract value to achievement of outcomes. Each outcomes framework domain, outcome and indicator has a number of points attached to it, and each point is worth a set amount of funding.

What were the challenges?

- One challenge was to craft indicators that were robust and relevant to the objectives for patients and were also intrinsically valid, meaning they measured what they claimed to measure. The indicators also needed to be feasible in terms of time, technology, cost and resources for providers to implement and manage.
- The CCG also wanted to ensure that the outcomes framework would place equal importance on mental health and physical health.

What lessons did commissioners learn?

To develop the outcomes framework, the CCG found it helpful to:

- engage extensively with stakeholders (the public, the bidders, local GPs, current community services provider staff, etc), which made the outcomes more relevant for patients and more workable for providers
- receive support from external clinical and academic experts, which increased the CCG's ability to build the appropriate measures for the outcomes framework.

In the future, the CCG will:

- regularly review the outcomes framework as they gain experience of which measures work well and which ones work less well

- share best practice with other commissioners as this will make it easier for others to develop outcomes frameworks.

Oldham CCG: involving patients in selecting community services providers

Oldham CCG used a new way of involving patients in its process to select community services providers.

Learning

- Commissioners can empower service users and get better results by thinking of creative ways to involve patients in the process to select providers.

What were commissioners trying to achieve for patients?

Oldham CCG's main goals for improving community services were to:

- provide planned, timely care for people with long-term conditions
- reduce duplication of services and the need for patients to repeat their story by joining up care
- ensure care is responsive to local needs
- provide personal, tailored care whenever possible
- improve continuity of care.

Working with local stakeholders to redesign services, the CCG decided they wanted to create eight locality teams to deliver co-ordinated care and four care planning teams, each to oversee two locality teams. Accountable to GPs, the locality teams would feature staff from different providers, such as practice nurses, district nurses, community matrons, consultants and specialists, working together to plan and co-ordinate care for people with long-term conditions.

As the CCG's community services contract was coming to an end, they decided to use a competitive tender process to select a provider or providers. The CCG wanted to make sure that the process of selecting a provider took into account the perspective of people who had experienced community services.

What services were involved?

The CCG was seeking a provider or providers for a wide range of community services, including integrated nursing teams, therapy, specialist nursing, continence,

and end-of-life care. They divided the services into six lots, with the largest lot including core community services and the others including specialist areas such as stoma, continence and respiratory services. The providers could bid for as few or as many lots as they wanted.

What did commissioners do?

The CCG decided to delegate responsibility for scoring the portion of the bids relating to patient experience entirely to service users. In the past, service users had scored parts of proposals along with clinical or other bid evaluators but this was the first time service users had full responsibility for scoring patient experience. The scores on this portion of the bids represented 12.5% of the total bid scores.

Through past work with patients and patient groups, and an announcement on Twitter, the CCG was able to recruit several people who had used community services in the past or experienced those services through loved ones. They included someone involved in a local carers activist group, a retired nurse, someone with multiple long-term conditions, and someone involved in his GP patient participation group. A core group of service users evaluated bids for all lots of services, and each separate lot had additional service users that joined for only those lots.

As a first step, the CCG gave the service users guidance on the process, copies of the bid submissions and the scoring criteria for the patient experience portion of the tender. The scoring criteria were developed from the NHS Patient Experience Framework.⁵⁹ The CCG asked each service user individually to score the bids, and then brought the service users together to consider the answers and form a group score. A representative of the CCG moderated the process.

After this step, each bidder gave a 20-minute presentation to the service users and answered questions. Service users pressed the bidders on questions such as 'how will you ensure that staff treats all patients with respect?'

What were the challenges?

One challenge in involving service users was to design a role for them that would draw on their experiences with current services and allow them to test how likely each bidder would be to provide a positive experience for patients. The CCG had to ensure that the process was fair and thorough, but also not too complex or time-consuming for service users.

⁵⁹ See

www.gov.uk/government/uploads/system/uploads/attachment_data/file/215159/dh_132788.pdf.

What lessons did commissioners learn?

Initially, the patient experience portion of the process included ten questions for bidders. However, it became clear that looking at ten questions for six lots of services would require more time from service users than might be necessary to get a good understanding of patient experience. In subsequent tenders, the CCG has narrowed this number down to six key questions.

The CCG estimates that services users devoted a total of nearly three days to the process. They emphasise the importance of respecting the commitment required of service users, who were not being paid for their time.

The CCG believes the bidders benefited from the service users' participation because service users are best placed to understand a good or bad patient experience.

Overall, the CCG believes that the patients' perspective and participation was highly valuable for the selection process. Ultimately, patients will benefit from the interaction between service users and providers during the process, as the selected provider was able to learn more about the perspective of people who used community services.

Camden CCG: integrating health and social care for families with complex needs

Camden CCG is working in partnership with local government to co-ordinate services and to improve support for families with multiple problems.

Learning

- Commissioners can potentially better meet the needs of certain families by building on a national programme to create integrated care models that take into account the full range of a family's social and healthcare needs

What are commissioners trying to achieve for patients?

In the London Borough of Camden, the local Health and Wellbeing Board identified the health and wellbeing of children and families as a priority. Camden CCG and Camden Council aimed for services to work more cohesively for children and families across health and social care.

Camden decided to build on the national Troubled Families programme, as well as its existing good examples of different agencies working together, to test a new

approach with a small number of families. They wanted to use learning from this group of families to re-shape services to meet various needs in Camden.

What services are involved?

- social care, including family support workers, children's and adult social care
- public health
- healthcare, including physical and mental health services for adults and children
- police
- educational psychology and school inclusion
- domestic and sexual abuse specialist worker
- Jobcentre Plus
- Housing and Community Safety
- Families in Focus
- youth offending
- probation.

What are commissioners doing?

Camden CCG is a member of the Camden Children's Trust Partnership Board which also includes representatives of Camden Council, Metropolitan Police, schools and the third sector. Members work together to improve support for families. As part of the plan to improve support for children and families, Camden is linking health services into the local authority's Troubled Families team. Building on the national Troubled Families programme, they are testing ways of providing support across health and social care to families with complex needs.

The national Troubled Families programme

In April 2012, the Government launched the Troubled Families programme, a £448 million scheme to incentivise local authorities and their partners to turn around the lives of 120,000 families by May 2015. The current programme works with families in which children are not attending school, young people are committing crime or are involved in antisocial behaviour and adults are out of work.

All 152 upper-tier councils in England have a Troubled Families co-ordinator, who is a strategic lead for delivering the programme locally. Local governments have built Troubled Families teams with members of various agencies and organisations,

including police, schools and, in some cases, the NHS. The teams take an integrated, whole family approach.

The government plans to expand the Troubled Families Programme for a further five years from 2015/16 and to reach up to an additional 400,000 families across England. The expanded programme will reach families with a broader range of problems, including those affected by domestic violence and abuse, with children who need help, where crime and antisocial behaviour problems may become intergenerational, and with a range of mental and physical health problems.

According to research published by the national Troubled Families team, health problems of families in the current programme are costly and pervasive. They have disproportionately high levels of health problems compared to the general population.

In response, Public Health England, the Department of Health, NHS England, the Department for Communities and Local Government and the Local Government Association jointly published the Troubled Families 'Health offer' in November 2014 to support the involvement of local health leaders and professionals in the programme. This is the start of a wider drive to improve health outcomes for troubled families and improve the integration of health, social care and family intervention services.

Camden's initiative for families with complex needs

Camden has built on the Troubled Families programme to develop its own initiative for families with complex needs. The Camden initiative, led by Lisa Clarke, who is lead for Camden's Troubled Families programme, expanded the remit of the original programme to test an integrated approach with a group of families. Camden will use learning from its initiative to inform working together across health and social care. Supported by the Health and Wellbeing Board, Dr Deepak Hora, a GP, leads Camden CCG's involvement in the initiative for families with complex needs. In addition to Dr Hora, other health professionals on the team include the clinical director of Child and Adolescent Mental Health Services (CAMHS), a consultant-grade CAMHS psychotherapist and an adult mental health clinical psychologist.

Camden's initiative aims to take a whole family approach and encourage care workers to use analytical, reflective practice to understand each family's needs and priorities. Each family has a primary worker or workers who have a team supporting them and providing specialist input or expertise. The role of the primary worker is to provide direct support for the family and to help co-ordinate services and agencies whose input would be beneficial. The families' needs and priorities are identified and services are tailored around those needs and priorities.

An important role for the primary worker is to build a relationship and gain the trust of families. Often these families have been involved with services for many years and

find it hard to trust professionals. The primary worker will help families through a range of issues and try to foster their resilience. Once family members have begun to resolve some of the pressing issues affecting them, they feel more confident requesting help with physical and mental health problems that they previously were not motivated to address or for which they were afraid to seek help. Dr Hora said it is important to understand the family story from the perspective of family members and to use a reflective analytical approach. This approach allows the care team to consider why a family may have certain problems or why previous interventions may not have worked.

Working alongside these families, some common themes emerged, including physical and mental health, domestic abuse, and employment. The Camden team developed work streams to focus on these areas. The team has worked in each area to improve support and remove barriers for families requiring help.

Physical health: Dr Hora is currently visiting a sample of families within the cohort of families with complex needs to try to understand their health needs better and identify any barriers they may face in accessing healthcare. As well as assessing lifestyle and health needs, Dr Hora is able to provide some direct support and health education to families to aid better management of chronic health conditions. Dr Hora will liaise with the family's GP if appropriate.

Dr Hora also supports families indirectly by training members of the team in delivering lifestyle interventions. For example, working with public health professionals, the team recently received training to deliver behaviour change and weight management advice. Local weight management referral services support this work by facilitating any onward referrals to more specialised support. The team also has linked in to local alcohol and smoking cessation services to provide more lifestyle intervention and improve the health of the families.

Mental health: The clinical director for CAMHS provides direct support for families or works with primary workers to provide indirect support. The team also have adult mental health practitioners who can work directly with these families. This has been extremely useful as adults with mental health needs often find it difficult to access support either due to long waiting times or because of not meeting the threshold required to receive a particular service. Families now have access to mental health professionals within the team and they provide support at a pace and time suitable for each family.

Domestic abuse: Camden CCG have commissioned a service based on the Identification and Referral to Improve Safety (IRIS) model. Dr Hora is the CCG clinical lead for this project and alongside a domestic violence educator has been involved in training Camden GP practices, both clinical and non clinical staff, to recognise signs of domestic abuse for both victims and perpetrators. GPs and staff are trained to ask questions and respond to the answers confidently and domestic

violence advocates support and advocate for victims identified within the primary care surgery setting. Nearly all GP practices in Camden have received training. Since Camden CCG launched the IRIS project, the number of referrals to domestic violence services has increased exponentially, from three referrals from GPs in the year before the project launch to more than 100 referrals from GPs since the project started in March 2014.

Employment: Another area of focus for the team is employment. The team includes a Jobcentre Plus worker who has worked with a number of families and provided support with 'stepping stones' towards employment and training. Having a Jobcentre Plus worker on the team is part of the approach to holistic assessment of family members' needs and to responding in a joined-up manner to their wider needs.

What are the challenges?

The national Troubled Families team has identified a number of challenges to integrating health and social care services for troubled families. For example, although there is strong evidence that the current Troubled Families programme is working with significant numbers of families with a range of health problems, many areas have struggled to prioritise families on the basis of their health needs because data sharing has been a major barrier in identifying such families.

To meet this challenge, the Department of Health, Public Health England, NHS England and the Department for Communities and Local Government have published a joint 'Troubled Families health offer'. This includes:

- a leadership statement aimed at local government and public health leaders calling on them to work together to provide tailored support to these families
- a training offer, including information on health issues and advice on training opportunities to help Troubled Families teams identify and support families' health needs
- interim guidance on sharing health information to enable health professionals to identify families eligible for the programme without sharing identifiable or confidential information, developed by the Department of Health and Public Health England.⁶⁰

⁶⁰ The Department of Health, the Department of Communities and Local Government, and Public Health England. (2014) *Interim guidance for troubled families programme early starter areas*. [Online] Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/370960/data_sharing_guidance.pdf.

What are the lessons learned?

- Camden CCG said it is important to allow the team for families with complex needs to operate flexibly and provide bespoke interventions according to each family's needs. The family's primary worker and the team use the psychological expertise within the team and regularly reflect on a family's symptoms and needs and formulate the next steps needed. The team has received training in a variety of tools and techniques to support its approach.
- Strategic support from all the stakeholders including the Health and Wellbeing Board and the CCG was important. This enabled the initiative to build on existing work in Camden to test the approach with a small group of families to inform broader changes.

The national Troubled Families programme is undergoing an independent evaluation that runs until autumn 2015. The evaluation will look at outcomes for families and cost savings.⁶¹

⁶¹ An interim report on the evaluation is available at:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/335261/National_Evaluation_of_report_web_copy-ecorys.pdf.



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