Cambridgeshire Community Services NHS
NHS Trust

STAFF BRIEFING: ADULTS & OLDER PEOPLE'S PROCUREMENT

13 May 2014 at Doddington Hospital
Attended by 17 CCS staff

Q&A

Resources

Q: You talk about local specialists and 24/7 care. How can this be delivered with the same level of resources?

A: It will be difficult to achieve, but this is an opportunity to move resources from acute into the community.

Q: There is a major need to invest in x-ray services to replace old equipment, renew licenses and ensure that computer systems are compatible. The new provider needs to know this.

A: Lets have a separate conversation outside the meeting about the details, but as a general rule we will ensure the cost implications are built into the specification.

Q: How will services be run with current resources? Won't there be cuts?

A: We share your concerns. Providers must deliver quality services against the outcomes in the contract. The relationship we have with them must be right to ensure that different parts of the system works together effectively.

Integrated working with social care (and others)

Q: Social care has changed since it transferred to Cambridgeshire County Council. An integrated approach is required, but the focus is now on the over 75s, rather than over 65s.

A: The Council sits on the Older People Programme Board to ensure joint working, and has worked closely with the CCG throughout the procurement process (as have Peterborough City Council and District Councils).

Q: Did the Council consult with you on these changes?

A: We're keen to work with the local authority and they will be part of the bid evaluation. We're committed to working with them to change how social care works, but there is some way to go..

Q: The Council commissions care homes. How we work with these is important.

A: The bids have to say how providers will work with local partners to improve care, and bidders clearly recognise the importance of supporting care homes.

Q: We have a pooled OT budget and we work in an integrated way with other services like assistive technology, falls prevention and speech and language therapy.

A: We recognise that OT works in an integrated way and that there is no advantage to changing this, so we need to look at how integration continues and develops.

Timeframes

Q: Are the timeframes realistic? We need to start giving notice to contractors.

A: We have set up a transition steering group to ensure to the process is properly managed and that notice is given as appropriate.

Age groups/services included in the specification

Q: You talk mainly about the over 65s. What about the under 65s?

A: The main focus is on the over 65 population, but the procurement covers adult community services as well, recognising that these deliver care to adults, older people (and in some cases children).

Q: Where does adult safeguarding sit within your quality measures?

A: Under the safety heading, but we will ensure this is explicitly included.

Evaluation

Q: You talk a lot about admission avoidance, but there hasn't been a definition agreed, so how will this be measured?

A: Having a single definition is difficult. It is subjective and is something we've been trying to resolve for a number of years. That is why we're focusing on emergency bed days which is a much better measure of how the whole system is working not just to avoid admissions but also to reduce length of stay and readmissions where it is safe to do so, .

STAFF BRIEFING: ADULTS & OLDER PEOPLE'S PROCUREMENT

14 May 2014 at Peterborough
Attended by 7 CCS staff

Q&A

- **Concern that the organisation that takes over can afford the services in the future, how that this been checked.**
  We have been through due diligence to ensure that this is affordable.

- **Have the shortlisted bidders got the skills and expertise to run these services. This will mean a change in culture e.g. self care. When is it not a health-care issue anymore, patients need realistic expectations as to what we deliver and do not deliver.**
  We will ensure that this is more prominent in future presentations.

- **Podiatry – parts of the service run jointly with MSK, concerns over them being fragmented, how can you ensure that this will not happen?**
  The ideology is not to fragment services, but we need to be mindful of this. The older people's board are aware of it. Bidders need to be aware of what is working well and continue to deliver services.

- **Are bidders talking to hospitals, about reducing long stays and incentives/engagement.**
  We are talking at Chief Executive level and acknowledge engagement with bidders.

- **A lot of the services are aimed at over 65, what will happen to the under 65s – will there be two services?**
  We are not looking to have two services, some services are predominantly over 65s but we would commission all ages (including children in some services) . These services are for Adults and Older People, not just Older People. We will however, check this through.

- **24 hour care, will services be wrapped around groups, ie via centres or on-call for some services. How will this affect us? Community Rehab have tried in the past to do 24/7 but resources are short.**
  We are looking at the public response, do they want 24 hour access or would they be happy with say 24 phone support – we will take into consideration what the public want.

- **We haven't been asked by any of the bidders about our services, how do they know about our services, what we do etc?**
  We are working with the transitions working group to ensure that everything is carefully monitored. Part of the transition is around ensuring that services will work. There will be 5 year contracts and it will need to be a process of evaluation. The CCG will need to support as well as contract management.

- **Patient question: A patient used to have support from a day service (council run), this has been withdrawn. She is concerned about who is going to help me now**
  The CCG are working with the council re a Better Care Fund which will allocate£ 47 million to the councils in 2015/16. We will work closely with the councils to ensure that they do deliver these services.

- **Corporate staff – what about us?**
  Are we covered, being factored into the TUPE arrangements.

This is being covered at the Transitions Group fortnightly meetings. This is currently being mapped out, and we have a preliminary list of corporate staff that this will affect.

STAFF BRIEFING: ADULTS & OLDER PEOPLE'S PROCUREMENT

20 May 2014 at the Professional Development Centre, Cambridge
Attended by 10 CCS staff

Q&A

- **OTs in the Stroke service have worked hard towards integration, over the last 10 years so now, 'you can't see the join'. However, the impression from the County Council is disintegration.**

It has been agreed with the council that where services are integrated that clarity is needed but the intention isn't to rip apart what has already been done. It could be that the team is brought into the council or the preferred bidder.

- **Is early supported discharge being considered in procurement submissions?**

There has been no micro specification of the services on offer but it is one element that the bidders will need to put together under the outcomes specified in the contract. The intention for this service as a whole is to continue to work towards reduced emergency bed days (including reduced length of stay in hospital)_where it's safe to do so .

- **How will the CCG ensure that the winning bid hasn't got a profit driven goal (e.g could they cut jobs to boost money)?**

All bidders would be bound by the same outcomes and financial envelope should they win the contract. There will be a clause in the contract about excessive profit. There is a joint -working group attended by CCG and CCS staff to think about each scenario – what would be the impact on staff should bidder x win the contract? TUPE applies to staff who work for affected services. The new bidder can make changes to terms and conditions once the transfer is complete, but the CCG should be made of aware of intentions in advance.

- **What if the chosen provider fails to meet the specified outcomes?**

This is a new way of looking at how these services are provided. If the provider fails to meet specified outcomes then they will need to remedy the situation, or lose money under the Payment By Outcomes approach. Ultimately, the CCG could terminate the contract for poor performance.

- **What about NHS pensions?**

New legislation, 'the fair deal', allows other non NHS providers to buy into the NHS pension scheme.. This is one of the questions for the dialogue sessions, so a more definitive answer will be available then.

- **The elephant in the room – why isn't CCS on the shortlisted bidders list?**

There was a rigid marking process and unfortunately when the scores were added up, the consortium in which CCS was participating were not shortlisted. .

- **Is the system going to be structured that removes freedom to treat younger patients with complex needs as by intervening early it saves cost and heartache later in life?**

On day one of the new contract, patients shouldn't notice any difference. The outcomes do have an emphasis on the elderly but the same features will apply to conditions affecting younger people. The CCG is looking into how to address the risks of very specialist patients, as although it may only be a small number of patients, they shouldn't be pushed aside.

- **Is there any stipulation in the contract that the new bidder will be on or will be steered towards systmone?**

The CCG will ensure that Systmone will stay in place for the first two to three years of the contract, which will coincide with the national review. If after that time the successful bidder can fly the flag for a new system, it will be considered.

- **Specific example – current referral for orthotics (braces or soft splints that help correct and support the function of limbs) is slow and cumbersome, with the referral going from the specialist team, to the GP then to Addenbrookes – is there a simpler way?**

STAFF BRIEFING: ADULTS & OLDER PEOPLE'S PROCUREMENT

21 May 2014 at Hinchingbrooke Hospital
Attended by 8 CCS staff

Q&A

- **Will the results of the CQC inspection taking place next week have any impact on this?**

If the CQC inspection of CCS is positive, then bidders can be reassured about the quality of the services they will be taking in, if the results are not positive, then the bidders will need to take this into account when looking at how they approach running services.

Should any of the bidders receive a CQC inspection during this procurement process, the results of that will feed into the assessment of their bids.

- **Do you look at what the bidders have done elsewhere,?**

We do as part of the Pre Qualification process. However, none of the bidders currently provide everything that this procurement covers: this is a new approach designed to integrate services across traditional boundaries.,

- **Has anything like this been done elsewhere?**

Internationally, providing services through this lead provider model has provided encouraging evidence. In England, this sort of work has been done on a smaller scale, for example looking at MSK services. We've done a lot of work on this model and other CCGs are very interested in this work.

- **Using lead providers hasn't worked in social services**

We're working closely with the county council during this process. The key is the outcomes framework, if we get it right then the correct objectives will be aligned.

There have been some questions about small specialist services and we will ensure they are protected in this model. We recognise that some teams are already well integrated and we don't want to force them apart.

- **Independent sector bidders will want to make a profit. Will money be sifted out of the services?**

Yes, they will want to make a return, but any profit will be based on the outcomes framework, which includes staff issues. If they hit outcomes and manage to make a profit, then it's a win-win situation.

Under an old-style contract you could imagine them trying to minimise costs – but this isn't that style of contract, they need to meet the outcomes, if they don't then they won't profit.

- **Workforce development and training are all added costs.**

There's a lot in the outcomes framework about staff and culture. If they don't invest in staff then they will not meet the outcomes framework and will lose money.

This contract will be for 5-7 years and part of the evaluation is on how credible their journey of change will be. All the bidders have talked a lot about training and the need to invest in it.

- **I lead a small county-wide service; we need to be together for clinical governance, for example. We don't have enough staff as it is.**

There is an issue about smaller services. The outcomes framework is about percentages and there could be a risk that smaller services could be disinvested to focus on the larger ones – we want to make sure that doesn't happen and we are working to ensure it doesn't happen.

Most bidders are looking at how they can shrink hospital activity, for example through early supported discharge for stroke patients. They are being incentivised to find community solutions.

- **Patients are already being discharged with not enough service in the community to get them the rehab they require.**

We need to think innovatively as we've never found a way of unlocking this problem on the current path.

- **How easy can it be to join things up when GPs are not a part of this model?**

In a perfect world, primary care would be included in this. The lead provider will be able to commission services from primary care,5-7 years is a long time and the contract will evolve. We still think we can effectively integrate services.

- **Who will we be working for? If we are TUPEd how long will we have protection for?**

We've been clear that we want the lead provider to directly employ the community staff in order to have direct oversight of the community function.

You would TUPE, but they would not be able to change your conditions without valid reasons. We're looking at if we can negotiate a period of protection.

. Private organisations can now provide NHS pensions; the landscape is much kinder for staff now. All the bids include robust workforce plans and they know what they will be doing.

- **So I won't be working for the NHS?**

It depends which bidder wins the contract: three out of the four contain NHS organisations. . It will be an NHS service provided free at the point of need to patients.

- **We all felt we would stay in the NHS, I don't think staff realise this is what will happen. I think people think it will be like Hinchingbrooke, where the staff stayed employed by the NHS, I want to work for the NHS.**

We've been meeting with unions throughout and the bidders will be meeting with unions soon. We've made all the bidders aware of staff concerns.

We also have the CCS transition steering group and these concerns will be taken back to them.

- **Will we be getting a rapid response team here?**

All four bids have identified that they need to take money out of the hospitals and all have suggested plans that identify patients at risk of admission and how they can be managed in the community.

- **Will reablement money be going to the provider? What will the county council do?**

The county council has said it will wait until the preferred bidder is announced before they decide how to approach that.

- **Could there be more than one winner, with the lots split?**

That is technically a possible result;

- **Could we have lead clinicians for patients who have complex problems, to help them through the system?**

All four bids have suggested exactly that.