Public Health Integrated Commissioning Market Engagement Event 5 | Collaboration

12 September 2023

ROYAL borough of GREENWICH

Market Engagement Event 5 | Collaboration

Topic		Lead(s)	Timing
1	Welcome and introductions, purpose of today	David Pinson	10.00am
2	Review our ambitions • Finalise our ways of working together	Charlotte Parkes	10.10am (35 mins exercise 5 mins feedback)
Break/networking			10.50am
3	• Our outcomes, how do we demonstrate and measure quality • Exploring how we can best understand what 'good' quality looks like for achieving our outcomes	David Pinson	11.05am (35 mins exercise 5 mins feedback)
4	The practicalities of working closer together • Group discussion: describing the characteristics of what contracting approaches are required to deliver our outcomes and what is needed from commissioners	Sarah Reardon	11.45am (35 mins exercise 5 mins feedback)
6	Next steps	Charlotte Parkes	12.25pm
7	Networking		12.30pm

Today

PURPOSE OF THIS SESSION

- Opportunity to keep building and **strengthening relationships**.
- Reflecting on feedback and agreeing our **core ambitions** for working together.
- Working through how we demonstrate **quality.**
- Exploring potential ways that we can **work together** to best deliver our outcomes framework.

THE WAY WE'D LIKE TO WORK TOGETHER

- Today our focus is on sharing our ambition and putting **residents at the heart** of how we work. Let's keep residents at the centre of all our thinking and conversations.
- We welcome **your views and challenge,** so please share your **honest reflections** with us and each other.
- This is **not part of the tender process** for future services. We will capture the key points from the session to inform our future approach and relevant information will be shared in future engagement sessions.

Today | Collaboration

This is the fourth of six market engagement events. So far, we have focused on our vision and ambitions and have begun to work together to design our new ways of working, delivering holistic services that are based around people not buildings or services, that are outcome focused. Today we focus on how we can best collaborate.

DP

Agreeing our core ambitions

Introduction

- Over the last few sessions, we have been developing together **our core ambitions** on how we work together to deliver services.
- We are now at a stage where we would like to reflect on what we have designed to date, with the aim of us gaining a **consensus** on the ways we will work together in the future.

What providers think 'good' looks like for residents

Our goal is to see a happy, healthy Greenwich, with health and wellbeing outcomes improved across the borough

Accessibility is key. It's vital that residents get the right support at the right time in the right place

Access and join-up could be supported through community wellbeing hubs, or better touchpoints in community spaces such as schools and clinics. These must be made visible to residents so that they know exactly where to get support

There should be a **smoother resident journey** with join-up of pathways. Waiting lists must be reduced, and some service users should be offered intermediate support whilst on a waiting list

Services should be **shaped by the community** and able to **adapt** to changing needs. This requires greater flexibility in contracts that are more outcomes-focused, with **less rigid KPIs**

More **sharing of data** is needed across the system, including data from providers, the local authority, and PCNs. This will help providers to adapt to changing need

Providers require more opportunities to network in order to **share expertise and learning.** Increased and improved communication will also support the **sharing of risk**

Ambitions overview: our ways of working together

The blueprint of how PH providers and commissioners in Greenwich will work together.

1 — Joint vision and outcomes

A culture of joint working, all singing from the same hymn sheet

2 — Flexibility to adapt to change in need

Utilise population health data and flexible contracts to adapt to resident need

3 — Collaboration and strong communication

Shared oversight, understanding how we communicate

4 — Awareness of our strengths and limits

Each provider knows their strengths, limitations and promotes a learning culture

5 — A human, person-centred approach

Residents at the heart of everything we do backed up by meaningful engagement

6 — Robust infrastructure that unlocks innovation

To support a 'can-do' approach

7 — A culture of shared, positive risk-taking

Organisations and the system flexing to meet the need and share risk, positive risk taking

8 — A highly skilled and motivated workforce

A motivated workforce open to adapt to meet the needs of residents

Ambitions in detail 1 & 2

1 Joint vision and outcomes

- We will create a culture of joint working, all singing from the same hymn sheet.
- Collaboration beyond boundaries is important to us providers will be able to work across contracts. There will be broader collaboration in all services.
- Together we will take a systematic overview, there will be a broader perspective in commissioning and providing services, one that understands health inequalities, navigates the challenges of stigmas and bureaucratic constraints.
- Tailored local services will be our ambition, with everyone understanding place-based challenges and solutions.
- Providers and commissioners will develop stronger inter-relationships, integrated service entry points, and a shift from purely KPI-driven models to more holistic outcome-focused ones.
- Service design will put residents first and will be inherently user-centric, focusing on resident goals and needs, and removing barriers to accessibility.

2 Flexibility to adapt to change in need

- We will utilise population health data and flexible contracts to adapt to resident need.
- Data-led services will be the norm, utilising analysed data to home in on populations that require services the most.
- Providers will have compatible systems to streamline data flow.
- We will ensure data gets transferred between both old and new providers.
- All providers will agree to share data at the end of their contracts.
- Services will be adaptable to fit the diverse cultural fabric of the communities they serve.
- We will design service pathways together with commissioners and we will also oversee the marketing of available services, ensuring residents are aware and can access them.
- We will develop a deeper understanding of conditions, further enhancing the design and delivery of services.
- Service contracts will enable adaptability and be oriented towards emerging needs.
- Providers and commissioners will be aware of and adaptive to government plans and will use flexible contracts with adaptable KPIs.

Ambitions in detail 3 & 4

3 Collaboration and strong communication

- There will be shared oversight and a clear understanding of how we communicate with one another.
- Open lines of communication will be encouraged.
- There will be transparent communication with relevant stakeholders.
- Openness, clarity, and regular communication between parties will be facilitated and encouraged by commissioners.
- There will be an emphasis on building trust through consistent data sharing and effective collaboration.
- Transparency in data sharing and adaptability strategies is paramount. We will implement data-sharing agreements to set standards.
- Robust data analysis and its dissemination to professionals beyond data experts, ensuring effective identification of unmet needs is a necessity.
- Trust will be built through consistent data sharing and effective collaboration.
- Greater collaborative efforts among providers with similar services, maximising the collective expertise will be encouraged.
- The importance of actively seeking community feedback and iterating services based on this feedback is a shared priority.
- We will encourage and prioritise projects that necessitate collaboration, ensuring that teamwork isn't just a stated goal but a practical reality.

4 Awareness of our strengths and limits

- Each provider knows their strengths, limitations and creates a learning culture.
- Regular touch-point co-ordination meetings will be scheduled to ensure alignment in goals, expectations, and deliverables.
- A two-way feedback system will be established where both providers and partners can voice concerns, share insights, and suggest improvements.
- Commissioners will facilitate joint work, emphasising networking and skill sharing.
- Contracts will be outcomes based and structured to incentivise innovation among providers, with potential funding set aside for innovation.
- Considerations around financial constraints, especially pertaining to NHS's non-roll-over budget system, is crucial.

Ambitions in detail 5 & 6

5 A human, person-centred approach, resident engagement and co-production

- We will act as if we are providing a service to a loved one.
- We will consider whether a comprehensive, one-stop shop is essential, reducing the redundancy in sharing resident information and ensuring local services are connected and seamless.
- Providers and commissioners will work together to understand resident journeys in depth and will establish deeper trust with residents.
- A deep understanding of one's community and effective use of local networks, including faith and community leaders, is seen as pivotal to service co-creation.
- Listening to resident's needs will be central to what services we design and deliver.
- We will establish definitive pathways for residents navigating public health services.

6 Robust infrastructure that unlocks innovation

- Our structures will support and encourage a 'can-do' approach.
- We will develop and implement digital platforms that:
  - allow seamless communication, planning, and project tracking between commissioned services and partners.
  - enable providers and commissioners to pool their best practices for communal benefit and access essential information.
- We will encourage different ways of working to ensure multi-disciplinary co-operation and dynamic skill sharing among providers.
- We will develop a user-friendly, streamlined and efficient digital interface where all including residents can search for and be directed to relevant information and services.
- Shared physical spaces are envisioned, enabling residents to access services from different providers in a single location.
- Program sustainability is paramount and will be prioritised.
- Achievable reporting and KPIs, the benchmarks set will be realistic, placing residents front and centre with room for manoeuvrability as community needs shift.
- Services will be allowed to be flexible, there will be allowances for adaptability where necessary.

Ambition in detail 7 & 8

7 A culture of shared, positive risk-taking

- Recognising this a now way of working, contracts will be longer to ensure consistency of the provision of outcomes.
- Positive risk taking will be encouraged, organisations and the system will flex to meet the need and share.
- Providers will be entrusted with centralising pertinent information. Removing bureaucratic hurdles (red tape) that hamper information sharing will be prioritised.
- Commissioners will facilitate discussions around data sharing, ensuring alignment between providers.
- Commissioners will work collaboratively with providers to maintain standards. Considering accreditation based on quality levels and ensuring appropriate evidence sharing will be essential.
- Both providers and commissioners are expected to be open, clear, and communicative, ensuring that governance structures are supportive and not restrictive in the new commissioning model.

8 A highly skilled and motivated workforce

- Residents are at the heart of our decision making and service design.
- A highly skilled, motivated workforce will be open to adapt to meet the needs of residents.
- Staff will be equipped with training and opportunities to interact and work as multi-disciplinary teams.
- Providers will conduct quarterly meetings to review staff capability and service quality.
- Discussions will centre on how to upskill staff for improved service delivery.
- Commissioners will play a pivotal role in co-ordinating efforts across various providers. They will also champion communication to ensure alignment in workforce development.
- Providers will consider pooling training opportunities providing training for staff across services. This will be underpinned by contracts that mandate a training fund for staff.
- A community of practice will be encouraged through various initiatives, like shadowing, mentoring, lunch-and-learn sessions, and secondments.

Agreeing our core ambitions

At your tables, please take 35 mins to discuss:

1. **Are there any that need amending?**
2. What do **we need** to be able **to implement** these ambitions?

Feedback 5 mins

Table 1

Ambitions: 1. Joint vision and outcomes | 2. Flexibility to adapt to change in need | 7. A culture of shared, positive risk taking

1. Are there any that need amending?

Joint vision and outcomes:

- Point 2 requires a clear definition of boundaries.
- "Flexibility to adapt to change in need": there are grammar issues in the second point.
- More detail is required.
- A systematic overview is essential – an effort to understand all service elements and their interactions.
- Mentioning timeframes might be beneficial, possibly integrating set times to achieve certain goals.
- Time should be allocated to understand what's happening within the borough.
- Consider replacing the word "understand" with "challenges."
- The user's journey might be better understood through 'patient's passports'.

Flexibility to adapt to change in need:

- Define "flexible" more specifically.
- Discuss the various options within a contract - time, funding, growth potential, adaptability, and fluidity.
- Encourage open conversations.
- Address the issue of data sharing at the end of contracts – especially the ability to remove individuals from reports after data transfer.

A Culture of Shared Positive Risk Taking:

- Clarify the concept of positive risk-taking.
- Adhering to guidelines, especially set by clinical leads, is crucial. There should be clear communication about the acceptable risks.
- Discuss the sharing of risks across the borough.
- Address potential failures: If risks don't pay off, what protection mechanisms are in place? How can individuals be supported?
- Define the acceptable risks clearly.
- Discuss contingency plans to maintain service quality in the face of risks.
- Encourage risk-taking in a supportive, non-blaming environment.
- Ensure flexibility in service delivery, backed by commissions.

2. What do we need to be able to implement these ambitions?

- An understanding of how data is translated between different providers. Different systems might have different requirements.
- The voice of the residents should be taken into account.
- Address the training needs; change often necessitates resources.
- Understand the frequency of changes – constant flux can be disruptive.
- Understand the actual practices and responsibilities, for instance, through documentation like health passports.
- Effective collaboration requires a deep understanding of the processes involved.
- Regular multi-sector meetings, cross-community interactions, and consolidation are crucial.
- Define terms like "boundaries."
- Avoid vague language.
- Address time constraints and potential for development.
- Emphasise the importance of training and integrated data systems.

Table 2

Ambitions: 3. Collaboration and Strong Communication | 4. Awareness of our Strengths and Limits

1. Are there any that need amending?

- **Collaboration and Strong Communication:**
  - Eliminate redundant mentions around trust.
  - Reframe the non-rollover point to emphasise the importance of effectively planning underspend to ensure it's allocated properly. If not, the funds might be redirected elsewhere.
  - Ambitions can be simplified for clarity.
  - Ensure that when feedback is mentioned, commissioners actually heed it.

2. What do we need to be able to implement these ambitions?

- Implement reasonable and workable KPIs for organisations.
- Schedule meetings to review contract delivery less frequently than quarterly, ensuring ample time to demonstrate results.
- Employ a genuine collaborative approach in commissioning.
- Adopt a flexible approach and convene when specific milestones (both positive and negative) are achieved.
- Address organisations that resist collaboration and data sharing. Commissioning teams should have levers to enforce collaboration, potentially removing non-compliant entities from contracts.
- Create a digital space to facilitate provider conversations.
- Develop a shared database to monitor the client's journey:
  - Select a dedicated organisation or provider to oversee this.
  - Provide staff training on new systems.
  - Address potential duplication across shared and internal databases.
- Support providers when innovative initiatives fail, offering guidance in such situations.
- Foster a shared learning culture through educational initiatives. Engage third parties like IMPOWER for L&D sessions. Involve residents who utilise the services.
- Incorporate partnership requirements into contracts. Mandate participation in learning and development sessions or risk contract-related penalties.
- Recognise and celebrate organisational achievements and outcomes.

Table 3

Ambitions:	5. A human, person-centred approach, resident engagement, and co-production:	6. Robust infrastructure that unlocks innovation	8. Highly skilled and motivated workforce

1. Are there any that need amending?

A human, person-centred approach, resident engagement, and co-production:

- Avoid setting excessively high expectations.
- Emphasise the importance of a one-stop shop; a hub to promote services collectively.
- Acknowledge that providers are currently content with their contracts.
- Professionals working within the borough must be familiar with the locality.
- Ensure clear and adaptable pathways, keeping patients/users/residents informed of their journey. It's about clarity: both residents and providers should know a user's stage in the pathway.
- Make ambitions concise and realistic.

Robust infrastructure that unlocks innovation:

- Promote peer support among service users from providers they are or intend to engage with.
- Encourage knowledge sharing among providers.

2. What do we need to be able to implement these ambitions?

- Promote a proactive, 'can-do' attitude among providers and encourage knowledge sharing.
- Prioritise quality over quantity, ensuring a realistic understanding by actively listening to residents and recognising their journey.

A highly skilled and motivated workforce

N.B. Time ran out and so ambition number 8 was not covered in this session attendees are aware that here will be an opportunity to review and input at the next session.

How do we demonstrate and measure quality?

Our Draft Outcomes Framework

- As you will be aware, our new approach involves **commissioning for outcomes**. For us to achieve this we need to develop our outcomes framework.
- Today we would like to discuss with you what **approaches** we need to take to ensure that are our residents get the outcomes they need

What does 'good' look like?

Area 1
Focus on outcomes
for **sexual health**

Area 2
Focus on outcomes
for **drug and alcohol treatment**

Area 3
Focus on outcomes
for **healthy living**

For the outcomes in your heading, please take **35 mins** think about:

1. Do you agree with the outcomes that have been identified
2. What other outcomes are needed?

N.B. We will be developing this further with our residents as it is essential for our outcomes to be person centric
Feedback 5 mins.

Table 1

Service Area Sexual Health
Outcome:

1. Do you agree with the outcomes that have been identified?	2. What other outcomes are needed?
• Broadly the outcomes, their indicators and metrics look good. • The stigma around discussing sexual health should be addressed. • The importance of empowering the population is notable. • Respect should be a focal point. • The frequency of screening mentions suggests it might need its category.	• In addition to sexual health, address outcomes for general health and well-being, such as weight management and smoking cessation. • Consider a patient's journey and their current stage. • Emphasise the importance of educating young people in schools. • Consider cultural factors and engage with faith and community groups to promote sexual health education. • Address accessibility issues, like young individuals accessing contraceptives. • Promote healthy relationships, regular STD testing, and provide guidance through signposting and referrals.

Table 2

Service Area Drug and Alcohol
Outcome:

1. Do you agree with the outcomes that have been identified?	2. What other outcomes are needed?
• Most indicators and outcomes appear appropriate. • The 6-month timeframe for readmission seems short. Metrics should have a more extended focus. • Prioritise the longevity and maintenance of recovery in indicators. • Investigate relapse causes and potential links to specific organisations. • Ensure metrics motivate rather than discourage; they should be realistic. • Design targets to promote transparency and honesty. • Set outcomes and targets collaboratively between commissioners and providers. • Allow more contractual flexibility. • Share successful innovative ideas across services. • Clarify reporting requirements and data usage. • Specify target groups instead of using the broad term 'diverse community'.	**Other outcomes are not necessarily needed but would be helpful to:** • Understand the stories behind the statistics and foster open dialogues. • Research international best practices for insights. • Promote peer support, especially during hospital admissions.

Table 3

Service Area Outcome: Healthy Living (Live Well)

1. Do you agree with the outcomes that have been identified?	2. What other outcomes are needed?
• General agreement with the listed outcomes and indicators. • Incorporate physical activity indicators here and in addition to the physical health section of the framework both local and national. • Provide a clear definition of 'outcome' (reference to the outcome framework cover sheet which wasn't shared). • Clarify the time taken for specific scenarios or statistics to influence a KPI.	• Introduce provisions for onward referrals. • Integrate physical outcome indicators into the 'Live Well' indicators. • Encourage collaboration between residents and providers. • Incorporate hypertension and cholesterol in the respective indicators. • Determine the method for capturing outputs from healthy activities and the associated reporting mechanisms. • Address data capture methodologies. • Consider a local indicator on social isolation, focusing on populations not nationally reported. • Engage providers in the subsequent phase of refining outcomes alongside residents.

Break

Different ways we can collaborate

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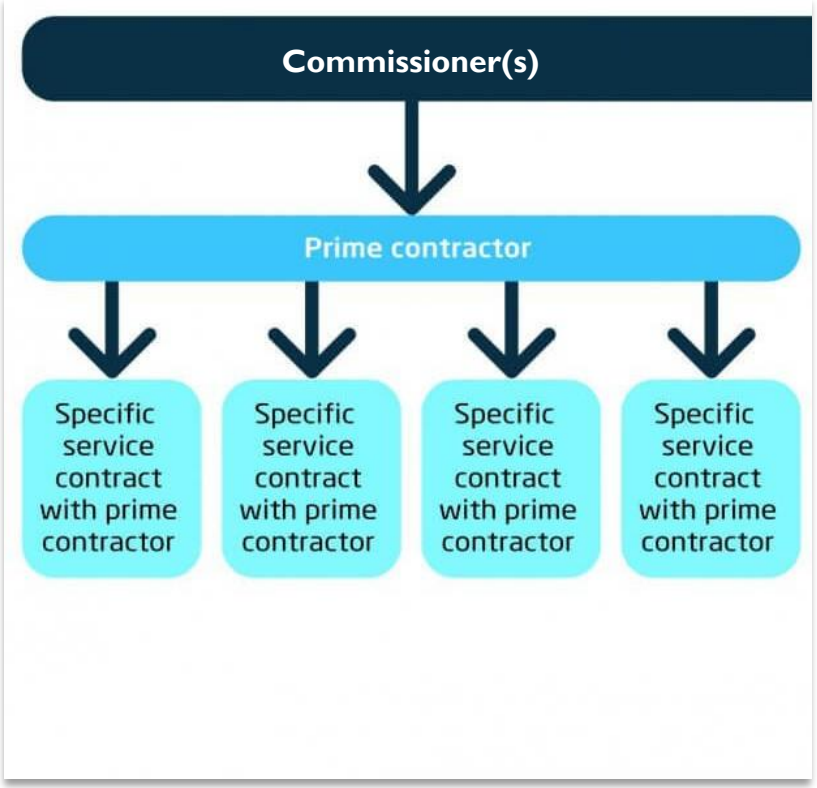
Introduction

- Now that we have a better idea of our outcomes framework, we want to explore the **next level** of detail of how **partnerships** would need to be structured to best deliver these outcomes.

Before the next discussion, we want to give some food for thought on how this could potentially look in practice by discussing example contracting models.

Prime Contractor Model

- One contract with a single organisation (or consortium), between the Council and the prime contractor.
- The prime contractor would then sub-contract to individual providers to deliver all of the required services.
- The prime contractor does not deliver services themselves.
- The prime contractor would take responsibility for designing a delivery model - that will most effectively meet the outcomes required which will be detailed in the specification.
- The prime contractor uses contractual terms between them and their sub-contracts to positively incentivise delivery and performance levels.



Source: Contractual models for commissioning integrated care | The King's Fund (kingsfund.org.uk)

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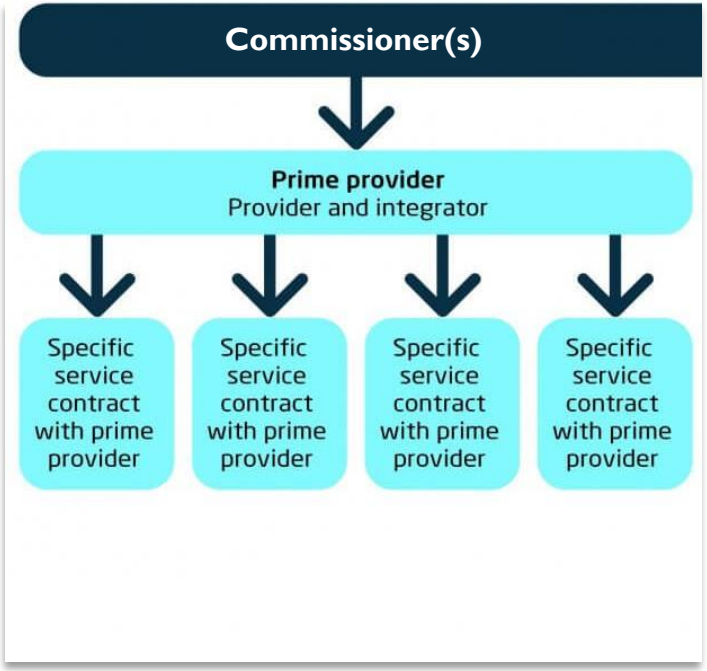
Prime Provider Model

- Similar to the prime contractor model.
- In this model, the prime provider also delivers services.
- The prime provider also would take responsibility for designing a delivery model that will most effectively meet the outcomes required which will be detailed in the specification. This includes additional services through sub-contracts that it cannot deliver directly.
- The prime provider would use additional contractual terms between them and their sub-contracts to positively incentivise delivery and the performance levels.



Source: Contractual models for commissioning integrated care | The King's Fund (kingsfund.org.uk)

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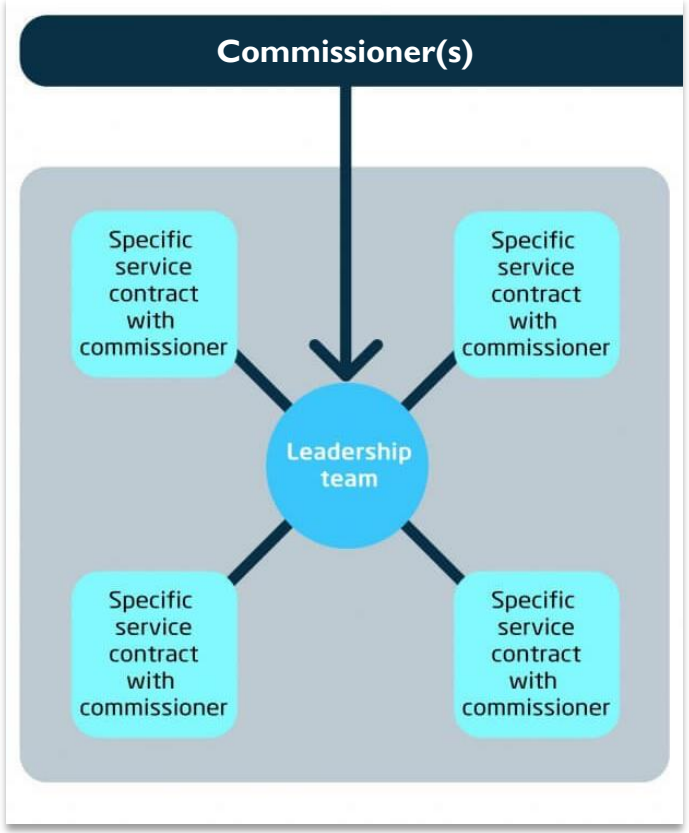
Alliance contracting

- One contract which is entered into by a number of providers and the Council.
- One performance framework and one set of outcomes.
- Success of the contract is judged on performance overall.
- Aligned objectives and there also shared risks
- Reliant on high levels of trust across Alliance Members as collective accountability is key.
- Requires strong governance arrangements through a formalised leadership board with an agreed terms of reference.
- Change and innovation in delivery are expected for example the Alliance would work to identify efficiencies across the system, rather than solely within their organisation.



Source: Contractual models for commissioning integrated care | The King's Fund (kingsfund.org.uk)

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Discussion

In the same groups, please take 20 mins to discuss:

1. **How do we reward the right outcomes in Greenwich?**

2. **Whether any of these ways of working would seem like a good fit with the characteristics of partnership working you described earlier? Why or why not?**

Table 1

1. How do we reward the right outcomes in Greenwich?	2. Would any of these ways of working align with the characteristics of partnership working you described earlier? Why or why not?
• Financial incentives can and should be considered. • Long-term contracts need adaptable terms. • Offer platforms for providers to advertise their services, such as through "Greenwich Together." • Provide free advertising, showcasing collaborative efforts. • Use case studies, videos, etc., for promotion on social platforms. • Engage large corporations in collaborations with charities or providers.	• Model 1 (traditional prime contractor), might lack feedback mechanisms as it's very top down which makes collaboration more challenging. • Model 2 (prime provider) appears to reflect current practices. • There's concern about smaller organisations being overshadowed by larger ones. • Model 3 (alliance contracting) whilst providing tighter grip over quality, it seems to involve more risk. Lots of questions that need answering. • Introducing a Partnerships Board could be beneficial. • Consider an alliance model where organisations are paired together, rather than providers choosing their partners. • Use examples to clarify concepts. • Address the potential staffing challenges to maintain momentum. • Opinions about the Prime contractor and Prime provider models vary, with a noted preference for the latter. • Address queries related to the alliance model.

Table 2

1. How do we reward the right outcomes in Greenwich?	2. Would any of these ways of working align with the characteristics of partnership working you described earlier? Why or why not?

• Commissioners should embed collaboration in contracts and take the lead in ensuring it.
• Balance power and control between different-sized providers and commissioners, finding equilibrium between alliance and prime models.
• Adopt a payment-by-results model to incentivise innovation, using a top-up approach rather than full payment.
• Reward both anticipated and unexpected positive outcomes.
	• Building relationships between organisations demands significant time. A 4–6-week bidding period isn't sufficient for identifying compatible providers.
	• Providers with direct communication lines to commissioners have more influence and autonomy.
	• Costs are more evenly distributed in an alliance model compared to a lead provider model.
	• Small charities might find the bidding process in an alliance model challenging but may prefer a lead provider model.
	• Bid process suggestions:
	  ○ Simplify the bid documentation to not overburden small providers.
	  ○ Consider innovative bidding models such as concise responses, case studies, or interviews.
	  ○ Interview partnerships collectively.
	  ○ Explore the use of AI for objective bid assessment.

Table 3

1. How do we reward the right outcomes in Greenwich?	2. Would any of these ways of working align with the characteristics of partnership working you described earlier? Why or why not?
• Extend contract durations based on performance evaluations. • Permit expansion in areas once capacity is achieved. • Prioritise early planning for new project extensions. • Emphasise outcomes over mere numerical achievements. • Provide prior notice regarding contract terminations or non-extensions. • Allocate budget for Learning & Development for staff. • Offer employee perks like loans or an emergency fund for users – e.g., aiding their physical access to services. • Structure payments based on outcomes, with bonuses for exceptional performance. • Tailor payment structures to benefit smaller organisations, offering larger sums upfront to assist with cash flow.	• Longer contract durations would mentally engage staff more, offering stability. • Any rewards provided should be supplementary to the set budget, ensuring that service delivery isn't compromised but enhanced.

Feedback

Next steps

Q&A

We will take any questions from these sessions and collate an ongoing 'FAQ' document, which will be shared via ProActis along with the session output after each of these meetings.

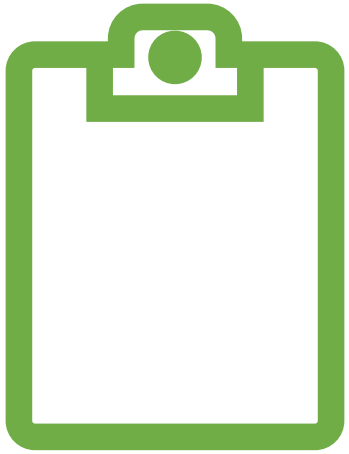
If you have any questions in the meantime, please email procurement@royalgreenwich.gov.uk

Next Steps

- We will use the information stemming from today to contribute to the codesign of a comprehensive engagement plan for the next 12 months
- The outputs from today will be collated, written up and shared via ProActis
- Our forward plan of market engagement events is below – contact procurement@royalgreenwich.gov.uk if you or someone you know would like any further info about them, or to RSVP:

Market Engagement Event		Date
1	Our vision	16 June
2	Our principles	5 July
3	Our language	16 August
4	Putting residents at the heart of how we work	6 September
5	Collaboration	12 September
6	The journey so far – what have we achieved together?	21 September

Feedback



Please take 2 minutes to tell us how you found today, and what we can improve on for future sessions

Thank you