Public Health Recommissioning Market Engagement Event

27th March 2024

ROYAL borough of GREENWICH

Public Health Recommissioning Market Engagement Event
Wednesday 27th March 2024

AGENDA

	Topic	Lead(s)	Timing
1.	Welcome and Housekeeping	DP	14:00
2.	Feedback on Proposed Categories & Packages for New Contracts Discussion	CP	14:05
3.	Single Point of Access	DP	14:15
4.	Round Table Discussion	ALL	14:30
5.	BREAK		15:00
6.	Provider Networks	CP	15:10
7.	Round Table Discussion	ALL	15:20
8.	Closing Summary	DP	15.50

Proposed Categories & Contract Packages Discussion Feedback

Charlotte Parkes– Head of Integrated Commissioning

Proposed Categories for Contract Packages

Drugs and Alcohol

- Residential & Community Treatment
- Prescribing
- Psychology support
- Aftercare

Live Well Prevention

- Smoking cessation
- Diet and nutrition
- Exercise and physical activity
- Health & wellbeing – NHS Health Checks

Sexual Health

- STI testing
- STI treatment
- Reproductive Health
- HIV prevention including PrEP

Group Response

- Positive response to the packages however many expressed that read across will remain vital.
- Pathways will need to be carefully considered.
- Important to consider residents/service users.
- Packages need consistent processes/policies.
- Important to consider the workforce across each package and how they will share specialist knowledge.
- Silo working remains an acute risk and so collaboration requirements would need to be explicit.

Contracting Models Recap

Lead Provider Model

In a Lead Provider model, the Royal Borough of Greenwich would contract with a single organisation which would take responsibility for the delivery of all of the service requirements, and for the day-to-day management of other providers who they would sub-contract to. The Lead Provider would be responsible for sub-contracting all the elements of the contract they do not wish to deliver themselves and would be responsible for managing their supply chain.

Traditional Contracting Model

A traditional contacting model would involve the Royal Borough of Greenwich entering into a contract with a single organisation to deliver services that they would usually be expected to deliver all of themselves.

Alliance Contracting Model

A set of providers enters a single arrangement with the Royal Borough of Greenwich to deliver services. All providers within the alliance share risk and responsibility for meeting the agreed outcomes. They are not co-ordinated by a prime provider, and there are no sub-contractual arrangements. All organisations within the alliance are equal partners and they must instead rely on internal governance arrangements to manage their relationships and delivery of services.

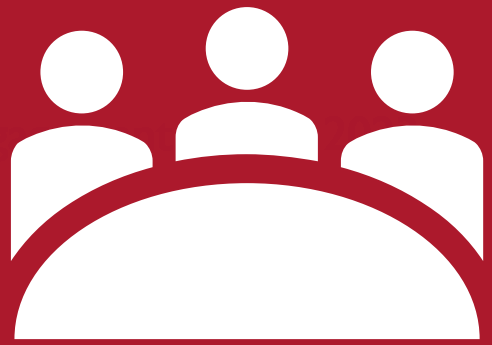
Group Response

- Lead Provider Model seems most fitting for the packages.
- Concern re management of risk in Lead Provider Model.
- Alliance model support equal roles however shared responsibilities and decision making could become problematic.
- Developing an Alliance is very intensive process.

Single Point of Access

David Pinson– Associate Director, Integrated Commissioning & Health Protection

Round Table Discussion



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Questions

- **How should a single point of access work and what is its role?**

- **Should it have a co-ordination role in the contract package?**

- Prompts for discussion:

  - Should there only be one entry point to it and if not how would this work?
  - Should we consider a payment by results model of delivery?
  - How can we forge stronger links with General Practice.
  - How could data sharing be organised to ensure that those at risk are identified and encouraged or linked to use services?

Provider Networks

Charlotte Parkes– Head of Integrated Commissioning

Ambitions overview: our ways of working together

The blueprint of how Public Health 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, that puts co-production at the core of delivery**
   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 3 & 4

3 Collaboration and strong communication

- **Shared oversight:** We will establish clear governance for how we communicate, ensuring a mutual understanding and fostering open lines of dialogue.
- **Transparent stakeholder communication:** All relevant stakeholders will be kept in the loop. This includes being transparent, clear, and regular in our communications, taking ownership by 'default' and flagging with commissioners can facilitate sharing further.
- **Data sharing & transparency:** Data sharing agreements will set clear standards. We will embed robust analysis, ensuring professionals beyond data experts can play their part in identifying unmet needs.
- **Collaborative expertise:** We will champion greater collaboration among providers offering similar services to harness collective expertise and build resilience.
- **Community feedback:** Embedding the 'voice of the resident' and community feedback is crucial. But more than just gathering it, we will ensure that providers and commissioners take actionable steps based on the feedback received.
- **Emphasis on collaborative projects:** Collaboration will not just be a talking point. We will give priority to projects that deliver the most impact and require teamwork, making it a tangible reality.
- **Effective use of funds:** It will be essential to effectively plan underspends to ensure proper allocation. If mismanaged, these funds should be re-deployed elsewhere, and this should be discussed and agreed in advance.

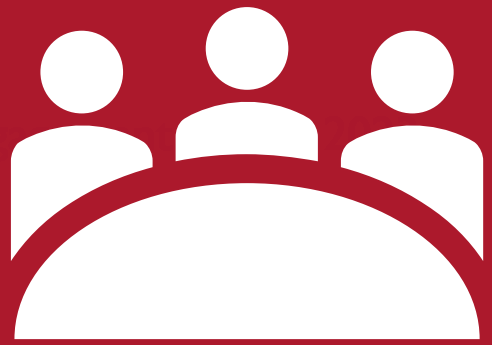
4 Awareness of our strengths and limits

- **Provider self-awareness:** Every provider will recognise their strengths and limitations, fostering a culture of continuous learning.
- **Coordination:** Governance arrangements will ensure alignment in goals, expectations, and deliverables.
- **Two-way feedback system:** A mechanism will be established allowing both providers and partners to voice concerns, share insights, and recommend improvements in a 'no blame' environment.
- **Innovative contract structures:** Contracts will be outcomes-based, encouraging innovation among providers. Potential funding will specifically be ring-fenced for pioneering approaches.
- **Financial considerations:** Acknowledging financial constraints is vital, especially with the NHS's non-roll-over budget system in mind. We will work together to overcome these pressures as best we can.

Provider Networks

We will be creating a formal network where all services will be required to come together, reflect on collective delivery of outcomes, share case studies and conduct learning reviews.

Round Table Discussion



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Question

Provider Network

- **What do you think the format for this should be and how should it be resourced?**

- Prompts:
  - How can this be a true partnership where all have ownership.
  - What would the structure of the meetings and network look like.
  - Sharing of information on service delivery and outcomes or where outcomes haven't been achieved.
  - How will it foster strengthened collaboration.

Round Table Feedback

Closing Summary

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