NHS
Scarborough and Ryedale
Clinical Commissioning Group

Scarborough and Ryedale Clinical Commissioning Group

Integrated Prevention, Community Care and Support Service

MCP Prospectus

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Statement from CCG Chair, Dr Phil Garnett:

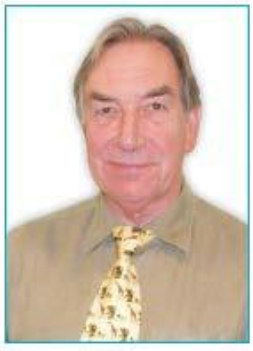
The CCG's Governing Body has overall responsibility for the healthcare of our communities, however we recognise that the challenges we face with our local health needs and our geography can only be overcome by working in partnership to ensure we deliver quality services for our local communities.

Addressing our significant challenges requires close working and cooperation across the system, and in particular across health and social care as we look to strengthen the services that operate outside of hospital and acute based settings. We need to work together to strengthen the community response and provide care when and where it is needed. Too often people end up in hospital when with a greater and earlier focus on prevention, faster access to diagnostic tests and results, and better joined up care from health and social services, many people could be treated at, or closer to home. Primary care needs to have the confidence to refer people for inputs and packages of care in the home setting, safe in the knowledge that the responsiveness and ability of our community services will provide the right care at the right time.

It is a time of unprecedented change for the NHS, and I truly believe that bringing the responsibility for the commissioning of local health services to a more local level, and empowering local clinicians to make decisions about those services for our populations, can only be a positive move for patient care. In five years' time the model of care will be less focused on hospital care and more focused on supporting patients to live healthy, active lives in the community supported by responsive services tailored to meet individual needs.

We want to see all of our community services organised around the communities where people live and the GP practices people use, and we want to work with partners who share our vision and can overcome barriers to joint working.

We envisage enhanced prevention and self-care at the core of our model and, if care becomes necessary, timely, integrated coordinated care and support. We want to enable providers to develop creative and innovative ways of working across organisational boundaries, and we are excited to be embarking on this new and different approach to securing the bespoke services we want to see for our population.



Dr Phil Garnett
Clinical Chair
Scarborough and
Ryedale CCG

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Executive Summary

The NHS and Local Authorities nationally and locally are facing significant funding and demand pressures that are not likely to ease in the coming years. Sustainability and Transformation Plans (STPs) are being developed and implemented across the country in order to drive the changes needed to work at scale across organisational boundaries, reduce the funding gap and better meet demand. As part of our Humber Coast and Vale STP, our place based plans for Scarborough and Ryedale seek to maximise the collectively available resource to avoid duplication and to spend the Scarborough and Ryedale pound more wisely to meet our challenging health and social care needs.

The CCG's health and social care system faces a combination of some of the most difficult challenges within England: urban and rural health inequalities; remote geography; an increasing shortage of GPs; an isolated market for care providers; a medium sized general hospital, reliant on significant support from neighbouring acute services 45 miles away; failure to recruit and retain sufficiently skilled staff to provide full range of services locally; variations in quality and quantity of services; and major seasonal fluctuations in population as a result of tourism. People using health and social care services in the area are more likely to have poorer health, to die earlier than elsewhere in North Yorkshire and to be more likely to be admitted to hospital or a care home or to be sectioned under the Mental Health Act. The CCG cannot solve these issues working alone.

The CCG wants to work with innovative and progressive providers in order to build resilience in the community and primary care services to support addressing these challenges, and this prospectus sets out how it intends to do this through the development of a new and innovative Multi-speciality Community Provider service model. The CCG intends that these arrangements will be underpinned by the NHS Accountable Care Model Contract.

The CCG has set out its high level model of services organised around the communities where people live and the GP practices people use, and has provided its early thinking about its outcomes framework, based on best practice and local engagement.

The CCG rationale for this model is that it will enable a truly clinically led multidisciplinary form, which will over a phased period, enable the CCG to integrate health and social care in a way that builds and sustains the resilience in the community, as part of the whole system in Scarborough and Ryedale into the future. These aspirations are in line with the CCG's submitted STP plans and form a significant part of ambition for the future.

This Prospectus should be read in conjunction the other supporting documents available from the Tender Portal and the CCG's dedicated web page and/or as otherwise indicated below:

- Contract Notice
- Draft Contract and guidance documentation from NHS England https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/community-sites/
- The CCG's finalised Engagement Report
- Background Information Document

Further information will be released at appropriate points in the Procurement Exercise.

Please note that where relevant defined terms have the meanings set out in the PQQ.

1. Background

This prospectus ("Prospectus") provides an overview of the CCG's proposals to work towards integrating adult health and social care and includes an overview of the population, the CCG's unique demography, the scope of services, and anticipated outcomes.

1.1 The CCG

The "CCG" was established under the Health and Social Care Act of 2012 which led the way for the creation of clinical commissioning groups.

The CCG is made up of 15 member practices. These GP practices serve a population of approximately 119,000 covering the geographic area of Scarborough and parts of Ryedale with a total funding allocation (including running costs and primary care co-commissioning) of £177 million in 2016/17. The CCG's largest providers are York Teaching Hospitals NHS Foundation Trust which currently provides acute and community services, and Tees, Esk and Wear Valleys NHS Foundation Trust which currently provide adult, children's and adolescent mental health services.

The 15 GP practices have list sizes ranging from 2,300 - 20,000 and services are delivered through 1 APMS, 2 PMS and 12 GMS contracts.

Six practices (Falsgrave, Belgrave, Prospect Road, Peasholm, Castle Health Centre, Brook Square) are located all within a mile radius in Scarborough Town Centre.

Four practices are located on the outskirts of Scarborough within 5 miles of Scarborough, two to the north, one to the south west and one to the east (West Ayton, Eastfield, Scarborough Medical Group, Hackness Road)

One practice is located in the market town centre of Malton (Derwent).

Four practices (Filey, Hunmanby, Sherburn, Ampleforth) are rural practices.

The map below demonstrates the geographic spread of the CCG:

1.2 Policy & Strategic Alignment

In 2014 the NHS Five Year Forward View[1] "FYFV" confirmed the need to do something different to ensure sustainability of NHS services. It set out a road map for the development of the NHS and its partners to 2020. This included instruction that the NHS must take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The drive for greater integration was further supported in the NHS Operational Planning and Contracting Guidance for 2017-19.

The planning guidance supported the FYFV and introduced the development of Sustainability and Transformation Plans ("STPs"), across health care, social care and public health systems, with a drive to test new models of care, and to enable health and social care and public health to work more closely together and drive the changes needed to work at scale across organisational boundaries, reduce the funding gap and better meet demand. It is anticipated that the implementation of STPs across the country will result in NHS England's new models of care being developed. 44 STPs have been developed across the country.

The CCG is part of the Humber Coast and Vale STP[2] "HCV" along with five other NHS Clinical Commissioning Groups and six local authority boundaries representing communities in Hull, East Riding, York, Scarborough and Ryedale, North Lincolnshire and North East Lincolnshire. The HCV STP is concerned with wider strategic and large scale commissioning opportunities as well as local place based commissioning. The wider HCV STP's "triple aims" are as follows:

- Achieving our desired outcomes "will the service be good?"
- Maintaining quality services "will the service be safe and operationally sustainable?"
- Closing our financial gap "will the service be financially sustainable?"

The HCV STP has six priorities which will be embedded within the change it is striving to achieve. These are:

- Helping people stay well
- Place-based care
- Creating the best hospital care
- Supporting people with mental health problems
- Helping people through cancer
- Strategic commissioning

Within the HCV STP, the CCGs local place based plans have been developed with the CCG and partners' Ambition for Health Programme[3], and are based on the development of:

- **Healthy lifestyles** – an ambition to help people lead healthy lifestyles, supporting them to take control of their own health to prevent illness.
- **Care closer to Home** – an ambition to improve out of hospital services through integration across community services, social care, mental health services and primary

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2] http://humbercoastandvale.org.uk/wp-content/uploads/2016/11/HCV-STP-summary_websingles.pdf
[3] http://www.scarboroughryedaleccg.nhs.uk/data/uploads/about-us/ambition-for-health/ambition-for-health-vision_may2016_lowres.pdf

care services with the aim of supporting people at home and preventing people needing treatment in hospital.
- **Sustainable services** – an ambition to ensure that acute and mental health hospital services are financially and clinically sustainable.

The Scarborough and Ryedale out of hospital care will develop in phases, ultimately bringing together primary care, elderly medicine in the community, nursing, community therapy and continuing healthcare, to deliver a service model that will shift care from being primarily hospital based, to that of a 'Home First' approach delivering care into patients' own residence, ensuring:

- improved prevention through single contact system of advice, guidance, signposting and direction into community support.
- a focus on maximising independence
- rapid/fast access to community response for those in crisis or stepping down from acute care
- combined integrated care teams, based around GP practice populations, to provide planned care, and proactive management of chronic diseases.

The current arrangements for the delivery of NHS and Local Authority out of hospital care locally are via a number of somewhat fragmented services and different contractual agreements with providers. This approach has limitations and provides boundaries that make it harder to provide joined up care that is preventative, high quality and efficient. In order to facilitate true integration and offer improved, joined up services for our population, the CCG and North Yorkshire County Council (NYCC) need to radically change the way care is commissioned to develop a one system approach, and there are a number of emerging new care models and contracting frameworks that support the integration agenda and that will help us to do this.

2. Development of the MCP Proposal

The CCG carried out a series of engagement events and activities between the 21st November 2016 to the 16th February 2017, on its proposal to develop plans for a new Integrated Prevention, Community Care and Support service. This period of engagement was the latest in a series of dialogues that the CCG has been having with its population, and with the staff who provide current services to find out what was important to them, what was working well and what needed to change.

Throughout the engagement the CCG has talked about its desire to utilise one of the nationally developing new care models to make sure that as far as possible the attention is focused on care in the community setting with people and their GPs at the core. A copy of the finalised engagement report is available from the CCG's website[4].

After initial discussions with NYCC about a joint commissioning approach and subsequently through a business case to the CCG Governing Body, including an options appraisal process, a partial MCP approach was selected for the CCG to pursue. This option enables the CCG to support a model for commissioning that helps to shape the provider market into the concept of one system for service delivery, centred around list based primary care.

The Multi-specialty Community Provider (MCP) model brings together GPs and other providers of community based services to deliver a more integrated model of care. It

[4] http://www.scarboroughryedaleccg.nhs.uk/commissioning-integrated-community-services

incorporates a much wider range of services and specialists than traditional models, and can encompass mental health services and social care services where this is agreed by the CCG and local authority. MCPs can vary in scope from a virtual alliance of providers, through a partial MCP which excludes the provision of primary medical care services, to a fully integrated MCP in which the delivery of primary medical care services are included. In some cases MCPs can also include the delivery of some elective services previously based in hospitals. The model is based on letting a contract to a single legal entity but this does not preclude innovative or multi-party bidding models and potential providers can consider a range of models which will meet the CCG's requirements. The MCP may provide all or some of the services, and all or some of the services may be sub-contracted.

In developing this route the CCG is laying the foundations, and signalling an intention that the model will, in phases, oversee a further transfer of funding and activity from secondary care into primary, community care. This approach will form the basis of the procurement and contracting model, subject to some adaptation to encompass integration with the NYCC services as well as General Practice.

The new service will bring together health and parts of social care in a way that has not been seen before locally and will put General Practice at the heart of the delivery model so that care is organised around the places where people live and the GPs they see. Section 4 of this Prospectus explains more about our proposed model.

3. Joint Strategic Needs Assessment

The health and social care needs of the population of Scarborough and Ryedale are changing. A combination of an ageing population, the changing expectations of our population with regard to timely care, the growing advantages and expectations of technology and a predicted increase in demand, against a backdrop of financial constraints, will all place additional pressures on this health and social care economy. The CCG is aware that:

- there is a lack of emphasis on prevention in an out of hospital community setting;
- there is a significant increase in the number of frail and elderly people in the population who require higher levels of care;
- there is a need for better understanding amongst patients, the public and professionals of the services available and how to access them;
- too many frail and elderly people are attending the emergency department with conditions that could be looked after in the home setting if the right level of support, care and supervision was available at the right time; and
- too many people die early from diseases such as cancer and cardio vascular disease.

When aiming to meet these challenges, the health and social care system must also take into account a combination of factors such as:

- a diverse population across a town and remote rural geography;
- distinctly different health needs in different parts of the patch including some wards in the Scarborough Borough that are in the 20% most deprived wards in the country;
- a significant increase in population size during the summer months;
- a relatively small and geographically isolated District General Hospital;
- significant recruitment and retention issues across the whole health and social care economy; and
- a fragile domiciliary and care home market.

The North Yorkshire Joint Strategic Needs Assessment (update 2016) available at http://www.nypartnerships.org.uk/index.aspx?articleid=26753 provides the following picture of Scarborough and Ryedale:

99.3% of the registered Scarborough and Ryedale CCG population are residents of North Yorkshire. Ryedale is an area of outstanding scenery with beautiful villages and vibrant market towns with a population of 53,052 (source-ONS 2015 mid-year estimate), approximately half of which is within the CCG boundary. The area, covering 575 square miles has a rich cultural heritage, and enjoys the legacy of long term, relatively stable social and industrial base.

The Scarborough Borough covers an area of 330 square miles with a population of 107,902 (source-ONS 2015 mid-year estimate), which includes the town of Whitby (that sits outside of the CCG). Although the Borough has a large rural area, 60% of the population live in the three main coastal towns of Scarborough, Whitby and Filey. The beauty, history and heritage of the area attract many thousands of visitors each year, as well as offering a high quality of life to many residents.

The 2015 Index of Multiple Deprivation "IMD" identifies 15 Lower Super Output Areas "LSOAs" out of a total of 69 across the CCG which are amongst the 20% most deprived in England. All of these LSOAs are in Scarborough district and almost 24,000 people live in these areas.

The total number of patients registered to practices within the CCG is currently circa 119,000. The CCG has around 1,200 births and 1,400 deaths annually. The population is ageing: Life expectancy at birth is 77.9 years, for males and 82.8 years for females, both below the national average. Life expectancy varies for men and women considerably across North Yorkshire.

The life expectancy gap at birth in North Yorkshire (between the most affluent and most deprived) is 8.3 years for males and 6.1 years for females. In Scarborough, this gap is 9.1 years for males and 5.6 years for females. In Ryedale, 4.5 years for males and 4.3 years for females.

Children living in poverty are a significant issue for the CCG area, with rates in Scarborough being significantly higher than the national average. The CCG has over 3800 children living in poverty (i.e. in "low income families" as defined by the Department for Work & Pensions) within its boundaries. More widely, some of North Yorkshire's most deprived communities can be found within the CCG boundaries.

Almost 1 in 4 residents in Scarborough District are economically inactive, and approximately 6000 individuals are classified as "long term sick". This equates to 38.8% of the economically inactive population within the district and compares with 23.5% across the wider region. This demonstrates the generally poorer health experienced by many residents within the district and the impact this has on wider socio-economic outcomes and is reflected in higher rates of premature mortality (346 per 100,000 in 2012-14) than elsewhere in the County. By comparison, in Ryedale in the same period the rate was 308 per 100,000).

Fuel poverty rates are an issue across the CCG. In parts of Scarborough Town, 1 in 5 households can be classified as "fuel poor". Merely tackling poverty would not necessarily relieve the fuel poverty issue as often housing type and access to affordable sources of energy are important in this area. Tackling the fuel poverty issue should in turn improve

winter health, improving excess winter mortality and the pressure on the health and care system over the winter months.

The economic importance of tourism, and seasonal nature of some employment, leads to transient elements of the population, and a higher proportion of multi-occupancy homes in comparison with other parts of the County. Pressures on services arising from homelessness in Scarborough district are reflected in the rate of households in temporary accommodation, which is significantly worse than the regional or County rate.

Although improvements are being made, the proportion of children with excess weight in the Scarborough area remains among the highest in the County at Reception and Year 6 and is above the national average for those children in reception (23.1%%). In the rest of the CCG area rates are not significantly different, although the proportion of children in Year 6 in Ryedale district with excess weight has increased to 32.3% in 2014/15 (from 30.8% in 2013/14). An increasing obesity issue in the child population is likely to lead to an increasing issue in the adult population, of which almost 70% are already overweight or obese, whilst in Scarborough over 1 in 3 adults (35.1%) are classified as inactive. This compares to 23.4% of adults in Ryedale and 27.7% across England. Turning this curve is important to reduce pressure on our health and care system from lifestyle affected long term conditions, such as diabetes.

In Scarborough district there is some evidence of higher rates of alcohol misuse and in 2014 the rate of Employment and Support Allowance “ESA” claimants for whom the main medical reason for the disability was alcoholism was 210.7 per 100,000. This is almost double the rate in England (131.0 per 100,000) and over three times the rate in Ryedale (67.5 per 100,000).

Smoking at time of delivery is a particular issue for the CCG area. Over half of all the mothers who smoke at the time of delivery in North Yorkshire are registered to the CCG. Smoking related deaths are significantly higher for the area, smoking being the leading preventable cause of premature mortality.

Smoking quit rates (at the four week follow up) are also significantly worse than the similar CCG average (466 per 100,000 locally compared to 807 per 100,000 across the 10 most similar CCGs).

The rate of hospital admissions as a consequence of violence is much higher in the Scarborough district (52.4 per 100,000 population) than in Ryedale (20.9 per 100,000) or across the wider County (36.1 per 100,000).

The rate for killed and seriously injured (KSI) casualties on England’s roads in Ryedale is significantly worse than the national average (at 119.4 per 100,000 compared to 39.3 per 100,000) and is higher than any other district in the County. Scarborough is a better performer in comparison, though still above the national average at 52.4 per 100,000. Over the last five years the gap between rates in Scarborough and the national average has narrowed, from 18.8 in 2009/11 to 13.1 in 2012/14. However, in Ryedale the gap has stubbornly remained at around 80 per 100,000.

Getting the best start in life may help prevent the obesity issues seen in the CCG’s area. The area struggles with lower breast feeding initiation rates (70.7%, Q1 2014/15) compared to the England average (74.0%). Childhood immunisation rates are also low for the CCG in Meningitis C coverage at 5 years (68%)

Long term conditions including asthma, CVD, COPD, hypertension, and stroke are all significantly higher than their respective national averages. It's no surprise that the CCG has a significantly higher rate for premature CVD mortality compared to England, although it should be noted that all-age mortality rate in respect of CVD fell by 9% between 2009 and 2013 in the CCG. However, mortality rates from CVD in the under 75 population in Scarborough district (85.3 per 100,000) remain worse than that observed nationally (75.7 per 100,000) or in any other district in North Yorkshire. Of those individuals admitted for circulatory disorders, genito-urinary conditions were a common co-morbidity and were present in almost 1 in 4 individuals (29 out of 126 individuals).

Although spend on patients with circulatory conditions is typically higher than nationally or regionally, outcomes remain worse locally in terms of mortality from cardiovascular disease and potential lives lost from ischaemic heart disease or cerebrovascular disease.

Smoking has a significant impact on the health of many residents within the CCG, particularly in Scarborough district. Here, the rates of smoking attributable mortality, smoking attributable deaths from heart disease and stroke are all significantly higher than the national average. Smoking attributable hospital admissions in adults aged 35 and over also remain above the national average. Whilst all age incidence of lung cancer is not significantly different to England or the 10 most similar CCGs the proportion of lung cancers detected at stage 1 or stage 2 is significantly worse than similar CCGs (7% locally compared to 18% across the 10 most similar CCGs).

Alcohol features as an issue for the CCG. Across the CCG the rate of hospital admissions for alcohol related liver disease in females is significantly higher compared to the England average (95.9 per 100,000 locally compared to 65.8 nationally), whilst rates in respect of admissions for intentional self-poisoning by alcohol and alcohol-related cancers arealso above the England average. The rate for alcohol specific hospital admissions for males in Scarborough remains higher compared to England's average, but has reduced from a peak in 2012/13 of 584 per 100,000 to 547 per 100,000 in 2013/14. Its status as a Local Alcohol Action Area pilot site will hopefully have the desired impact on alcohol related admission rates.

The percentage of NHS Health Check Uptake amongst those offered has improved but remains lower in Scarborough and Ryedale CCG (46.9%) compared to England (49%). NHS Health Checks present an opportunity to identify high risk patients and begin treatment sooner for CVD.

In 2013 31.4% of all cancers were diagnosed at Stage 1 or Stage 2, which is below the national average of 37.3%. The proportion of breast and prostate cancers diagnosed at stage 3 or stage 4 was also higher than that observed nationally. More positively, in 2014/15 breast, cervical and bowel cancer screening rates for the CCG were all above the England average rate.

The percentage of people with diabetes meeting treatment targets is lower (30%) for the CCG than the national average (36%).

The Commissioning for Value information pack for the CCG identified 347 "complex" patients across the CCG who averaged around 5 admissions per year. Approximately half of this group of patients are aged 70 or over. The most common reasons for admission of "complex" patients were as a result of circulatory conditions (126 patients). The most common co-morbidities associated with these admissions were respiratory or genito-urinary conditions.

The potential years of lost life from conditions considered amenable to health care are significantly worse than national average in the CCG for men (3466 per 100,000 for males in the CCG compared with 2210 nationally) reflecting the health outcomes of some the lifestyle and inequalities issues that the population face. Unplanned hospital admissions for asthma, diabetes and epilepsy in the under 19s are a significant issue.

The admission rate for these conditions in the under 19 population in Scarborough district was 570.2 per 100,000 in 2013/14, over 80% higher than the national average of 313.4 per 100,000. By comparison, the rate in Ryedale was much lower, at 186.9 per 100,000."

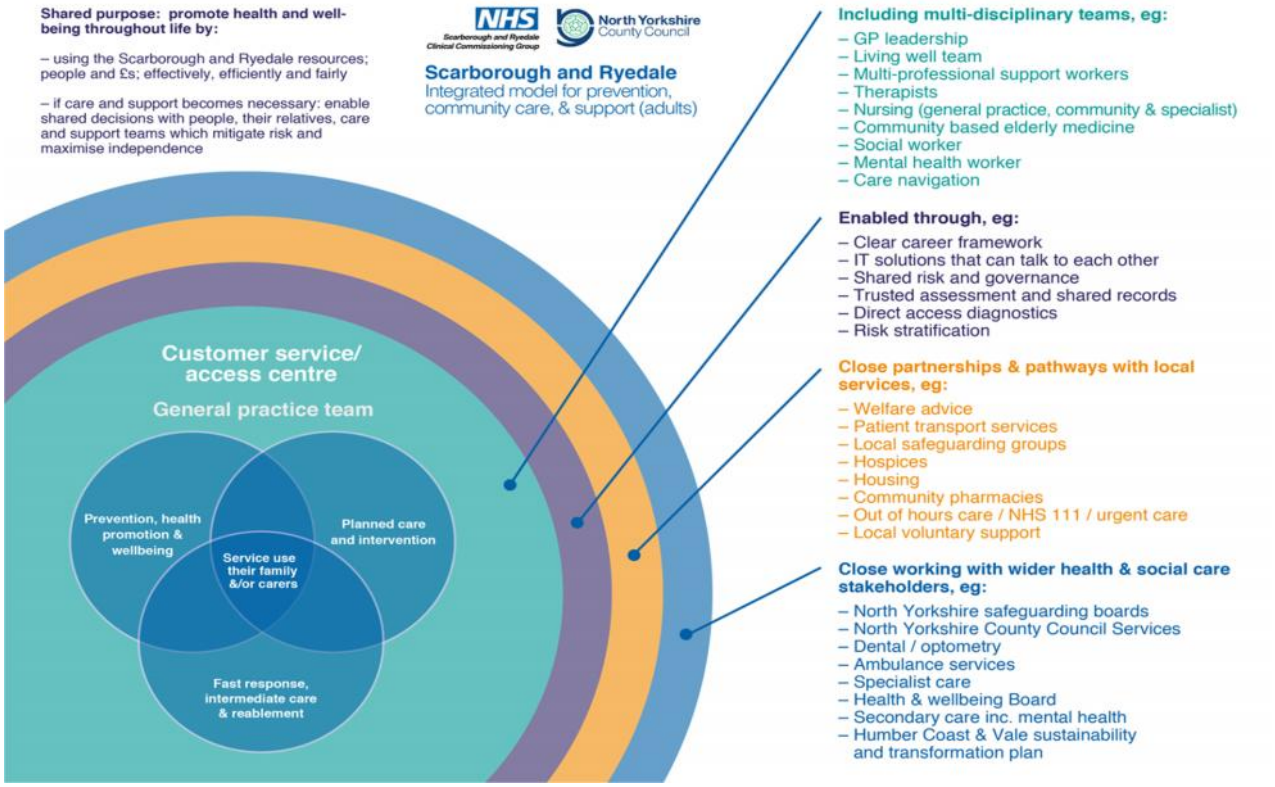
The JNSA recommends: *"focusing on improving community management of these conditions and the wider determinants"*

4. Multi-specialty Community Provider (MCP): Our plans for the future

The Overall Integrated Health and Social Care Service Delivery Model

The vision is for all teams looking after the adult population across health and social care to be integrated, sharing knowledge and skills, and having respect for each other's strengths; one team delivering a service in equal partnership, based on the highest level of commitment to service quality and patient safety, and founded upon list based general practice in a structure that supports and strengthens the leadership and decision making of general practice and maximises independence.

The vision includes developing 3 or 4 hubs grouped around primary care, and around which integrated multidisciplinary support teams will be built.



We intend that the service moves away from a traditional model delivered to suit organisational boundaries, to a model that starts with the needs of the individual and builds arounds the functions that will mean care can be delivered as close to home as possible when it is needed.

The service will work towards ultimately integrating health and social care delivery. This will mean considerable work to build new relationships, new role profiles that will develop over time, and a significant level of commitment to new ways of working.

The CCG wishes to work with organisations who share its vision for this new model of care, and who demonstrate innovation and willingness to work in partnership to deliver a truly seamless service from the patient / population perspective, including minimal hand off between agencies, rapid access to the right services and a strong ethos of promoting education and self-care.

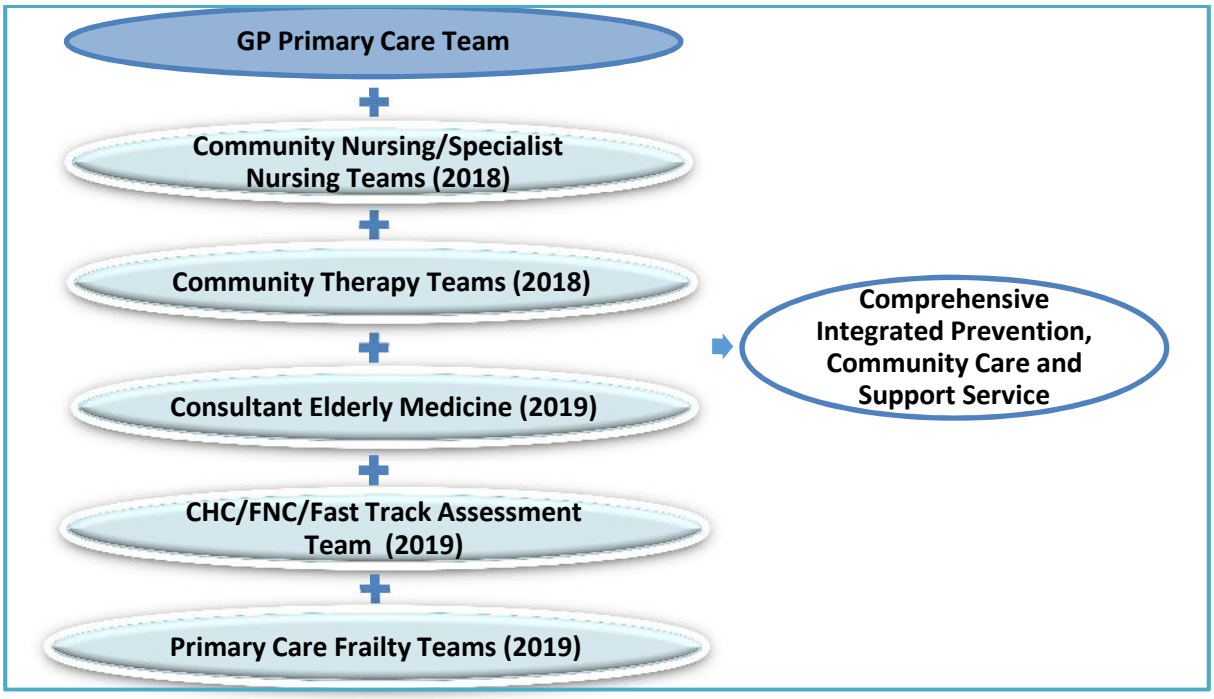
An MCP is about integration. It involves redesigning care around the health of the population, irrespective of existing organisational arrangements. It is about creating a new system of care supported by a new financial and business model. Establishing an MCP requires strong clinical leadership and management, good relationships and trust, with primary care at the heart of service delivery.

The CCG believes this represents a unique opportunity to bring about significant benefits for its population by focusing on prevention, well-being and self-care, while securing care for its older and frail population within the community, without the current and historical barriers between organisations.

Using the MCP as a contracting model, we intend to look at how providers will bring together social and community services with primary care at the core, through a series of integrated multi-disciplinary teams and clear career frameworks and supporting social care integration agreements. The delivery model will support people in their homes and communities, working with partners and across boundaries to enhance individual independence, help people live well for longer, prevent unnecessary admissions to secondary care and facilitate speedy discharge when an admission becomes necessary.

Detail on the in-scope services for the MCP is set out in **Appendix two** of this Prospectus. Many of the service types listed are part of the Phase 1 services and required from the services commencement date (3rd April 2018), with other services going live on 1st April 2019.

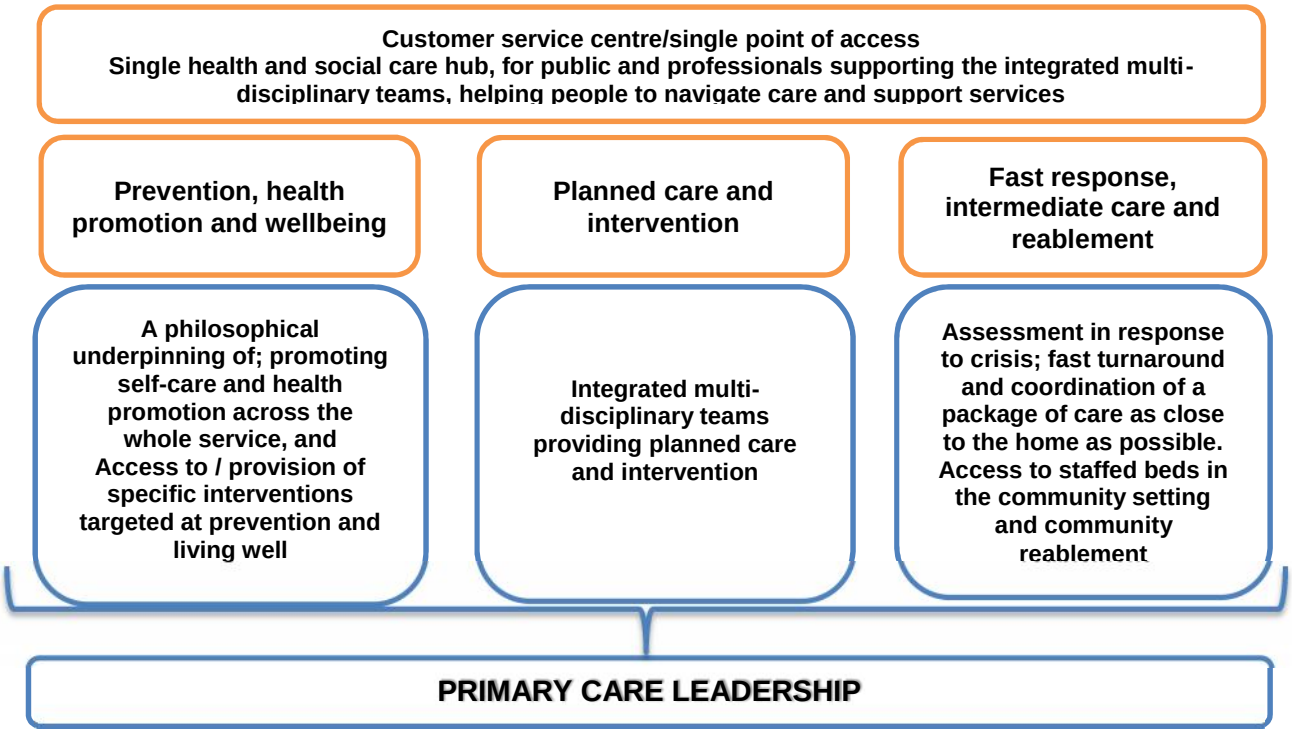
The following graphic forms the basis of the various components being brought together within the **Outline of Service Requirements** document which provides further detail.



The CCG wants to collectively focus and refocus the in-scope services to respond to three key strands, all supported by a customer service/ access centre. These are:

- prevention and self-care, including strengthening wider community response and reducing social isolation
- planned on going care and treatment, including continuing health care
- intermediate and fast response, re-ablement including admission avoidance and discharge to assess

The diagram below provides more information about the service model we intend to commission.



Together these elements support improving the health of the population, improving the individual's knowledge, skills and confidence in their ability to understand their condition and self-care, promote better coordination of care, and offer better access to the right care in the right place at the right time. The overall model will not be achieved on the Services Commencement Date, nor does the CCG believe it can be delivered by a single agency without a significant commitment to partnership and integrated working. A phased approach will be needed to secure full integration and this will be subject to further development and discussion as the procurement progresses.

The service delivery model will be built upon the unique position of primary care - starting with the individual patient registered with a practice and the role of the GP being fundamental (General practice takes overall responsibility for the care provided by other services). These services will include integrated multi-disciplinary teams "IMDTs", a wider network of community based and voluntary sector services organised around populations of approximately 30,000.

The MCP provider will be required to work with NYCC and Scarborough and Ryedale Borough Councils to tackle the wider determinants of health and reduce health inequalities and ensure parity of esteem across all services.

The MCP model/process will need to have a clear community identity and presence within the CCG localities. The MCP will bring together a wide range of integrated services around general practice, removing historic barriers to care delivery. The **CCG's Outline of Service Requirements document** sets out the full range of services to be provided by the MCP.

4.1 Critical success factors:

The CCG considers the following to be the critical success factors for this new care model:

- a connected system with a 'can do' and 'it is my job' approach
- a service that is integrated from the viewpoint of the people who access the service
- a service that supports the user of the service wherever they live, at the right time, with the right level of intervention
- a shift in focus to prevention rather than reaction
- support to people to self-care and maximise their independence as far as possible in order to reduce their resilience on direct care where appropriate
- a supported and enhanced primary and community care system led and delivered by primary and community care
- a register of the most vulnerable patients in each practice and a system of contact and escalation so that contact can be made in the event of a wider event such as extreme weather, major incident etc.
- a multi-professional approach to elderly medicine in the community that supports primary care and enables access to specialist elderly care without the recourse to hospital attendance
- assessment and direct access diagnostics provided as close to patient as possible
- a career framework where people can see their futures wherever they enter the caring professions.
- a service that wastes nobody's time… and that includes not admitting to hospital or attending accident and emergency departments when the right care and support can be at home
- risk satisfaction, shared governance, agreed risk thresholds and trusted assessments
- minimal transfers between team and agencies
- better use of resources across the economy
- Information Technology (IT) innovations and developments, telecare and telehealth will also, where appropriate, be utilised to support patient care and potentially including near patient testing
- mobilising third sector and wider community assets including working with housing partners and local community groups

5. Contractual Structure

The CCG intends to let a contract for 5 years with the option of a 2 year extension.

The CCG intends to use the NHS Accountable Care Model Contract as the contractual basis for these services. This contract is under development with NHS England's new models of care team and will be available in due course. Interested providers are advised to read the draft MCP contract available from https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/community-sites/ in the meantime as this forms the basis of the NHS Accountable Care Model Contract. The CCG's draft contract for use in the dialogue phase will be released to those Bidders selected for the second stage of this Procurement

Exercise.

The CCG will award a single contract. However, the CCG does not wish to exclude innovative or multi-party bidding models and as such interested providers are welcome to consider prime and sub-contracting bidding models, special purpose vehicles or other bidding structures as meet the requirements of the CCG.

The Successful Bidder will have a clear strategy for managing and delivering clinical, patient and service user outcomes as specified in its contract. The Successful Bidder will manage a single whole population budget and have the "right of decision" in terms of determining how this budget is allocated to deliver contracted outcomes. The Whole Population Budget is part of the financial payment package which also includes an Improvement Payment Scheme, a requirement for gain/loss share agreements and performance measurement against KPI's.

The Successful Bidder will be expected to demonstrate the highest level of commitment to service quality and patient safety.

This is a partially integrated MCP model which will not see primary medical care services commissioned through it. The CCG's GP Practices are committed to this new model of service delivery and have signaled (via the LMC chair) their commitment to entering into Integration Agreements. The aggregation of the populations of those practices opting to participate will de facto constitute the MCP's population upon which its budget will be based.

6. Integration Agreements

Integration with primary and social care is central to the delivery of the CCG's MCP model. Therefore, interested providers are advised that they will need to forge a successful relationship with the CCG's GP practices and with the NYCC as current provider of the social care services. The Integration Agreements will need to be in place before the Services Commencement Date.

The CCG is using NHS England's template Integration Agreement to draft baseline Integration Agreements which will be released with the draft contract to those Bidders who are selected to take part in the dialogue phase of this Procurement Exercise. There will be 4 baseline Integration Agreements:

- 1x baseline Integration Agreement for use with NYCC (and which are being developed in conjunction with the commissioner arm of NYCC);
- 1x baseline Integration Agreement for use with the CCG's rural GP Practices (and which are being developed in conjunction with representatives from those practices);
- 1x baseline Integration Agreement for use with the CCG's semi-rural GP Practices (and which are being developed in conjunction with representatives from those practices); and
- 1x baseline Integration Agreement for use with the CCG's urban GP Practices (and which are being developed in conjunction with representatives from those practices).

It is the CCG's expectation that the Selected Bidders will, during that period, engage with our GP provider community and NYCC to consider how the relevant baseline Integration Agreements can be developed to reflect the Selected Bidder's model. The CCG has made arrangements for appropriate representatives who are not engaged in bid vehicles to participate in this. Further details of this process will be released with the ITPD.

7. The Scope of the Services

Bidders will need to consider both the Phase 1 Services (3rd April 2018) and the Phase 2 Services that are due to transfer into the MCP on 1st April 2019 **(section 7.3)** when setting out how they will reconfigure current service provision to achieve the outcomes, and to meet the CCG's service specification for the development of the new model of integrated prevention, community care and support. Further information can also be found in the **Background Information Document** and in the **Outline of Service Requirements document**.

7.1 Phase 1 Services (3rd April 2018)

The following broad service groupings are within the scope:

Community Services – Ryedale
- Community nursing
- Physiotherapy and occupational therapy
- Inpatient (step up/down) beds for facility based rehabilitation/intermediate care
- Community Response Team – Ryedale Hub

Community Services – Scarborough
- Community nursing
- Physiotherapy and occupational therapy
- Community Response Team – extension of Ryedale hub to cover Scarborough

MSK Physiotherapy

Early Support Discharge (ESD) for Stroke

Community Specialist Nursing and Therapy
Specialist nursing and therapy support in respect of:
- Cardiac rehabilitation
- Continence including supply of products
- Diabetes
- Heart failure
- Nutrition and dietetics
- Respiratory
- Home oxygen service
- Tissue Viability
- Adult Speech and Language Therapy

7.2 Phase 2 Services (1st April 2019)

The following services will be transferred into the MCP in April 2019, the procurement documents and the Contract will set out further detail about this:

Continuing Healthcare ("CHC") including FastTrack
The CHC service is currently an in-house CCG service that arranges care packages on a case by case basis from a number of providers from both the public and private sectors. The funding that will be part of the new model includes assessment services for adults that are both fully funded by the CCG and joint funded alongside NYCC and includes Fast Track packages for patients at the end of life.

Funded nursing care ("FNC")
FNC covers assessment services as part of the continuing healthcare team to enable payment to homes to support patients who require the support of a registered nurse.

Elderly Medicine
YFT's Department of Elderly Medicine provides both acute medical and rehabilitation care to people over 75 years of age in inpatient and outpatient settings. It is the CCGs understanding that the current outpatient service includes one general elderly medicine clinic, offering five or six slots for patients. New patients are seen by the consultant geriatrician and follow up patients seen by specialist nurses.

In addition there are three specialist clinics:

- Parkinson's - two clinics per week, geriatrician and specialist nurse. Requires access to diagnostics
- Falls clinic - one stop all day clinic at Bridlington Hospital, multi-disciplinary team ("MDT") including geriatrician, OT and physio. Access to cardio testing and TILT tables plus other diagnostics
- TIA/stroke - Daily clinics, requires access to CT

As part of the acute medical model in accident and emergency, there is a plan to introduce rapid access clinics and advice and guidance. Currently in accident and emergency there is rapid access to geriatrician and assessment and diagnostics Monday to Friday 9-5. There is no community geriatrician within the directorate.

Primary care frailty service
The Primary Care Frailty Team for Scarborough and Ryedale is delivered by GP practice teams during the core hours of Monday to Friday 0830 – 1830. The overarching aim of the service is to support people living with frail or complex needs, to maintain their optimum level of independence and wellbeing, through the provision of effective and coordinated services.

The frailty team is predominately nurse-led but with access to a GP and other members of the MDT if required. This ensures that there is one key contact point in the GP practice, with the appropriate skills and experience to manage the needs of the patient.

8. Anticipated outcomes

The outcomes below give an indication of the more macro level expectations of the CCG. Additionally the Successful Bidder will be expected to contribute to meeting the NHS/CCG/Adult Social care and Public Health Outcomes Frameworks.
These documents are available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/375431/ASCOF_15-16.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385749/NHS_Outcomes_Framework.pdf

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

Further detail on the Service outcomes and KPIs proposed by the CCG are included at **Appendix 2** of this document.

9. The Procurement Process and Contracting Model

The CCG has started a Procurement Exercise using a call for competition in the form of a contract notice released through OJEU and Contracts Finder.

Prospective Bidders should note that the procedure will fall under the "light touch" regime of Regulations 74 to 78 of the Public Contracts Regulations 2015 (the "2015 Regulations"). Therefore, the procurement exercise will be run in accordance with the 2015 Regulations as they apply to "light touch" services. The CCG is also subject to the requirements of the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and the requirements of these Regulations will be taken into account throughout the procurement process.

The CCG is using a Pre-Qualification Questionnaire to select three Bidders who will be invited to participate in a dialogue process, akin to competitive dialogue.

The CCG reserves the right to:

- conduct engagement and consultation exercises where required to do so based on the solutions put forward to comply with legal obligations
- move to a managed negotiated procedure in the event it only receives 1 compliant response to its PQQ or if bidders drop out or are removed from the process at any point, leaving only 1 bidder
- amend, add to, or withdraw all, or any part, of any tender document at any time during the tender process and consider alternative procurement options without any liability to operators or prospective bidders

Please refer to the Contract Notice for additional information.

Bidders should note that this Procurement Exercise is subject to the NHS England Integrated Support and Assurance Process (ISAP) for novel and complex contracts. This Assurance Process is a series of checkpoints or gateway reviews which enable NHS England and NHS Improvement to gain assurance and assess the likelihood of the procurement delivering a sustainable service for the lifetime of the contract. Its aims are to:

- ensure the proposals represent a good solution in the interests of patients and the public;
- ensure a system view has been taken of the potential consequences of a contract award; and
- enable the risks of the complex contract to be identified, understood and mitigated as far as possible

It is a requirement that procurements which meet the criteria for ISAP, take account of the timescales for the checkpoint reviews and the CCG reserves the right to take the necessary steps to comply with the ISAP process.

The CCG anticipates awarding a single contract as a result of this Procurement Exercise. However, the CCG does not wish to exclude innovative or multi-party bidding models and as such interested providers are welcome to consider prime and sub-contracting bidding models, special purpose vehicles or other bidding structures as meet the requirements of the CCG when published.

10. Indicative Procurement Timetable

Set out below is the timetable for the Procurement Exercise. This is intended as a guide and whilst the CCG does not intend to depart from the timetable, it may do so at any time in its absolute discretion.

Matter	**Date(s)**
Publish Contract Notice and release PQQ	13th July 2017
Deadline for PQQ clarification questions	5 pm, 21st July 2017
PQQ response deadline	9 am, 31st July 2017
Evaluation of PQQ responses	1st August 2017
Notification of outcome of PQQ evaluation	3rd August 2017
Issue ITPD and key contractual documents	3rd August 2017
Opening of Data Room	3rd August 2017
Service solution presentations to CCG and dialogue meetings	15th August – 6th October 2017
Call for Final Tenders	6th October 2017
Deadline for receipt of Final Tenders	23rd October 2017
Evaluation of Final Tenders	30th October 2017
ISAP Checkpoint 2	17th November 2017 - 31st January 2018]
Notification of intention to award the contract	1st November 2017
Standstill Period Ends	13th November 2017
Mobilisation	1st January 2018 – 2nd April 2018
ISAP Checkpoint 3	15th February 2018 – 2nd April 2018
Go Live	3rd April 2018

Appendix 1. Scope During Term of Contract

List of services within, and which will become part of, the overall scope of the MCP during the term of the Contract and their proposed inclusion dates.

Service Line	Current Commissioner	Current Provider	Proposed MCP Inclusion Phase (reconfigured to new model)	
			3 April 2018	1 April 2019
Community Services - Ryedale	Scarborough and Ryedale Clinical Commissioning Group	YFT	X	
Community Services - Scarborough	Scarborough and Ryedale Clinical Commissioning Group	YFT	X	
Community Specialist Nursing	Scarborough and Ryedale Clinical Commissioning Group	YFT	X	
Early Supported Discharge for Stroke	Scarborough and Ryedale Clinical Commissioning Group	YFT	X	
Community Response Team (Ryedale Hub)	Scarborough and Ryedale Clinical Commissioning Group	YFT	X	
Community Response Team extension to Scarborough	Scarborough and Ryedale Clinical Commissioning Group	YFT	X	
Continuing Healthcare Assessment Team and linked Admin (including Funded Nursing Care)	Scarborough and Ryedale Clinical Commissioning Group	SRCCG/Various		X
Fast Track (packages) Admin	Scarborough and Ryedale	SRCCG/Various		X

Service Line	Current Commissioner	Current Provider	Proposed MCP Inclusion Phase (reconfigured to new model)	
			3 April 2018	1 April 2019
included within CHC	Clinical Commissioning Group			
Elderly medicine out-patient services	Scarborough and Ryedale Clinical Commissioning Group	YFT		X
Frailty service	Scarborough and Ryedale Clinical Commissioning Group	Primary Care		X

Appendix 2. Expected Outcomes from the Service

National Outcomes Framework Domains

The CCG is looking to commission the new service based on a model of commissioning that focuses on achieving outcomes for individuals. In terms of the processes needed to capture baseline outcomes and indicators this will require time to develop and establish. The Successful Bidder will be required to work with the CCG to establish such processes.

The Successful Bidder is also required to work in collaboration with the CCG, and its partners, to continuously develop and implement appropriate outcome measures over the life of the Contract.

The outcomes framework below is based on good practice from other areas as well as on the things people told us they wanted to see. It will be developed further during the Procurement Exercise including detailed information requirements and data sets.

Because the new service relies on closer working across agencies, as well as formal integration agreements between primary care and NYCC, we would expect an integrated service to contribute to the achievement of the following outcomes frameworks (subject to change following any national reviews) with underpinning key performance indicators being set out in the contract.

NHS Outcomes domains:
Preventing people from dying prematurely
Enhancing quality of life for people with long term conditions
Helping people to recover from episodes of ill health or following injury
Ensuring that people have a positive experience of care
Treating and caring for people in a safe environment and protecting them from avoidable harm

Adult Social Care Outcomes domains:
Enhancing quality of life for people with care and support needs
Delaying and reducing the need for care and support
Ensuring that people have a positive experience of care and support
Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Public Health Outcomes domains:
Improving the wider determinants of health
Health improvement
Health protection
Healthcare, public health and preventing premature mortality

Local Outcomes Framework

(subject to discussion and development of more detailed key performance indicators and data collection requirements during the Procurement Exercise)

Outcome	Ref	Key Performance Indicator
1 Improving Health, Wellbeing and Independence		
1A Patients and carers are empowered to lead the planning of their care in partnership with professionals	1A1	Proportion of adults (over 18) feeling supported to manage their long term condition
	1A2	Proportion of people who use services and carers who find it easy to find information about support
	1A3	Health related quality of life for people with long term conditions
	1A4	Proportion of people on caseload that have a crisis management plan
	1A5	Uptake of NHS Health Checks in line with national and local requirements
	1A6	Permanent admissions to residential and nursing care homes, per 100000 population
	1A7	Estimated diagnosis rate for people with dementia
	1A8	A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life for patients with dementia
1B The incidence of admission and re-admission to secondary care is reduced by providing support and education to both patients and carers about self -management and early intervention	1B1	Number of unplanned medical admissions for over 65s
	1B2	Number of patients presenting at A&E with problems which may have been avoidable if they had been managed better in the community (Need to define a list from the Ambulatory Sensitive Care Conditions)
	1B3	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service
	1B4	Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital
	1B5	Number of avoidable emergency readmissions within 30 days of discharge from hospital
	1B6	Average LOS for medical admissions in over 65s
1C Patient activation measures demonstrate people's knowledge, skills and confidence in their ability to understand their condition and self-care	1C1	Number and proportion of people with a health condition or long-term condition who a validated measure (such as the Patient Activation Measure) identifies as showing active involvement in their own health and well-being

Outcome	Ref	Key Performance Indicator
1D The use of personal health budgets is actively promoted to give patients and their carers the option to manage their healthcare and support such as treatments, equipment and personal care, in a way that suits them	1D1	Number of Personal Health Budgets in place
2 Improving the Experience of People who use the services		
2A Patients, Carers and families have an overall excellent experience of care and support	2A1	Proportion of people and carers reporting they are satisfied with the service(s) they receive
	2A2	Number and proportion of people who report that they have confidence in the support, advice and care they receive
	2A3	Friends and Family Test Results
2B Carers report that they have been included or consulted in discussion about the person they care for and carers know who they can call to discuss care matters related to themselves or their dependent that may impact on the continuity or future levels of care	2B1	The proportion of carers who report that they have been included or consulted in discussion about the person they care for
	2B2	Health related quality of life for carers
	2B3	The proportion of carers who have been assessed using recognised tool such as the Caregiver Strain Index
2C Access to services including Fast Response enables packages of care to be implemented in a timely manner to overcome crisis point or support planned care	2C1	Proportion of patient/service users maintained at home or in an intermediate care facility by day 5 following referral to fast response
	2C2	Urgent/Fast Response - Number of patients assessed within 2 hours as a % of total fast response referrals in period
	2C3	Urgent one hour response pathways (to be agreed, for example falls and catheterisation) Number of patients assessed within 1 hour (as a % of total referred in period)
	2C4	Non Urgent - Number of patients assessed within minimum response parameters (as a % of total referrals in period)
	2C5	Routine planned care - Number of patients seen next day or day the appointment for the intervention is requested as a % of total patients seen
	2C6	Therapy and specialist Nursing Services (including CHC and FNC) - Number of patients seen within

Outcome	Ref	Key Performance Indicator
		specified response time as a % of total patients seen (target to be agreed for each service)
2D When life is at an end the quality of care experienced by the person who died, and their families, as reported by carers, was excellent	2D1	Bereaved carers' views on the quality of care in the last 3 months of life
	2D2	Proportion of people on an end of life care pathway who have been offered DNAR discussion and have had their preference recorded
	2D3	Proportion of patients on an end of life care pathway who have a personalised care plan
	2D4	Proportion of patients where place of death was consistent with their documented place of choice
3 Reducing Health Inequalities		
3A Improved Life Expectancy through reduced inequality	3A1	Healthy life expectancy (HLE) at age 65
	3A2	Reduced Inequality in Life Expectancy
3B Reduction in potential years of life lost from conditions amenable to healthcare	3B1	Potential years of life lost from causes considered amenable to healthcare: adults
3C The system supports improved rehabilitation and recovery from Stroke	3C1	Proportion of patients with an improvement of at least 1 point on the Modified Rankin Scale at 6 months and 1 year post stroke. Or improvement in TOMS at six months and one year post stroke
	3C2	Percentage of applicable patients receiving a joint health and social care plan on discharge
	3C3	Percentage of patients treated by a stroke skilled Early Supported Discharge team
	3C4	Proportion of patients seen by the team on the day of or day after discharge
	3C5	a) Proportion of patients with agreed goals (agreed with patient and family) within 1 week of start of service b) Proportion of patients achieving goals by end of service
	3C6	a) Proportion of appropriate patients who rate access to vocational support as good or very good b) Proportion of patients with no unmet vocational needs at six month and annual review (e.g. have had an assessment and have actions in care plan to address identified needs)
	3C7	Proportion of patients with no unmet emotional/psychological needs at 6 month and annual review
	3C8	Proportion of stroke patients rating the overall services as good or very good

Outcome	Ref	Key Performance Indicator
3D The system supports people who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community for as long as possible with the ability to exercise choice over how they spend their time	3D1	Emergency hospital admissions due to falls in people aged 65 and over
	3D2	Hip fracture: proportion of patients recovering to their previous levels of mobility/walking ability at 120 days
4 Making the best use of collective resources		
4A People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	4A1	Number and proportion of health professionals reporting that they are satisfied that they are delivering a safe, high quality, evidence based service that meets the needs of different service users
	4A2	Staff friends and family test
4B Staff and volunteers are empowered through training and support to deliver excellent outcomes for individuals	4B1	Number and proportion of staff trained in brief interventions (list to be agreed) and are able to demonstrate competence
	4B2	Number and proportion of staff who have completed role specific training (list to be agreed) and are able to demonstrate competence
	4B3	Number of appraisals carried out as a percentage of total workforce numbers
	4B4	Number and proportion of health professionals reporting that they are provided with opportunities for learning
	4B5	Use of volunteers: Number of volunteers within the workforce
4C A community of care where there is wider integration and collaboration across all sectors	4C1	Numbers of people on caseload reporting an improvement in the size and range of their social networks
	4C2	A system indicator focused on wider integration with the voluntary and community sector e.g. Use of social prescribing (to be developed in conjunction with the provider)

Outcome	Ref	Key Performance Indicator
4D Staff and the whole organisation are committed to working in a joined up and integrated way, reducing duplication and increasing value for money	4D1	Improving people's experience of integrated care
	4D2	Percentage of patients whose discharge or transfer from hospital is delayed (to be developed)