Scarborough and Ryedale Clinical Commissioning Group

MCP Prospectus - Integrated Prevention, Community Care and Support Service

Images by Richard Burdon, courtesy of: http://www.discoveryorkshirecoast.com

MARCH 2017
Contents
Statement from CCG Chair, Dr Phil Garnett: ........................................................................ 3
Executive Summary .............................................................................................................. 4
1. Background .................................................................................................................... 4
2. CCG’s proposed model ................................................................................................... 8
3. Joint Strategic Needs Assessment .................................................................................. 10
4. Multi-specialty Community Provider (MCP): Our plans for the future ................. 14
4.1 Critical success factors include: .................................................................................. 15
5. The Service Provider ..................................................................................................... 16
6. Contractual structure ..................................................................................................... 16
7. The Scope of the Services ............................................................................................. 18
7.1 The Overall Integrated Health and Social Care Service Delivery Model ............ 18
7.2 Day 1 (April 2018) .................................................................................................... 19
7.3 At defined points in the contract ................................................................................. 20
8. Anticipated outcomes ................................................................................................... 21
9. The Procurement Process and Contracting Model ..................................................... 22
10. Provider Engagement Event ........................................................................................ 23
Appendix 1. Potential Scope During Term of Contract ................................................... 24
Appendix 2. Expected Outcomes from the Service .......................................................... 27

Images by Richard Burdon, courtesy of: http://www.discoveryorkshirecoast.com
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.

Images by Richard Burdon, courtesy of:http://www.discoveryorkshirecoast.com
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.

Our 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. We cannot solve these issues working alone.

We want 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 we intend to do this using joint commissioning through Section 75 powers, and the development of a new and innovative Multi-Speciality Community Provider service model. The CCG envisages that these arrangements will be underpinned by NHS England’s MCP contract to secure delivery.

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

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

NHS Scarborough and Ryedale 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.

In 2014 the NHS Five Year Forward View¹ (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.

Scarborough and Ryedale CCG is part of the Humber Coast and Vale STP² (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 “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 Programme³, 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 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.

Our out of hospital care will be transformed by the emergence of an integrated adult health and social care service, bringing together social care, community and primary care to deliver service models that will ensure:

- Improved prevention through single contact system of advice, guidance, signposting and direction into community support.
- Rapid access to community response for those in crisis or stepping down from acute care
- Combined integrated care teams, based around practice populations, to provide planned care and proactive management of chronic diseases.

This new model of care will develop in phases and will ultimately shift elderly sub-acute care from being primarily hospital bed-based, to that of a ‘Home First’ approach delivering care into patients’ own residence.

The current arrangements for the delivery of NHS and Local Authority out of hospital care locally is 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.

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 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 PMS/GMS/APMS contracts for primary care services, to a fully integrated MCP in which the delivery of primary medical 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.

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. Based on the earlier work an overall model for the new approach was drafted which formed the basis of this latest engagement.
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 engagement report is available from the CCG’s website.

By September 2015, 50 “Vanguards” had been selected by NHS England to take a lead on the development of new care models to act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system. In parallel with our engagement work and local model development, the CCG has been closely following the progress of the 14 Vanguard sites who are leading the development and commissioning of the Multi-Specialty Community Provider model, with several providing advice and support directly to the CCG team on various aspects of their experiences.

After discussions initially 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.

In developing this route the commissioners are 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, and also to set out the longer term intention and vision.

The new service will bring together health and 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. The commissioning model has been developed in conjunction with the commissioning arm of NYCC and over time, we propose that financial resources will be brought together under joint management to fundamentally change the way care outside of a hospital is organised and delivered in Scarborough and Ryedale.

Our proposed integrated model will from commissioning to delivery, support the systems and processes needed to enable individuals with and without long term conditions to benefit from a connected system, partnership working and effectively co-ordinated care. At the highest level we see the overall service made up as demonstrated below:

---

The CCG wishes to work with partners 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.

We are actively working with NYCC to establish a substantial Section 75 partnership agreement with pooled commissioning budget arrangements. This will be subject to consultation. We believe that this framework will help deliver our preferred integrated model. Our preferred method for the delivery of our shared vision for a prevention, community care and support model is via a Multi-Specialty Community Provider (“MCP”) which will take on responsibility for the whole of out of hospital services as defined within our scope (page 18/19).

2. CCG’s proposed model

The CCG now wishes to take this to the next stage; by entering into a procurement process with the intention of awarding a long term contract (potentially ten years with an optional 5 year extension) for a partially integrated MCP model of care.

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

Using the MCP framework as a contracting model, we want to look at how interested providers can bring together services with primary care at the core, through a series of integrated multi-disciplinary teams and clear career frameworks. The delivery model will

need to 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 proposed in-scope services for the MCP model is set out in Appendix two of this Prospectus. It is anticipated that some services will be required from Day 1 with other services going live at a later pre-determined point in time. A final category of service lines may also be transferred in during the life of the contract subject to NYCC approvals.

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. Our largest providers are York Teaching Hospitals NHS Foundation Trust who currently provide acute and community services, and Tees, Esk and Wear Valleys NHS Foundation Trust who currently provide adult, children’s and adolescent mental health services.

The 15 practices have list sizes ranging from 2,300- 20,000 and services are delivered by 1 APMS, 2 PMS, 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:
This Prospectus should be read in conjunction with a number of other supporting documents available from the CCG’s dedicated website or as otherwise indicated below:

- Prior Information Notice
- Engagement Report

Further documentation will be released at appropriate points in the procurement process.

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. We are 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
- too many people die early from diseases such as cancer, 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
- a fragile domiciliary and care home market

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 Scarborough and Ryedale 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. SRCCG 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 SRCCG 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 SRCCG. 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 SRCCG. The area struggles with significantly lower breast feeding initiation rates (70.7%, Q1 2014/15) compared to the England average (74.0%). Improving this figure by promoting good infant nutrition should help improve the obesity figures in children and ultimately adults. 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 Scarborough and Ryedale 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 are also 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

An MCP model 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 model requires strong clinical leadership and management, good relationships and trust, with primary care at the heart of service delivery.

An MCP model combines the delivery of primary care with community based health and care services as required to meet the needs of the local population. This will mean organisations coming together to drive a more integrated approach to care and that some services currently based in hospital settings such as out-patient clinics, care of the frail and elderly, diagnostics and end of life care become part of the MCP model as the community services base is strengthened. Nationally, there are three broad levels of contractual arrangements for MCPs emerging:

- Virtual – commissioners continue to contract with individual providers and the providers also enter into an alliance agreement.
- Partially integrated – the scope of the MCP contract excludes primary medical services. However, the service provider is required to enter into an integration agreement with the relevant GPs to achieve integration at operational level. Please note in our model, an integration agreement with NYCC (as a service provider) will be required to drive operational integration with adult social services.
- Fully integrated – the scope of the MCP contract includes all primary medical and community based services.

Following periods of engagement with staff and the public we want to collectively focus and refocus the in-scope services to respond to three key strands, all supported by a customer service/access centre, as will be more fully described in in due course. The four key strands are:

- A customer service access centre/single point of access
- 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

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 service will be based upon the highest level of commitment to service quality and patient safety, and will be population-based and founded upon list based general practice. The structure and accessibility of the service will support and strengthen general practice through integrated services which engender a strong ‘can do’ attitude based on agreed risk thresholds and competency based protocols across partners.

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 service specification will set out the full range of services to be provided by the MCP.

4.1 Critical success factors include:

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

- A connected system with a “can do” and “it’s my job” approach
- A service that is integrated from the viewpoint of the people who access the service.
- Built around people – in their community
- An emphasis on prevention rather than reaction
- A supported and enhanced primary and community care system led and delivered by primary and community care
- A career framework where people see their futures wherever they enter the caring professions.
- A system that wastes nobody’s time… and that includes not admitting to hospital or attending the emergency department when the right care and support is available closer to home
- Shared and trusted assessments
- Minimal transfers between teams and agencies
- Better use of resources across the economy
- Use of innovative IT systems that enable information sharing across health and social care and all partner sectors to help with service delivery
- Use of technology, such as tele-health and tele-care where appropriate, to support patient care
- People using health and social care services are safe from harm
- Health and social care services are centred on helping maintain or improve the quality of life of people who use those services
- Resources are used effectively and efficiently in the provision of health and social care
- People who provide unpaid care are supported to look after their own health and well-being
- People who work in health and social care feel engaged with the work they do, are supported to continually improve the information, support and care they provide.
- Health and social care services contribute to reducing health inequalities
5. The Service Provider

Integration with primary and social care is central to the delivery of the MCP model. Therefore interested providers are advised that they will need to forge a successful relationship with the CCG’s practices and with the current provider of the specified social care services (NYCC). Integration agreements will need to be in place before service commencement with both General Practices, and with NYCC to set out the level and scope of integration once the service commences. It is the CCG’s intention to test the strength of interested providers’ integration arrangements in the procurement process and we will, where possible, make arrangements to facilitate discussions with GP representatives and with NYCC.

6. Contractual structure

As already noted the CCG envisages letting a contract based on the draft MCP contract.

The CCG anticipates awarding the contract to a single legal entity. 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.

The contractual form entered into will have, the flexibility to expand to provide for:

- the inclusion of local enhanced services and other specified services at pre-determined points in the life of the contract;
- primary medical services to come in scope where GP practices wish to become ‘fully integrated;
- additional social care services to transfer in, at the sole discretion of NYCC and subject to Council approval in accordance with specified contractual mechanisms. the inclusion of general practices that sit outside of the current CCG boundaries

The Service provider will have a clear strategy for managing and delivering clinical, patient and service user outcomes as specified in its contract. The Service provider 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 Service provider will be expected to demonstrate the highest level of commitment to service quality and patient safety.

The MCP model is population-based and founded upon list based general practice. Those GP Practices wishing to participate will either do so on a partially integrated basis (entering into an integration agreement with the service provider) or on a fully integrated basis (where by their primary care services are contracted through the MCP model) 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. Whilst the CCG would like all its practices participate in the MCP model, where this is not the case, the CCG will contract separately with the MCP to deliver services to the populations of those practices choosing not to become a member.

The contract will define the nature of the relationship the MCP will have for those providers delivering the MCP services to the CCG population. This will include appropriate risk/gain share agreements. In some cases the MCP will have sub-contract arrangements in place with these providers.
The MCP will be required work with NYCC and Scarborough and Ryedale Borough Council’s
to tackle the wider determinants of health and reduce health inequalities and ensure parity of
esteem across all services.

The MCP 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.

Services will be delivered from community based locations which could include existing
community bedded facilities. These will support the movement of services more traditionally
delivered in secondary care settings to community based settings. Some of these services
may be the responsibility of other providers but could be co-located with MCP services.

The MCP is based upon the principle of mutuality with:

- Clear accountability to the public for the delivery of high quality care within the resources
  available;
- Emphasis on co-production of care and maximising the potential of the individual;
- Promotion of responsibility for individuals to manage their own health and wellbeing and
to access services appropriately.
7. The Scope of the Services

7.1 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 the adult population, and founded upon list based general practice in a structure that supports and strengthens the leadership and decision making of general practice.

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 overall model will not be achieved on day one of the new service, nor do we 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, and in later years of the contract term.
7.2 Day 1 (April 2018)

The CCG anticipates that the services which will need to be provided from day 1 of the contract are those set out below. It is these services that the interested bidders will need to consider when setting out how they will reconfigure 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:

**Community Services – Ryedale**
- Community nursing
- Physiotherapy and occupational therapy
- Malton Community Hospital including inpatient (step up/down) beds. This budget also includes funding for the costs associated with the Malton Hospital building.
- Community Response Team – Ryedale Hub

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

**Early Support Discharge (ESD) for Stroke**

**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

**Continuing Healthcare and Fast Track**
The continuing healthcare 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 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 payments to care homes to support patients who require the support of a registered nurse.

**Commentary**
Whilst fragmentation remains, there have recently been significant efforts made to bring together teams and work increasingly with partners, in particular through the Better Care Fund schemes and the Community response team (Malton hub) model, however the wider community and specialist nursing teams are not an integral part of this, nor is the service spread equitably across the patch in response to need. While there is some level of
integrated working within the Ryedale hub, there are limited generic support worker posts, with training in place for the development of the generic worker recently commencing. The ambition to reduce hospital emergency admissions following the introduction of the Ryedale Hub has not yet been fully realised, however this has been extended to cover Scarborough over the winter period to provide cover for the areas with greatest level of need.

Community nursing services currently work in teams grouped around practices with some crossover to cover annual leave and shifts etc. There is no integration with practice staffing or with other care teams working across the community, and no shared assessments, however the Nurses and Health Care Assistants (HCA) do work closely with General Practice teams. There is an evening nursing service but no access to service overnight. The hospice at home service that is outside of the scope of this procurement is provided to the Scarborough locality but provision for this has not yet been made in the Ryedale area, however Malton Hospital beds are used for palliative care patients as needed.

Community therapy provision is split into different teams who work on early supported discharge, within the Ryedale hub, on rapid access and treatment, and on specific patients referred to them. Some of the therapists work as part of wider teams. We know that some specialist nurses and therapists e.g. diabetic specialist nurses, dieticians work across acute and community making the separation of staff in the community services more complex. We are aware that in some cases the models of blended teams have been implemented where it may have been difficult to recruit to specific community posts.

While Specialist Nursing services as part of the community contract, support primary care and community nurses in managing patients at home or in care homes, the precise make up of the specialist nursing teams and volume of bespoke community activity is not currently clear.

7.3 At defined points in the contract

It is envisaged that the following services will be transferred into the MCP model form year 1 and the contract will set out the process for this:

- Community Out Patients (Rheumatology, Gynaecology, ENT, Dermatology)
- Community Diabetes
- Elderly Medicine
- Primary care frailty service
- Adult and Older People’s mental health

The further potential scope of services that commissioners may wish to add to the MCP over the term of the contract is included in Appendix 1. There is no pre-determined date for the inclusion of such services which will be at the discretion of NYCC and subject to Council approval but it is envisaged that the contract will contain a mechanism for this.
8. Anticipated outcomes

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


Further detail on the draft outcomes proposed by the CCG are included at Appendix 2 of this document.

Outcomes will be supplemented by a set of key performance indicators and minimum data requirements in addition to those set out with the core MCP contract.

- People are able to look after and improve their own health and wellbeing and live in good health for longer
- People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- People using health and social care services are safe from harm.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Resources are used effectively and efficiently in the provision of health and social care services.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- 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.
- Health and social care services contribute to reducing health inequalities.
9. The Procurement Process and Contracting Model

The CCG does not bind itself to commencing or running any public procurement procedure further to, or as a result of, the publication of the Prior Information Notice (PIN) or this market engagement event. Any subsequent procurement will be commenced by way of a separate call for competition. The CCG, therefore, reserves the right to make changes to the scope, characteristics and outcomes of the procurement procedure as set out in the PIN, this Prospectus and any other associated documentation.

Prospective Bidders should note that any subsequent procurement procedure would fall under the “light touch” regime of Regulations 74 to 78 of the Public Contracts Regulations 2015 (the “2015 Regulations”). Therefore, any procurement exercise would 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.

It is the CCG’s intention to run a process which is akin to the “competitive dialogue” process. It will be a two stage process with an initial selection stage and then a dialogue phase for the selected bidders.

Whilst the CCG can define the funding streams (but not necessarily the payment mechanisms) and existing services that would be part of the new MCP model and the outcomes and benefits that we would like from a newly commissioned integrated service it does not wish to describe or define the delivery method. The CCG is interested in receiving proposals from the market in respect of the service solutions as part of the procurement process. The dialogue stage of the procurement (structured discussions between the CCG and the selected bidders) will permit the development and refinement of solutions that are shaped to deliver the outcomes as set out in the service specification.

Interested providers should note that this procurement process will be subject to the Integrated Support and Assurance Process (ISAP) for novel and complex contracts. This Assurance Process (designed by NHS England and NHS Improvement) 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 contract award;
- 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, which can total an additional 6 months in the procurement process. The use of a competitive dialogue process provides an opportunity to manage some of the ISAP process, working alongside NHS England, in parallel to stages of the procurement process.

The CCG anticipates awarding the contract to a single legal entity. 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.
The CCG intends that the new MCP model shall:

- be contracted on the basis of the model MCP contract prevailing at that time subject to local variation where permitted
- be supported by integration agreements entered into with the CCG’s general practices and NYCC
- receive a whole population budget as funding for the delivery of the services and may also have risk/gain share features and/or an improvement payment scheme
- commence service delivery from 3rd April 2018

10. Provider Engagement Event

A provider event will be held:

7th April 2017 starting at 9.30 am
Scarborough Campus, Coventry University, Ashburn Road, off Valley Road, Scarborough, YO11 2JW

Organisations who wish to attend this event should register their interest using the event registration form on the website http://www.scarboroughryedaleccg.nhs.uk/commissioning-integrated-community-services

And return it by the stipulated deadlines.
Appendix 1. Potential Scope During Term of Contract

List of services within, and which may become part of, the overall scope of the MCP during the term of the contract and their proposed inclusion dates where known.

* Services that might be moved into MCP during term of contract using contractual mechanisms are at discretion of NYCC and subject to Council approval.

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Current Commissioner</th>
<th>Current Provider</th>
<th>Proposed MCP Inclusion Phase (reconfigured to new model)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 April 2018 1 April 2019 To be determined by commissioner*</td>
</tr>
<tr>
<td>Community Services - Ryedale</td>
<td>Scarborough and Ryedale CCG</td>
<td>York FT</td>
<td>X</td>
</tr>
<tr>
<td>Community Services - Scarborough</td>
<td>Scarborough and Ryedale CCG</td>
<td>York FT</td>
<td>X</td>
</tr>
<tr>
<td>Community Specialist Nursing</td>
<td>Scarborough and Ryedale CCG</td>
<td>York FT</td>
<td>X</td>
</tr>
<tr>
<td>Early Supported Discharge for Stroke</td>
<td>Scarborough and Ryedale CCG</td>
<td>York FT</td>
<td>X</td>
</tr>
<tr>
<td>Community Response Team (Ryedale Hub)</td>
<td>Scarborough and Ryedale CCG</td>
<td>York FT</td>
<td>X</td>
</tr>
<tr>
<td>Community Response Team extension to Scarborough</td>
<td>Scarborough and Ryedale CCG</td>
<td>York FT</td>
<td>X</td>
</tr>
<tr>
<td>Continuing Healthcare including Fast Track</td>
<td>Scarborough and Ryedale CCG</td>
<td>SRCCG/Various</td>
<td>X</td>
</tr>
<tr>
<td>Funded Nursing Care</td>
<td>Scarborough and Ryedale CCG</td>
<td>SRCCG/Various</td>
<td>X</td>
</tr>
<tr>
<td>Adult and older peoples mental health and Learning disability services</td>
<td>Scarborough and Ryedale CCG</td>
<td>Tees Esk and Wear Valley NHS Foundation Trust</td>
<td>X</td>
</tr>
<tr>
<td>Elderly medicine out-patient services</td>
<td>Scarborough and Ryedale CCG</td>
<td>York Foundation Trust</td>
<td>X</td>
</tr>
<tr>
<td>Service Line</td>
<td>Current Commissioner</td>
<td>Current Provider</td>
<td>Proposed MCP Inclusion Phase (reconfigured to new model)</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 April 2018</td>
</tr>
<tr>
<td>Frailty service</td>
<td>Scarborough and Ryedale CCG</td>
<td>Primary Care (General Practice)</td>
<td>X</td>
</tr>
<tr>
<td>Local enhanced services</td>
<td>Scarborough and Ryedale CCG</td>
<td>Primary Care (General Practice)</td>
<td>X</td>
</tr>
<tr>
<td>Community Diabetes</td>
<td>Scarborough and Ryedale CCG</td>
<td>York Foundation Trust</td>
<td>X</td>
</tr>
<tr>
<td>Community Outpatients eg rheumatology, ENT, Dermatology, gynaecology</td>
<td>Scarborough and Ryedale CCG</td>
<td>York Foundation Trust</td>
<td>X</td>
</tr>
<tr>
<td>Primary care services (GMS/PMS/APMS)</td>
<td>Scarborough and Ryedale CCG</td>
<td>Primary Care (General Practice)</td>
<td>X</td>
</tr>
<tr>
<td>Living Well prevention services</td>
<td>North Yorkshire County Council</td>
<td>North Yorkshire County Council</td>
<td>X</td>
</tr>
<tr>
<td>Emergency duty team</td>
<td>North Yorkshire County Council</td>
<td>North Yorkshire County Council</td>
<td>X</td>
</tr>
<tr>
<td>Day services</td>
<td>North Yorkshire County Council</td>
<td>North Yorkshire County Council</td>
<td>X</td>
</tr>
<tr>
<td>Customer centre</td>
<td>North Yorkshire County Council</td>
<td>North Yorkshire County Council</td>
<td>X</td>
</tr>
<tr>
<td>Re-ablement</td>
<td>North Yorkshire County Council</td>
<td>North Yorkshire County Council</td>
<td>X</td>
</tr>
<tr>
<td>Extra care housing</td>
<td>North Yorkshire County Council</td>
<td>North Yorkshire County Council</td>
<td>X</td>
</tr>
<tr>
<td>Service Line</td>
<td>Current Commissioner</td>
<td>Current Provider</td>
<td>Proposed MCP Inclusion Phase (reconfigured to new model)</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------</td>
<td>------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 April 2018</td>
</tr>
<tr>
<td>Budgets for day to day management of home care, residential and nursing home care placements within framework</td>
<td>Council</td>
<td>North Yorkshire County Council</td>
<td>North Yorkshire County Council / Various</td>
</tr>
</tbody>
</table>
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 provider will be required to work with the CCG to establish such processes.

The provider 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 process 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)
<table>
<thead>
<tr>
<th>High level outcomes</th>
<th>System and personal outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>People are able to look after and improve their own health and wellbeing and live in good health for longer</td>
<td>Patients and carers are empowered to lead the planning of their care in partnership with professionals</td>
</tr>
<tr>
<td>Patients have access to information in an appropriate language and format, when they need it including brief interventions at opportune moments</td>
<td>Patients have equitable access to a range of community services which meet their needs</td>
</tr>
<tr>
<td>The system supports a reduction in the number of days spent in hospital from emergency admissions</td>
<td>The service supports the timely discharge of medically fit patients by secondary care back into the community</td>
</tr>
<tr>
<td>The system supports a reduction in the number of days spent in hospital from emergency admissions by people with alcohol or drug related dependencies</td>
<td>People make a sustainable recovery after admission to acute or intermediate care, with a reduction in readmissions or complications and no avoidable deterioration in health and functioning</td>
</tr>
<tr>
<td>The system supports a reduction in the number of GP appointments (planned and home visits)</td>
<td>GPs are supported to put in place immediate packages of care without recourse to multiple phone calls</td>
</tr>
<tr>
<td>People feel supported in the community following discharge and during their recovery period</td>
<td>Rapid response services enable packages of care to be quickly implemented to support ongoing care to overcome crisis point</td>
</tr>
<tr>
<td>Increase in the average age of person permanently admitted to residential and nursing care homes</td>
<td>People report improvement in size/range of social networks.</td>
</tr>
<tr>
<td>Patient activation measures demonstrate people’s knowledge, skills and confidence in their ability to understand their condition and self care</td>
<td>People who use health and social care services have positive experiences of those services, and have their dignity respected.</td>
</tr>
<tr>
<td>People, including those with disabilities or long term conditions or 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</td>
<td>People and carers have an overall excellent experience of care and support.</td>
</tr>
<tr>
<td></td>
<td>People and carers experience effective joined-up working and coordinated care</td>
</tr>
<tr>
<td></td>
<td>All patients with a long term condition (under the care of community services) feel supported to self-manage their condition and maintain their independence</td>
</tr>
<tr>
<td>People using health and social care services are safe from harm.</td>
<td>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</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>People using health and social care services are safe from harm.</td>
<td>Care is provided in a safe environment with robust safeguarding plans in place including staff training across the provider-led system plus audit for protecting vulnerable people from avoidable harm with responsive action plan</td>
</tr>
<tr>
<td>People using health and social care services are safe from harm.</td>
<td>Reduction in the number of adverse experiences for patients and carers</td>
</tr>
<tr>
<td>People using health and social care services are safe from harm.</td>
<td>Care provided is evidence based and takes a proportionate view of risk versus patient choice</td>
</tr>
<tr>
<td>People using health and social care services are safe from harm.</td>
<td>Staff are trained to understand principles of the Mental Capacity Act and Deprivation of Liberty Standards and can apply, or seek help in applying these as needed</td>
</tr>
<tr>
<td>People using health and social care services are safe from harm.</td>
<td>All staff are appropriately trained in safeguarding of adults and children</td>
</tr>
<tr>
<td>Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.</td>
<td>All people can access care, information and support which is timely, co-ordinated and recognises the importance of wider determinants of health –</td>
</tr>
<tr>
<td>Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.</td>
<td>People’s health and independence is maintained or improved through proactive assessment, care planning and interventions</td>
</tr>
<tr>
<td>Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.</td>
<td>People experience improved mental health and wellbeing and quality of life through early support and diagnosis</td>
</tr>
<tr>
<td>Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.</td>
<td>People are supported to develop personalised Advanced Care Plans, including DNAR conversations.</td>
</tr>
<tr>
<td>Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.</td>
<td>When life is coming to an end people are able to plan for their death if they wish and to achieve their preferred place of death</td>
</tr>
<tr>
<td>Resources are used effectively and efficiently in the provision of health and social care services.</td>
<td>Robust processes are in place to ensure learning from audits and reviews of patient care</td>
</tr>
<tr>
<td>Resources are used effectively and efficiently in the provision of health and social care services.</td>
<td>Robust systems and measures are in place to reduce pressure ulcers, healthcare acquired infections, falls and medicines related incidents</td>
</tr>
<tr>
<td>Resources are used effectively and efficiently in the provision of health and social care services.</td>
<td>The service effectively works with primary care to manage acute health episodes of people with long term conditions, minimising unnecessary hospital admissions where medically appropriate</td>
</tr>
<tr>
<td>Resources are used effectively and efficiently in the provision of health and social care services.</td>
<td>Personalised packages of care are constructed, and treatment systems are responsive to people’s needs</td>
</tr>
<tr>
<td>People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their</td>
<td>Carers report that they have been included or consulted in discussion about the person they care for</td>
</tr>
<tr>
<td>People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their</td>
<td>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</td>
</tr>
<tr>
<td>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.</td>
<td>Staff and whole organisations are committed to working in a joined up and integrated way</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Carer’s feel connected to their communities and feel less lonely and socially isolated</td>
<td>Staff are empowered to deliver excellent outcomes for individuals</td>
</tr>
<tr>
<td>Carer’s can be signposted to carers groups and or wider support networks within local community. Where these do not exist carers may be supported to start groups if they so wish</td>
<td>Staff are able to access the right care and support for the individual at the time it is needed without recourse to multiple phone calls and hand offs between agencies</td>
</tr>
<tr>
<td>Carer’s feel connected to their communities and feel less lonely and socially isolated</td>
<td>Authentic and collaborative leadership is evident across and within organisational boundaries</td>
</tr>
<tr>
<td>Carer’s feel connected to their communities and feel less lonely and socially isolated</td>
<td>There is an organisational culture characterised by high staff engagement which supports and facilitates a duty of candour and openness</td>
</tr>
<tr>
<td>Carer’s feel connected to their communities and feel less lonely and socially isolated</td>
<td>There is an organisational culture that supports staff to learn and improve</td>
</tr>
<tr>
<td>Carer’s feel connected to their communities and feel less lonely and socially isolated</td>
<td>Staff are trained, enabled and supported to look after those who are dying in an appropriate and compassionate way</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and social care services contribute to reducing health inequalities.</th>
<th>The service supports delivery of the national public health outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with long term conditions experience improved stability and reduced complications</td>
<td>People feel connected to their communities and feel less lonely and socially isolated</td>
</tr>
<tr>
<td>People feel connected to their communities and feel less lonely and socially isolated</td>
<td>All staff in the service feel confident to recognise when a brief intervention such as stop smoking, healthy eating, emotional well being, alcohol, harm minimisation etc may be needed and know how to deliver or access this</td>
</tr>
<tr>
<td>People feel connected to their communities and feel less lonely and socially isolated</td>
<td>Improvement in population health gain and reduction in health inequalities over life of contract</td>
</tr>
</tbody>
</table>