NHS Cambridgeshire and Peterborough CCG
Integrated Older People’s Pathway & Adult Community Services Procurement

Memorandum of Information

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1 Executive Summary

The purpose of this Memorandum of Information is to provide an overview of NHS Cambridgeshire and Peterborough CCG (CCG), the Older People Programme, and the CCG’s high level service specification. It also provides headlines on the CCG population, current performance and the range and location of current services.

As one of the largest CCGs in England, Cambridgeshire & Peterborough CCG operates a federated structure with eight Local Commissioning Groups which reflects the value placed on local clinical and patient engagement in commissioning. The CCG is clinically-led at every level.

The CCG has identified three main strategic priorities: this procurement and the high level outcome specification in Annex 1 focuses on services and care for older people, specifically urgent care pathways, and prevention of ill health. The main service scope focuses on joining up unplanned acute and community care for older people, including older people’s mental health.

Increasing numbers of older people, constrained finances for the foreseeable future and fragmented services have led the CCG to conclude that a radical new approach is required, driven by a set of Critical Success Factors described in the high level specification. Providers will need to deliver a holistic approach which encompasses entire patient pathways and signals the need to think beyond traditional organisational demarcations in and outside the NHS.

The CCG’s preferred approach to organising care for older people is based on Lead Providers responsible for the whole patient pathway. The CCG wishes to support transformation and investment in community services through a longer term contract. The CCG intends through dialogue to agree new payment mechanisms which will focus on outcomes and support delivery of the right care in the right place at the right time.

The CCG’s approach to procurement is one of engagement with providers from the outset, leading to competitive dialogue, on the basis that this is likely to produce the most sustainable and innovative solutions.
2 Introduction

2.1 Cambridgeshire and Peterborough CCG is the second largest CCG in England with 108 practices, over 800 GPs and almost 900,000 registered population. The CCG’s members include all practices in Cambridgeshire and Peterborough plus three practices from Hertfordshire and two practices from Northamptonshire.

2.2 The CCG is organised into eight Local Commissioning Groups (LCGs): Borderline, Peterborough, Isle of Ely, Wisbech, Hunts Health, Hunts Care Partners, Cambridgeshire Association to Commission Health (CATCH) and Cam Health. The LCGs have authority...
to make local change happen and manage resources through delegated budgets. The eight LCGs form four systems: Borderline-Peterborough; Isle of Ely-Wisbech; Hunts; and Greater Cambridge.

2.3 NHS Cambridgeshire & Peterborough CCG’s mission is to empower communities to keep healthy and commission quality healthcare. Its vision is for the CCG to be led locally by clinicians in partnership with their communities, commissioning quality services that ensure value for money and the best possible outcomes for those who use them.

2.4 The CCG’s three key priorities are:
- Improving out of hospital care for frail older people.
- Improving out of hospital end of life care.
- Reducing inequalities: coronary heart disease.

2.5 This programme aims to address the CCG’s first priority: improving older people services. The CCG wants to design integrated care for older people that achieves the overall ambitions of improving outcomes and improving patients’ experiences of older people services. The CCG is also currently coordinating the process for determining future arrangements for other community services and therefore most adult community services currently delivered by Cambridgeshire Community Services NHS Trust are included in this Procurement.

2.6 The CCG has adopted the National Voices narrative for integrated care where integrated care means “person-centred coordinated care”. The National Voices headline definition of coordinated care is “My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes.”

2.7 The CCG sees the competitive procurement of the integrated older people’s care pathway and adult community services as the opportunity to modernise and target services that best meet the needs of the population. The delivery model will offer an ‘urgent’ and planned response to ensure patients’ needs are met in a timely manner within an environment that promotes independence.

2.8 Bidders are expected to provide an integrated service model, with the patient and carer at the centre, and be dynamic and accountable.

2.9 The ‘programme’ has an Older People Programme Board, chaired by the CCG’s older people clinical lead. The Board includes patient representatives, local clinical GP representatives from each LCG, local authority representatives and key members of the CCG’s management team. Its role is to oversee delivery of older people’s service transformation. The following diagram illustrates the delivery structure for this programme:
2.10 The approach includes local service redesign, supported by CCG wide work on evidence and best practice; getting the financial incentives right to achieve the outcomes required; challenging current assumptions and ensuring that the most innovative and effective services are commissioned; and, achieving ‘Value for Money’ for both the CCG and the public sector as a whole whilst achieving our high level aims and desired outcomes for the service.

2.11 The CCG’s approach also includes wide engagement with patients and stakeholders through Patients’ representative organisations and patient groups and forums across Cambridgeshire and Peterborough; local councils; local providers; our eight local commissioning group boards; and, CCG staff.
3 The Procurement Requirements

3.1 The CCG has identified that the current model of commissioning services for older people has serious shortcomings including: fragmentation; non-aligned incentives; is a reactive illness service; focusing on the measurement of specific processes rather than outcomes; and, is subject to local issues such as delayed transfers of care, high hospital occupancy and challenges around sharing information.

3.2 Accordingly the commissioning of older people’s services through integrated service transformation is an opportunity to make significant improvements and to introduce innovative solutions.

3.3 The range of services, relevant to the older people care pathway, is shown in the diagram below. The underlying principle is to join up the whole pathway.
3.4 The core scope of services is acute unplanned hospital care for older people (65 and over), older people’s mental health services and community services for older people. This includes A&E, unplanned admissions, community nursing services and intermediate care.

3.5 The Authority is mindful of the obligations under the Equality Act 2010 not to discriminate on unjustifiable grounds in the provision of services and public functions. It is also mindful of its obligations as a public sector body to have due regard to the need to eliminate any conduct prohibited by the Act; advance equality of opportunity; and foster good relations between those with protected characteristics and those without. The Authority has had due regard to these matters in identifying its strategic priorities and developing its service vision for this Procurement and this will remain under review throughout.

3.6 In particular, given the nature of the Services (and the stated preference for a population approach to funding, defined by age) the Authority has considered whether differentiation on the grounds of age (to allow a whole pathway approach to older people) is appropriate and capable of justification in these circumstances and concluded that it is. The High Level Specification in Annexe 1 contains further outline information about the aims and objectives of this Procurement and why the Authority considers this approach to be a proportionate means of achieving those aims. Again, this issue will remain under review as the process unfolds.

3.7 Constructing a new approach to commissioning and provision of whole pathway services for older people raises a number of issues relating to the range of services required, and the extent to which they can be separate from the same or similar services for adults.

3.8 Estimates have been made regarding the percentage of older patients served by existing community services, based on samples or querying patient records. Even where this is high – such as district nursing – some patients are younger and still need the service. The CCG’s preferred approach is to commission one service from the same provider, but with different funding approaches.

3.9 The CCG has therefore determined that adult community services are included within the scope of the procurement, but that, there are a small number of adult community services which the CCG wishes to handle outside this procurement process, the main one being MSK physiotherapy services in Greater Cambridge.

3.10 The CCG does not intend to specify in detail how the outcomes should be achieved, but wishes to stimulate provider dialogue, through the Procurement, to lead to innovative delivery models.

3.11 Annex 1, the High Level Specification, contains the pertinent details including background to the older people programme, vision, critical success factors (metrics), financial principles, options and scope.
4 The Procurement Process

4.1 The procurement process involves three main stages: Pre-qualification (PQQ), Invitation to Submit Outline Solutions (ISOS), and Invitation to Submit Final Solutions (ISFS). An indicative timetable is given in the PQQ.

4.2 For the purposes of this Procurement, the Services are being tendered in five Lots: one Lot per health system and a fifth Lot covering Services in the entire CCG (i.e. all health systems), as per Table 1.

4.3 Responses to the PQQ will be used to select between five and seven bidders per Lot. See Annex 3 for a description of the Lots and their anticipated financial value. The PQQ describes how Potential Bidders can express their interest in specific Lots.

Table 1 – Health Systems

<table>
<thead>
<tr>
<th>Health System</th>
<th>Commissioning LCGs</th>
<th>Lot</th>
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<tbody>
<tr>
<td>Borderline-Peterborough</td>
<td>Borderline LCG and Peterborough LCG</td>
<td>1</td>
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<tr>
<td>Wisbech - Isle of Ely</td>
<td>Wisbech LCG and Isle of Ely LCG</td>
<td>2</td>
</tr>
<tr>
<td>Huntingdonshire</td>
<td>Hunts Care Partners LCG and Hunts Health LCG</td>
<td>3</td>
</tr>
<tr>
<td>Greater Cambridge</td>
<td>CATCH (Cambridgeshire Association to Commission Health LCG and Cam Health LCG)</td>
<td>4</td>
</tr>
<tr>
<td>Borderline-Peterborough, Greater Cambridge, Hunts, and Isle of Ely-Wisbech</td>
<td>Borderline LCG, Peterborough LCG, CATCH (Cambridgeshire Association to Commission Health LCG, Cam Health LCG, Hunts Care Partners LCG, Hunts Health LCG, Isle of Ely LCG, and Wisbech LCG)</td>
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4.4 This document includes the following annexes:

- The High Level Specification at Annex 1. This includes:
  - Aim.
  - Vision.
  - Case for Change.
  - Critical Success Factors.
  - Financial Principles.
  - Options for Service Organisation, Contracts and Funding.
  - Scope of Services Covered.
  - Services Excluded from Scope.
• Background on the CCG and existing commissioning and contracts is included at Annex 2 including:
  o Demographics, Population profile and health.
  o Performance.
  o Workforce.
  o Services and Estates.
  o IM&T.

• Anticipated financial values are given at Annex 3.

• A Glossary is included at Annex 4.
Annex 1 of MOI: High Level Specification

1 Aim

1.1 Cambridgeshire & Peterborough CCG has identified three main strategic priorities, which aim to improve outcomes for patients, and support service and financial sustainability for the health system. This summary outcome specification focuses on Priority 1: Services and care for older people, with a particular focus on improving out of hospital care for frail older people, specifically urgent care pathways.

1.2 Using high level outcome specifications reflects the new approach to commissioning which the clinically led CCG wishes to pursue: the emphasis is on delivering measurable improvements in specified outcomes. It will require a holistic approach which encompasses entire patient pathways and signals the need to think beyond traditional organisational demarcations in and outside the NHS.

1.3 There are a range of community services for older people which also serve younger adults: the CCG wishes to commission a single service for both age groups for the reasons set out in Section 7.
2 Vision

2.1 CCG Organisational Vision
Cambridgeshire & Peterborough Clinical Commissioning Group will be led locally by clinicians in partnership with their community, buying quality services that ensure value for money and the best possible outcomes for those who use them.

2.2 Service Vision for Older People

- For older people to be proactively supported to maintain their health, well-being and independence for as long as possible, receiving care in their home and local community wherever possible;

- For care to be provided in an integrated way with services organised around the patient;

- To ensure that services are designed and implemented locally, building on best practice;

- To provide the right contractual and financial incentives for good care and outcomes; and

- To work with patients and representative groups to design how we commission services.

2.2.1 The CCG does not intend to specify in detail how the outcomes should be achieved, but wishes to stimulate provider dialogue leading to innovative delivery models which may involve collaboration, prime vendor or fully integrated services. Providers will need to consider how they intend to meet the Critical Success Factors and funding principles set out in this document.

2.2.2 Whilst this is a CCG wide priority, providers are expected to address locally developed commissioning intentions, which are summarised in Appendix C. In all models, close working with social care services and other related partners will be essential.

2.2.3 This initial high level draft Specification has been developed taking into account feedback from providers and a range of other stakeholders.
2.3 Health & Well-Being Board (HWB) Priorities

2.3.1 Both the Cambridgeshire HWB and Peterborough HWB have identified priorities in their draft strategies which relate to older people and support this Outcome Specification. For Cambridgeshire priority 2 is to ‘Support older people to be safe, independent and well’. This includes a particular focus on preventative interventions which reduce unnecessary hospital admissions for people with long term conditions; integrating services for frail older people and ensuring that we have strong community health and care services tailored to the individual needs of older people which minimise the need for long stays in hospitals, care homes or other institutional care; and timely diagnosis and inter agency services for the care and support of older people with dementia and their carers.

2.3.2 For Peterborough, the priority is ‘healthier older people who maintain their independence for longer’. The intention is to address this through actions to promote and support people to maintain their independence, reduce unnecessary hospital admissions, deliver a personalised approach to care, and empower people to engage with their communities and have fulfilled lives, including health active ageing.
3 Case for Change

3.1 In summary, significant transformation is needed to deliver the vision of ‘joined up care focused around the patient’ described above in the context of:

a) Forecast demographic change (see figures below for 2010 – 2016)

<table>
<thead>
<tr>
<th>Peterborough</th>
<th>Cambridgeshire</th>
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<tr>
<td>23% growth in 65+ population</td>
<td>25% growth in 65+ population</td>
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<td>23% growth in 80+ population</td>
<td>18% growth in 80+ population</td>
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<td>32% growth in 85+ population</td>
<td>22% growth in 85+ population</td>
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b) Minimal if any financial growth in the health sector, alongside likely reductions in funding for Local Authorities;

c) Shortcomings in current service provision. There is evidence of a lack of ‘joined up working’ between acute – community – primary care and social care organisations. The way in which services are organised is reactive to illness rather than proactive to prevent crises and maintain independence. This results in known current service issues – pressure on Emergency Departments, high occupancy in hospital beds, delayed transfers of care, extended lengths of stay in hospital, and pressure on limited resources in community and primary care services. In addition, there are issues with information sharing, financial incentives not being aligned to support effective care, and short term contracts; and

d) Cambridgeshire Community Services transition. In 2012 the CCG advised the Strategic Health Authority that it was not able to support progress to Foundation Trust status for Cambridgeshire Community Services. The main rationale was that this would provide flexibility over future service configuration to improve outcomes in the context of significant demographic and financial pressures. This has led to the CCS Transition Programme, and whilst the main driver is our strategic focus on older people’s services, we are also currently coordinating the process for determining future arrangements for other CCS functions with partner organisations (note that the Trust Development Authority is now responsible for working with CCS to determine future organisational arrangements in the context of CCG and Local Authority commissioning intentions).

3.2 All these factors lead to the conclusion that we need to engage with providers and stakeholders to re-design how services are commissioned and provided - no change would be a very high risk option.
4 Critical Success Factors

4.1 It is very important that there is clarity regarding how success of the Programme will be measured, as this drives the assessment of options for service delivery and funding, the assessment of bids which may be received as part of a procurement process, and also informs the longer term evaluation of the programme.

4.2 The CCG has agreed the following success criteria.

The extent to which any option or proposal will deliver the vision and specifically:

a) Improve patient experience and service quality for older people and their carers through care organised around the patient;

b) Deliver services which are sensitive to local health and service need, as defined in local outcome specifications;

c) Move beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly together to deliver seamless care;

d) Supporting older people to maintain their independence, and reducing avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care);

e) Deliver an organisational solution for the older people’s care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners;

f) Demonstrate credible approach to engaging patients and representative groups in design and delivery of services; and

g) Provide a sustainable financial model (see financial principles below).

The CCG is developing measures for the CSFs – see Appendix A.
5 Financial Principles

5.1 The CCG has agreed the following principles, and these will be used to develop the financial framework for dialogue and assessment of options / proposals;

a) Aligning improved patient outcomes with financial incentives;
b) Sharing financial gain and risk across the commissioner – provider system;
c) Delivering recurrent financial balance in a sustainable way; and
d) Creating the conditions for investment and delivering a return on investment.

5.2 Funding Options

5.2.1 The purpose of dialogue with providers is to explore and develop options which could meet the financial principles set out above, including how financial risk is shared and efficiencies are achieved in the context of improving quality.

5.2.2 The CCG’s preferred approach for dialogue is Outcome Based Incentivised Contracts. The approach would link a proportion of payment to specified outcome / performance measures, with funding based on a year of care (capitation) payment for the services defined as in scope. The phasing and scope of outcome / performance measures will form part of dialogue at Outline Submission stage.

5.2.3 The preferred approach still allows potential providers to propose alternatives based on dialogue with local clinical and management leads, provided they are consistent with the CCG’s four financial principles.

5.2.4 The CCG’s preferred approach is for Lead Providers to take the total annual cost for the defined range of services and divide this by a weighted population to produce an average cost per year per patient. This is based on two principles:

a) If the fundamental aim is to ensure care is organised around the patient in the most cost effective and efficient way possible, and a single organisation or provider alliance is responsible for providing that care, then they should receive funds to pay for all elements of it.

b) If the provider can use the funding as it sees fit across the whole pathway, it will have the incentive to use it effectively to achieve LCG specified outcomes and cost efficiency. This could include investment in community services and services to help patients manage chronic conditions for example.

5.2.5 Lead Providers will have flexibility to negotiate financial arrangements with ‘sub contractors’: for example, movement away from Payment By Results for acute care is permitted within national guidance. The CCG reserves the right to stipulate conditions for specific sub contracts as part of its approach to managing transition risks and ensuring there is fair and open competition, but this is likely to be the exception not the rule.
5.3 Creating Conditions for Investment: Length of Contract

5.3.1 A key consideration in this new approach will be how to create the right conditions for investment by providers. The current 3 year standard NHS contract with annual re-negotiation does not provide an environment in which providers will feel confident to invest in (for example) improving community services with a view to deriving health outcome and financial benefits later down the line.

5.3.2 It is therefore proposed that a longer term contract (5 years with an option to extend by a further 2) will be offered which would provide more confidence for investors, and the conditions for providers to manage significant service improvement programmes which may take 12 – 18 months to implement.
6 Options for Service Organisation, Contracts and Funding

6.1 Development Process

The following sections set out a number of options for how services for older people could be configured, funded and contractually managed to deliver the aims of the Programme. The options are not exhaustive or mutually exclusive, and it is anticipated that further options will emerge through the process of engagement with stakeholders and dialogue with providers.

6.2 High Level Options

The diagram below summarises at a high level some potential options on a scale of innovation.

6.3 Do Nothing

In any assessment of options it is necessary to consider a ‘Do Nothing’ option as the comparator. In this option all current arrangements for older people’s services would continue including a CCG wide community services provider funded through a block contract, older people mental health services funded through a block contract, separate contracts for acute care funded via Payment By Results, and separate arrangements for palliative care, voluntary organisations and social care. It would seem reasonable to assume that all the attendant challenges would also continue:

- Services for older people remain fragmented;
- CCG struggles to manage complexity of multiple contracts;
- Perverse funding incentives persist; and

High hospital occupancy, high delayed transfers of care, knock on effects to planned care, ‘black alerts’, inadequate community capacity, and disjointed pathways.

Commercial in Confidence
• Lack of local focus, investment and pace in development of community services.

These challenges would become worse as demand for services increases at least in line with demographic growth in the older population. In short, this option is likely to fail against all Critical Success Factors.

6.4 **Change within current system: local community provider**

6.4.1 There are a number of possibilities within this broad option, and the version below is intended to illustrate the pros and cons as a basis for discussion. In essence older people’s services would continue to be delivered through multiple separate contracts with acute providers and with separate but local community providers (for the Cambridge system for example). Acute care would continue to be funded through PBR, and a block contract for community provision.

6.4.2 There would be a procurement process for a new local community provider. The local community services provider would be tightly managed by LCG commissioners against a clear service specification to deliver proactive care of patients in the community, with a serious commitment by all parties to integration with acute and primary care.

6.4.3 The local acute contract would also be tightly managed by LCG commissioners, with service development against clear pathway specifications and staff at the ‘front door and ‘back door’ of the hospital integrated with community and primary care.

6.5 **Local Service for older people with a Lead Provider and a new funding approach**

6.5.1 Once again there are several permutations within this broad option, which is intended to illustrate the pros and cons. The process of dialogue with LCGs, providers and other stakeholders is likely to develop our thinking on how this option could operate in practice.

6.5.2 The Lead Provider for Older People Services would work with LCGs through a single local contract to deliver the outcomes specified by the LCGs. The Lead Provider would have responsibility for the whole older people healthcare pathway across acute (unplanned care) and community settings for one* specified local systems defined as:

1) Borderline & Peterborough LCGs patients;
2) Wisbech and Isle of Ely LCG patients;
3) Huntingdonshire – Hunts Care Partners and Hunts Health LCGs patients;
4) Greater Cambridge – CATCH and Cam Health LCGs patients;

* Through the tender process a Lead Provider may bid for one or more local system contracts.

6.5.3 The incentives would be built in to deliver the care in the most joined up way possible, minimising duplication, focusing on outcomes and most cost effective use of care settings. The anticipated benefit would be reduced delayed transfers of care,
reductions in length of stay in hospital, reduction in avoidable admissions, based on investment in community, interface and primary care services.

6.5.4 A good Lead Provider would seek to build an excellent relationship with its local LCGs as its main funder / customer, and be held to account for delivery. Within the framework of the specification, the Lead Provider (integrator) would need to engage GP practices as commissioners to develop its delivery plans, and also as primary care providers who are key to a successful pathway / care experience for older people.

6.5.5 The local Lead Provider (‘integrator’) could be:

- a single organisation; or
- a formal alliance of organisations, one of which takes on the lead role.

6.5.6 The Lead Provider could be a community services provider, a hospital provider or another type of organisation. It may be an existing organisation, or a new one set up specifically to deliver the older people pathway for one or more systems in Cambridgeshire & Peterborough CCG. It may employ staff directly, and / or sub contract for services from a range of acute, community, voluntary sector and primary care providers.

6.6 **CCG Wide Lead Provider and a new funding approach**

6.6.1 This option is similar to the previous one with the same potential variants illustrated in the examples. However, it envisages a Lead Provider (or alliance of providers) being contracted to manage and deliver (unplanned) acute and community care for older people across the whole CCG.

6.6.2 As with the local option, the incentives would be built in to deliver the care in the most joined up way possible, minimising duplication, focusing on outcomes and most cost effective use of care settings. The intended net effect would be reduced delayed transfers of care, reductions in length of stay in hospital, reduction in avoidable admissions, predicated on investment in community, interface and primary care services.

6.6.3 A CCG wide provider of older people’s services may generate some economies of scale with overheads being smaller relative to overall costs (this would depend on the model and provider form); have greater service resilience and flexibility in particular for smaller more specialist services; have greater financial resilience to manage risk; be able to use its scale to leverage investment; spread innovation across the area more effectively; and enable tackling health inequalities across the CCG.

6.6.4 However, a CCG wide provider of older people’s services may lack local focus; be more complex to manage; be less responsive with decisions taking longer and find it harder to achieve clinical / staff engagement / ownership.
6.7 CCG Preferred Approach for Services, Contracts & Funding

The CCG’s preferred approach to form the basis of dialogue is:

a) To base the contract and service configuration on the four local systems of (1) Borderline – Peterborough (2) Wisbech- Isle of Ely (3) (Huntingdonshire 4) Greater Cambridge (recognising that the specific needs of each LCG in this area will need to be addressed). This will be reflected in the structure of the procurement. In this option, it is envisaged that one local system would host specialist services which may be more efficiently / safely managed across the whole CCG area (see Appendix D (ii)).

b) To offer a further option for pricing to cover the whole CCG. For this option Providers will need to demonstrate how they would ensure sensitivity to local needs and commissioning intentions.

c) That there should be a clear ‘Lead Provider’ which is accountable for delivery of the defined service scope for older people in each local system. This may be a single organisation or alliance as described previously, but our preferred approach is for Lead Providers to directly provide some patient services for older people, and that they must be capable of coordinating care both at individual patient level and through contracts with ‘supplier organisations’.

d) That the Lead Providers must be able to demonstrate how local clinical commissioning leads (and primary care provider representatives) will be involved in design and sign off of pathways.
7 Scope of Services Covered

7.1 Acute hospital unplanned care and community services

The underlying principle for the programme is to join up the whole pathway. Within this the major components are **acute hospital unplanned care for 65 and over’s and community services**. The initial scoping exercise has focused on unplanned acute hospital care for older people as the area which presents the greatest challenges locally and which we want to include in scope. Further definition is provided below.

7.2 Older People’s Mental Health Services

Our preferred approach is to also include **Older People’s Mental Health Services** in scope on the grounds that integrating physical and mental health is one of the key themes of our OPMH joint commissioning strategy and a key OPMH priority. We will need to mitigate the risk of fragmentation of the CCG OPMH service to assure quality, resilience, service coherence and efficiency: this will be covered by contract conditions to support transition risk management for a specified time period.

7.3 Voluntary Sector Grants / Contracts

The CCG commissions a number of services from the voluntary sector which are relevant to older people’s services and believes that the voluntary sector has a vital role to play in improving out of hospital care for older people in the future. Our preferred approach is the Lead Provider(s) should be responsible for commissioning services from the main voluntary sector organisations delivering services to older people, as well as being able to invest in voluntary sector provision to strengthen services. Lead Providers would need to work with other commissioning organisations to manage / develop joint funding arrangements where appropriate.

7.4 End of Life Care

End of life care is an important element of the care pathway for many older people, and is included in the CCG’s preferred funding approach.

7.5 Specified primary medical services

At this point, the Care Home enhanced service is included in scope. Further work to explore the potential for improving the quality of primary care for older people will be developed in consultation with the Local Medical Committee.

7.6 Issues relating to scope

Constructing a new approach to commissioning and provision of whole pathway services for older people raises a number of issues relating to the range of services required, and the extent to which they can be separate from the same or similar services for adults.
7.7 Older People – Adult Services

Estimates have been made regarding the percentage of older patients served by each CCS community service, based on samples or querying patient records. Even where this is high – such as district nursing – some patients are younger and still need the service. The CCG’s preferred approach is to commission one service from the same provider, but with different funding approaches. For example, a relatively simple solution would be to apply the capitated year of care approach for the older population (65 and over), with an ‘adult community services premium’ or ‘top up’ to cover the costs of providing services to the minority adult care group.

7.8 Focus on Needs and Age Defined Funding

The CCG’s fundamental aim is to commission an integrated hospital and community service for older people in line with the vision and critical success factors. Our preference is to use a population approach defined by age (65 and over) for funding purposes, noting that:

- An age defined population is readily understood, and enables a year of care approach to be applied to the relevant group of patients in line with the CCG’s strategic priorities and needs assessment (as opposed to limiting the service to a constantly changing smaller population defined by risk or need criteria);
- This will involve risk stratification and identification of patients likely to benefit from new approaches to care within the total 65 and over patient population;
- The expectation is that Lead Provider(s) would introduce targeted approaches to care and services within the total population which are likely to support older people remaining independent and well for longer, reducing crises which result in unplanned admissions, and reducing the amount of time patients spend in hospital beds when they no longer need to be in them; and
- Patients under 65 with similar high needs (multiple long term conditions for example) identified through risk stratification will benefit from the same approach to care (see reference to adult community services ‘top up’ above).

The rationale for 65 and over’s as opposed to other possible age definitions (e.g. over 75s) is:

a) the 65 and over age defined population reflects the CCG’s assessment of where the main health needs exist;

b) the scale of opportunity for changing services to deliver improved patient experience and greater cost effectiveness, in the context of the scale of the challenges faced by the CCG and local providers;

c) Increases the opportunity for preventative approaches (how far ‘upstream’ we wish to focus proactive care for older people).

Taking the 65 and over population potentially gives greater opportunity to make changes to improve services. For example, when the level of emergency bed days for
Cambridgeshire and Peterborough is benchmarked against national comparators, and we aim to achieve the upper quartile, the number of EBDs which could be reduced is far greater for 65 and overs than it is for over 75’s.

65 and over’s gives greater scope for providers to introduce proactive care at an earlier stage, and it may incentivise them to introduce healthy ageing approaches which pay dividends in terms of a healthier population and lower costs later on.

7.9 **NHS Continuing Care / Free Nursing Care - OPTION**

Most of the funds for NHS Continuing Care and Free Nursing care relate to older people (approx. £28m). There may be potential to contract for care more efficiently either for NHS placements or combined with social care placements working with Local Authority partners. The CCG is proposing NHS Continuing Care / Free Nursing Care commissioning as an option for dialogue within this procurement.
8 Services Excluded from Scope

8.1 Planned Acute Care

There are arguments that planned care for older people should be included within the scope of the programme on the premise that good planned care (e.g. cataract operations) may reduce unplanned admissions. However, the CCG preferred approach is to exclude planned care at this stage on the grounds that inclusion would (a) potentially distract from the focus on community and unplanned care pathways and (b) the complexities of operating choice for planned procedures within the preferred Lead Provider model. There may be very specific areas of acute planned care for older people (next day care of the elderly out-patient clinics for example) which could be included in scope, and this will form an element of dialogue with providers. The option to negotiate planned care in by agreement at a later stage in the contract will be kept open.

8.2 Specific Adult Community Services

There are a small number of adult community services which the CCG wishes to handle outside the main Older People’s procurement process, the main one being MSK physiotherapy in Greater Cambridge.

8.3 Social Care – general position on scope

Both Cambridgeshire County Council and Peterborough City Council have stressed that they see close alignment between health and social care leadership and frontline staff as essential for older people’s services, but neither currently wish to include social care funds in any new pooling arrangement, or integrate social care staff with health provision. This does not preclude the possibility that social care may be negotiated in at a later stage in the contract subject to agreement by all parties.

8.4 Cambridgeshire County Council Social Care specific services

8.4.1 Occupational Therapy

The County Council provides funding of £1.76m toward the cost of the integrated community based Occupational Therapy Service. The Council wishes to maintain an integrated community based OT service with the Health Sector which it believes to be of considerable benefit to service users and patients as well as providing the right platform for a cost effective service.

The Council is prepared to consider the option of including its funding within the CCGs capitated sum for Older People’s Services. This would be through a Section 75 agreement with the CCG for the commissioning of OT services or dependent on the successful provider organization through a Section 75 agreement with the provider. The Council, through the Section 75 agreement would wish to see performance targets that reflect the importance of the Occupational Therapy Service to social care outcomes particularly with regard to maintaining independence and the successful delivery of reablement. The Council would be willing to enter into discussions about it directly managing and providing this integrated service.
8.4.2 Intermediate Care and Reablement

The Council currently provides funding of £5.861m toward the Intermediate Care and Reablement Service. This makes the Council the significant majority funder of the Service. The Council’s investment has grown significantly over the last few years with the development and subsequent expansion of the reablement service. The Council's service and financial plans are based on reablement being the default pathway for all older people requiring a service, with a view to reducing demand on more costly specialist services. The fundamental importance of the reablement service means that the Council is not proposing to add its funding for the Intermediate Care and Reablement Service to the CCG’s capitated sum. Instead it is expecting that it will directly manage and intends consult on a TUPE transfer of staff for the services that it currently funds through Cambridgeshire Community Services.

The Intermediate Care and Reablement Service is an integrated service at present and the Council would want to work closely with successful providers to ensure that the benefits of integration are secured after the current procurement exercise. The shape of these arrangements would be determined through future discussion and the Council would consider the option of managing the health funded part of the Service on behalf of future providers. However, this is only one option and the Council would be prepared to discuss others, with the caveat that it will be looking to directly manage the social care funded services.
## Appendix A of High Level Specification: Critical Success Factor Measures

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<th>CRITICAL SUCCESS FACTOR</th>
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| 1. Improve patient experience and service quality for older people and their carers through care organised around the patient. | a) NHS Outcome Framework indicators:  
• People’s experience of integrated care (under development); proportion of people feeling supported to manage their condition.  
b) Patient and carer satisfaction surveys administered independently from the provider (e.g. building on the National Voices work, the Family & Friends test, 2013/14 local OPMH questionnaire)  
c) Patient and carer outcome measures, including good quality end of life care  
• ‘Health-related quality-of-life for people with long-term conditions’ and ‘health related quality of life for carers’.  
• Bespoke QOL patient surveys using SF-36 or EQ-5d measures; also OPMH instruments e.g. CORE  
d) Core quality measures e.g. eliminating never events, reducing pressure ulcers; medication errors; hospital-acquired infections; OPMH quality measures; relevant NHS Constitution standards |
| 2. Deliver services which are sensitive to local health and service need, as defined in local outcome specifications. | a) Extent to which proposals meet local outcome specifications, measured by member practice satisfaction survey / baseline and audit and local contracts performance indicators  
b) Impact on health inequalities  
• measured by local health needs assessments and health equality impact assessments; monitored through access and local data;  
c) Extent to which proposals are evidence based or would contribute to development of the evidence base |
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| **3. Supporting older people to maintain their independence, and reducing avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care)** | a) Core indicators for the interface of health and social care:  
- Emergency Bed Days (upper quartile benchmark) for people aged 65 and over  
- Reduced delayed transfer of care from hospital  
- Admissions to residential and nursing care direct from hospital  

b) Core indicators for inappropriate acute admissions:  
- Reduced acute bed occupancy percentage  
- Emergency admissions for conditions which should not usually require admission (NHS OF)  

c) Core indicators of effective recovery & rehabilitation:  
- Proportion of patients with a fragility fracture recovering to their previous level of mobility at 30 days / 120 days (NHS OF)  
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (NHS OF)  
- Increase in number of patients cared for at home / maintain independence: numbers of people having a reablement service after discharge plus (i) % needing no care after (ii)% needing less care after  

d) Inclusion of preventative approaches & early interventions (see JSNA & Health Wellbeing Strategy) to support older people in the community (e.g. measurable using PHOF Falls indicators); provision of effective information for patients and carers on services and access |
| **4. Move beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly together to deliver seamless care.** | a) Agreement and delivery of strategic plan for transforming services for older people  
b) Delivery of information sharing and communication plan covering communication standards (e.g. discharge summaries, use of care plans); visual performance management systems; IT systems to support care delivery  
c) Staff experience and views survey to evaluate co-ordination of care  
d) Evidence of workforce development and training plan |
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| 5. Deliver an organisational solution for the older people’s care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners. | a) Agreement and delivery of strategic plan for transforming services for older people  
b) Confidence of commissioner / provider partners (survey of views)  
c) Method of assessing functional integration and overall transformational approach |
| 6. Demonstrate credible approach to engaging patients and representative groups in design and delivery of services. | a) Delivery of engagement plan, including involvement of HealthWatch, local voluntary sector colleagues, District Councils and Local Health Partnerships  
b) Survey of patient views on engagement in design and delivery |
| 7. Provide a sustainable financial model based on the principles below: | 1. Delivery of 5 year financial plan which supports the CCG’s financial plan. To include pricing, investment profile, risk share arrangements, and approach to inflation, efficiency savings and population growth.  
2. Agreed percentage of contract value clearly linked to delivery of specified patient experience, quality and system efficiency outcomes.  
3. Reduced reliance on long term social care packages and placement in care homes:  
a. Number in receipt of home care packages  
b. Number in residential & nursing homes plus number of new admissions plus turnover. | a) Aligning improved patient outcomes with financial incentives  
b) Sharing financial gain and risk across the commissioner – provider system  
c) Delivering recurrent financial balance in a sustainable way  
d) Creating the conditions for investment and delivering a return on investment |
Appendix B of High Level Specification: Emergency Bed Days Measure

1. As stated in the vision above, the CCG’s commissioning intention is to improve out of hospital care for frail older people, and reduce ‘emergency bed days’ in terms of both admissions and the amount of time spent in hospital as a result of unplanned admissions.

2. In order to measure progress in improving outcomes associated with this specification, the following outcome indicators will be used based on a national benchmarking exercise carried out by the King’s Fund. These figures are indicative and may be subject to minor amendments.

3. Moving towards ‘top ten’ PCT performance by achieving 1.75 emergency bed days per weighted population aged 65+.

4. The outcome indicator used is for the population aged 65+, because this has the most reliable benchmarking analysis. The highest rates of emergency bed day use are amongst frail older people aged over 80 and system change will need a strong focus on the most elderly age group, which is a strategic priority for the CCG.

1 Rationale
A recent King’s Fund Report on ‘Older People and Emergency Bed Use’ compared Primary Care Trusts across England assessing total emergency bed days per weighted population aged 65+ for the year 2009/10, together with associated emergency admission rates and lengths of stay. One of the findings is that Areas that have well-developed, integrated services for older people have lower rates of hospital bed use. Areas with low bed use also deliver a good patient experience and have lower readmission rates.

2 Cambridgeshire
 Ranked 98th (out of 151 PCTs) for emergency bed days per weighted population aged 65+
 Ranked 59th nationally for emergency admission rate per weighted population aged 65+
 Ranked 126th nationally for average length of stay for emergency admissions for people aged 65+

3 Peterborough
 Ranked 27th nationally for emergency admission rate
 Ranked 100th nationally for average los (1 = lowest los)
 Ranked 36th nationally on overall emergency bed days (therefore top quartile)
Appendix C of High Level Specification: Local Visions and Commissioning Intentions

CATCH & Cam Health LCGs
Hunts Health & Hunts Care Partners LCGs
Borderline & Peterborough LCGs
Isle of Ely / Wisbech LCGs
CAMBRIDGE SYSTEM
LOCAL VISION & COMMISSIONING INTENTIONS
OVERVIEW

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2. Vision
3. Principles/Outcomes
4. The Greater Cambridge Older People Integration Team
5. Target population
6. Scope of services
7. Key areas of focus
1  **Demographic background**  

The Greater Cambridge system comprises of two Local Commissioning Groups (LCGs) CATCH and Cam Health.

We have been working together to develop our thinking around how services for older people could be better commissioned in light of our frail older population is growing even more quickly than the national average. In less than ten years (by 2021) it is estimated that the number of frail elderly people will have increased significantly.

2  **Vision**  

Our vision is to build innovative, responsive community services coupled with multidisciplinary working and much better links with secondary care to ensure patients receive high quality care in the most beneficial location. This aims to deliver better patient outcomes and patient experience together with a reduction in avoidable admission to hospital, and a significant reduced length of stay.

CATCH and Cam Health are committed to making this vision a reality to improve the quality and range of services offered to patients. To do this we will reshape services around the needs of patients and communities. This will deliver urgent and responsive services to those who need them whilst helping to prevent deterioration for others.

3  **Principles/Outcomes**  

The older people programme has identified the following programme outcomes:

- Improvement in patient experience measures as care provided with services organised around the patient.

- A reduction in avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care).

- An increase in the % of frail older people cared for “out of hospital” and improvement in quality of these services.

- Better partnership working between different parts of the health and social care system and other partners.

- The above delivered within the identified budget.

**Our key aims for the service are:**

- Ensuring that patient care and the service commissioned is primarily community based.

- Enabling patients where appropriate to remain independent in their own homes by providing pro-active and efficient reactive care.

The following local principles will underpin the future delivery model to improve the effectiveness and outcomes in health and care:
• Ensuring that we identify, manage and share financial risk as a local health system.

• Shaping, commissioning and influencing locally, a model of service provision and a provider network which is appropriate for Greater Cambridge.

• Early identification and assessment of patients with complex needs at risk of admission.

• Responses from services will be patient focused and based on the patient’s needs.

• Speed of response from services needs to be appropriate to the circumstances, and if necessary needs to be rapid and robust.

• Care provided closer to home when appropriate, providing suitable alternatives in the community to acute hospital care.

• Strong clinical leadership across all services to secure the highest levels of quality and safety at the point of care.

• Optimise quality and quantity by ensuring services are delivered by experienced clinical staff with the capacity to deliver personal management plans.

• Provide seamless continuity of care through coordination and integration of services.

• To have excellent means of communication of key summary and management plan information through the use of information technology management, so that such information is available 24/7 to all services, with patient consent.

• To have well-coordinated multi-disciplinary team (MDT) working including well organised MDT meetings and other MDT activities.

• Rapid, comprehensive geriatric assessment and discharge from hospital.

4 The Greater Cambridge Older People Integration Team
Locally we have established the Greater Cambridge Older People Integration team which is responsible for:

• Commissioning older peoples services.

• Leading the dialogue and engagement with providers for the Greater Cambridge area.

• Setting the commissioning intentions in line with the LCG Boards’ priorities.
Overseeing and managing the performance of the provider network.

Negotiating contracts on behalf of both LCG Boards.

For completeness, we have shown the model below as a process / structure chart:

5 Target population
The target population for the integrated model include:

- Those over the age of 65; Lead Provider to prioritise patient needs using risk stratification.

- Those over the age of 75 with reduced functional reserve, presenting ‘geriatric’ syndromes such as falls, confusion, dementia, delirium and immobility.
6 Scope of services

Subject to local dialogue, the scope of services is in line with the description in Section 7 of the main high level specification, but note that community Musculo-skeletal physiotherapy services (office based) are excluded.

7 Key areas of focus

Primary care will be an essential part of integrated care providing a local hub and working with partners to assess and meet the needs of older people. With patient consent and full discussion with patients and carers, multidisciplinary teams will work together in a better, coordinated way to assess need, plan and implement plans to ensure the provision of the best possible services for each patient. There will be individual health and social care summaries available for patients with the key information available to all providers 24hrs a day, seven days a week.

This requires the development of new and redesigned services including:

- Effective and coordinated MDT working supported by MDT coordinators. MDT meetings are one of the tools of effective MDT working, and will be well supported.

- Robust intermediate care services when needed at home or in short-term community beds providing rehabilitation and therapy. This will help people to remain independent, and live well in their own homes for as long as possible.

- Enhanced community matron and community nursing teams, providing better and more robust urgent and acute care in the community and enhanced supported discharge, with effective links into acute care, and providing a holistic approach to the care of the frail elderly population.

- Rapid MDT response as an alternative to admission when appropriate, including a community geriatrician service and falls ambulance.

- Co-ordinated prevention, planning and commissioning with social care, voluntary sector organisations and other partners, promoting healthy ageing and providing support at an earlier stage in a proactive manner.

- Recognition that frail elderly people needing hospital admission should in general be under the care of a hospital geriatrician.

- Acute and community services aligned with patient need, to avoid inappropriate admission and enable timely discharge.

- Improved mental health services which enable early diagnosis and support which will also help prevent deterioration in physical health.
• Robust IT systems, including access to all key data, and the use of risk stratification tools and Urgent Care Dashboard.

• Coordinated care and management of long term conditions in the community.

• Improved advanced care planning towards the End of Life.
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7. Level 3 - Managed care in the community.
8. Level 4 - Intermediate care to focus on.
9. Level 5 - Community based sub-acute services
10. Key dependencies
1 Demographic background

Peterborough has a relatively young population compared to the national average. Based on 2010 figures the population aged 65+ is set to rise by 34% by 2024 (an increase of 8,300) and by 57% for people aged 85+ by 2024 (an increase of 1,700).

Peterborough’s older population has relatively high levels of deprivation which is a significant risk factor for poor health and demands on health and social care services. In 2013, the overall percentage of people aged 65+ affected by deprivation in Peterborough is 25.8% compared to a CCG rate of 15.7%.

By contrast Borderline LCG areas older population sits within the national average and the population is relatively wealthy. The challenges for meeting the needs of frail elderly in Borderline are rurality and managing the interface with three local authorities; Peterborough, Cambridgeshire and Northamptonshire.

2 Vision

Borderline & Peterborough LCGs have a vision of a whole system, integrated model of community services where patients and their carers are fully involved in service developments and individual care planning. We describe 5 levels of activity:

Level 1  Information and advice for those able to manage their own needs.

Level 2  Prevention and early intervention for those at risk of deteriorating physical and mental health, Activities of Daily Living (ADL) and who have multiple or complex needs.

Level 3  Managed care in the community for those benefiting from coordinated assessment, care planning and service delivery.

Level 4  Medically led intermediate care for people with deteriorating functional abilities in need of rehabilitation, reablement and recovery.

Level 5  Medically lead sub-acute care in the community and in-reach to facilitate early discharge.

This outcome specification focuses on levels 3, 4 and 5.

3 Principles/Outcomes

The older people programme has identified the following service outcomes:

- Improvement in patient experience measures through services organised around the patient.

- A reduction in avoidable emergency admissions, re-admissions and extended stays in acute hospitals and step-down facilities (including delayed transfers of care).

- An increase in the number of frail older people cared for “out of hospital” and improvement in quality of these services.

- Better partnership working between different parts of the health, social care, housing and the voluntary sector system and other partners.
• The above delivered within the identified budget.

The main principle for the Borderline and Peterborough LCGs integrated model is ‘get it right first time’ to ensure timely access to the right service at the right time.

The integrated care model focuses on working across organisations for the benefit of patients/people who use the services. We believe that true integration is about a way of working rather than about organisational structures. The Borderline and Peterborough LCGs believe that integrated community services, for this group of patients, include:

• Holistic and coordinated assessment and care that meets the general, mental health and social needs of older people.

• Seamless delivery of services across health and care domains provided by public, third or private providers.

• Full support and involvement of carers.

• Working closely with housing providers to increase options of supported living in the community.

4 Target population
The target population for the integrated community service model in this specification are persons who have one or more of the following needs:

• Health and care needs associated with ageing.

• Co-morbidities, including organic and functional mental health needs.

• High level dependencies for activities of daily living.

• At risk of admission to long term care or acute hospital.

The age of 65+ is a guide but not a restricting factor. More important are the presenting needs of the individual. The model is based on meeting the needs of older people who are the highest volume of patients. The services will also meet the needs of people aged 18 and over.

5 Scope of services
Subject to local dialogue, the scope of services is in line with the description in Section 7 of the main high level specification, but note that due to key dependencies within the local system Borderline and Peterborough LCGs prefer an incremental approach to the scope of acute unplanned services.

6 Key areas of focus
Borderline and Peterborough LCGs have a clear vision for the seamless delivery of health and care for vulnerable older people. The LCGs are looking for a provider that will build on our local innovations and embrace working in partnership, both vertically and horizontally. The LCGs wish to encourage innovative services that deliver at key stages of the patient journey.
7 Level 3 - Managed care in the community;
Multi-disciplinary team working to stratify risk/vulnerability of patients, and coordinate assessment and services. MDTS should include mental health, social care third sector providers and patients/carers.
Support people to manage their health and care needs in their own homes by exercising self-management, choice and control.
Use of telecare and telehealth to support self-care.

8 Level 4 - Intermediate care to focus on:
- Medically led therapeutic interventions to maximise functional abilities.
- Admission avoidance to long term care.
- Reablement to reduce dependence on high intensity, long term home support.
- Therapeutic interventions to facilitate early discharge from acute hospital.
- Assess for aids and adaptations in the home.
- Manage interim beds.
- 7 day working.

9 Level 5 – Community based sub-acute services:
- Focus on clinical care e.g. IV antibiotics, catheterisation.
- Manage patients in the community (including care homes) at risk of hospital admission.
- Assertive in-reach to ED and MAU to avert admission.
- Manage interim beds.
- 7 day working.

Integral to the delivery of this vision is creation of a workforce that has the skills and competencies that match their grade and who are able to provide appropriate services.
The LCGs have identified a number of key enablers to ensure delivery of integrated care pathways;
- Creation of a workforce trained to deliver the right level of clinical, therapeutic and support services and who work effectively within the whole system.
- Integrated working between community health provider and third sector/social care providers.
• Utilize IT systems that enable information sharing across health and care and all sectors of providers.

• Create Single Point/s of Access to enable timely and easy access to the right service.

• Institute Single Assessment Process/Common Assessment Framework.

We also wish to engage a provider who can exploit the opportunities offered through Personal Health Budgets and work alongside social care Personal Budgets.

10 Key dependencies

Due to the financial circumstances at PSHFT, Monitor has sent in a Contingency Planning Team to assess the viability of the Trust and potential future options. Monitor will decide what course of action to take which will take several months to determine. There is a potential significant impact on the Older People programme that will need to be risk assessed at each stage as greater clarity emerges.
HUNTS SYSTEM
LOCAL VISION AND COMMISSIONING INTENTIONS OVERVIEW

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5. Care when and where it is needed.
6. Multidisciplinary working.
8. Target population.
9. Scope of services.
10. Key areas of focus.
1 **Demographic background**

The older population in the Hunts area is growing faster than the national average. In 2011 in Hunts there were 27,400 of people aged 65 years or over (16.2% of all residents) compared with 20,400 in 2001 (13% of all residents), a growth of 3.2%.

2 **Vision**

Our vision is to provide the best care and support for older people in Huntingdon and March. This will be achieved through creating an environment where providers of Health & Social Care work in a more integrated way.

The overarching aim is to:

- Support individuals to remain independent in their own home/care facility.
- Meet the needs of patients by working in an integrated and collaborative way.
- Ensure high quality care through the best use of resources.

The vision and strategic outcomes have been produced in partnership with local providers and commissioners and reflect the local ambition to increase the quality outcomes, responsiveness and affordability of services for Older People with unanimous agreement that this can only be achieved through improved integration.

3 **Principles/Outcomes**

The older people programme has identified the following programme outcomes:

- Improvement in patient experience measures as care provided with services organised around the patient.
- A reduction in avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care).
- An increase in the number of frail older people cared for “out of hospital” and improvement in quality of these services.
- Better partnership working between different parts of the health and social care system and other partners.
- The above delivered within the identified budget.

The following local principles will underpin the future delivery model for Hunts:

‘Nothing about me without me’ – the patient voice must be at the heart of all provision. This requires a cultural change in all services with a new emphasis on the patient voice and/or their family/carer’s experience and the way that this is incorporated into the planning, delivery and evaluation of services.

The integrated service model must include social care functions. Closer working between health and social care is needed to enable more effective management of the risks associated with hospitalisation (leading up to and following admission, as well as preventing the need for
admission). This needs to be coupled with the delivery of better coordination of services to promote independent living and to prevent illness and social isolation.

4 **Where possible tasks/processes should be carried out once.**

The removal of duplication and waste is essential in designing an effective service including having single points of access, single assessments supported by shared common data sets and IT/Telehealth systems/platforms.

5 **Care when and where it is needed.**

Care must be provided when it is needed, and in the setting that is most appropriate. For many patients this will mean the identification of need and provision of services early on in the assessment process, within the community, to promote good health and prevent the escalation of problems to crisis stage. At the same time, it is important to preserve the ability of general practitioners to continue to refer patients to specialist hospital based services where this is the most appropriate option for them.

6 **Multidisciplinary working.**

Integration should be founded upon the development of strong multidisciplinary working, drawing on generalist and specialist skills. In particular, this means pioneering new ways of joint working between GPs, consultants, nurses & AHPs with advanced skills, as well as strengthening primary care teams and the links between general practice, secondary, community health services, and social care.

7 **Clinical Leadership and Support.**

The process of change must be underpinned by strong clinical leadership and engagement. For service redesign to work, it must be shaped by a strong clinical input, and must have the support of a broad base of local clinicians.

8 **Target population**

The success of the Hunts Older People service is based on improving integration between Health and Social Care organisations. The focus for this is predominantly the 65 and over year old age group as the largest consumer of Health and Social Care. However, ageing is a dynamic biological process, which is not necessarily associated with chronological age. Therefore, if services are meeting the needs of 65 and overs, they are likely to be fit for purpose for adults outside this age group.

9 **Scope of services**

Subject to local dialogue, the scope of services is in line with the description in Section 7 of the main high level specification, with the following potential local variations: community Musculo-skeletal physiotherapy services (office based) are excluded.

10 **Key areas of focus**

The service will require the development of new and redesigned services including:
• Effective and coordinated MDT working supported by care coordinators, enabled by regular MDT meetings that involve all key stakeholders.

• Robust enhanced intermediate care services provided at home or in short-term community step up beds providing rehabilitation and therapy. This will help people to remain independent, and live well in their own homes for as long as possible.

• Enhanced community matron and community nursing teams, providing better and more robust urgent and acute care in the community and enhanced supported discharge, with effective links into acute care, and providing a holistic approach to the care of the frail elderly population.

• Intermediate care supported by GPs/medical clinicians.

• Effective medical in-reach to nursing homes to prevent admissions to hospital, particularly at end of life.

• Rapid medical response as an alternative to admission, when appropriate, facilitated by senior clinicians (GP & geriatrician).

• Integrated prevention, planning and commissioning functions with social care, voluntary sector organisations and other partners, promoting healthy ageing and providing support at an earlier stage in a proactive manner.

• Recognition that frail elderly people needing hospital admission should in general be under the care of a hospital geriatrician.

• Acute and community services aligned with patient need to avoid inappropriate admission and enable timely discharge.

• Improved mental health services which enable early diagnosis and support which will also help prevent deterioration in physical health.

• Robust IT systems, including access to all key data, and the use of risk stratification tools and Urgent Care Dashboard.

• Coordinated care and management of long term conditions in the community.

• Improved advanced care planning towards the End of Life.

• The use of Telehealth/Telecare solutions to support independence.
ISLE OF ELY AND WISBECH SYSTEM
LOCAL VISION AND COMMISSIONING INTENTIONS OVERVIEW

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6. Key areas of focus
1 Demographic background

Isle of Ely (IoE) and Wisbech LCG system services a population of 140,000. IoE LCG is made up of 10 GP practices with a population of 93,000, 18% of which are aged 65 years or older. Wisbech LCG is made up of 4 GP practices with a population of 47,000, 20% of which are aged 65 years or older.

IoE LCG geography means its population is serviced by 5 acute trusts. The table below shows all Isle of Ely LCG non elective activity for 65 years and above by provider:

<table>
<thead>
<tr>
<th>Acute Trust</th>
<th>Percentage activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>CUHFT</td>
<td>64%</td>
</tr>
<tr>
<td>HHCT</td>
<td>19%</td>
</tr>
<tr>
<td>PSHFT</td>
<td>4%</td>
</tr>
<tr>
<td>QEH</td>
<td>3%</td>
</tr>
<tr>
<td>WSH</td>
<td>5%</td>
</tr>
<tr>
<td>CCS</td>
<td>4%</td>
</tr>
<tr>
<td>other</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: SUS 12/13 activity

Wisbech LCG geography means that the majority of its patients go to QEH. The table below shows all Wisbech LCG non elective activity for 65 years and above by provider:

<table>
<thead>
<tr>
<th>Acute Trust</th>
<th>Percentage activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papworth</td>
<td>2%</td>
</tr>
<tr>
<td>PSHFT</td>
<td>6%</td>
</tr>
<tr>
<td>QEH</td>
<td>83%</td>
</tr>
<tr>
<td>CCS</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: SUS 12/13 activity
2 Vision

IoE and Wisbech LCG System want to commission an Adult and Older Persons service that delivers high quality patient care in, or as close as possible, to the patient’s home. This is especially important to the GPs in this area because of the challenging geography and isolation of their population. The LCG system wants to embed a more proactive approach to care by identifying and supporting vulnerable people in the community preventing acute illness where possible. They are also keen to implement alternative urgent care pathways recognising that a number of patients currently accessing the acute sector could be treated more effectively either in their homes or in step-up community provisions.

3 Principles/Outcomes

The older people programme has identified the following programme outcomes:

- Improvement in patient experience measures as care provided with services organised around the patient.
- A reduction in avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care).
- An increase in the number of frail older people cared for “out of hospital” and improvement in quality of these services.
- Better partnership working between different parts of the health and social care system and other partners.
- The above delivered within the identified budget.

4 Target population

The target population, in terms of acute care, is 65 plus. Although the LCG system understands the pressures faced by health and social care provisions due to the ageing population, the new service commissioned in Ely and Wisbech needs to be able to cater for all adults which includes everyone 18 years of age or older.

(See Scope of Services Covered section in CCG High Level Specification).

5 Scope of services

Subject to local dialogue, the scope of services is in line with the description in Section 7 of the main high level specification, with the following local approaches:

Older Persons Mental Health – the recently commissioned work around the dementia pathway needs to be incorporated as a key element of the wider Adult and Older People’s pathway. There needs to be clear referral criteria and rapid access into the dementia pathway and joint working with patients accessing the pathway to make sure all health and social care needs are being met. The Adult and Older Persons service will play an important role in identifying patients suitable for referral into the pathway. GPs in the LCG system are very keen to have access to a named mental health specialist which is likely to be accessed via MDT working which will be coordinated by the Adult and Older Persons service.

Diabetes / Congestive Heart Failure / COPD: the LCG system wants patients with these long term conditions to be managed within the community. Community clinics and teams should
hold a caseload of patients, each with clear management plan in place for helping patients to stay in the community.

Falls / Continence / Speech and Language / Parkinson’s / Cardiac Rehab / Pulmonary rehab and other smaller provisions: the LCG system is open to exploring a CCG shared approach to these services to maximise economies of scale.

6 Key areas of focus

The LCG system believes that the Older Persons Service should align interventions into four areas to deliver the outcomes listed in section 3. The suggested four areas for the new service include:

I. Maintenance;
II. Proactive Care;
III. Active Care; and
IV. Urgent Care

The key focus for both LCGs is ensuring that the resources at each of the four stages of care deliver quality interventions which are timely and measurable and address patient needs in a holistic and individualised way.

The following key areas need to be included in the service:

- Community Nurses: ideally nurses will be aligned to GP practices to facilitate continuity of care.
- Medicines Management and Community Pharmacy: named individuals aligned to GP practices.
- Reablement and Long Term Therapy (provided jointly with the County Council): support to help people regain independence, provided in the patient’s home.
- MDT Coordination: pulling together professionals from within and across organisations to provide one seamless pathway of care to the most vulnerable patients and developing care plans for on-going interventions.
- Consultant Geriatrician: both the community geriatrician role and increased access to acute geriatricians.
- Rapid Response MDT team: to rapidly assess and treat adults and elderly patients at home who are at risk of hospital admission and set up the appropriate support to manage them in the community.
- End of Life Care: support for the various charities and hospices within the local area to deliver a seamless End of Life service.
- Community Inpatient Beds: step-up and step-down care and collaborating with social care to ensure that interim beds and respite beds as well as intermediate health beds are available.
• Minor Injury Units: manage existing provision of MIU clinics in Princess of Wales and Doddington Hospital in Ely and in North Cambs Hospital (Wisbech).

• The new Adult and Older Persons service needs to work closely with social care to ensure that these services are integrated with future healthcare pathways. Social workers and care managers should be aligned to GP practices to support the MDT working model.

• Community Voluntary Service contracts: the LCG system wants to ensure that voluntary services available in their geography are accessed and utilised as much as possible. Any new service will be asked to work closely alongside voluntary services to ensure maximum throughput into their services. Close links need to be formed between MDT working and the voluntary sector and consideration should be given as to how partnership working in the voluntary sector can help with the wider prevention agenda.
**Appendix D(i) of High Level Specification: Core Scope of Services**

**Bold = core**  
**Non bold = options**

<table>
<thead>
<tr>
<th>CAPITATED BUDGET POOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACUTE HOSPITAL UNPLANNED CARE</td>
</tr>
<tr>
<td>Unplanned admissions</td>
</tr>
<tr>
<td>A&amp;E</td>
</tr>
<tr>
<td>COMMUNITY SERVICES</td>
</tr>
<tr>
<td>Community nursing</td>
</tr>
<tr>
<td>Rehab &amp; therapy</td>
</tr>
<tr>
<td>Discharge Planning</td>
</tr>
<tr>
<td>Specialist nursing</td>
</tr>
<tr>
<td>Community Beds</td>
</tr>
<tr>
<td>Dietetics</td>
</tr>
<tr>
<td>Podiatry</td>
</tr>
<tr>
<td>Intermediate Care Unit</td>
</tr>
<tr>
<td>Other adult services</td>
</tr>
<tr>
<td>PRIMARY CARE</td>
</tr>
<tr>
<td>Nursing / care home LES</td>
</tr>
<tr>
<td>VOLUNTARY SECTOR GRANTS</td>
</tr>
<tr>
<td>OLDER PEOPLE MENTAL HEALTH</td>
</tr>
<tr>
<td>END OF LIFE CARE</td>
</tr>
<tr>
<td>NHS CONTINUING CARE</td>
</tr>
<tr>
<td>&gt; 65s continuing care, 70% of total</td>
</tr>
<tr>
<td>Free Nursing care</td>
</tr>
</tbody>
</table>
Four local system Lead Providers responsible for Older People’s Services including acute unplanned care and a wide range of community services for older people and adults. The same Lead Provider for several or all Lots are possible permutations depending on the outcome of the procurement.

Preferred funding approach: outcome based contracts, using capitated budgets for over 65s and an adult community services premium to cover other patients e.g. under 65s with long term conditions; *other options may be developed provided they are consistent with the CCG financial principles.

**Some small specialist services would be hosted by one local system on behalf of the whole CCG area – the precise scope may alter during dialogue.**
Annex 2 of the MOI: Background and Existing Commissioning

1 Demographics, Population Profile and Health

Cambridgeshire and Peterborough have a combined population of 831,500 (Census 2011). The registered population of the CCG’s practices is 878,000. The population is diverse and ageing with significant inequalities.

Table 1 – Total Population of Cambridgeshire & Peterborough

<table>
<thead>
<tr>
<th>Age band</th>
<th>Less than 18</th>
<th>18-64</th>
<th>65+</th>
<th>Total (65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C&amp;P</td>
<td>196,378</td>
<td>508,557</td>
<td>126,600</td>
<td>831,535</td>
</tr>
</tbody>
</table>

Source: Mid 2011 population estimates, based on 2011 Census, ONS

Based on census 2011 data, 15% of Cambridgeshire and Peterborough’s population is 65 and over and 2.1% is 85 and over (17,500).

Table 2 – Older People Population of Cambridgeshire & Peterborough

<table>
<thead>
<tr>
<th>County/UA</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>Total (65+)</th>
<th>Percentage (of total 65+)</th>
<th>Percent age of C&amp;P total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>53,800</td>
<td>33,500</td>
<td>14,100</td>
<td>101,400</td>
<td>53.1%</td>
<td>80.1%</td>
</tr>
<tr>
<td></td>
<td>12,800</td>
<td>9,000</td>
<td>3,400</td>
<td>25,200</td>
<td>50.8%</td>
<td>19.9%</td>
</tr>
<tr>
<td>C&amp;P</td>
<td>66,600</td>
<td>42,500</td>
<td>17,500</td>
<td>126,600</td>
<td>52.6%</td>
<td>13.8%</td>
</tr>
<tr>
<td></td>
<td>4,592,200</td>
<td>2,944,100</td>
<td>1,193,300</td>
<td>8,729,600</td>
<td>52.6%</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

Source: Mid 2011 population estimates, based on 2011 Census, ONS

Based on the census 2011 projections, it is estimated that by 2021 there will be 39,000 more people aged 65 and over in Cambridgeshire and Peterborough (31% increase compared to a 24% increase in England). The largest proportional increases are in the older age bands (44% increase in 85+ compared to a 38.5% increase in England).

Table 3 – Older People Population Projections for Cambridgeshire & Peterborough

<table>
<thead>
<tr>
<th>County/UA</th>
<th>2011 Total (65+)</th>
<th>2021 Total (65+)</th>
<th>Percentage (of total 65+)</th>
<th>Percent age of C&amp;P total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridgeshire</td>
<td>101,350</td>
<td>134,520</td>
<td>18.5%</td>
<td>32.7%</td>
</tr>
<tr>
<td>Peterborough</td>
<td>25,080</td>
<td>30,840</td>
<td>12.0%</td>
<td>23.0%</td>
</tr>
<tr>
<td>Cambs and Peterborough</td>
<td>126,430</td>
<td>165,360</td>
<td>17.2%</td>
<td>30.8%</td>
</tr>
<tr>
<td>England</td>
<td>8,729,670</td>
<td>10,787,130</td>
<td>13.5%</td>
<td>23.6%</td>
</tr>
</tbody>
</table>

Source: Mid 2011 based interim population projections, ONS
The population of 18-64 year olds is growing more rapidly than the England average, particularly in Peterborough.

### Table 4 – 18-64 Population Projection for Cambridgeshire & Peterborough

<table>
<thead>
<tr>
<th>County/UA</th>
<th>2011 (ages 18-64)</th>
<th>2021 (ages 18-64)</th>
<th>% change 2011 to 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridgeshire</td>
<td>393,217</td>
<td>406,268</td>
<td>3.3%</td>
</tr>
<tr>
<td>Peterborough</td>
<td>115,940</td>
<td>125,865</td>
<td>9.1%</td>
</tr>
<tr>
<td>Cambs and Peterborough</td>
<td>508,557</td>
<td>532,133</td>
<td>4.6%</td>
</tr>
<tr>
<td>England</td>
<td>33,036,751</td>
<td>34,381,583</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

Source: Mid 2011 based interim population projections, ONS

The following table summarises some key statistics.

### Table 5 – Summary Statistics for Cambridgeshire & Peterborough

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Cambridgeshire &amp; Peterborough</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011 Total Population</td>
<td>831,535</td>
</tr>
<tr>
<td>2011 Population 65+</td>
<td>126,600</td>
</tr>
<tr>
<td>% of total population 65+</td>
<td>15.2%</td>
</tr>
<tr>
<td>% of total population 85+</td>
<td>2.1%</td>
</tr>
<tr>
<td>Prevalence of frailty – estimate of older people aged 65 and over</td>
<td>20,288</td>
</tr>
<tr>
<td>Prevalence of frailty – increase in % frail older people aged 65+ by 2021</td>
<td>33%</td>
</tr>
<tr>
<td>% Older people living in deprivation</td>
<td>15.7%</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>Males 79.8 Females 83.5</td>
</tr>
</tbody>
</table>

Source: Census 2011  
Note: Prevalence of frailty based on MRC CFAS Study estimates applied to ONS mid 2011 interim population projections

Further information about the health and wellbeing of the local population and specifically the needs of older people can be found at [http://www.cambridgeshirejsna.org.uk/](http://www.cambridgeshirejsna.org.uk/) and [http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen.aspx](http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen.aspx)
There is considerable variation within the LCGs as demonstrated in the table below.

**Table 6: Population and Health profile of NHS Cambridgeshire & Peterborough CCG by LCG**

<table>
<thead>
<tr>
<th>System</th>
<th>Cambridge</th>
<th>Hunts</th>
<th>Borderline &amp; Peterborough</th>
<th>Isle of Ely &amp; Wisbech</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Population</td>
<td>306,000</td>
<td>188,000</td>
<td>244,000</td>
<td>140,000</td>
</tr>
<tr>
<td>LCG</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of practices</td>
<td>9</td>
<td>28</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Inc 3 practices from Herts</td>
<td></td>
<td></td>
<td>Inc 3 practices from Northants</td>
</tr>
<tr>
<td>% of total population 65+</td>
<td>14%</td>
<td>14.5%</td>
<td>18.8%</td>
<td>16.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19.7%</td>
</tr>
<tr>
<td>% Older people living in deprivation</td>
<td>15%</td>
<td>11.1%</td>
<td>11.7%</td>
<td>12.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20.8%</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>m 79.6 f 82.9</td>
<td>m 81.8 f 85.5</td>
<td>m 81.2 f 84.4</td>
<td>m 79.0 f 82.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>m 78.9 f 82.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>m 77.7 f 82.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>m 80.3 f 84.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>m 77.7 f 81.5</td>
</tr>
<tr>
<td>All Cause Mortality rates</td>
<td>Avg CCG rate</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Avg CCG rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>High</td>
</tr>
<tr>
<td>High rates of mortality in:</td>
<td></td>
<td></td>
<td></td>
<td>Respiratory disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Circulatory disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Respiratory disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Circulatory disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cancer</td>
</tr>
<tr>
<td>Higher rates of disease prevalence in:</td>
<td>Heart failure, Mental Health illness, Dementia</td>
<td>Mental Health illness</td>
<td>CHD, CVD, Stroke, Hyper-tension, Atrial fibrillation, Depressio-n, Diabetes, COPD, Asthma, Chronic kidney disease, Cancer, Hypo-thyroidism, Obesity</td>
<td>CHD, CVD, Stroke, Hyper-tension, Atrial fibrillation, Depressio-n, Dementia, Epilepsy COPD, Asthma, Chronic kidney disease, hypo-thyroidism, learning disability, Obesity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Diabetes, COPD, CVD, Hypertensi-on, Obesity, Palliative care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CHD, Hypertension, Atrial fibrillation, Depressio-n, Diabetes, COPD, Asthma, Chronic kidney disease, Hypo-thyroidism, Palliative Care, Obesity</td>
</tr>
</tbody>
</table>

Source: Health profiles 2012
Note: Total registered population of CCG April 2013 is 878,434
2 Background on Performance

Summary performance information is given for the CCG below. This summarises performance by NHS Constitution and by NHS mandate.

NHS Constitution

- Referral to Treatment (RTT) - At an aggregated level, the CCG in 2012/13 (then in shadow format) met all national operating standards. There are still some areas not meeting the standard at specialty level.
- A&E performance was below threshold (95%) for 2012/13 with 94.3% of patients being seen within 4 hours.
- Cancer waits have improved overall with all standards being met at CCG level in Q4 of 2012/13.
- Ambulance performance has also shown an improvement and for the week ending 5th May 2013, the standard ambulance performance targets (Red 1, Red 2 and A19) were all above standard and trajectory.
- Mixed Sex Accommodation: Provisional data for 2012/13 highlights that there were 27 breaches.
- Diagnostic waits: performance targets were achieved in 2012/13 (99.6%).

NHS Mandate

- MRSA: The CCG exceeded the annual ceiling of 6 MRSA cases with actual cases of 10 in 2012/13.
- Clostridium Difficile: The annual C difficile ceiling of 132 was exceeded by the CCG with an actual of 171 at year end in 2012/13.
- Emergency readmissions within 30 days: This was slightly above the 5% plan throughout 2012/13 with the full year position at 5.7%.
- Friends and family test: Since September 2012, the net promoter score average for the CCG, based on four providers has remained above the regional mean. One provider is below the regional mean.

Quality Indicators

- Summary Hospital-level Mortality Indicators (SHMI) and Hospital Standardised Mortality Ratios (HSMR).
  - Peterborough & Stamford Hospitals NHS Foundation Trust – Both SHMI and HSMR indicators are within expected limits, although SHMI is around five points higher than the HSMR rolling average for the same periods.
  - Cambridge University Hospitals NHS Foundation Trust - Both SHMI and the HSMR are consistently below expected limits, although the SHMI is slightly higher than the HSMR rolling average.
  - Hinchingbrooke Health Care NHS Trust - The SHMI is within expected limits. The HSMR has been consistently within or below expected limits since 2005-06 and has been below 100 for the last ten quarters.
  - The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust - Both SHMI and HSMR are within expected limits, although SHMI is around five points lower than the HSMR rolling average for the same periods.

SHMI & HSMR data is available by provider: [Click here](#)
• Delayed Transfers Of Care (DTOC)
  o Peterborough & Stamford Hospitals NHS Foundation Trust – 905 bed
days were lost on average per month from April 12 to April 13 with the
main reason being incompletion of assessment.
  o Cambridge University Hospitals NHS Foundation Trust – 1,858 bed
days were lost on average per month from April 12 to April 13 with the main
reason being lack of a care package in own home.
  o Hinchingbrooke Health Care NHS Trust – 366 bed days were lost on
average per month from April 12 to April 13 with the main reason being
incompletion of assessment.
  o The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust – 346
bed days were lost on average per month from April 12 to April 13 with
the main reason being incompletion of assessment.

Delayed transfers of care (DTOC) data is available by provider and local authority: [Click here](#).

Detailed performance reports can be found in the 2013/14 Integrated Delivery Report in
the May 2013 CCG Governing Body papers [Click here](#).
3 Background on Workforce

3.1 The health system’s main providers include three acute trusts (Cambridge University Hospitals NHS Foundation Trust(CUHFT), Hinchingbrooke Healthcare NHS Trust (HHCT) and Peterborough & Stamford Hospitals NHS Foundation Trust (PSHFT); one community service provider Cambridge Community Services NHS Trust (CCS); and, one mental health trust Cambridge and Peterborough NHS Foundation Trust (CPFT).

3.2 It is anticipated that the provisions of TUPE will apply in respect of the employees currently employed by CCS as they are fully engaged in the provision of services constituting the Services. These employees are either active members, or eligible to be members, of the NHS Pension Scheme (“Eligible Employees”). In relation to pension benefits, in accordance with HM Treasury Guidance: Staff Transfers from Central Government - A Fair Deal for Staff Pensions all Eligible Employees who transfer their contract of employment as a result of the outcome of this Procurement must be offered in respect of future service:

1. The opportunity to join or remain in the NHS Pension Scheme; or

2. Membership of an occupational pension scheme which is actuarially certified as providing pension benefits that are at least broadly comparable to those benefits provided by the NHS Pension Scheme. The certification should be by reference to the criteria for ‘broad comparability’ set out by the Government Actuary’s Department (GAD).

Further details on workforce will be supplied at ISOS stage.
4 Background on Services and Estates

4.1 The following is a headline summary of the current range and location of services and is provided to Potential Bidders for information. No requirements for continued use of these facilities is anticipated to be placed on Potential Bidders.

4.2 Please note that in the event that Cambridgeshire Community Services NHS Trust is dissolved, its occupation of the estate will terminate such that it will be subject to any rights exercisable by the freeholder/landlord (which may be NHS Property Services Limited).

4.3 Cambridgeshire Community Services NHS Trust (CCS)

The portfolio of services delivered by CCS includes:

- Integrated health (and social care services in Cambridgeshire) for adults and older people.
- Specialist Nursing services and specialist palliative care.
- Community Rehabilitation including physiotherapy, occupational therapy, speech and language therapy and assistive technology.
- Diagnostic radiography, outpatient clinics and minor injury units.
- Four inpatient units for older persons rehabilitation.
- Specialist podiatry and musculoskeletal.
- Acute inpatient rehabilitation services to Hinchingbrooke Healthcare NHS Trust.

CCS utilise 50 properties in total. The breakdown by system is:

- 13 in Borderline and Peterborough.
- 8 in Wisbech and Isle of Ely.
- 12 within Huntingdonshire (including March).
- 17 within Greater Cambridge.

CCS have five community hospitals with in-patient beds. There are three within the Isle of Ely & Wisbech system comprising of 48 beds in total, currently used for palliative care/end of life, step-down and intermediate care. There is one in Cambridge comprising of 20 intermediate care beds, currently undergoing refurbishment. There is one community hospital in Peterborough comprising of 34 intermediate care beds.

4.4 Acute services

Most acute care for older people including A&E, unplanned admissions and palliative care is delivered at the following locations:

- Cambridge University Hospitals NHS Foundation Trust (Cambridge)
- Hinchingbrooke Hospital Healthcare NHS Trust (Huntingdon)
- Peterborough & Stamford Hospitals NHS Foundation Trust (Peterborough & Stamford)
- Queen Elizabeth Hospital Kings Lynn Foundation Trust (mainly serving Wisbech)
4.5 Older People Mental Health Services

Most acute and community mental health services including dementia services are provided by Cambridgeshire and Peterborough NHS Foundation Trust which has locations across the CCG area. Locality services include Day Therapy, Liaison Services, Intensive Support Teams, Community Older Peoples Mental Health Teams (including a range of professions psychiatrists, social workers, psychologists, community psychiatric nurses, occupational therapists). The portfolio of services delivered by CPFT includes the following to be provided on a countywide basis: Out of Hours Services, Training Services (CAMTED), Young Onset Dementia Services, Advice and Referral Centre – available for all ages, Inpatient beds.

4.6 Specialist Palliative Care Services in Cambridgeshire and Peterborough

In addition to acute hospital and community services above, three main hospices support patients at end of life. Arthur Rank House is a 12 bedded unit for Cambridgeshire patients; St John’s Hospice is a 15-bedded unit based in Moggerhanger; Thorpe Hall Hospice in Peterborough is a 20-bedded unit.

4.7 Primary Medical Services

Primary Medical Services are delivered by 108 GP practices. Out of Hours care is provided mainly by Urgent Care Cambridgeshire from bases across the CCG (Peterborough OOH services are provided by CCS).

4.8 Social Care & Housing

Social care for older people is commissioned by Cambridgeshire County Council and Peterborough City Council. Two member practices within CATCH LCG relate to Herts County Council, and three within Borderline LCG relate to Northamptonshire County Council. Responsibility for housing services rests with five District Councils within Cambridgeshire and Peterborough City Council.

Further details will be supplied at ISOS stage.
5 Background on IM&T

5.1 It is expected that Information Management and Technology will be a key enabler to support “joined up working” within the health and social care services working within the Cambridgeshire and Peterborough CCG area.

5.2 Currently there are multiple clinical systems and IM&T platforms in use across the primary, acute, community, mental health and social care services operating in the Cambridgeshire and Peterborough CCG area.

5.3 The predominant clinical system currently used in primary care, out of hours, and community services is TPP SystmOne and this footprint is expanding.

5.4 Acute Trusts, Mental Health and the East of England Ambulance service are in the process of implementing TPP SystmOne clinical record viewer as means of accessing SystmOne clinical records subject to patient consent. CRV is used in addition to these organisations main clinical and business systems.

5.5 Further work is needed to ensure a common position in the exchange of clinical information and business intelligence, in a seamless manner to consistent standards such as compliance with Interoperability Toolkit (ITK) or other interfacing/messaging standards.

5.6 As previously identified lack of sharing of information across acute – community – primary care and social care organisation and ensuring appropriate financial incentives generate the desired results use of accurate and timely information is key and data quality be a key driver and area in need specific attention.

5.7 There is a growing national expectation that more services will communicate and exchange information electronically as the NHS moves to become “paperless” in 2018.

5.8 There is also a demand for greater Patient involvement through the use of IM&T.
Annex 3 of the MOI: Value of Current Services by Anticipated Lots

The values of current services broken down into anticipated Lots are given as an annual range below. Lot 5 is approximately £150million (which includes Lots 1, 2, 3 and 4) and can be broken down as:

<table>
<thead>
<tr>
<th>Lots</th>
<th>Current Annual Value £’million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lot 1: Borderline - Peterborough</td>
<td>£35m to £40m</td>
</tr>
<tr>
<td>Lot 2: Wisbech – Isle of Ely</td>
<td>£35m to £40m</td>
</tr>
<tr>
<td>Lot 3: Huntingdonshire</td>
<td>£30m to £35m</td>
</tr>
<tr>
<td>Lot 4: Greater Cambridge</td>
<td>£40m to £45m</td>
</tr>
<tr>
<td>Lot 5: Cambridgeshire &amp; Peterborough (Lots 1-4)</td>
<td>£140m to £160m</td>
</tr>
</tbody>
</table>

Each lot includes:

- Unplanned acute care for people over 65 years of age; i.e. inpatients and A&E
- Community services for adults and over 65s. The range of community services differs for each lot and greater detail of what is included is in the high level specification; a summary of which is given below. Wisbech and Isle of Ely are hosting a small number of shared CCG wide specialist community services valued at £1.57m; this is included in the value of Lot 2.
- Older people’s mental health services.
- A named list of voluntary sector services.
- Palliative care.
- Nursing home local enhanced service.

Continuing health care is currently excluded but is being considered for inclusion. The value of continuing health care for the over 65 population is approximately £28m. All GP prescribing is excluded from the Lots above.
<table>
<thead>
<tr>
<th>Lot 1: Borderline – Peterborough</th>
<th>Acute unplanned hospital care for over 65s community nursing; rehab &amp; therapy; continence; respiratory; speech and language therapy; discharge planning; tissue viability; dietetics; MSK physiotherapy; podiatry; diabetes; palliative care; older people’s mental health services; care home LES; named voluntary sector services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned Hospital care for Over 65s and Community Services for older people and adults.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shared CCG wide specialist community services host.</td>
</tr>
</tbody>
</table>

**NOTE:** Potential Bidders should note that the details of the contractual obligation of how these services will be provided from the Provider for Lot 2 to other Providers will be defined in the ISOS.

<table>
<thead>
<tr>
<th>Lot 2: Isle of Ely – Wisbech</th>
<th>Acute unplanned hospital care for over 65s; community nursing; rehab &amp; therapy; continence; respiratory; speech and language therapy; discharge planning; tissue viability; dietetics; MSK physiotherapy; podiatry; diabetes; palliative care; Community hospital in-patients; out-patients, MIUs, x-ray; day rehab; older people’s mental health services; care home LES; named voluntary sector services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned Hospital care for Over 65s and Community Services for older people and adults.</td>
<td>Parkinson’s disease; multiple sclerosis; CFS/ME; lymphoedema; Oliver Zangwill centre.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lot 3: Huntingdonshire</th>
<th>Acute unplanned care for over 65s; community nursing; rehab and therapy; continence; respiratory, speech and language therapy; discharge planning; tissue viability; dietetics; podiatry; diabetes; palliative care; community hospital in-patient beds; older people’s mental health services; care home LES; named voluntary sector services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned Hospital care for Over 65s and Community Services for older people and adults.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lot 4: Greater Cambridge</th>
<th>Acute unplanned care for over 65s; community nursing; rehab and therapy; continence; respiratory, speech and language therapy; discharge planning; tissue viability; dietetics; podiatry; diabetes; palliative care; community hospital in-patient beds; older people’s mental health services; care home LES; named voluntary sector services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned Hospital care for Over 65s and Community Services for older people and adults.</td>
<td></td>
</tr>
</tbody>
</table>
**Annex 4 of MOI: Glossary of Terms**

Throughout this Memorandum of Information the following definitions shall apply:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Authority</td>
<td>Means NHS Cambridgeshire and Peterborough Clinical Commissioning Group.</td>
</tr>
<tr>
<td>Bidder</td>
<td>Means an economic operator that has been invited to participate in this Procurement.</td>
</tr>
<tr>
<td>CCG (Clinical Commissioning Group)</td>
<td>Means NHS Cambridgeshire and Peterborough Clinical Commissioning Group.</td>
</tr>
<tr>
<td>Clinical Services</td>
<td>Is the term used to describe the current range of clinical services.</td>
</tr>
<tr>
<td>Competitive Dialogue</td>
<td>Means a competitive dialogue process pursuant to regulation 18 of the Public Contracts Regulations 2006 SI2006/5 (as amended).</td>
</tr>
<tr>
<td>Consortium</td>
<td>Means an association of two or more individuals, companies, organisations or governments (or any combination of these entities) with the objective of participating in a common activity or pooling their resources for achieving a common goal.</td>
</tr>
<tr>
<td>Consortium Member</td>
<td>Means an organisational member of a consortium.</td>
</tr>
<tr>
<td>CQC</td>
<td>Means the independent regulator of health and adult social care in England.</td>
</tr>
<tr>
<td>CSF and/or (Critical Success Factor)</td>
<td>Means the agreed necessary elements that need to be in place for the project objectives to be achieved.</td>
</tr>
<tr>
<td>EOI</td>
<td>Means an expression of interest.</td>
</tr>
<tr>
<td>ICT</td>
<td>Means Information and Communications Technology.</td>
</tr>
<tr>
<td>ISFS</td>
<td>Means the Invitation to Submit Final Solutions stage of the Procurement.</td>
</tr>
</tbody>
</table>
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISOS</td>
<td>Means the Invitation to Submit Outline Solutions stage of the Procurement.</td>
</tr>
<tr>
<td>Lot</td>
<td>Means the Services that relate to one of the four health systems in Cambridgeshire and Peterborough, and for which two specific Locality Commissioning Groups are responsible, as described in Annexe 3 of this MOI.</td>
</tr>
<tr>
<td>Material Subcontractor</td>
<td>Means a subcontractor to which the Potential Bidder intends to subcontract the provision of Services amounting to ≥ 25% of the Services contract value.</td>
</tr>
<tr>
<td>MOI and/or (MOI)</td>
<td>Means this document which sets out the background to and requirements of the Procurement.</td>
</tr>
<tr>
<td>NHS</td>
<td>Means the National Health Service – is the name of the publicly funded healthcare system in the UK.</td>
</tr>
<tr>
<td>NHS TDA</td>
<td>Means the NHS Trust Development Authority.</td>
</tr>
<tr>
<td>OJEU</td>
<td>Means the Official Journal of the European Union.</td>
</tr>
<tr>
<td>Potential Bidder</td>
<td>Means a healthcare organisation that wishes to be considered as the provider of the Services and is therefore submitting a response to the PQQ.</td>
</tr>
<tr>
<td>PQQ Response</td>
<td>Means a response to this PQQ.</td>
</tr>
<tr>
<td>PQQ Return Date</td>
<td>Means the final date (&amp; time) by which Candidates can return submissions; submissions received after this date &amp; time will not be accepted.</td>
</tr>
<tr>
<td>PQQ (Pre Qualification Questionnaire)</td>
<td>Means Pre-Qualification Questionnaire relating to this Procurement dated the same date as this MOI and beginning the Procurement whereby Potential Bidders are pre-qualified as to their capability and capacity to provide the Services.</td>
</tr>
<tr>
<td>Preferred Bidder(s)</td>
<td>Means the Bidder(s) selected as the preferred Bidder(s) for the Project.</td>
</tr>
<tr>
<td>Procurement</td>
<td>Means the procurement process relating to the commissioning of Integrated Older people’s Pathway &amp; Adult Community Services by the CCG.</td>
</tr>
<tr>
<td>Procurement Rules</td>
<td>Means the Public Contract Regulations 2006 SI2006/5 (as amended) and the general principles of the Treaty of the Functioning of the European Union.</td>
</tr>
<tr>
<td>Project</td>
<td>Means the project to commission and procure the delivery of the Services.</td>
</tr>
<tr>
<td>Relevant Organisation</td>
<td>Means any organisation that forms part of a consortium with the Potential Bidder to bid for the Services or a Material Subcontractor.</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Services</td>
<td>Means the community services being commissioned by the CCG further to this Procurement, as described in the Specification.</td>
</tr>
<tr>
<td>SMR</td>
<td>Standardised Mortality Ratio which tells how many persons, per thousand of the population, will die in a given year and what the causes of death will be. It is the ratio of actual to expected deaths in a given area.</td>
</tr>
<tr>
<td>Specification and/or High Level Specification</td>
<td>Means the High Level Outcome Specification: Services &amp; Care for Older People at Annex 1 of the MOI.</td>
</tr>
<tr>
<td>SRO (Senior Responsible Owner)</td>
<td>Means the individual responsible for ensuring that the Project meets its objectives and delivers the projected benefits and being the owner of the overall business change that is being supported by the project.</td>
</tr>
</tbody>
</table>