Prospectus for Single Contract for Out of Hospital Services

THIS IS A PROSPECTUS FOR THE COMMISSIONING OF A SINGLE CONTRACT FOR OUT OF HOSPITAL SERVICES

Forward – Ealing's Commissioning Intentions

This prospectus signals Ealing CCG's intention to commission a single contract for the provision of services outside of hospital for the population of Ealing from May 2019.

The prospectus sets out the over-arching model of care and requirements and should be read in conjunction with the current service specifications. The prospectus and current service specifications are underpinned by a business case which is not for public release. The full suite of documents supporting the procurement will only be released at advert.

Ealing CCG currently commissions a number of community Out of Hospital services with different providers, which are often delivered in isolation and silos with multiple handoffs and with variation in service delivery, quality, configurations and efficiency. Patient experience data and feedback suggests that services are fragmented, complex and difficult to navigate for the service user, and frontline health and social care staff. We believe that this often leads to service users defaulting to use of acute services.

Aligned to the NW London Health and Care Partnership delivery plan, the CCG is looking to commission a lead provider for community Out of Hospital services for adults and children from 2019. Once commissioned, the provider will be responsible for the coordination and delivery of all community services, removing the constraints of separately held multiple contracts, and providing a unique opportunity to commission care that can be fully coordinated and integrated and able to respond to patient need rather than operate in rigid service lines. This will be a building block in the development of integrated care systems for Ealing in support of the NW London Health and Care Partnership ambition for an integrated care system for North West London.

In line with the CCG's vision for services outside of hospital care 'To provide holistic and integrated care outside hospital that empowers people to be in control of their healthcare outcomes, and works to deliver care that feels local, working seamlessly with the local authority, primary, mental health, acute care services and the voluntary sector', the CCG is looking to procure a provider that puts the patient at the centre of their care. Working alongside their GP and primary care teams, Patients will feel more informed about their health condition and care plans, starting with prevention, coupled with structured community support from local teams working alongside general practice. Should their condition deteriorate, care will be responsive and coordinated through a single community clinical triage and booking system ('Single Point of Access' or Community SPA). The IT functionality of the community SPA will enable the sharing of care plans, and will facilitate and support access to relevant services (acute and community) to meet the needs of patients at any given point in time.

It is important that the successful bidder undertakes to lead, deliver and coordinate a holistic package of community care working in an integrated and co-ordinated way with primary care and acute care.

The CCG is looking for a bidder who can demonstrable evidence a track record in transformation and integration and is able to set out how they will respond to the need to drive focused change over the first four years of the Contract and beyond that whilst at the same time having a strong grip on the provision of care that is being delivered.

The successful bidder will be expected to deliver services as currently configured on day one and then enter into the transformation journey in partnership with the CCG, services users and carers, general practice, the local authority and other stakeholders.

The ultimate ambition of any clinical service is to provide evidence based safe and high quality care to the people in receipt of care and therefore ultimate measures of success will be the ability to demonstrate improvements in the outcomes and goals that matter to people. To do this in a meaningful and valid way, the CCG has reviewed feedback from service users collected over time, supported by user feedback collected and used internationally, and developed an outcome/shared goals framework for adults, children and young people. This will enable the CCG to develop and assess the performance of community services based directly on the needs and wants of the local population over time.

Context

Ealing borough population

Located in North West London (NW London), and covering just under 22 square miles, the London Borough of Ealing borders the London Borough of Hillingdon to the west, the London Borough of Harrow, the London Borough of Brent to the north, the London Borough of Hammersmith and Fulham to the east and the London Borough of Hounslow to the south.

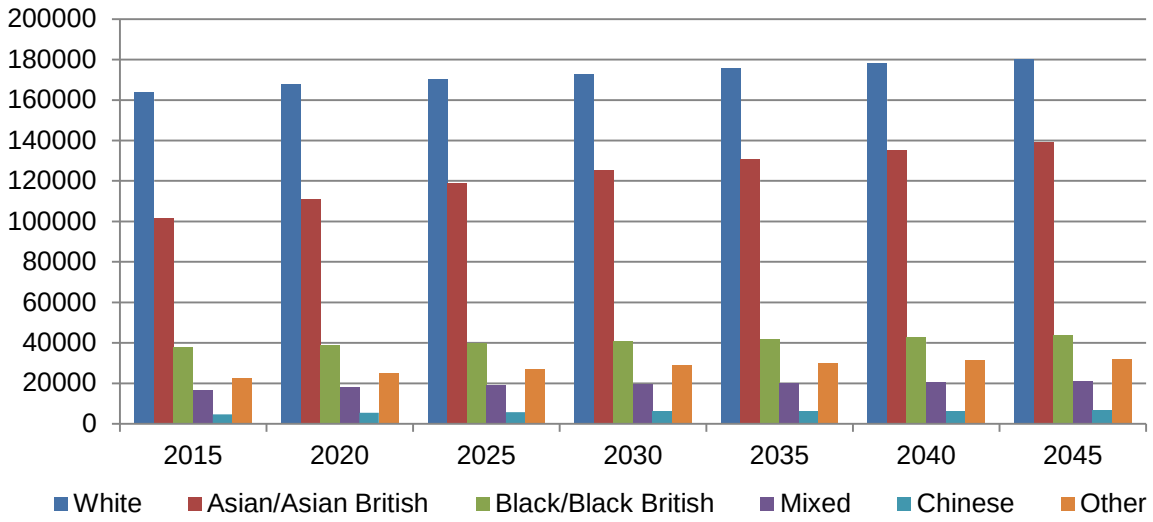
Figure 1. Geographical location of London Borough of Ealing

Ealing is the third largest Borough in London in terms of population, which was estimated in 2013 as 342,500. Ealing's resident population was 349,000 in 2016, which is expected to rise to over 394,000 by 2036. The number of children and young people (age group 0–24) is predicted to rise by 6% over the next 20 years; whereas, the number of residents aged 65 and over will increase by 50% Ealing has a higher proportion of both males and females aged 0-9 years and 25-44 years compared to other areas of England. Ealing also has a lower proportion of persons aged 50 years and above as compared to England. It is also an increasingly diverse borough, with a steady rise projected for black and minority ethnic (BAME) groups.

Between 2015 and 2045 the white population in Ealing is expected to grow by 10%. For all other ethnicities the projected rise in numbers is steeper over this time period: Asian/Asian British by 37%, Black/Black British by 16%, residents of mixed ethnic heritage by 27%, Chinese by 40% and population of other ethnic origin by 43%[1] .

[1] GLA Ethnic Group Projections Trend, 2015 (LTM)

Ealing Population Estimates by Ethnic Group, 2015-2045



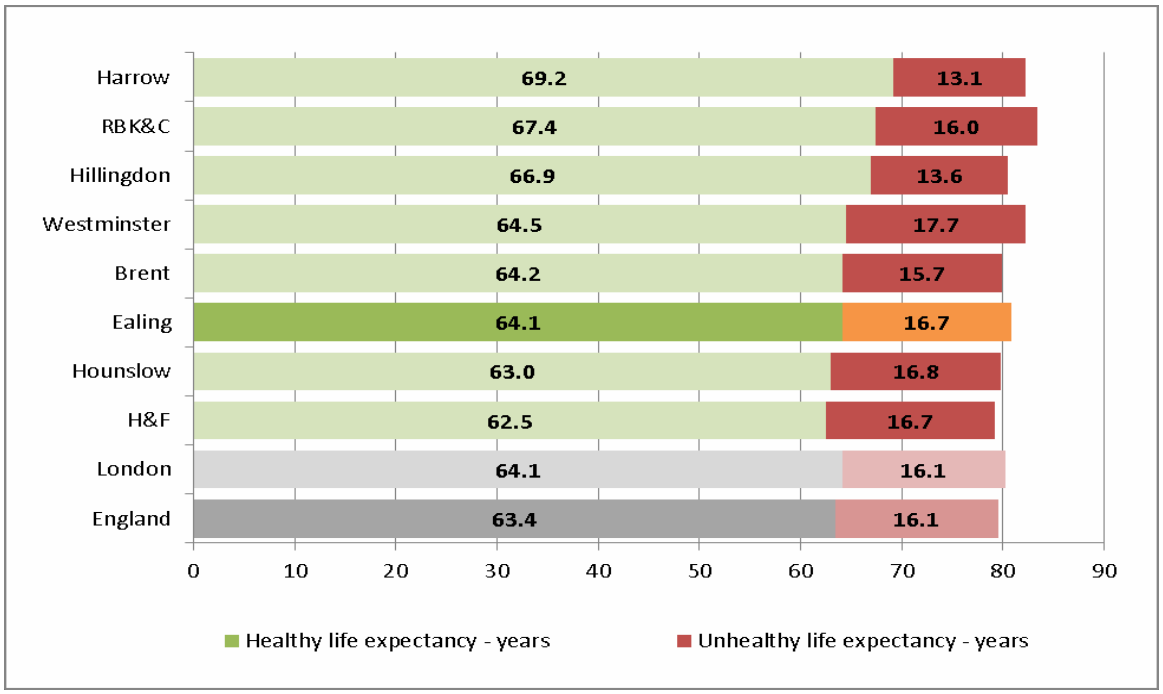
Source: GLA Ethnic Group Projections Trend, 2015 (LTM)

Health inequalities and deprivation varies across the borough. Records show that up to 35% of households are deprived in one dimension of the Index of Multiple Deprivation and 28% of the households in Ealing suffered multiple deprivation (in two or more dimensions). This figure is higher than that for Outer London (25%) as well as London overall (26%). It also makes Ealing the 18th ranked borough nationally in terms of households with multiple deprivation[1].

Male healthy life expectancy at birth in Ealing (64.1 years) is identical to the London one (64.1) and not significantly different from England average (63.4 years). Ealing's figure for male healthy life expectancy is 14th highest in London, but 6th lowest in NW London

As the latest average life expectancy for males in Ealing is 80.8 years, after the 64.1 years in good health, an average male born today and staying in the area would be expected to live for a further 16.7 years with some long term health problems. This is just slightly higher than London and England averages (both show 16.1 years of life in bad health).

Male healthy and unhealthy life expectancy at birth in Ealing, NW London, London & England, 2013-15



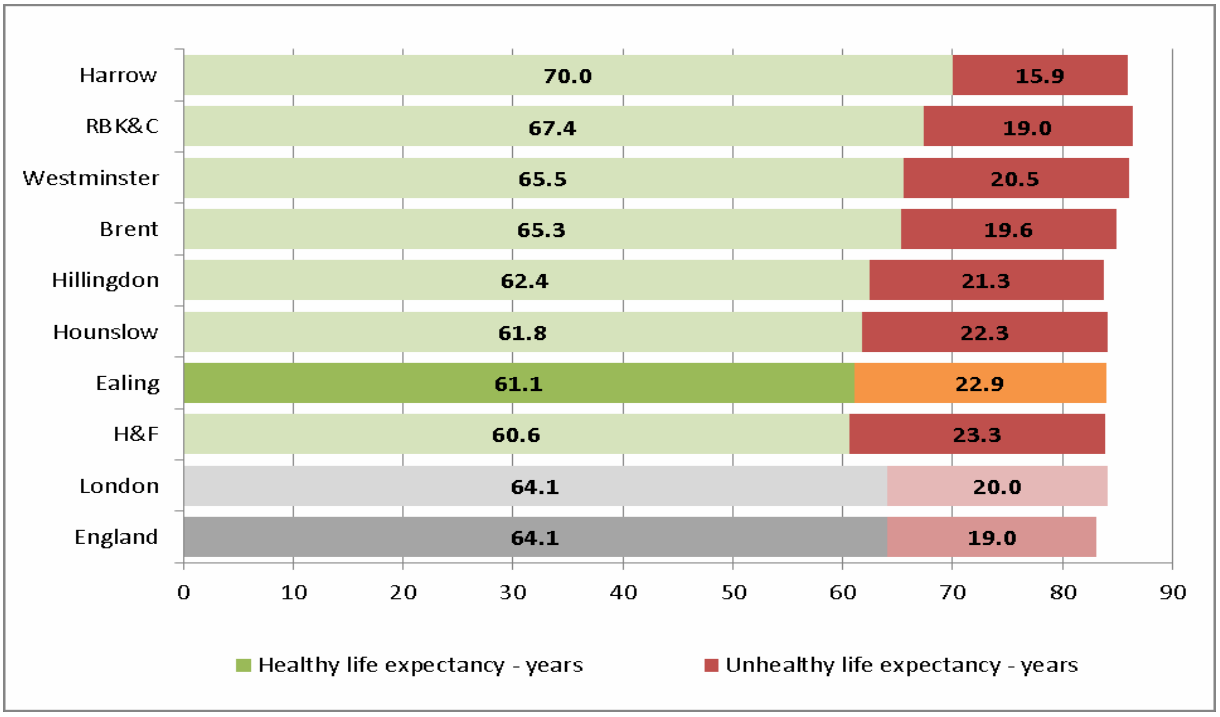
Source: ONS (QOF), 2016

Healthy and unhealthy life expectancy among females

Female healthy life expectancy at birth in Ealing (61.1 years) is significantly lower than London and England averages (both 64.1 years). Ealing's figure for female healthy life expectancy is 9th lowest in London and 7th lowest in NW London

As the latest life expectancy for females in Ealing is 84.0 years, an average female born today and staying in the area could expect to live after a healthy 61.1 years for a further 22.9 years in bad health. This is significantly higher than London and England averages (20 and 19 years of bad health respectively).

Female healthy and unhealthy life expectancy at birth in Ealing, NW LONDON, London & England, 2013-15



Source: ONS (QOF), 2016

Ealing also has a significant number of nursing homes within the Borough meaning that 0.26% of the population is residing in a care home. The Borough is supported by 20 nursing homes and 35 residential homes. The diagram below highlights that Ealing has a significant number of people that reside in residential and nursing homes compared to other CCGs in North West London.

	HEADCOUNT IN Nursing Homes		% OF HEADCOUNT IN NH	
Row Labels	01/10/2017	01/01/2018	01/10/2017	01/01/2018
NHS Brent CCG	551	537	0.15%	0.14%
NHS Central London (Westminster) CCG	264	243	0.12%	0.11%
NHS Ealing CCG	1,175	1,153	0.27%	0.26%

NHS Hammersmith And Fulham CCG	295	281	0.14%	0.12%
NHS Harrow CCG	503	587	0.19%	0.22%
NHS Hillingdon CCG	556	536	0.18%	0.17%
NHS Hounslow CCG	411	449	0.13%	0.14%
NHS West London CCG	123	120	0.05%	0.05%
Grand Total	**3,878**	**3,906**	**0.16%**	**0.16%**

The Joint Strategic Needs Assessment for the Borough of Ealing is available on the Local Authority and CCG website. The JSNA provides detailed information about the needs of the population and is reviewed and updated on a rolling basis. For detailed information about the population, the needs of the population and key recommendations in relation to each of the areas bidders should access the JSNA.

Existing healthcare provision

This section outlines the current healthcare provision serving the borough of Ealing.

Primary care

Ealing CCG commissions services from 76 GP practices, meeting the needs of 430,000 registered patients (residing in Ealing and neighbouring boroughs). Practices are arranged into three localities (North, Southall, Ealing & Acton). The practice locations and sizes (according to practice size lists) are shown in figure 2.

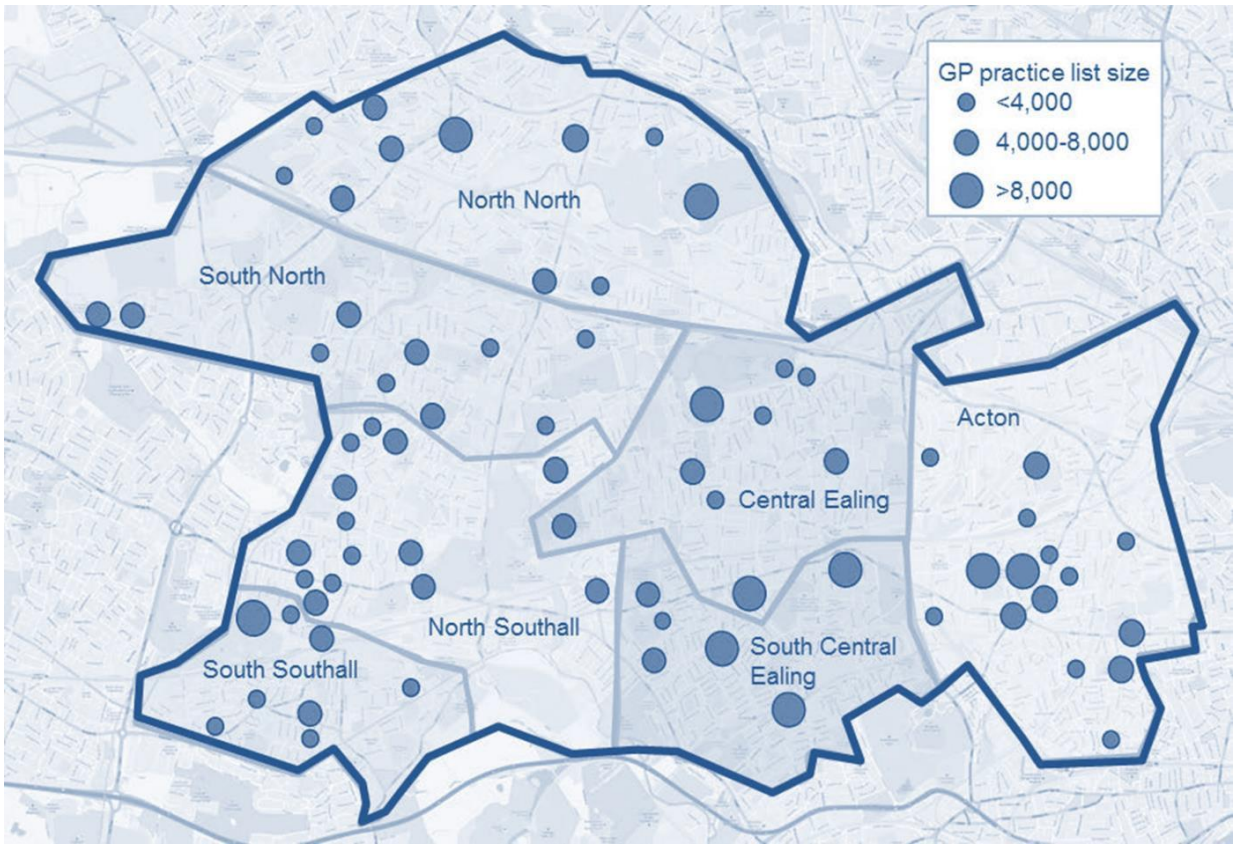


Figure 2. Ealing GP practice locations and sizes

GP practices are grouped into GP networks, of which there are seven operating across the CCG; each with a GP Clinical lead who in turn sits on the Governing Body (Figure 3). Formed in October 2014, the Ealing GP Federation currently represents all Ealing GP practices supporting the delivery of services in general practices across Ealing. The GP federation has supported the delivery of the out of hospital services which will be superseded by the Ealing Standard in April 2018. Significant efforts are being made to improve primary care services across the borough. The CCG plans to invest £33m between 2018/2019 and 2020/2021 in the delivery of enhanced primary care services for patients in Ealing. The investment will be used to fund delivery of the Ealing Standard for Primary Care[2], which aims to improve access for patients, improve the resilience of general practice, reduce unwarranted variation in health outcomes and ensure long term sustainability of the local health system.

The Ealing Standard is a contract for primary care providers for the delivery of a set of 23 standards that focuses on the delivery of high quality care in general practice. The re-commissioning of out of hospital services is not dependent upon these changes taking place, but – once made – they will significantly support the development of out of hospital care in Ealing.

[2] http://www.ealingccg.nhs.uk/media/130130/Paper-4-Ealing-Primary-Care-Standard.pdf

Community care

Ealing CCG currently commissions a range of community-based Out of Hospital services for adults and children & young people (CYP), some in partnership with the Local Authority, from a number of different providers, provided in a range of settings across the borough including GP surgeries, community clinics, community inpatient wards, A&E, residential and nursing homes, schools, and in the home. An overview of the community services currently commissioned by both the CCG as the single commissioner and where jointly commissioned with the LA in Ealing is provided in Appendix 1 of this document. Community services are currently provided by the following organisations:

#	Provider	Service
1.	London North West Health Care NHS Trust	Community Services Contract
2.	West London Mental Health Trust	Ealing Integrated Care (Home ward)
3.	West London Mental Health Trust	Primary Care Mental Health
4.	London North West Health Care NHS Trust	Community Bedded General Rehabilitation (Clayponds Jasmine & Rosemary Wards)
5.	Argyle Road Surgery	The Argyle Care Home Service
6.	West London Mental Health Trust	Increasing Access to Psychological Therapies
7.	West London Mental Health Trust	Dementia Link Workers (via Dementia Concern)
8.	Dementia Concern	Dementia Support Service
9.	Marie Curie Cancer Care	Planned and Variable Response
10.	Mind	Pathways

Ealing CCG also commissions a range of non-statutory, voluntary sector services in partnership with the local authority, to provide support to patients in the community. These services complement statutory requirements.

Acute care

Acute activity is spread across four different NHS Trusts and the principal places of referral are across eight different sites within Ealing and neighbouring boroughs (Northwick Park Hospital, Ealing Hospital, Charing Cross, The Hammersmith Hospital, St Marys Hospital, West Middlesex University Hospital, Chelsea and Westminster Hospital, The Hillingdon Hospital). Mental Health services are provided by West London Mental Health Trust.

As part of the 'Shaping a Healthier Future' (SaHF) programme (agreed by the Secretary of State in 2013) to shape hospital and out of hospital health and care services in NW London, significant changes have been agreed to services currently provided at the Ealing hospital site[3]. Ealing hospital is the smallest district general hospital in London. To better serve the needs of the local population, it was agreed that Ealing

[3] SaHF programme (https://www.england.nhs.uk/london/2015/11/09/healthier-future/)

hospital will become a local hospital, with a local A&E department playing a critical role within the wider urgent and emergency care network. The transition of Ealing hospital to a local hospital status is within the life time of the current STP, however further change will only happen provided there is assurance of capacity and capability in the receiving sites and in the out of hospital setting.

2. Case for change

This section sets out the case for change in terms of the national, regional and local drivers for change; all of which bidders will be expected to be aware of and have an understanding of their application.

National

NHS England's Five Year Forward View[4] (FYFV), published in October 2014, sets out recommendations for sustaining and improving the NHS: improving quality of services, reducing fragmentation, and accelerating integration. It describes new models of care to improve integration of services, with a particular focus on the delivery of out of hospital care. This includes:

- A drive towards outcomes-based commissioning: *"personalised care will only happen when statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be key outcomes of care; and that patients, families and carers are often "experts by experience"*
- Decisive steps are needed to break down the barriers in how care is provided between services, including health and social care, and to develop radical new care delivery options. This includes permitting groups of general practices to combine with community nurses, other community health services and hospitals to create integrated out-of-hospital care.
- A 'new deal' for GPs, including investing more in primary care, while stabilising core funding for general practice nationally over the next two years, and a shift in investment from acute to primary and community services.

Transformation work is being undertaken across the country in relation to new models of care through vanguard sites. This includes a number of "vanguard" Multispecialty Community Providers (MCPs). In addition, individual areas such as Manchester and Dudley are driving new ways of commissioning care in line with these principles.

Regional

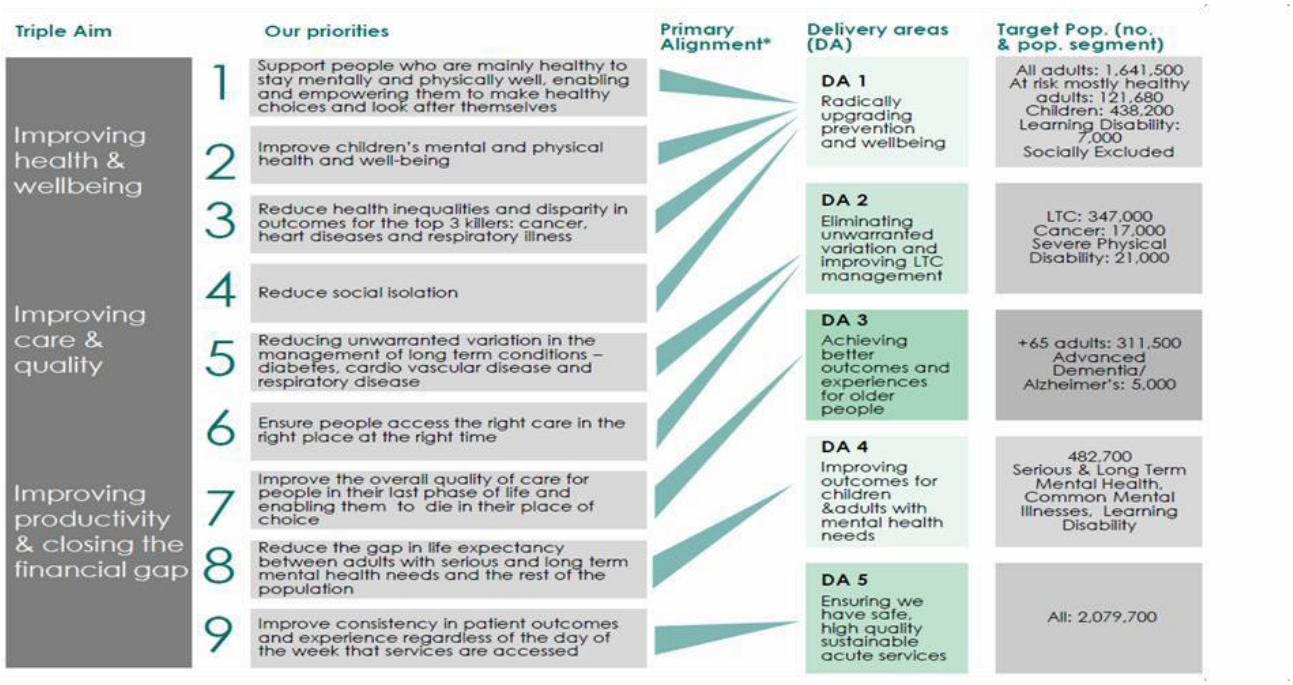
The eight CCGs in North West London (NW London) work together as a collaboration. The five CCGs of Central London, West London, Hounslow, Hammersmith & Fulham and Ealing share a single Accountable Officer, as do the CCGs in Brent, Harrow and Hillingdon. Together these CCGs have developed and led significant transformation, including the Whole Systems Integrated Care programme, and the implementation of '7 day services'. Of particular relevance is the Shaping a Healthier Future (SaHF) programme which will be enabled in part by improvements to out of hospital services across the borough.

The Sustainability and Transformation Plan (STP) for North West London, submitted to NHS England in October 2016[5], builds upon these programmes in the context of the FYFV. It outlines a vision developed by commissioners, providers and local authorities, whereby the historic approach to managing care is inverted, turning a reactive and increasingly acute-based model on its head, to one where patients take more control and are supported by an integrated system that proactively manages care. A core expectation of this is that care will be provided close to people's homes, wherever possible.

[4] https://www.england.nhs.uk/publication/nhs-five-year-forward-view/, October 2014

[5] https://www.healthiernorthwestlondon.nhs.uk/documents/sustainability-and-transformation-plans-stps/stp-october-submission-2016

Figure 2: NW London Health and Care Partnership priorities and delivery areas



Out of hospital services (primary and community services) are a priority throughout the STP. The STP states that these will be organised at four different levels: in individual GP practices, in networks of GP practices, at community hubs (aligned to localities) and at borough level.

Each of the NW London CCGs is currently delivering an ambitious out of hospital programme intended to ensure that patients are at the centre of care, with the registered GP providing, managing and coordinating the care received. Community hubs are a key component of the new model of out of hospital care, providing a setting where primary, community, mental health, social and acute care providers can come together to deliver integrated, patient centered services. This will also allow more services to be delivered outside of hospital settings. The STP sets out the principles of care closer to home and in the right care setting to meet the patient need.

The STP is enabling North West London organisations to collaborate on the standards of care and pathways that are required across the health and care system whilst still enabling local organisations to meet local needs and determine the most optimal way to do so. All partners in the STP see this as a way of iterating the approach to the delivery of improved care in a sustainable way across the system in which the provider will need to play its role within. The provider will be expted to work as part of the STP in North West London.

Importantly organisations across NW London are working towards delivering a financial sector control total and the provider would be expected to play its part in meeting these requirements.

Local drivers

The way in which Ealing CCG has commissioned care to date does not encourage providers to focus on coordinated care delivering the best possible outcomes for patients. With the majority of the contracts for community services due to expire by March 2019, the CCG has an opportunity to move to a single contract for these services as a key step in delivering its vision for out of hospital care.

In moving to a single contract, the CCG aims to make care more proactive; reduce fragmentation; improve the quality of – and access to – community services; and improve financial sustainability. This will support alignment with the national vision for greater integration of services, reduced demand on the acute sector and improved out of hospital care. These drivers of change are explained in more detail below.

Increasing focus on preventative care and proactive planned care, reducing reactive care

Preventative and proactive planned care agendas are not widely implemented, with the current system primarily reacting once a need has arisen. The consequences of this are reflected in A&E attendance and non-elective admission rates, increasing pressure on the acute sector and hospitalising patients whose experience and health outcomes could be significantly improved by care in community settings.

There is insufficient focus on early intervention and preventative care at the moment to either prevent or minimise deterioration in health and wellbeing. The opportunities to help service users remain healthy for longer and receive help as early as they feel is necessary, is therefore often missed. Community services work in isolation from primary care as they are managing patients who are referred to them and although communications between community services and primary care is improving, the care is still reactive in response to a referral. There are therefore significant opportunities to provide proactive planned care based on a population management approach, with service delivery that wraps around population groups and primary care to develop joined up working and support care closer to home.

Increasing care integration and reducing fragmentation of services

One of the principal drivers of change is to reduce the visible fragmentation of care that currently exists across different providers and services. The services in scope for consideration are commissioned through 12 different contracts across 7 different organisations; and they are commissioned on an activity and outputs basis rather than an outcomes basis.

There has been significant engagement with public and patients on care outside of the hospital setting over the last few years. Feedback from patients and carers suggests existing community services in Ealing are fragmented, complex and difficult to navigate for some service users (such as those with dementia) as well as for professionals in primary and acute care services. This often leads to service users defaulting to use acute services. Key themes from feedback include:

- Information (e.g. test results, background histories, lifestyle, home situation) is seldom shared, with service users often having to repeat this information at every contact
- Service users feel a lack of empowerment to own their own care and be responsible for their own health
- Community services are hard to navigate with multiple entry points, with service users experiencing difficulty in identifying where to go for what type of support, and are unaware of opportunities to be proactive in their care
- GPs find it hard to get a coordinated response to meet the needs of patients
- Ealing residents use every acute trust in NW London and community care is not always co-ordinated
- Service users have experiences of getting lost in the hand-offs between providers/services.

A more integrated approach will help to address the current gaps in care and challenges around care co-ordination that lead to these adverse impacts on patient experience and outcomes.

In particular, a more holistic and less disease-based approach will help the cohorts of frail older people, those living with long-term chronic illnesses and mental health disorders and people with medically complex needs, for whom effective community services are a vital support. .

Increasing consistency and reducing variation in quality of (and access to) services

There is variation in the quality of services across Ealing and patient engagement and feedback from patients across the borough has shown that experience varies across the borough. Examples of this variability and ways in which the single contract approach will help to address them include the following:

- Community services have historically been delivered in specific locations, which can result in some local residents struggling to access particular services. The new model of care proposed aims to address this by organising services in line with the access needs of the service user and aiming to deliver care as close to the patients home as possible.
- Where services are split across different locations, service quality has varied across the CCG catchment. The new model aims to support more consistency through single operating plans
- Where services have been established within specific team structures (e.g. standalone specialist services such as podiatry), this can impact response / patient waiting times during periods of staff vacancies. Without creating a different set of silos, the new model aims to align services into core work groups so that specialist functions have greater operational continuity through increased joint working
- Currently, the management of care plans across community specialties for children transitioning into adults creates gaps in service delivery and causes anxiety for families and carers. The new approach aims to improve alignment between services offered for children and those offered to adults and support patients through the transition, in line with national guidance
- Waiting times for key services (e.g. musculoskeletal community therapy, and falls prevention) experience higher than average waiting times for a number of reasons. The new approach aims to jointly develop new pathways to support the needs of the local population, using innovative delivery models and therefore attract and retain staff into the local service
- With existing clinical IT systems used across community and primary care services, delays often occur in the transfer of clinical information between community services and primary care (e.g. where intervention notices are sent to registered GP to inform the status of patients and their current care plans). With more services under the scope of the single contract, those involved in the delivery of care will have a greater understanding and a more integrated approach to care delivery and will be expected to keep all parties informed and involved in the tailored care provided using where appropriate the clinical IT systems.
- Delayed Transfers of Care are a system-wide challenge, which services in scope for the proposed approach can help to address. The new approach increases the scope of commissioned services within the single contract, reducing fragmentation between providers and ultimately contributing to fewer delayed bed days for Ealing residents in both acute and community bedded services as services are more integrated as a direct consequence of being under a single contract.

3. Ealing's commissioning vision for community services

Vision for out of hospital care

Building on the intentions outlined in the NW London Health and Care Partnership plan, Ealing CCG is now looking to take the next step towards strengthening Out of Hospital services through transformation. The CCG is commissioning a provider to deliver community Out of Hospital services (for adult and children and young people (CYP)) from May 2019. Once commissioned, the provider will be responsible for the coordination and delivery of all of the out of hospital care, removing the constraints of multiple contracts, and providing a unique opportunity to commission community services that are fully coordinated and integrated.

Ealing CCG has set out a vision for out of hospital care as follows:

- *To provide holistic and integrated care outside hospital that empowers people to be in control of their healthcare outcomes, and works to deliver care that feels local, working seamlessly with the local authority, primary, mental health, acute care services and the voluntary sector.*

Ealing CCG aims to deliver both physical and mental health services in the lowest intensity settings, providing consistent, high quality care as close to home as possible and where appropriate.

Establishing an integrated contract for out of hospital care

In line with the vision for out of hospital services, Ealing CCG is looking to establish a single integrated contract that puts the patient at the centre of their care. Working alongside their GP and primary care teams, the intention is that patients feel more informed about their health condition and care plans and encouraged to undertake measures to manage their health conditions when it is clinically appropriate with support from their GP and community teams in a setting close to home. The aim is for the single contract to be clinically led and coordinated through a single point of access to oversee, clinically triage and book all services in scope.

Should a patient's condition deteriorate, care would then be quickly coordinated through a designated community triage and booking system (single point of access or 'Community SPA') which, through shared IT functionality enabling the sharing of care plans, would support the patient to access the most appropriate team or location (acute or community setting) for on-going care and support.

Community services are currently measured on activity (e.g. appointments) or outputs (e.g. blood tests) undertaken. The new contract will enable a move over time towards measures of outcomes delivered, including quality of provision, for patients and not the activity or outputs generated.

Bidders will need to build on the established multi-disciplinary integrated teams and support them to work more closely with acute and primary care services.

It is the intention that the provider will deliver a service that will be:

- Person-centred, based on specific needs of an individual
- High quality, safe, sustainable & affordable
- Coordinated, with information shared between service providers and users
- Easy to navigate (utilising the community SPA functionality)
- Designed to facilitate patient empowerment and support greater self-care for those for whom it is appropriate
- Innovative in its design and delivery with a drive to continuously learn and adapt to improve
- Have a strong sense of local 'place' which the community recognises and values

It is expected that the lead provider will deliver the following benefits for service users and carers of all ages:

- Joined up care across a person's life from child to adult in the community responding to patient need, and delivering care to address the changing needs of an individual
- The provider will wrap their teams around networks of practices to develop a joined up and closer working relationship with primary care to support care in the community
- The provider will deliver seamless proactive planned care in order to deliver better health outcomes for patients resulting in better quality of life and independence
- A reduction in the need to attend hospital, having the flexibility to remain at home and receive any care necessary in community settings or in their own home where safe to do so
- If hospital admission does become necessary, a reduction in the length of stay, ensuring discharge is supported and patients can go home as soon as their medical conditions allows for it, with appropriate and timely support in place in the community as needed
- Patients will receive timely access to community services coordinated by their care coordinator to maximise improvements to individual's health and well-being, without the need for repeated referrals from the GP
- Focus on early intervention and preventative care will minimise the deterioration of conditions, helping service users remain healthy for longer and receive help as early as they feel is necessary
- Shared information amongst care providers, ensuring service users will only need to tell their story once, rather than have their history repeated with every professional they work with
- Improved integrated coordinated care and case management thus providing seamless care – high quality rapid response care that is patient centered, coordinated and offers continuity of care to high need patients.

Principles underpinning of the Clinical Model

The clinical model has been developed based on the information set out and according to a set of design principles that have been developed in conjunction with local clinicians and which reflects the outputs from previous engagement events with service users.

Principle 1: Community services should work seamlessly alongside primary care

- Population health management in primary care can shape how best to use community-based services for individual patients
- Emphasis on primary prevention (proactive rather than reactive)
- Establish and use formal & informal communication channels between care professionals
    - Understanding of pathways to ensure appropriate referral
        - Aligning with sector-wide pathways where available,
        - Continuing trend of decentralising model of care for LTCs e.g. specialist nursing provided in community
    - Education/training on disease conditions so primary and community professionals are working with same approaches to care
    - Regular Multi-disciplinary team (MDT) and Joint Care Team (JCT) meetings
    - Responsive to feedback from primary care, and adaptable to ensure seamless and integrated care pathways between primary and community services are evident

Principle 2: Community care should be truly 'community' and have a strong sense of local place

- Familiar, consistent teams working with primary care teams to build relationships and trust, and familiarity with the local patient populations
- Bases/hubs for specific services e.g. palliative care, diabetes, MSK interface, Tissue Viability services
- If services centralised, they should still feel local to the patient
- Good in-reach service into the hospital setting, with escalation policy

- Services are tailored to the needs of the local population, with a workforce that are reflective of the local population
- Services that recognise the value of non-statutory services in the borough and how they can help service users

Principle 3: Care should be based on what matters to each patient

- Care should be planned around and delivered in the context of achieving the goals that matter to patients
- Care should help patients feel empowered and enabled
- It should encourage and facilitate self-management and embrace health literacy as an approach to knowing how best to adapt care to suit individuals
- Patients who already have relationships with specific teams e.g. cancer, Parkinsons, should be able to self-refer to those teams
- From the patient's perspective, care should feel coordinated

Principle 4: The type and route of care delivery should suit the type and preferences of patients. This can mean different modalities for different types of patients.

- Patient segmentation is done not just on clinical or health need, but on personal characteristics, such as: familiarity with technology; school and/or work commitments; caring responsibilities; patient activation levels
- Make routine the use (for suitable patient cohorts) of online apps, web videos, and other non-face to face routes to care
- Pay particular regard to vulnerable populations, e.g. nursing homes, adolescents and young adults

Principle 5: Professionals providing community-based care are delivering at the top end of their licence, enabling primary care to focus on population health management and acute teams to focus on people requiring specialist provision

- Use of best practice from elsewhere such as Home First
- Joint learning and trust at clinical level to enable appropriate transition out of hospital and into community-based care
- Knowing what 'normal' is for each patient
- Building awareness of models of care available in community with acute team colleagues, and vice versa to ensure best use of mutual resources
- Community services actively in-reaching to acute care

Principle 6: Services are delivered in a way that constantly improves health outcomes of the population, by providing high quality of care, efficiently and within financial control targets

- There is accountability for achieving high quality of care for the population of Ealing working with primary care, commissioners and all other providers in the local health and care system
- Services are delivered as efficiently as possible, without compromising on quality of care, wellbeing of workforce and in a way that unnecessarily impacts on waiting times
- Staff are empowered to innovate and work across teams to deliver a holistic approach to the needs to individuals
- The provider and the commissioner work using open book principles particularly around the financial elements.

2. Requirements

This section sets out the scope and requirements expected of the provider in the delivery of an out of hospital community service for adults and CYP. Whilst it is expected these requirements will be met, the CCG envisages the provider will use this opportunity to be innovative in their approach to designing and implementing a community service model which best meets the CCG's vision for the service and delivers the outcomes that matter for the population of Ealing, as outlined later in this document. The provider will need to work towards being able to be part of a system that uses a population health management approach. The provider needs to work with other health and care providers iteratively over time to achieve this.

2.1 Type of provider

The CCG is looking for a partnership with the provider over the contract term. The CCG recognises how critical it is to spend time developing the care provided outside of hospital for both adults and children and is therefore looking for a partner who is willing to put patient care at the heart of its business, empower and invest across the organisation, whilst taking a transformative view of the way in which those services are delivered. The CCG wants to commission a provider whose philosophy is orientated around delivering high quality evidence-based care, where the use of translational research into best practice is pushing the boundaries of how and what can be delivered outside of hospital. This should be complemented by recognition that IT and digital innovation are paramount to continually improving patient and carer experience whilst driving efficiency and productivity improvements over the duration of the contract.

The CCG will only want to commission a provider that can actively demonstrate its ability to lead and work with partner organisations in the best interests of local residents.

The successful provider will need to demonstrate a track record of engagement with patients, service users and carers that is used in an on-going way to inform and develop models of care. The transformation requirements on the provider will be significant and key to successful change will be the ability for the provider to engage, understand views and concerns and incorporate these into any changes to services. The CCG expects to work with the provider in determining when changes being proposed require engagement and/or consultation and then to agree responsibilities in terms of determining how any requirements will be safely managed.

Finally the CCG will be looking for a provider whose passion is demonstrable in the out of hospital landscape and who is able to drive the integration of care across all parts of the health and care system whilst being able to find a collaborative way of working with all partners. Put simple the CCG wants a partner in the provider with the leadership ability to inspire its staff to deliver the right care to people in the way that meets their needs most effectively and feel empowered to make changes that continually drive improved outcomes, experience and efficiency whilst being adaptable and innovative.

Operating as part of the NW London Health and Care Partnership

With 80% of the care for a patient who lives in NW London being delivered by providers within North West London the CCG needs a provider who can demonstrate that they can work with the NW London health and social care system through developing and maintaining effective relationships with partner organisations to enable the optimal provision of care for Ealing residents. This will include working closely with acute, mental health and primary care providers to provide care for the patient and demonstrate how patients will be supported from an acute setting into the community. The provider would be expected to work as part of the Provider Board, and in other STP forums, with the aim of supporting the aims set out in the STP being delivered.

Operating in the Ealing Health and Care system

The Local Authority:

Ealing CCG and Local Authority have been successful in jointly commissioning and supporting the integration of services outside of hospital over a number of years. The CCG and Local Authority will look to maintain the level of integration and joint commissioning in place currently and the appointment of a provider to deliver this contract should not impact on what has been achieved. The CCG and Local Authority hold a Section 75 which supports the joint commissioning of services. Within the scope of the contract are services that are delivered through the integrated local authority teams with current providers of community services. The expectation is that the successful provider will need to enter into a Section 75 agreement or a partnership agreement with the local authority to enable the teams to continue to work together and to the same level of joint working as has been achieved so far. The aim will be to understand and drive further integration of health and social care services over the duration of the contract. Later sections set out the potential opportunity for integration as transformation takes place that could be realised through either increasing the scope of provision through the contract or by enhancing the partnership working through a section 75 or partnership agreement. Both the CCG and the local authority are committed to achieving this at commissioner level, in the out of hospital landscape at a pace that works for all partners to meet the needs of residents.

Given this important and critical relationship both the CCG and the Local Authority consider that the local authority will need to work as partners through a section 75 or partnership agreement with any successful bidder and entering into such arrangements would be a condition precedent to the overall contract.

General Practice and the GP Federation / At scale provider of General Practice

As already highlighted the partnership between general practice and the provider of the single contract will be important in enabling the coordination and integration of care. The ability to work in partnership with general practice, and for general practice to work in partnership with the preferred bidder is critical in delivering high quality care that meets the needs of patients. Experience has shown that building two way trusted relationships, being responsive to each other and operating with transparency is most likely to enable that partnership to operate successfully and create the environment for staff to work at the top of their licence. Ealing CCG is fortunate to have a GP Federation made up of all 76 practices. Recognising the importance of the partnership that will be required between the successful bidder and the GP Federation; the GP Federation has sought and achieved a mandate from practices across Ealing to enable them to represent all practices in dialogue with bidders and the eventual preferred bidder.

Given this important and critical relationship both the CCG and the GP Federation consider that the Federation will need to work as partners with any successful bidder that they should be considered as a required partner although not a contract signatory. The CCG will expect the successful bidder and the GP Federation to have a partnership agreement in place by the end of the mobilisation period.

The Voluntary Sector

The CCG sees the voluntary sector as an important part of the care delivery system in and across Ealing. There are currently many examples of health services working in partnership with the voluntary sector and the CCG would expect this to grow over the course of the contract term. The CCG would expect the successful bidder to form strategic and operational relationships with the voluntary sector and for these to evolve and strengthen over time

The CCG currently lets grants to the Voluntary Sector in collaboration with the Local Authority on a four year cycle. The new grants/contracts round would be live in April 2019. There are 8 areas under which the voluntary sector will be asked to bid, these are: Improving self-care, Increasing community connections and reducing social isolation and user involvement, Improving access to high quality information and advice, Improving mental health, short breaks/respite care/young carers, domestic violence service,

infrastructure support, small grants. The successful bidder will be expected to work closely with the VCS organisations commissioned under these areas over the first four years of the contract.

The CCG will work with the local authority, the bidder and the voluntary sector to determine how grants should be let before the end of the next round of grants and contracts.

The successful bidder will be encouraged to work with the voluntary sector to access external funding throughout the term of the contract.

Model of Care

The single contract for out of hospital services aims to bring together a range of existing physical and mental health community services to provide a holistic community services offer, closer to patients' homes, to deliver improved benefits and outcomes for the patients of Ealing. The model of care for the single contract aims to address feedback from patients, the workforce, providers and other stakeholders regarding how healthcare is commissioned and delivered in Ealing.

The CCG recognises that there is significant work in getting to the new model of care and requirements about this are set out in later sections. The CCG mainly expects care to be delivered as currently configured at contract commencement but then to commence transformation as detailed later in the prospectus. The specifications underpinning the prospectus are those which are currently commissioned with the three new specifications and some specifications that have been aggregated to enable the same care to be delivered from one specification e.g. bedded care.

The CCG has a genuine desire to shift, transform and innovate the delivery of care in Ealing in the medium to longer term, we have moved away from describing existing services/contracts in our model of care. Instead we describe functional groups of services, which cover the continuum of care across a patients' life cycle e.g. children and young people through to working age adults and older people. Within each functional group we have detailed the individual functions within the scope of this contract, which we would see as working together, within and across, functional groups in order to deliver truly holistic care. The CCG envisages that over the course of the transformation phases detailed later in the prospectus the specifications would be updated to reflect the functions rather than service lines as they do at the moment.

The functional groups are described as follows:

Community therapies

This functional group aims to improve health and wellbeing, rehabilitate and find self-management strategies in order to overcome the physical, psychological and social problems caused by ill health. Community therapy works to support individuals and their families to live healthy fulfilling lives at home, or as close to home as possible, for as long as possible.

Long term conditions (excluding therapies)

This group of functions aims to ensure patients with long term mental and physical health conditions receive the best treatment and support to manage their condition/s. This functional group also includes support services to address broader socio economic factors particularly in relation to dementia and severe and enduring mental illness (e.g. schizophrenia, bi polar etc.).

Complex and specialist care

This functional group aims to provide support to cohorts of patients who may have complex needs or a need for locally delivered specialist care and support.

Community nursing

These functions aim to provide community and domiciliary nursing care for children and adults who are housebound, or whose care is more appropriately delivered in the home (including residential and nursing homes) or a community setting (including schools and respite settings). The functions aim to:

- Provide professional nursing care, advice and support to patients who have acute, chronic and terminal conditions
- Provide training on specific procedures to parents/carers/others involved in a patients care
- Improve quality of life, patient outcomes, maximise independence and, wherever possible, prevent inappropriate admission to and facilitate safe and timely discharge from hospital
- Case manage and co-ordinate care for patients with complex multiple co-morbidities and needs, ensuring a unified, individualised plan of care with the patient, their parents/carers, and all health, education and care partners involved in their care
- Support patients, GPs, district nurses and other healthcare professionals in the management of complex and problematic wounds, particularly the prevention and treatment of pressure ulcers and leg ulcers
- Promote continence and provide an integrated service for the early identification, treatment and management of bladder dysfunction and bowel management, with or without incontinence. This will include provision of a specialist enuresis service where required, and assessment, provision and review of continence aids.

For those patients in their last phase of life, these functions aim to provide holistic care of patients with advanced progressive illness in a community setting through participation in advanced care planning; which should be recorded on CMC. They aim to improve the quality of life of people and their parents/carers affected by serious illness, by paying attention to the physical, psychological, social and spiritual needs of the individual. Specifically they will:

- Help maintain independence, dignity and enable patients to have end of life care in their preferred place
- Help improve quality of life by providing relief from pain and other distressing symptoms
- Offer a support system to help the family cope during the patient's illness and in their own bereavement.

Additionally for children specifically, this group of functions will:

- Provide a nursing service for Special schools in the Borough, including provision of training and support to school staff with regard to clinical interventions that may be required.
- Provide a continuing care service, providing packages of care at home.

Enhanced primary care in care homes

This functional group will provide proactive, personalised primary care and support that is centered on the needs of residents, their families and care home staff. The specific aims of these functions are to provide continuity of primary medical services care for residents, timely medicines reviews, access to hydration and nutrition support, and streamlined referral to out-of-hours services and urgent care.

Coordination and Case Management
These functions aim to support coordination of patients' care ensuring services are accessible, and responsive, with shared care planning in order to achieve patient outcomes. These functions will also ensure a holistic approach to supporting the needs of patients.

Crisis response:
These functions aim to avoid an unnecessary hospital admission by providing a high quality, timely, home based health and social care assessment and short term treatment for patients or carers with an identified physical health crisis.

Discharge
These functions aim to provide home based short term assessment and treatment, where required, to enable patients to safely return home as soon as medically well following an acute hospital stay.

Community beds
These functions provide bed based 'step up' care and rehabilitation, for those patients that do not require an acute bed but cannot be safely treated/supported in their own home or other community setting. The provider will be expected to take medical responsibility for the community beds.

Enablers
These functions aim to deliver all the support functions which enable sustainable, safe, efficient and quality services.

Trusted Assessor model

Adoption of a trusted assessor model will be a key enabler for this service transformation, facilitating the speedy and safe transfer of service users from an acute hospital to a community or residential setting. The provider will be expected to demonstrate plans for the development, agreement and implementation of a protocol or memorandum of understanding between community services and other service providers (in acute, primary or community setting) for assessments, documenting who can carry them out, what competencies are required, how they will be delivered, what the review mechanisms will be and what will happen if the receiving service judges that the assessment is flawed. The bidder will be expected to demonstrate a robust governance approach to implementing the trusted assessor model.

Shared care plan functionality

Every service user in Ealing with complex health care needs will need to be under case management as per their agreed care plan. This plan, developed through consultation with the patient's GP or another suitable registered healthcare professional, users and their carers (where appropriate), focuses on the patient's outcomes/goals and has a clear plan of specific actions which members of the team will deliver. The care plan is a shared record, visible to all those involved in the patient's care including the patient, family members and carers. The plan will include information to address how their care will be managed to:

- Enable effective management of their long term condition/s
- Enable optimum supported self- management
- Provide clear contact points for times of crisis / exacerbation
- Understand the patient's interactions with other agencies providing support to them
- Consider the needs of the patient's carers
- Review medications being taken by the patient and support improved compliance, where appropriate
- Agree the case management approach with the patient, i.e. frequency of review of care plan, review arrangements in the event of an unexpected admission to hospital etc.
- Reduce their risk of avoidable admission to hospital

The provider will be expected to work with primary care teams to ensure that there is a single care plan supporting the care of an individual. The care plan will need to be maintained and updated on review by the provider and/or GP with the expectation that any changes are discussed with the registered GP. GP Practices across Ealing (except two) use SystmOne as their clinical system of choice as do other organisations delivering care across Ealing and CCGs in the collaboration Ealing is part of. It is the provider's responsibility to ensure all community service teams have access to SystmOne or another clinical system that offers the same level of interoperability with general practice and other service providers.

The following table sets out how the functional groups could deliver care for adults, children and people of all ages.

Care delivery by functional group

Functional Group	Adults	Children	All ages
Integrated Community therapies	• Community neurological and stroke rehabilitation • Integrated Community therapies (physiotherapy, occupational therapy, women's physiotherapy, Community falls, speech and language therapy, musculoskeletal) including for those with disabilities/additional needs	• Audiology • Community therapies (physiotherapy, occupational therapy, speech and language therapy) including for those with disabilities/additional needs	• Nutrition and dietetics • Podiatry
Long term conditions (excluding therapies)	• COPD including pulmonary rehabilitation and education • Diabetes including all age diabetes education • Dementia support • Primary care mental health • Dementia link workers • Mental health benefits and employment support for those with severe and enduring mental illness • Physical and Psychological community pain management service	• Children's specialist nursing: asthma; diabetes; haemoglobin	
Complex and specialist care	• Community learning disability services including continuing healthcare assessment, review, nurse-led case management, music and art therapy • Clinical psychology and psychiatry including for those with disabilities/additional needs	• Child development • Health needs for looked after children including statutory health assessments	
Community nursing	• Community non-specialist palliative care including night sitting services • Community nursing • Tissue viability	• Specialist school nursing • Children's community nursing including paediatrics, disabilities/additional needs, physical healthand continuing healthcare (on-going case management) • Specialist health visiting	• Continence service for bladder, bowel and enuresis conditions
Enhanced primary care in care homes	• Primary medical services for patients residing in nursing homes • Enhanced primary care for nursing homes • Medicine management support for care homes		
Co-ordination	• Care coordinators		• Single point of access for all functions/services within the

			scope of this contract
Rapid response	• Rapid response (acute and community) • Urgent Palliative • Social workers • Reablement		
Discharge	• Short term rehabilitation • Reablement • Home First/discharge to assess • Early supported discharge for planned and unplanned from all hospital sites		
Community beds	• General rehabilitation • Neurological and complex rehabilitation • Step up beds • Bed management function		
Enablers			• Medicines management • Pathology • Diagnostics • Provision of consumables to support in scope services • Education to referrers on pathways of care • Patient transport • Shared IT infrastructure to support coordination, information sharing and single care planning • Governance, quality and safeguarding • Estates • Workforce • Education and training (all functional groups) both within and external to the organisation to up skill and build sustainability as appropriate

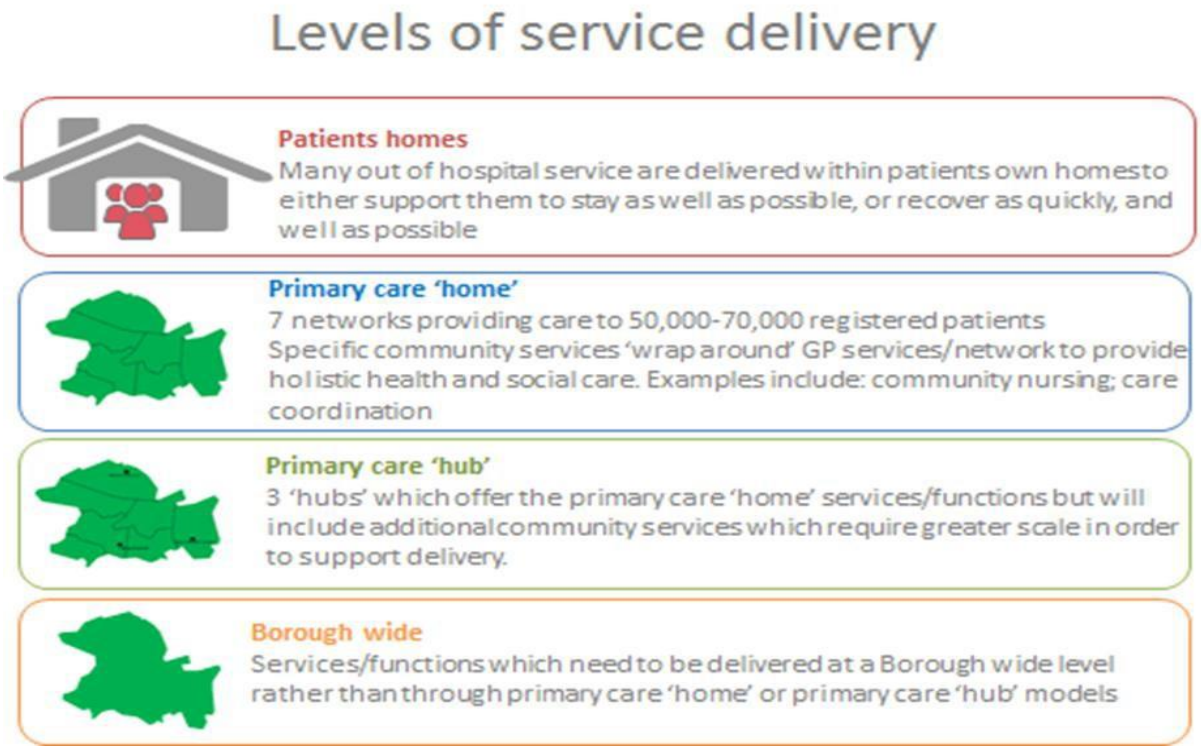
Service delivery: The following principles underpin service delivery regardless of functional group:

- Care is delivered as close to a patients home as possible
- Care is accessible and responsive to local needs and adapts and improves in response to feedback from users
- There will be a single point of access to all services/functions within this contract that will offer clinical triage enabling clinician to clinician dialogue as well as offering a single conduit to support patient flow
- Support is holistic and provided via a multi-disciplinary team where required, including working across the pathway with primary and secondary care
- That a patient has one care plan which accounts for the totality of the healthcare needs and goals, and where a patient consents, that this shared with all those who are involved in a patients care
- That all functions will seek to promote and encourage self-care and self-management where appropriate
- That all functions will deliver education and training, both within and external to the organisation to support best practice and delivery of care in the least restrictive setting

- That all functions will support research into new care approaches and encourage and foster innovative practice, including the use of technology, which supports delivery of modern and efficient healthcare services.

Service delivery levels

As detailed above, a key principle of service delivery for the out of hospital model of care is delivery of care as close to the patient's home as possible. It is recognised, though, that it may not always be practical, feasible or safe to deliver all care in a patient's home, so the following section sets out a view of the levels of service delivery by functional group. It should be noted that in some instances delivery may be across multiple 'levels', which might be reflective of the range of functions within a functional group and not necessarily indicative for all functions.

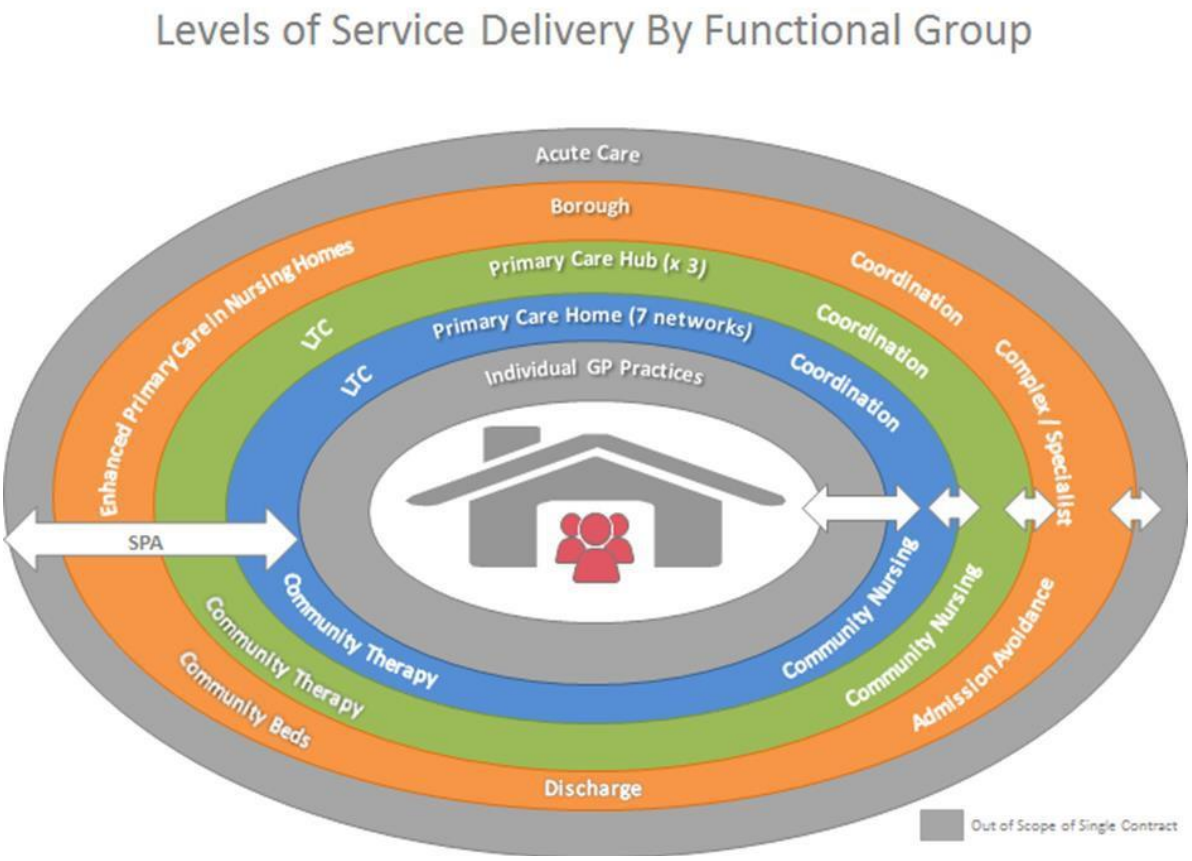


Bidders will need to determine through the transformation work, and with appropriate engagement, which functions are most optimally delivered at which levels whilst allowing for flexibility on an individual need basis where a patient might require multiple services to be delivered at home.

The diagram below provides the commissioner view of what functional groups are delivered at which levels but this will need to be considered and tested by the eventual provider. The commissioner will want to see the development of the primary care home model at network level hence enabling the relationship with general practice through the Federation. The bidder will need to determine the exact nature of the primary care homes with general practice.

The CCG has plans for two new hubs in the Borough, with a third being created at Ealing Hospital whilst expecting that other key buildings such as Jubilee Gardens are further developed acting either as hubs or spokes to hubs. Again bidders will need to determine how care is delivered from hubs to support the needs of the population at a locality level and how the model will support the delivery of the Out of Hospital Standards as they relate to hubs. The standards are provided at Appendix 3 The work with general practice to deliver this model and move towards the management of a broader population's health needs

through the hubs will be critical. The CCG would expect to work with the eventual bidder in this as the timeline for the development of hubs becomes clearer.

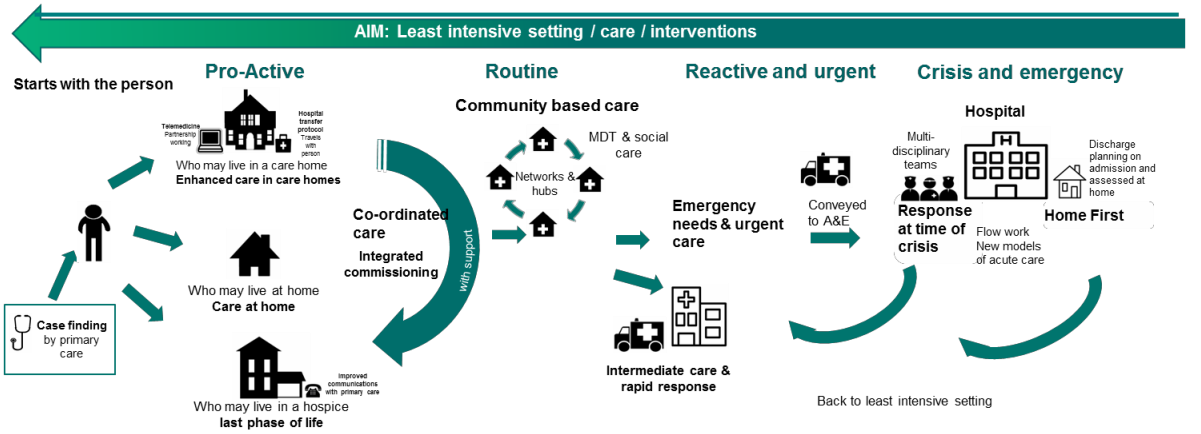


Pathways

As well as considering the model of care from a functional and point of delivery perspective is important to consider out of hospital services as part of a broader pathway of care.

The two diagrams below provide the commissioner view of the older persons pathway as set out through the NW London work and the diagram underneath shows a simplified version and how the functions fit in. The diagrams are helpful in demonstrating the alignment between the NW London pathway and the local approach as well as showing the need for focusing on improving planned care and ensuring unplanned care is responsive and helps support people return to a more planned care approach.

It should be noted that, despite the representation of the pathway below for illustrative purposes, it is acknowledged individual patients' access to and journey within healthcare services is often not linear, and that people may access and exit the pathway at different points and at different times, or may be concurrently receiving care from different parts of the pathway dependent upon their individual needs. Hence the need for, and emphasis on, coordination of care and information sharing, with patient consent



Supporting people to be healthy at home and providing proactive care

Supporting people to get back on their feet

Supporting people to get home quicker

Getting the whole health and care system working together for older people

Proactive and coordinated health and social care services supporting older people in their homes and in hospital

Improving health care and support for older people living in care homes

Delivering optimal quality of life for people residing in care homes

Last phase of life

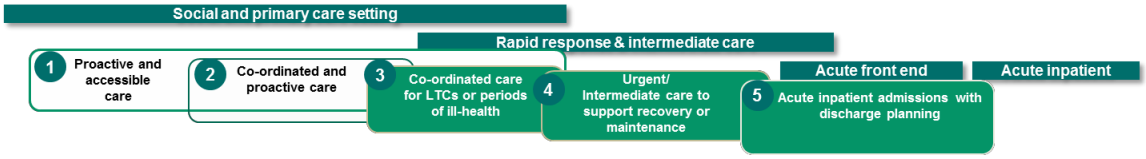
Make sure health and care staff are aware of and respect older people's wishes during their last phase of life

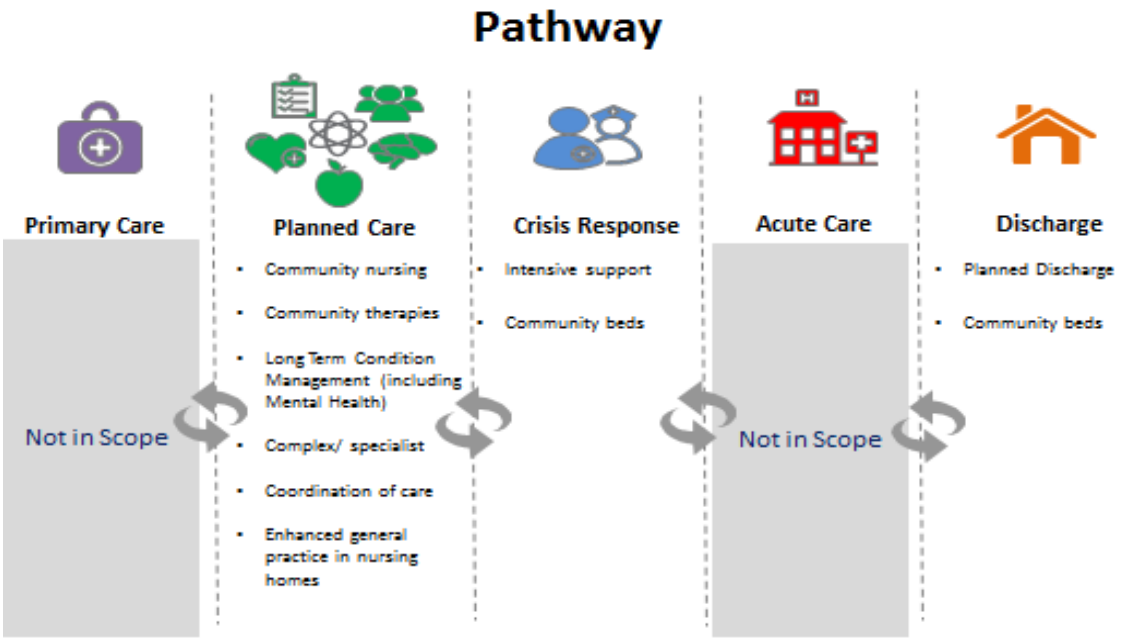
Commissioning high-quality and effective care for older people

NHS England and local authorities will work together to plan and buy the highest quality, most effective and best-value care for older people in their local communities

Home from hospital

Make sure people return home as they no longer need hospital care, with the right support in place





Integrated Services with the Local Authority

Ealing CCG and the Local Authority have a good track record of working together in the out of hospital environment. The Local Authority have provided support for the approach being taken in the prospectus and have provided commitment to being part of the Oversight Board described later. There are some services that are already operating in an integrated way that the provider of the single contract will need to continue to work with local authority to deliver.

The Local Authority have provided their commitment to these ongoing arrangements which are also supported in a Section 75 between the CCG and the Local Authority. The expectation is that the provider will continue to deliver the health components of the integrated team and through the establishment of a section 75/partnership agreement the integrated delivery will continue. This arrangement is expected from service commencement.

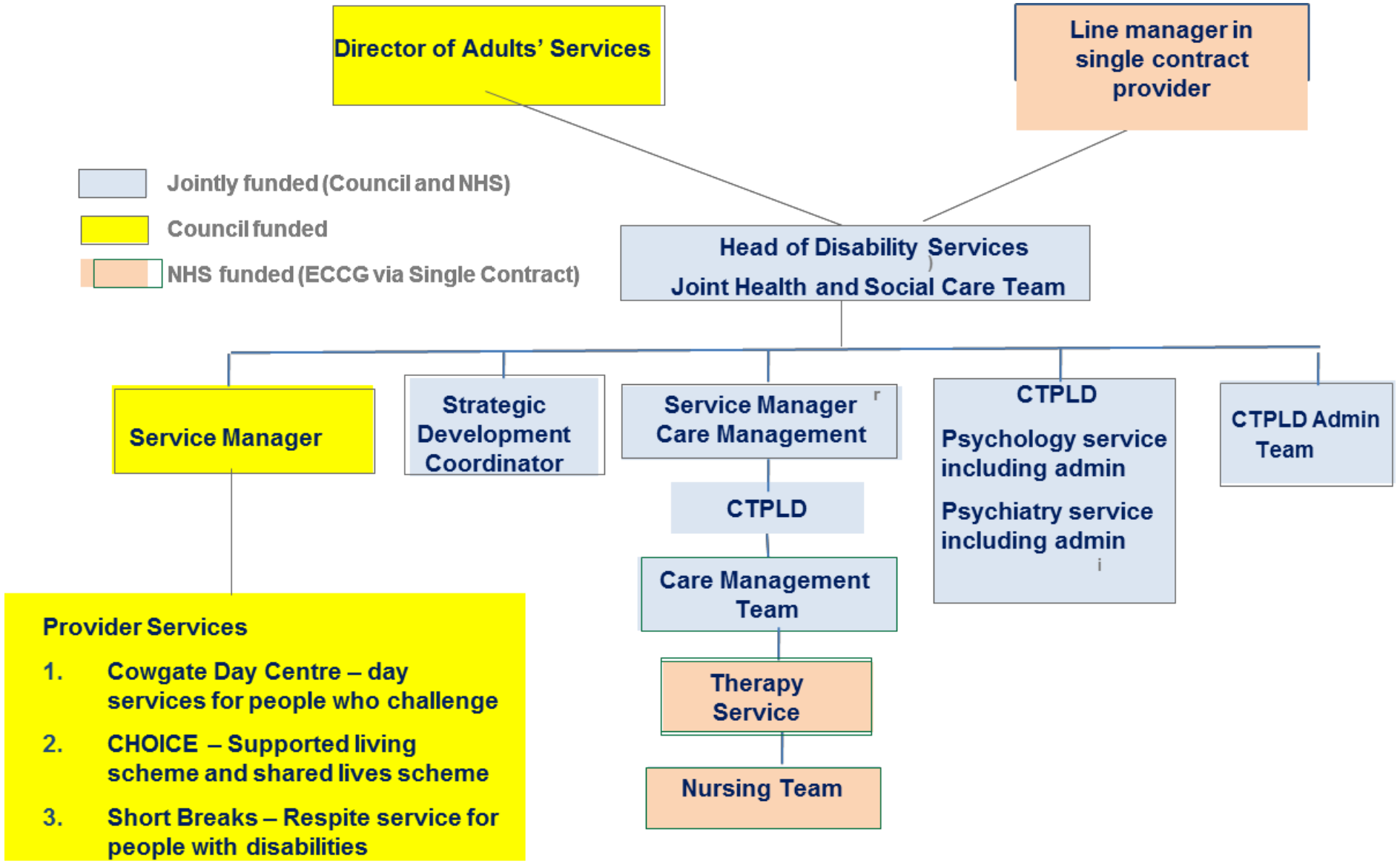
The services this applies to are set out below:

- **Community Team for people with Learning Disabilities**

  This is an integrated service that is managed by the local authority. The provider of the single contract will need to deliver the health component of the community team for people with learning disability with the local authority providing the social care component of the team. The local authority has the lead management responsibility for the integrated team. The provider of the single contract would need to deliver services according to this arrangement and would be expected to enter into a Section 75 (or appropriate equivalent agreement) so that the delegated functions and the staffing arrangement for the service are clear. The bidder will need to maintain the funding for the joint posts as shown in the diagram. The team is based at Green Lane and this is expected to continue. Any changes to the operation of the team would need to be agreed jointly with the LA and the CCG.

CTPLD TEAM

Please see structure on next page.


Director of Adults' Services
Line manager in single contract provider
Jointly funded (Council and NHS)
Council funded
NHS funded (ECCG via Single Contract)
Head of Disability Services
Joint Health and Social Care Team
Service Manager
Strategic Development Coordinator
Service Manager Care Management
CTPLD
Care Management Team
Therapy Service
Nursing Team
CTPLD
Psychology service including admin
Psychiatry service including admin
CTPLD Admin Team
Provider Services
1. Cowgate Day Centre – day services for people who challenge
2. CHOICE – Supported living scheme and shared lives scheme
3. Short Breaks – Respite service for people with disabilities

- **Ealing Community Equipment Service**

The Council currently holds a contract with Medequip for Integrated Community Equipment Services (ICES) on behalf of Adults' Services and Ealing Clinical Commissioning Group. The contract was called off a framework agreed on behalf of the London Community Equipment Consortium - 17 local authorities and NHS bodies - by the London Borough of Hammersmith & Fulham. The current contract commenced in April 2017 for a contract period of 4 years, with scope to extend for a further 2 years.

The purpose of the service is to supply, deliver, fit, adjust, service, collect, refurbish, recycle or dispose of items of equipment as requisitioned by authorised prescribers on behalf of Service Users. The contract is funded through an NHS/LA pooled budget for an Integrated Community Equipment Service (ICES) covering equipment for both health and social care. The pooled budget is included within the CCG's S75 Commissioning Agreement with the Council as part of the Better Care Fund arrangements.

“Authorised Prescribers” includes community nurses, therapists and care coordinators within the community health services who are authorised to prescribe items from an agreed catalogue. Non-catalogue items can be individually ordered by prescribers and are classed as "Specialist Equipment". These items are ordered through the community equipment service but are not purchased under the 'purchase/repurchase model'. The prescriber will source the item but Medequip will attempt to negotiate a better price with the supplier. There is a 20% mark-up fee for specialist equipment. When no longer required by the service user the equipment is collected, cleaned and put back into the "Refurbished Specials Catalogue".

Authorised Prescribers can contribute to revisions to the catalogue through the Ealing Equipment Operational Group. This group is also able to address any concerns about the operational working of the service with Medequip provides.

The provider will be expected to work within an agreed budget annually which will be treated as a pass through cost. The provider will be expected to demonstrate how it is supporting the most efficient use of the community equipment. The CCG will expect to track spend through contract meetings. The Provider will be expected to actively participate in the Ealing Equipment Operational Group and work with the appropriate officers to address any issues arising from the process of prescribing, delivering or collecting equipment by Medequip.

Background to the Integrated Community Equipment Service

Community equipment services aim to provide essential care for people that require equipment and mobility aids to stay independent and in their own home, as long as possible. By providing an equipment service at the point of need, the service should also help people stay out of hospital. There will be a proportion of people that access the community equipment services after a hospital episode. For these people, it is crucial the provider works with hospital practitioners to ensure they receive equipment that facilitates their discharge.

The community equipment service plays a key preventative role, by supporting people with their mobility or ability to live well independently. This preventative function will include a range of preventative services including falls prevention, healthy eating and social inclusion services. Local authorities will support the prevention agenda with their partner health organisations to minimise the reliance on care and maximise independence, choice and control.

- **ESCAN**

This is an operationally integrated service that will need to be jointly managed between the local authority and the single contract provider. The local authority has the lead management responsibility for the integrated team. The provider of the single contract would need to deliver services according to this arrangement and would be expected to enter into a Section 75 or Partnership Agreement with the local authority by the contract start date so that the delegated functions and the staffing arrangement for the service are clear.

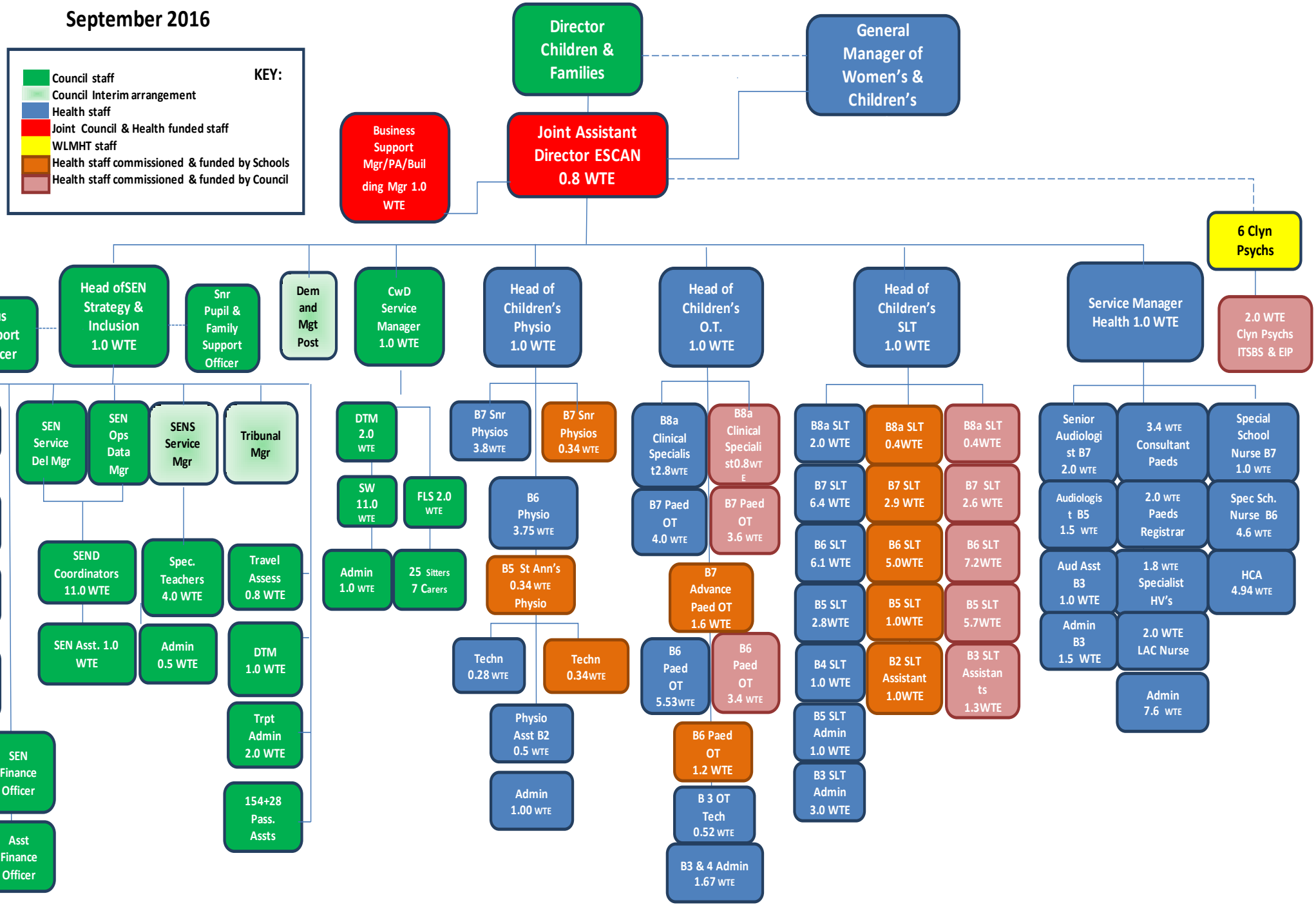
The provider of the single contract will need to provide the team to deliver the health component of the integrated community team and maintain the existing arrangements with the Local Authority funded team. The provider will need to maintain the existing operational pathways with CAMHS Learning Disabilities services, primary care and acute providers.

Outside the scope of this contract or the section 75 agreement between the local authority and the existing provider, there are approximately 65 separate service level agreements for Speech and Language Therapy between a provider and the individual Ealing schools which are part of the existing integrated community. There is a separate community health contract between a provider and the local authority for the provision of therapy for ECH plans, early years and community OT services.

The team is currently based at Carmelita House. Any changes to the operation of the team would need to be agreed jointly with the LA and the CCG.

Please see structure on next page.

ESCAN ORGANISATIONAL CHART
September 2016



- **Intermediate Care**

  The provider will work collaboratively with the services provided by Ealing Social Services in an integral way to ensure staff are part of the Intermediate Care Service - Rapid Response, short term rehabilitation and re-ablement teams to support people to live in the Borough or who have an Ealing GP.

  The aim is to offer safe and flexible care for patients in their own homes, to people requiring short term intensive support either after a stay in hospital or to prevent an unnecessary hospital admission.

  The service will operate as a fully integrated health and social care team, albeit the social workers will continue to be employed by Ealing Council. The provider service manager and clinical lead will have day-to-day oversight and line management responsibility for all of the integrated health and social care staff within the service including the social workers.

  Within the Intermediate Care Service there will be a Senior Social Work Team Leader who will be the supervisor for the social work staff, responsible for supervision and performance management and will report to the Service Manager. The Service Manager will have authority to deploy social care staff in accordance with the needs of the integrated service, including those in out of area hospitals to maximise use of Intermediate Care Service and support timely discharge of patients, and to keep patients in the community.

  For professional accountability, the Senior Social Work Intermediate Care Team Leader will have a line to the Senior Social Work Manager at Ealing Social Services.

  To promote integration the teams will be co-located with the provider and not sit separately within the Hospital Social Work department and/or the Social Services community social work teams.
  The arrangements with Social Services are such that the provider is able to provide care packages within clear protocols, whether they are new, restarts or bridging care or return back to placement during the operating hours of the Intermediate Care Service.

  At the time of referral into the Intermediate Care Service, some patients will have existing named social workers from the community teams, these staff work to different time-scales, therefore Intermediate Care social workers will intervene early to make any changes required to care packages and hand back the cases to the community teams for subsequent reviews.

  However, long term needs, including residential placements, may require more detailed assessments and a longitudinal view of the case, therefore these may still require involvement of named community social workers, or the hospital assessment teams.

  Where health rehabilitation goals have been identified and the patient accepted for short term rehabilitation, this should be considered as implying re-ablement goals for patients, therefore the provider and the Council will work towards a Trusted Assessment process, minimising duplication of assessment and contact with referrers by different professional groups.

  The provider will be expected to have agreed with the local authority a standard operating procedure as part of the S75 agreement or partnership agreement

  All health and social care staff will be expected to utilise the provider systems for recording activity and information in order to minimise duplication. However the provider will also have access to Council IT systems as required.

Operational standards

The service model must be based on delivering the following operational standards that will need to be delivered from service commencement. These expectations are already contained within the specifications currently commissioned:

- Population served
    - The service will be provided for people registered with an Ealing GP (including patients in Ealing care homes or other bedded non-acute units) and/or living within Ealing (residence in Ealing is an essential requirement for receipt of services from the London Borough of Ealing). This is expected from the commencement of the contract.
    - People who sleep rough, live in hostels, 'surf' on sofas or who are chronically insecurely housed within the borough of Ealing. This is expected from the commencement of the contract.
    - Where home visits are warranted for patients residing outside of the borough, these will only be offered to those living within 1 mile of the Ealing boundary. The provider will be expected to demonstrate how reciprocal arrangements with other community service providers will manage cross boundary patients for health needs. This is expected from the commencement of the contract.
    - Adult community services will be offered to people aged 18 and over, based on a needs assessment. This is expected from the commencement of the contract.
    - The majority of CYP services currently offered in Ealing treat those up to the age of 18 (with the exception of those cohorts in special education (up to age of 25) or requiring MSK Physio (up to age of 16). Consideration will be given to the National Directive on CYP age ranges and the transitional 16-18 year cohort when planning the transformation of these services in Phase 2 of the contract.
    - Where an individual has caring duties, the needs of the carer and the person being cared for will be taken into consideration allowing for as much flexibility as possible so as not to impact on the wellbeing of the person being cared for. This is expected from the commencement of the contract.
    - All services will have access to Interpreting and Translation services in various forms to ensure that individuals that have language barriers or those that are deaf or hard of hearing are supported to receiving care recognising the population mix of the borough. This is expected from the commencement of the contract.

- Operational hours

    - In line with the 7 day service initiative, and extended hours operated by GP access clinics, all adult community provision delivering non-urgent care will provide care between 0800 and 2000, 7 days a week. In year one this will be delivered as per current specifications and for year 2 the provider and commissioner will agree a transformation plan to reach 7 day care delivered between 08:00 and 20:00 where appropriate.

    - Community services providing unplanned care will provide a service 24 hours per day, 7 days a week, 365 days a year. The provider will need to determine the optimal staffing structure for the 24 hour period (and adjust for seasonality as appropriate) ensuring that capacity is matching demand throughout the 24/7/365 period. It is expected that the care overnight will include the ability to respond in a crisis and palliative care supports both rapid response and night sitting.

      The bidder will be required to set out its plans to be able to achieve this during year one and by October 1 2019. Until October 1st 2019 services should be delivered as per the current specifications.

Note, operational hours for CYP services will not change until Phase 2 of the contract and should be delivered as per the current requirements until agreed through the transformation plan. In the planning for this change, options will be considered that allow for clinic attendance for CYP and their families outside of school hours. Options will also need to be considered to align timeframes to those implemented for adult services.

Referral/assessment timeframes

Each of the clinical service specifications supporting this prospectus set out the clinical, referral and assessment requirements as currently commissioned or where appropriate the prospective requirements contained in the new specifications.

For Children's services:

For children's services these will remain the same as currently commissioned with no change for the first two years unless agreed through the contracting mechanisms. Note the Statutory requirements for LAC service referrals and assessment which will need to be met from contract commencement[7].

For adult services the expectation is as follows:

1. Unless specified the services should be delivered as per the existing specifications until agreement is reached through the transformation planning to move to the new requirements
2. Some of the services will need to be delivered according to the new specifications from the 1st October 2019 and this is set out as a transformation requirement in year one.
3. Where services as currently commissioned are already delivering the specification requirements, or elements reflect these, the provider will be expected to continue to meet these from Contract commencement.

The specifications should be referred to for a full set of requirements. Each specification is clearly labelled so that bidders can be clear which specification should be delivered at the start and, where known, when the new specification is expected to commence from. The full set of specifications will be released with the full procurement documents at advert.

The table below sets out the functions, the services and the expectations on response times as per points 1,2 and 3 above.

The key for the table below is:

Emergency response = 

Urgent response = 

Routine response = 

[7] LAC standards (https://www.nice.org.uk/guidance/qs31)

Coordination	**Community Nursing**			**Discharge**	**Community Therapy**	**Crisis**	**Complex and specialist**	**Long term conditions**	**Enhanced Primary Care in Nursing Homes**	**Community Beds**
SPA and co-ordination	**Adults Nursing**	**Children's Nursing**	**Continence**	**Discharge**	**Therapies**	**Crisis**	**Complex and specialist**	**Long term conditions (excluding therapy)**	**Enhanced Primary Care**	**Community Beds**
<15 mins	Average response of 2 hours	TBD as part of transformation planning. To default to existing specifications until agreed	48 hours	Average response of 2 hours	48 hours	Average response of 2 hours	TBD as part of transformation planning. To default to existing specifications until agreed	TBD as part of transformation planning. To default to existing specifications until agreed	Average response of 2 hours	
<24 hours	<48hours		2 weeks	<24 hours	2 weeks				Enhanced Primary Medical Service available 08:00-20:00, 7 days/365	Triage referral for bed <24 hours
<72 hours	<7 days		4 weeks		4 weeks					Transfer to ward on same day the bed becomes available
<u>IMPLEMENTATION DATE / COMMENCEMENT DATE</u>										
31st October 2019	31st October 2019	TBA as part of transformation planning for Year 3	May 2019	Emergency – 1 May 2019 Urgent – 31st October 2019	TBA as part of Transformation planning For year 2	May 2019	TBA as part of transformation planning for year 2	TBA as part of transformation planning for year 2	May 2019	May 2019

- Transition of CYP to adult services
    - It is the responsibility of the provider to ensure that there are appropriate processes in place to ensure the safety and quality of services for CYP are maintained as they transition to adult services. This should be irrespective of the pace of change.

- Quality standards
    - It is the responsibility of the provider to ensure all services meet the standards set out within the Contract that will include those set locally by the CCG and NW London Health and Care Partnership and by National standard setting bodies (including but not limited to NHSE, NICE, CQC) for the duration of the contract. It is expected that the provider and the CCG will work together to refresh quality indicators annually to ensure that they remain aligned to best practice. The provider will need to report on patient experience and patient safety with clear evidence of learning that improves service outcomes.
    - The STP is enabling North West London organisations to collaborate on the standards of care and pathways that are required across the health and care system whilst still enabling local organisations to meet local needs and determine the most optimal way to do so. All partners in the STP see this as a way of iterating the approach to the delivery of improved care in a sustainable way across the system in which the provider will need to play its role within. The provider will need to clinically and managerially support work across the five delivery areas. Where requirements are agreed pan NW London the CCGs expectation is that the provider will need to agree through the contract mechanism as to how these will be implemented and the timeframe. Given the open book working that we would expect to have in place with the provider the CCG would expect to be able to determine the impact of any change to care delivery from a financial perspective.

    - The outcomes framework will be contained within the quality schedule in addition to the above requirements.
    - The provider will need to ensure it meets all aspects of Safeguarding as set out in the contract and should plan for appropriate staff members to be able to attend and participate in the adult and children safeguarding boards in Ealing.

- Primary care clinical list for Nursing Home patients
    - The scope of services includes the requirement for the provider to hold the primary medical services list for those patients who reside in a nursing home in the Borough of Ealing. The requirement is for the delivery of enhanced primary care as set out in the specification. The provider will need to ensure they have the ability and can meet the required conditions to enable them to hold the function of registered GP for this cohort of patients.

- Medical responsibility
    - The lead provider will hold medical responsibility for all patients within the rapid assessment and response period of care (up to 5 days) and within the step up beds (Magnolia ward) and rehab beds (Rosemary and Jasmine) and will need to demonstrate organisational capability to deliver this. Where a GP is willing the provider will have the flexibility to agree joint management for patients where the medical responsibility is shared; this arrangement would need to be underpinned by a protocol and for each practice a clear and documented agreement.

- Transport
    - The provider will have the responsibility of securing patient transport for community services provision aligned to national guidance for access to transport for community service providers.

- Prescribing
    - The provider will have the responsibility for ensuring that staff (who have the required skills, experience and qualifications) are able to prescribe drugs, consumables, continence products and equipment (from the Mediquip contract) as required by individual patients and service users.

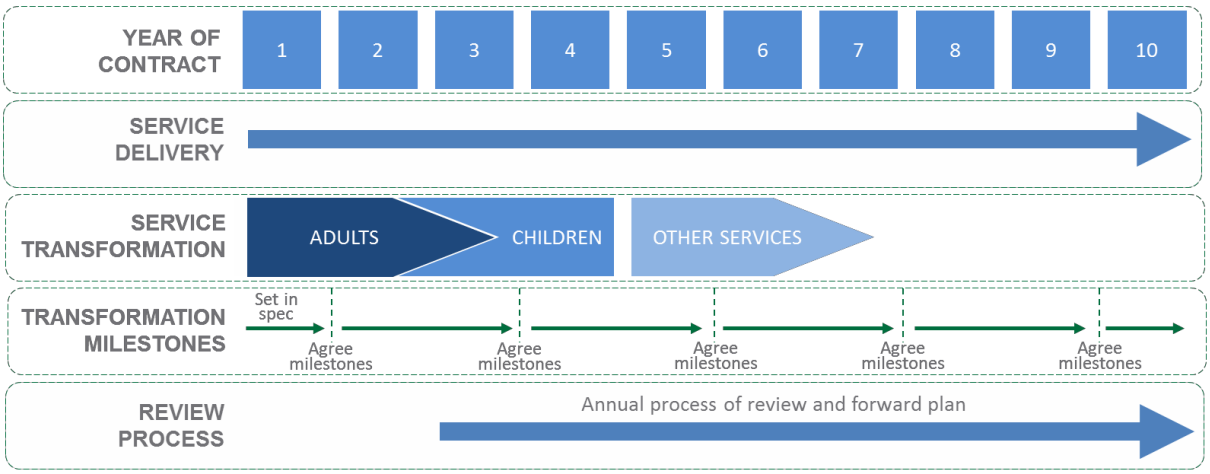
Transformation

Transformation runs through the core of this approach. The provider will need to work with the patients and the public, the CCG, and partners to deliver an agreed transformation plan for adult services across the first two years of the contract, children's services through years three and four with years five to ten left open to focus on areas that will be determined through mutual agreement.

The provider will commence the contract delivering the services as currently commissioned in 2018/2019 and the specifications that accompany this prospectus provide the detail for all of these. The provider will be tested on their approach to transformation as set out below through the procurement process. The commissioner recognises that in moving to the new model of care further engagement and testing will be required with partners, stakeholders, patients, carers and the public on some elements. The commissioner will work with the provider to undertake the necessary engagement.

The diagram below sets out a high-level view of the transformation expected over the 10 year term of the contract. This will operate in concert with the investment, development of metrics, incentives and risk share to provide the right environment for transformation.

High-level view of approach to transformation



Transformation requirements in year one:

1. Mobilisation and stabilisation
2. Implementation of single point of access operating 24/7/365 days a year with clinical triage by 31 October 2019.
3. Implementation of the requirements for unplanned care by 31 October 2019
4. Functions for supporting a response in time of crisis and discharge from hospital established and consistently meeting operating requirements 24/7/365 by 31 October 2019.
5. Delivery of 24/7/365 Nursing service by 31 October 2019
6. Joint care teams established across the borough by 31 March 2020.
7. Implementation of the Chronic Pain service by 31 July 2019.

Transformation in year two is likely to have a focus on the functions that reflect more planned care services with the aim that by the end of year two that the provider has implemented the model of care for adults.

As indicated the provider will need to work with and as part of the NW London Health and Care Partnership. Work is underway to determine a consistent set of clinical standards and pathways with the expectation that once these are agreed they will be adopted by commissioner and providers. The CCG

would expect the bidder to commit to this approach and would then anticipate that the Partnership Board would determine the timeline to include any of these and understand any impacts in doing so.

The approach to transformation will be supported by a funding stream that sits outside of the core payment that the provider will receive on the basis of clearly set out and agreed plans. This will incentivise the single contract holder to deliver prioritised goals, outcomes, transformation objectives above those stated in the national definition and requirements for CQUIN. Given the commitment to transformation the CCG expects to work with the provider in an open book way for the duration of the contract term. Working in an open book way will help the provider and commissioner have a shared understanding of the changing requirements for, and demand of, the community services in Ealing over the contracted period. The CCG would require the provider to work collaboratively in a transparent manner through adoption of an open book approach on aspects relating to activity, quality, performance and finance.

The contract will be overseen by the Partnership Board which will govern the transformation fund. The Partnership Board will include the CCG, the provider, the LA, the GP Federation / or at scale provider of General Practice and service user representation.

The proposed membership of the board is as follows:

Provider	**Commissioner**	**Partner Organisations**
Chief Operating Officer	Chair of ECCG	Chair of GP Federation
Medical Director	Vice Chair of ECCG	Chief Executive of GP Federation
Chief Finance Officer	Managing Director ECCG	Executive Director Adult and Children's services Local Authority
Director responsible for quality	Director of Quality for ECCG	Associate Director Adult Services Local Authority
Director responsible for Transformation	Deputy Managing Director	HealthWatch / Patient Representatives

The terms of reference for the Board will be developed in conjunction with the provider once selected and agreed with the broader group as set out in the draft Contract.

The aim of the Board is to oversee the contract, agree and set the transformation plan and troubleshoot. The Board will also have a role in understanding how the contract will need to change to meet any demographic changes over and above the growth already allowed for within the funding envelop. The Board will need to understand and consider changes to care delivery within the broader NHS environment. The Board may need to consider changes to pathways including cessation of pathways and the de-commissioning of elements of service provision from within the scope of the Contract.

It is envisaged that it will begin by meeting every 6 weeks, stepping back to quarterly at a mutually agreed time. The Partnership Board will be underpinned by contracting groups as set out in the contract.

Provision for changes to scope of the contract

Ensuring that provision of care outside of hospital can transform, recognising that what this might look like and require can't be known now for the future it was important to consider how the commissioner can enable changes to the scope of the contract at a point during the contract term. In order to surmount this issue, in a manner that complies with procurement law obligations, commissioners will include a variation clause within the contract to allow for further services to be incorporated. The variation clause will set out a clear process to agree how those specified new services can be incorporated into the scope of the contract. This approach recognises that the health and care landscape will change over the contract term, and that the commissioner requires that the contract has the ability to support further integration of health services and with general practice and the local authority over its term.

The Partnership Board would oversee the development of any proposals to change scope (such changes to be within the parameters of the variation clause referenced above) which would need to include a clear clinical rationale, sustainability rationale or new/best practice reasons and it would have the remit of recommending the change to the appropriate decision making governance forum of the commissioner and provider. Where any change to scope is being proposed it is anticipated that the following outline process would be followed:

1. Initial proposal considered by Partnership Board.
    a. Permission to develop full proposal
    b. Decision taken not to pursue

2. Development of full proposal to include:
    a. Rationale for inclusion
    b. Current commissioning and provision arrangements
    c. Funding source clear and recurrently available
    d. Funding level supports on-going provision of service.
    e. Financial risks identified
    f. VAT Implications understood – both between commissioner and contract holder as well as within any subcontract arrangements that are required.
    g. Workforce implications understood – TUPE, Pensions
    h. Any implications for Section 75 or Partnership Agreements understood.
    i. EQIA undertaken
    j. Engagement undertaken and appropriate advice taken on whether any form of Consultation is required
    k. Risk assessment undertaken
    l. Implementation plan developed.

3. Proposal formally considered by the Partnership Board who can take a decision to formally recommend the change in scope to:

    a. The CCG Governing Body
    b. The relevant governance forum of the provider

4. The CCG would expect the provider to consider the proposal and provide the CCG with the outcome of its consideration before it held its formal Board meeting.

5. The outcome of the CCG Governing Body, board of the contract provider and any relevant partner board will be provided to the Partnership Board.

6. Where the outcome is to move forward with inclusion, appropriate legal advice should be sought to ensure that a deed of variation is drafted to vary the contract, and include any ancillary documentation (such as the implementation plan) as part of the revised contractual obligations.

The list of services that are outside the scope at the commencement of the contract, but could be considered to be brought within the scope of the contract during the term include:

	Service	Approx. Value (£k)	Commissioner	Cohort	Contract End Date	Transformation Timing
1	111 Service	408	ECCG	All Ages	31-Mar-19	20/21-24/25
3	Continuing Healthcare Brokerage	259	ECCG	Adults	31-Mar-18	20/21-21/22
4	GP Out of Hours	1,714	ECCG	All Ages	31-Mar-18	20/21-24/25
5	Home Oxygen Service	242	ECCG	All Ages	31-Mar-19	20/21-24/25
6	Improving Access to Psychological Therapies	2,406	ECCG	Adults	31-Mar-19	20/21-21/22
7	Interpreting Services	68	ECCG	All Ages	31-Mar-18	20/21-24/25
8	Learning Disabilities Continuing Healthcare	3,969	ECCG	All Ages		20/21-24/25
10	Primary Care Out of Hospital Services	11,624	ECCG	All Ages	31-Mar-21	21/22-24/25
11	Self Care	65	ECCG	Adults		20/21-21/22
12	Specialist Palliative Care	320	ECCG	Adults		20/21-21/22
13	Urgent Care Centre	4,059	ECCG	All Ages	25-Apr-21	20/21-24/25
14	Adults' Placements	6,544	LBE	Adults		
15	Domiciliary Care	2,927	LBE	Adults		
16	Health Visiting and School Nursing	5,962	LBE	CYP		
17	Hospital Assessment Team	447	LBE	Adults		
18	Independent Mental Health Advocacy	85	LBE	Adults		
19	Learning Disabilities Placements	27,040	LBE	Adults		
20	Public Health Commissioned Services	4,358	LBE	All Ages		
21	Reablement	921	LBE	Adults		
22	Social Work CTPLD	959	LBE	Adults		

Key to timing assumptions: in line with proposed transformation timescales unless driven by current contract expiry

Adults Principal focus in Years 2&3 (assumed to be 20/21-21/22)

CYP Principal focus in Years 4&5 (assumed to be 22/23-23/24)

All ages To follow, unless alignment with adults and/or children is the most practical approach to transformation

To note that the services commissioned by the London Borough of Ealing (LBE) are a mix of commissioned and in-house provision and that no decision at present has been made regarding any additional services or service provision to become part of the contract, Any transformation timings are indicative and subject to joint governance process and agreement.

No acute services are included in the financial or contractual scope of this procurement at the start or are included within the changes that could be proposed.

Measuring success

The ultimate ambition of any clinical services is to improve the lives of the people in receipt of care and therefore we will measure the success of our commissioned services by their ability to demonstrate improvements in those outcomes and goals that matter to people.

To do this in a meaningful, valid and reliable way, we have developed outcomes/shared goals frameworks for adults, and children and young people in Ealing. These frameworks directly relate to the metrics we will use to monitor and reward improved outcomes based on the needs and wants of our local population, thereby showing to all stakeholders the "so what" of care. The frameworks have been built out of the outputs of engagement with the local population and local clinicians, and best practice in outcomes measurement nationally and internationally. The underlying structure of the shared goals frameworks is based on Porter's Hierarchy of Outcomes.[8]

Each framework has the same components:

- **Domains**: Reflect, in general terms, the sorts of issues that are important to local people.
- **Goals**: Within each domain, more specific definitions of what people want or need from the service. They are designed as "I" statements, based on feedback from patient and public engagement undertaken in Ealing in summer 2016 and cross-referenced with the National Voices "I" statements from their narrative on person-centred co-ordinated care.[9]
- **Metrics**: Ways of monitoring how the health and care system are meeting the outcome goals

To demonstrate how the frameworks are laid out, the figure below sets out the domains and goals as currently configured in the Ealing shared goals framework for adults, with the current working draft of both the adult and children/young people's frameworks available in the Appendix 2.

Whilst the domains and goals are likely to be non-negotiable – as these are considered by the commissioners to be the consistent priorities for and of local people – the metrics currently suggested are the initial suggestions by the commissioners which have been shared with a number of patients who have felt these seem reasonable. The key feedback from patients has been for the need of the contract holder to be accountable to commissioners but also its users and that the information should be shared transparently. The provider would also need to demonstrate that it is flexible in its ways of working, and the workforce need to demonstrate empathy and compassion to the needs of the population. Where possible, metrics have been selected from standard indicator sets such as the ICHOM Older Person's standard set[10] or indicators in use for specialist children and young people's care (e.g. those on mental wellbeing via the Child Outcomes Research Consortium.[11] There may be other valid and reliable methods of collecting and reporting on the goals of which we are not aware at present and/or which may become available during the lifespan of this contract. We would therefore expect the final choice of metrics to be discussed and agreed with the provider, and the continued use of these metrics to be reviewed at set periods over the contract duration. Similarly, we will work with the provider to agree methods of independent monitoring of progress towards achieving the metrics, for example through the use of Healthwatch or voluntary sector resource to conduct interviews or surveys with patients and carers.

The provider will be held to account for improvements in the metrics over the course of the contract and will be financially rewarded against an agreed schedule for achieving improvements against an agreed trajectory. To reflect this accountability for achieving improvements in outcome-based goals, the shared goal frameworks will form part of the Local Quality Schedule within the contract that the commissioners will hold with the provider.

The Contract sets out the expectation that the provider will collect a much larger volume of information and data, especially on process and activity, in order to co-ordinate and deliver care effectively and efficiently. We reserve the right to undertake planned and unplanned audits of all data collated by the provider in appropriate situations, such as understanding in more detail the progress towards achieving improvements in goals, provide assurance in key areas and demonstrate care delivery to achieve equity of outcomes across the Ealing population.

[8] See https://www.hfma.org.uk/docs/default-source/our-networks/healthcare-costing-for-value-institute/external-

resources/measuring-health-outcomes---the-outcome-hierarchy
[9] See http://www.nationalvoices.org.uk/sites/default/files/public/publications/narrative-for-person-centred-coordinated-care.pdf
[10] See http://www.ichom.org/medical-conditions/older-person/
http://www.corc.uk.net/outcome-experience-measu

Perspective	Goals
Domain 1: health status achieved/retained	I want to live a life that's normal for me
	Important clinical outcomes are improving
	Everyone has access to the care that helps them live normal lives
	I have as much social contact as I want
Domain 2: Process of care	I need to trust the people looking after me
	I am listened to
	As a staff member, I am supported to do a good job
	As a staff member, I feel I can trust the other partners in the system
	Care is safe
	My care was timely
Domain 3: Sustainability of health	I feel I'm in control
	I am able to live at home
	As a carer, I feel involved, supported and have time for myself
	The resources available are used in the most effective way to provide 24/7 care
	Different organisations work well together
Drivers	Technology is used to innovate and support
	Staff have the right skills for working together
	There is investment in building community resilience

Draft Ealing adult shared goals framework: proposed domains and goals

Enabling a reduction in non-elective admissions and supporting length of stay reductions

The single contract provider will be expected to enable a reduction in non-elective admissions and support length of stay reductions across all acute sites for Ealing residents. The profile of non-elective admissions will need to be reviewed annually and will need to mirror the non-elective reduction requirement for the CCG. The provider will need to be able to demonstrate how it has supported a length of stay reduction for Ealing residents. This table is therefore indicative and will be reviewed at ahead of May 2019.

Non Elective Requirements

Year	2019 2020	2020 2021	2021 2022	2022 2023	2023 2024	2024 2025	2025 2026
NEL Reduction	3,594	1,801	1,561	1,561	1,561	1,561	1,561

Gain / Loss Share – Non Elective and Length of Stay Reduction

The CCG is developing an approach to a gain / loss share focused on non-elective admissions and reduction in length of stay. The aim of the gain/loss share will be to support a non-elective reduction beyond that required as part of the contact agreement. The principle being considered is how those organisations that are part of the approach can share in that benefit. The Bidder will be expected to commit to the principle of a gain / loss share with the expectation that the final detail is worked through once contract award is made, providing time for this approach to be developed locally and across NW London.

Drivers and enablers to delivery

1. Workforce

Having the right workforce, with the right skills and leadership will be key to successfully delivering the service. This will be complex with a very wide range of services being delivered in an increasingly integrated manner across multiple professions and multiple providers. The provider will need to offer clear leadership and direction to make sure staff have the opportunity to work to the top of their licence and increase productivity to deliver the required improvements in the population health of Ealing.

The provider will also need to successfully address the key workforce challenges, which are present in the current NHS structures. This includes workforce shortages across a range of roles and increasing workloads; meaning that many organisations are currently working at the edge of their capacity. It is evident that the successful delivery of such a contract is reliant on the workforce, and the provider will be required to demonstrate their commitment to supporting, attracting, retaining and retraining staff, capitalising on the ideas and innovative approaches to care that front line teams often want to implement, but do not have the support to do so. The provider will be expected to support and nurture such innovation that deliver improvement in care outcomes and actively listen to the views of the workforce.

The opportunity to invest in the workforce over the 10 year length of the contract will allow the provider to develop innovative solutions to both address these challenges and realise the opportunities for improvements across the workforce. Given the challenges with delivering integration over a lengthy period of time, we expect the provider to describe how they will achieve these ambitions. As a guide we endorse Health Education England's vision for the characteristics of the workforce for the future;

1. Include the informal support that helps people prevent ill health and manage their own care as appropriate.
2. Have the skills, values and behaviours required to provide co-productive and traditional models of care as appropriate.
3. Have adaptable skills responsive to evidence and innovation to enable 'whole person' care, with specialisation driven by patient rather than professional needs.
4. Have the skills, values, behaviours and support to provide safe, high- quality care wherever and whenever the patient is, at all times and in all settings.
5. Deliver the NHS Constitution: be able to bring the highest levels of knowledge and skill at times of basic human need when care and compassion are what matters most.

We have set out what we consider to be important to successful implementation of effective integrated care.

- **Leadership**

  Professional leaders will play a crucial role in the success of developing and implementing integrated care. The effective leadership required can be characterised by sustained long-term commitment, enthusiasm to deliver to standard and involvement to work together to deliver integrated care locally. Matched with credibility, trust and respect from their juniors, peers and seniors that has built up over time. High performing leaders need the skills and strategies necessary to understand, influence and lead the local agenda in the design, commissioning and delivery of integrated care, this includes:

  - Identifying and demonstrating the core values and purpose that underpin approaches to integration
  - Building a common vision and goals between care partners
  - Engaging professionals, developing good relationships, and building commitment, understanding and a shared culture
  - Maintaining a clear vision communicating this clearly to staff and users

- Driving quality improvements, for example through benchmarking performance, user feedback and peer-review
- Actively listening to and empowering the workforce to take ownership and work across teams as needed to improve outcomes for patients

It is also essential that leaders take the initiative to promote integrated care, rather than adopt a fortress mentality focusing on the survival of their organisations, working together across the health community to achieve financial balance.

We recognise that integrated care does not evolve as a natural response to emerging care needs; its achievement requires strong system leadership, professional commitment and good management.

We expect:

- As a minimum, leaders will follow the Nolan principles of: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership
- Leaders throughout the organisation that have the right knowledge to run the service
- Leaders must be able to credibly identify and demonstrate the core values that underpin approaches to integration
- Leadership must be visible to the whole organisation - engage professionals, develop good relationships and commitment to build, communicate and maintain a common vision and goals between care partners
- There must be a focus at all levels of continuous quality improvement to drive quality improvements
- Leaders must be transparent and open to challenge and responsive to feedback from the workforce and users

- **Development**

NHS England's Integrated Care Pioneers have demonstrated the importance of development to achieving the goals of integrated care. Our requirement is for providers to build on these lessons. This must include putting in place the right development for staff to support them to work in a more integrated way but also importantly address the known barriers that are evident in preventing integration.

We recognise the tension that exists between the relative merits of developing new occupational roles, flexing existing roles or simply improving the co-ordination of existing professionals. Any new roles developed will need to be specific to the local context. We believe these decisions should be led by the provider; to describe the specific solutions to achieving these aims for Ealing.

A credible plan to support staff development must support the changing way that learning takes place. Innovation in technologies offers opportunities that must be taken up in order to succeed with this agenda.

- **Skills**

As noted, the core of the service must be care based on what matters and is deemed as important to each individual patient. The workforce must be able to work with patients to deliver this ambition. Embedding and continually reinforcing this new way of working and these skills must be at the heart of the workforce strategy for the provider.

The evidence for new roles to support boundary-spanning places a strong focus on skills. We expect the provider to build a workforce with the right skills to deliver the aims of the framework and in particular there must be a focus on two key areas;

Self-care

We need clinicians and care professionals to develop their skills to improve the level at which people feel they are involved in decisions about their care and managing it well. This must integrate with the wider community of health including non-paid carers. In North West London we have prioritised self-care through

Patient Activation Measure licences, Making Every Contact Count training and Health Coaching Training. Our requirement is to further enhance self-care by building in the key self-care principles in to any training offered.

Trusted assessor

The role of the trusted assessor is at the centre of providing integrated care. To be effective this approach demands organisations to work together to co-design appropriate and credible assessor training processes. Importantly staff will need to have the right skills to both perform the role with competence and organisation wide trust and confidence in the role and responsibilities to meet the expectations of all the different health and care bodies involved in the care of the individual.

It is essential that patients and service users are engaged in the development of this area of work. We expect that this will require leadership and clarity from all organisations working together and continuous review and revision of operational processes and training. Expectations of bidders relating to the Trusted assessor model are set out earlier in the prospectus.

- **Setting the Right Culture**

Ealing expects that the organisations providing care to its local population have a shared sense of belief, confidence and understanding of the benefits of integrated care and behave in accordance with these aims. We require that the provider creates the organisational culture that puts the patient at the centre of care and allows highly trained and skilled professionals to deliver the best care possible.

- **Capacity**

Organisations daily face the challenges of recruiting and retaining the right workforce in the face of growing demand. The provider will need to be able to address both of these issues over the length of the contract. The provider will need to consider policy level direction and how these strategies might be used to support recruitment. The provider will also need to consider how it retains its existing workforce particularly challenging when considering the high cost of living in and around Ealing. Finally the provider must seek out and implement strategies to increase workforce productivity. This will be key to meeting the challenge of keeping pace with the rising demand for care.

2. IT

The CCG is looking for a provider who is willing to embrace and be at the forefront of digital innovation. To this end the CCG is considering how best to approach the identification of a digital partner for and with the provider and would expect any successful bidder to work with CCG on this.

The successful bidder of the single contract will be expected to enable transformation through the provision of agile, anytime, anywhere IT services for both professional staff and patients and to be aligned with the intentions of the NW London ‘Local Digital Roadmap’ and the NW London Health and Care Partnership plan (overview below).

Specifically the commissioner expects the single contract provider to be able to manage:

a) Physical infrastructure in healthcare settings including:
   - Secure network provision (hard wired and Wi-Fi) with sufficient bandwidth to support applications in the cloud, video-conferencing and VOIP services, and access to the Internet
   - Physical network infrastructure e.g. switches (VoIP capable with POE), routers and firewalls
   - On site servers for secondary authentication but with no or minimal local data
   - UPS provision and cabinets

b) Professional staff devices
   - PCs, laptops, printers etc. including universal docking stations and VoIP/soft phones
   - Mobile devices including phones
   - 'Bring your own device'

c) Patient facing systems
   - Intelligent telephony triaging phone systems
   - Patient arrival screens and patient call screens
   - IT integrated medical devices (e.g. blood pressure)
   - Video-consultations
   - Public facing websites
   - Apps

d) Business support systems
   - Office 365 or equivalent cloud based systems
   - Cloud based administrative systems including HR and Finance
   - Web content management systems supporting intranets, extranets and public facing sites
   - Licensing

e) Clinical systems
   - Full interoperability with SystmOne.

- Interoperability with the NW London 'Whole Systems Integrated Care' system for direct care dashboards
- Interoperability with the NW London and London 'Care Information Exchange' for real-time transfer of patient data
- Licensing

f) Business Intelligence reporting systems
- Activity tracking, monitoring and reporting
- Financial reporting
- Population Health analyses

g) Information Governance
- Information Sharing Agreements
- Fair Processing Notices
- Data Protection officer and IG processes and policies
- Cyber-security
- Compliance with GDPR

h) IT support arrangements
- Working and out of hours support arrangements for IT services
- Incident reporting levels and escalation processes
- Service Level Agreements and KPIs

3. Estates

The commissioner expects that at contract commencement the current estate will continue to be utilised by the successful bidder unless explicitly agreed with the commissioner.

The successful bidder will need to agree commercial terms with the current owners/leaseholders between November and March to agree lease terms and associated costs. The successful bidder will be required to enter into legally binding tenancy agreements for the duration of the contract and will be expected by the CCG to manage the premises it uses in a professional and compliant manner.

The sites that are currently utilised for the provision of community services will be available with the full suite of procurement documents.

Bidders will need to identify from which location they will be able to deliver the single point of access from within the Borough.

The successful bidder will be required to work with the Strategic Estates Group in Ealing, and as part of the broader STP strategic estates work stream, to ensure service delivery is fully aligned with strategic estate principles. As part of that they will need to work to meet the aims of the One Public Estate initiative and any guidance/targets set through the Carter and Naylor reviews. The expectation that Community Health Partnership (LIFT buildings) will need to be fully utilised before other estate can be occupied will also be set out. Any changes to location or consolidation of services will need to be agreed with the commissioner and would include having transparency over any efficiency created.

As part of the CCGs strategic estate investment plans the successful bidder will be required to engage in the planning of new Hub facilities and will be required to relocate services to support the implementation of these transformational plans further detailed in the section below.

- **Hubs**

There are major capacity issues across Ealing and a significant proportion of the estate does not meet all of the required standards, which can impact on quality of care. So in line with SaHF and the STP, a key

aspect of delivering Ealing's out of hospital strategy is the creation of three primary care hubs (Ealing North, Ealing East and Ealing West). Project initiation documents (PIDs) for the Ealing North and Ealing West hubs were approved by the CCG in November 2016 and by the NHS England London Capital Committee in April 2017. Options appraisals have subsequently been developed and were approved by the CCG in June 2017. The next stage is the development of business cases for these hubs.

The re-commissioning of out of hospital services is related to the hubs business cases, as it makes the assumption that these business cases will be successful and therefore that some services that are part of the re-procurement will eventually be provided in hubs. However, the case for change and ability to implement a different approach to commissioning out of hospital services is not dependent on approval of the hubs business cases. The commissioner will expect to work with the provider in developing the detailed operational model for the hubs ahead of these coming on line aligned to the model of care and the points of delivery set out earlier in the prospectus. The commissioner and provider will need to work together to ensure appropriate engagement takes place on any movement of services at the point it is reasonable to commence this work.

Appendix One – Full List of services in scope

Adult Community Services

Existing service	Service descriptor
Intermediate Care	Stabilisation & transitional care service offering rapid response, step up beds (Magnolia ward, Clayponds Rehabilitation Hospital), short term rehab and re-ablement packages
Jasmin Ward, Clayponds Rehabilitation Hospital	Short term bedded rehab unit for level 3b care (general rehab) for up to 6 weeks. Nursing, OT & physiotherapy support. 25 beds in total
Rosemary Ward, Clayponds Rehabilitation Hospital	Provision of Complex, General and Neuro Rehab Bedded Unit with medical, nursing and therapeutic support. 25 beds in total 20 Ealing CCG commissioned beds • 2 complex general rehab beds • 13 neuro rehab beds • 5 general rehab beds 5 Hounslow CCG commissioned beds for neuro, complex and general rehab.
Enhanced Nursing Home Service	Enhanced primary medical care services and integrated enhanced primary and community care to nursing home residents and residential home residents
Ealing Day Treatment Centre (EDTC)	Multi specialist therapy-led rehabilitation day centre for adults with disability or injury including community physiotherapy and general therapies
Falls service	Education & assessment service for people aged over 65 years with history and/or fear of falls, includes prevention programme
Enable	Multi specialist, multi-agency led support for adults with progressive neurological conditions and community stroke rehabilitation
Clinical Psychology	This function is not a standalone service, it is integrated across a range of service lines to support patients with psychological needs
Community nursing	Community based nursing support for adults with disability, long-term conditions or following discharge from acute setting
Tissue viability service	Assessment and treatment service for adults with impaired tissue viability
Bladder & bowel service	Assessment and treatment service for adults with faecal and/or urinary incontinence
Care coordinators	Coordinates delivery of health and social care services for people over 18 who have one or more long term condition and/or living with frailty or complex needs. Aligned to GP practices
Palliative care	Rapid and planned palliative nursing support for patients (and their carers) for adults in the end of life stage
Musculoskeletal (MSK) Physiotherapy service	Assessment, advice and treatment of people with muscle, joint and bone problems
MSK interface service	Diagnosis, investigation, treatment and surgical assessment of people with muscle, joint and bone problems

Podiatry service	Assessment and treatment service for adults with foot and lower limb pathologies
Speech & Language Therapy (SALT) service	Assessment and treatment service for adults with complex communication and/or swallowing problems
Nutrition & dietetics service	Assessment and education service for adults with medical conditions, to prevent illness and promote good health
Community diabetes service	Prevention & health promotion through to intensive care and support (case management & self-management programmes) for adults with Type II Diabetes.
Pulmonary rehabilitation service	Education and exercise classes for adults diagnosed with COPD and other chronic respiratory disease
Benefits and employment advice for people with SMI needs.	Supports adults with stable mental illness to stay well and avoid acute admission. Aligned to GP practices to provide benefits, debt, housing and well-being advice service, working with Primary Care Mental Health Workers to set up a simple one-stop point of access to non-clinical / statutory services that benefit people discharged under Ealing's Shifting Settings of Care scheme. Provided through face to face, telephone and on line support
Primary Care mental health service	Primary care mental health team to support patients with mental health conditions to be supported in primary care under the care of their registered GP.
Dementia link workers	Coordinates delivery of health services for adults diagnosed with dementia. Aligned to GP practices
Dementia support service	Support service for adults with dementia, and their carers, who are on the dementia link worker caseload
Adult Learning disabilities	An integrated service with Ealing Council providing specialist assessment, diagnosis, condition management and care co-ordination

Children and Young People Community Services

Existing service	Service descriptor
Children's Enuresis service	Tier 1&2 assessment and treatment service including the onward referrals to tier 3. Tier 2 treatment includes provision of alarm and/or desmopressin based on assessed need. There is a separate interim pathway in development as there is a service gap. This provides assessment, treatment, supply of products and reassessment for 0-18years with specific exclusions i.e. routine toilet training
Children's Specialist Community Nursing Service (CSCNS)	Specialist community nursing support to CYP with acute short term conditions, long term conditions, disabilities and complex conditions (including requirement for continuing care), life-limiting & life-threatening illnesses, palliative and end of life care. Team includes children's community nursing, specialism in diabetes, haemoglobinopathy, asthma, continuing care, special school nursing services.
Ealing Service for Children with Additional Needs (ESCAN)	An operationally integrated service commissioned separately by the CCG, Ealing Council and Ealing Schools. The CCG commissioned function to be delivered the

	provider is for SLT, OT, physiotherapy, audiology, medical staff (to support child development, LAC health, diagnostics and treatment) as described in the below service lines
Audiology service	CYP Tier 2 assessment, diagnostic, referral or discharge. School hearing screening programme
Speech & Language Therapy (SALT) service	Assessment and treatment service for CYP with complex communication and/or swallowing problems
Physiotherapy service	Physiotherapy assessment and treatment for CYP with disabilities, respiratory, neuro-developmental, neuromuscular and orthopaedic needs
Occupational Therapy service	Occupational Therapy assessment and treatment service for CYP with Autistic spectrum disorders, social communication disorders, special needs or specific developmental disorders
Child Development Team (CDT)	Assessment, treatment and review service for CYP with physical, sensory, learning or neurological disabilities or other developmental delay or disorder or serious emotional or behavioural disorders or nutritional difficulties.
Looked After Children (LAC)	Supports local authority in promoting health and wellbeing of CYP in their care. Undertakes review of adult health assessments of foster carers and prospective adoptive parents who are assessed and approved by London Borough of Ealing. Support and advice on adoption and permanency matters to professionals, carers and the Adoption and Permanence Panel.

Jointly delivered Adult & CYP community services

Existing service	Service descriptor
Diabetes education service	Nurse-led (with dietetic input) education service for adult and CYP newly diagnosed with type I or II diabetes
Community equipment service (via S75)	Access to community equipment supply service including provision, maintenance, and storage

Appendix Two – Ealing Single Contract outcomes framework
Embedded item available as separate document

Copy of Ealing Community outcome b

Appendix Three – Standards of care for out of hospital and hubs
Embedded item available as separate document

Standards of Care.pp