**Integrated Community MSK Service**

**Memorandum of Information (MOI)**

**NHS Hillingdon**

**Clinical Commissioning Group (CCG)**

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1. **Purpose**

The purpose of this Memorandum of Information (MOI) is to support a market testing exercise being undertaken by NHS Hillingdon CCG (HCCG). The market testing exercise is intended to inform future commissioning plans with respect to the potential future procurement of an Integrated Community Musculoskeletal (MSK) Service.

The MOI is intended only as a preliminary background explanation for the procurement of the service. It is in no way intended to form the basis of any decision on the terms upon which the CCG will enter in to any contractual relationship.

**2. Definition**

The CCG wishes to inform the potential future commissioning of an integrated community MSK service for Hillingdon residents. The service is intended to deliver safe, high quality and innovative MSK services in line with the CCG’s strategic vision.

**3. Strategic context**

3.1 National context

The CCG has taken into consideration national, regional and local strategies and frameworks in the development of initial commissioning plans for MSK. There are strong and robust strategic drivers for change and key related strategies have been highlighted in this Section of the MOI.

Over recent years, the NHS has been increasing its focus on improving the provision, access and quality of care provided outside of an acute hospital setting. The White Paper ‘Our Health, Our Care, Our Say’ outlined the ambition to create a fundamental shift of care from hospitals to more community-based settings and this was reiterated by Lord Darzi in ‘Our NHS, Our Future with the principle to ‘localise where possible, centralise where necessary’.

The NHS Five Year Forward View further emphasised the need to break down barriers in how care is provided; with far more care delivered locally, supported by specialist centres for more complex needs. The provision of more MSK services in the community is a step towards meeting this objective of care closer to patients and primary care. This has significant benefits; providing a more convenient service to patients and helping to relieve the pressure on secondary care services, focusing the most complex MSK diagnostics and treatment in secondary care. Patient feedback from other similar community services indicates high satisfaction by patients for community alternatives to hospital outpatient care.

In July 2006 the Department of Health (DH) published the Musculoskeletal Services Framework, which promotes the redesign of services’ together with the development of multidisciplinary interface services (that act as) a one-stop shop for assessment, diagnosis, treatment or referral to other specialists. This framework encouraged the sharing of care across organisational boundaries and improvements to integration and collaboration between primary and secondary care. Service redesign of this nature would achieve for health economies the avoidance of unnecessary patient attendances and elective admissions.

NHS England’s publication; ‘London: A Call to Action’, reported that London’s diverse population has resulted in a broad and growing range of health needs and that there had been a failure to close the inequalities gap. It considered that the pattern of healthcare provision with its emphasis on hospital services would not address this problem in the future and that much more should be done to support people to live healthier, independent lives through services provided in community settings that are more accessible to patients. The publication recommended that care needs to move away from traditional hospital-centred delivery and that local community based health services are developed to address the type and severity of local needs and to raise the health and wellbeing of those who are the least healthy to be in line with the healthiest. The report recognises that doing nothing is not an option and that bold transformational change is needed to the way in which services are currently delivered.

3.2 Local context and vision

Hillingdon CCG is involved in NWL’s Shaping a Healthier Future programme which seeks to deliver a health care system that keeps patients well at home and, when patients do become unwell, provides cost-effective, evidence-based and timely care at the right place appropriate to their needs. This involves:

• Making sure that every healthcare provider consistently delivers high standards of care

• Joint working between GPs, community and social care, hospital and consultants, with early

intervention and care in the right place at the right time

• Patients having easier access to consistently high quality primary care

• Patients with long-term conditions who need care from different services will receive better

coordinated care with one package of care

• Patients will be better supported when they are discharged from hospital. The care they receive

will be more joined-up between the different parts of the system.

Hillingdon also works collaboratively with its neighbouring North West London (NWL) CCG’s toward delivering a joint vision which is to ensure that everyone living, working and visiting NWL has the opportunity to be well and live well – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country. NWL’s strategic plan involves turning a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care in areas close to people’s homes, wherever possible. This is intended to improve health & wellbeing and care & quality for patients across NWL.

Hillingdon CCG’s commissioning priorities are built around the NWL Sustainability and Transformation Plan. In addition, Hillingdon is continuing to work locally towards establishing a model of ‘accountable care’ where the CCG commissions providers of services to work together to look after the needs of a whole population, rather than commissioning distinct services that can sometimes be fragmented and duplicative.

**4. The commissioning organisation**

4.1 Hillingdon CCG’s population

Hillingdon is the second largest of London’s 32 boroughs covering an area of 42 square miles (11571 hectares), over half of which is a mosaic of countryside including canals, rivers, parks and woodland. As the home of Heathrow Airport, Hillingdon is London’s foremost gateway to the world, and is also home to the largest RAF airport at RAF Northolt. Hillingdon shares its borders with Hertfordshire, Buckinghamshire, Hounslow, Ealing, and Harrow.

Hillingdon is the second largest London borough by area, located 14 miles from central London with the 12th largest population. Based on the Office for National Statistics (ONS) sub-national population projections, the Hillingdon population in 2017 is projected to be 309,300 with 23,100 (7.5%) aged 0-4 years, 40,100 (13.0%) aged 5-14 years, 205,600 (66.5%) aged 15-64 years, 21,400 (6.9%) aged 65-74 and 19,100 (6.2%) aged over 75. The age structure of the population in Hillingdon is intermediate between that for London and that for England, with, for the most part, a distribution that is slightly older than London as a whole but younger than England. Among children and young adults however, there is a larger proportion resident in Hillingdon than for both London and England. A growth of just over 18,300 residents is projected by 2021, with children aged 5-14 years and adults aged 65-74 years projected to have the highest growth rates. Comparatively, the population growth in Hillingdon is projected to be higher than any other North West London CCG and will be above both the average for London and England.

Important information about the borough this procurement covers, including the needs and challenges can be found in the relevant Joint Strategic Needs Assessment (JSNA). Below is a brief summary of some of the key characteristics.

4.1.1 Ethnicity

Hillingdon is an ethnically diverse borough with 47% of residents form BME groups. In 2011 Census in Hillingdon 52% of the population were White British, 8.4% White other and 40% BME Groups including 25% that are Asians. In London over half (55%) population are from BME groups and in England 20% from MBE Groups.

Top 5 Languages Spoken

English 212,834 81.2%

Punjabi 8,837 3.4%

Polish 3,994 1.5%

Tamil 3,556 1.4%

Urdu 3,344 1.3%

Remaining Languages 29,424 11.0%

4.1.2 Religion

Data from 2011 Census provides following statistics on Religion

Christian 134,813 49.2%

Muslim 29,065 10.5%

Hindu 22,033 8.0%

Sikh 18,230 6.7%

Buddhist 2,386 0.9%

Jewish 1,753 0.6%

No Religion 46,492 17%

Hillingdon actively engages these religious groups and continues to work closely by outreach programmes in settings sensitive to cultural needs of these groups.

4.1.3 Gender

Hillingdon’s population pyramid shows an even distribution of males (149,000) and Females (148,700) with the highest age group in the 20-44 year.

4.3.4 Disability

The 2011 Census identified that there were 37,850 people in Hillingdon who considered their day to day activities were limited a little or a lot by a disability or limiting long term illness. 69% of these were aged 50 and over Official labour Market statistics, NOMIS) received 10,260 Disability Allowance claimants and 1,820 incapacity Benefit

People with limiting Long Term Illness and General Health

People with LLTI 38,179 14.3%

Very good/good 230,274 28%

Fair 31,492 11.5%

Very bad/bad 12,170 4.4%

4.3.5 Mental Health

The release of the JSNA “Better Mental Health” toolkit signals the National Mental Intelligence Networks (NMHIN) intent to support the development of mental health and wellbeing joint strategic needs assessments (JSNAs). It has been developed for those seeking to understand the breadth and complexity of mental health issues in their area, such as JSNA and mental health leads in Local Authorities and clinical commissioning groups (CCGs). It helps people to consider factors that affect mental health and wellbeing and to identify some of the key data, information and knowledge that local areas may use to build a picture of need.

Locally, a business case to extend provision of IAPT Talking Therapies for the local population will enable easier access for the adult and young people. The recently commissioned Single Point of Access for mental health also provides local residents and healthcare professionals a streamlined process to a host of crisis and routine support.

**5. Proposed MSK Integrated Community Service**

5.1 Current MSK services in Hillingdon

The current MSK service provision in Hillingdon is mixed. Current services are:

|  |
| --- |
| Service |
| MCATS |
| Trauma & Orthopaedics |
| Pain Management |
| Physiotherapy (incl. post-op rehabilitation) |
| Community Chronic Pain |
| Rheumatology |
| DMARDs |

5.2 Scope of proposed service

The scope of the service will be developed by Hillingdon CCG in response to the needs of the local community. The CCG has not currently mandated the scope or the method for delivering the service, and encourages providers to innovate to deliver as much of the specification as possible out of hospital. A key objective of the service will be to reduce the existing burden on specialist secondary care services.

5.3 Anticipated cost & activity

Below is the current **indicative** activity for the service, which is subject to further review:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Services | Activity | Cost |
| Secondary Care  (T&O, Rheumatology, Pain Management) | Outpatient FA | 11,317 | £1,705,544 |
| Outpatient FU | 24,306 | £2,114,590 |
| Outpatient Proc | 3,379 | £223,834 |
| In-patient DC | 4,557 | £5,209,761 |
| In-patient EL | 1,051 | £5,714,100 |
| DMARDs | - | - |
| Community | Physiotherapy | 81,826 | £2,615,796 |
| MCATS | 8225 | £920,444 |
| Chronic Pain Service | 302 | £223,371 |
| **Total** | | **134,963** | **£18,727,440** |

5.4 Expected service outcomes

It is anticipated that commissioning an integrated community MSK service will result in the following local outcomes:

* Significant reduction in secondary care activity by reducing inappropriate referrals to secondary care services, and by facilitating early discharge back to a community setting
* Improved referral and booking processes via a single point of access
* Improved clinical outcomes for patients
* High levels of patient satisfaction with care
* Increased knowledge within general practice regarding MSK conditions and treatment options
* Standardised educational tools and resources for GPs and patients, and a robust educations programme for primary care
* Improved waiting times for patients
* Improved integration of the clinical pathway to ensure a seamless service for patients
* Reduce health inequalities by providing equitable access to MSK services.

**6. Programme Mobilisation**

* Once the contract has been awarded, a detailed mobilisation plan will be developed by the provider and agreed by the CCG. The plan will include key activities and milestones to provide reasonable assurance that the service will be mobilised on time.
* It is envisaged that in order to support the effective set up, mobilisation and implementation for the new service model, there will be resource with the knowledge, skills and experience to achieve and deliver the project objectives (part time for the entirety of the project). This will involve planning and monitoring the project from set up to implementation and include:
  + Building, managing and sustaining effective partnership relations and communications with all project stakeholders
  + Assessing and managing project risks
  + Monitoring overall progress and use of resources, escalating actions as required;
  + Reporting through appropriate management / governance processes
  + Establishing baseline activity and monitoring the impact and benefits realization;
  + Managing project administration; and
  + Applying quality / change management principles and processes

During the service mobilisation period, the service Provider is expected to deliver the following milestones;

|  |  |
| --- | --- |
| **Description** | **Target Threshold** |
| Programme manager post recruited | Contract signature |
| Hub staff & SPA staff recruited (where required) | 1 month before service starts |
| System integration with SystmOne, CMC, Hillingdon Care Records (HCR) and other applicable systems | 1 month before service starts |
| Communication plan developed – including clear timeframes pre- and post-mobilisation to raise awareness and reinforce/ re-communicate messages | 2 weeks after contract signature |
| Implementation plan developed – including risk management log | 2 weeks after contract signature |

**7. Governance and administration**

Further details on the requirements for the Community MSK Service are provided separately in the draft service specification.

Disclaimer

The information contained in this MOI is presented in good faith and does not purport to be comprehensive or to have been independently verified.

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