Out of Hospital Contract (Community Services) update

- Contract term: 1 July 2018 – 31 March 2025 (with the option to extend for a further 2 years)
- Provider: Nottingham CityCare Partnership CIC
- Value: £31.5m per annum
- Summary: The contract is made up of a core specification with service specific appendices (sub-specifications) as follows:

A	Access, Navigation and Self-Care	Care coordination, service navigation, social prescriptions
B	MOSAIC (Musculoskeletal, Orthopaedic, Spinal, and Integrated CFS)	Triage, assessment, and treatment service
C	Long Term Conditions and Case Management	Diabetes, respiratory, neurology, cardiac and stroke, SLT, cancer, NUH in reach smoking cessation, podiatry, continence, nutrition, end of life care, 24/7 community nursing, bone health, community matrons and therapy
D	Integrated Care	Admissions avoidance, urgent and crisis care, reablement, community beds
E	Integrated Care Homes	Care homes nursing, dementia support to care homes and advocacy services
F	Continuing HealthCare and Section 117	(Children and adults) - Greater Nottingham
G	Infection, Prevention and Control	GP practices; Care Homes with Nursing beds; Care Homes providing Discharge to Assess pathway
H	Paediatric Specialist Services	Continence and nutrition and dietetics
I	Homeless Health Team	Until 31/01/19 pending review of primary care mental health services
J	PLT admin support	Until 31/03/19 pending review of support to GP Practices across Greater Nottingham

The contract specifications have been consolidated, reviewed and integrated to provide a much more flexible approach to service delivery. The specifications have been made less prescriptive which allows the provider to use their innovation and experience in order to meet the contract outcomes.

- Quality and Patient Outcomes: Established quality and CQUIN schedules and a newly developed Local Incentive Scheme will monitor and assess the quality, safety, satisfaction rates and effectiveness of the service provision and financially rewarding key outcomes.
- Social Value: The contract aligns to the CCG's 3 main objectives to ensure that the provider not only improves the health of the patient, but also contributes to the health of the City through: improving employment and training; promoting healthy lifestyle behaviours; and supporting a healthy environment.
- Affordability and sustainability: The CCG has had to reduce the contract envelope as part its wider savings plan. CityCare have responded to the contract requirements and financial envelope and have developed new flexible staffing models to maintain service delivery, safety and quality at a local level. The CCG has built a quarterly financial health check report into the contract to review the financial sustainability of the provider.
- Mobilisation: CityCare are leading the mobilisation of the contract and are on track to deliver the full specification by 1 July 2018.

Update from Nottingham CityCare Partnership regarding mobilisation and future service offer:

What are the key changes to the service offer?

- **The Musculoskeletal (MSK) and pain service** pathway will change to incorporate the following from 1 July 18: Community acupuncture, Community pain management, Community assessment and triage, Community MSK physio and secondary care pain services. The integrated pathway will provide level two of a three level system approach to the management of pain and orthopaedic conditions.

  A key change to that delivery is that patients currently receiving secondary care pain treatment will no longer have open appointments and will be discharged or have their care reassessed within the new Integrated MSK Pain service.

  Patients requiring secondary care procedures will be case managed within the community by the new service.

- **The Integrated Care Homes team** has been commissioned to deliver the functions and outcomes that are currently being delivered by the Care Homes Nursing Team, City Dementia Outreach Team, GP LES to Care Homes and Age UK Notts Advocacy. The service however will be delivered under one contract from 1 July 18 which will allow for more integrated, seamless pathways of care, increased flexibility of workforce and improved sustainability.

- From 1 July 2018 the **Continuing HealthCare Assessment Service** will expand to include the three Greater Nottingham CCGs (Nottingham North & East, Nottingham West and Rushcliffe CCGs), as well as Nottingham City CCG. Mobilisation work is currently being undertaken to de-couple from the wider County CCGs Service currently in place. The new service will follow the current Nottingham City CCG service standards which will offer consistent provision across Greater Nottingham and aligned administrative functions.

- CityCare have responded to the contract requirements and financial envelope and have developed new flexible staffing models to maintain service delivery at a local level (based on the well-established Care Delivery Group model across Nottingham City), but offers cross cover for sustainable service delivery and access to specialist nursing support when required.

- The financial envelope has reduced from 1 July 18 which has meant that staffing numbers have reduced, but flexible approaches to service models have given assurance that the quality of care, patient experience and patient outcomes will be maintained.

- The previous reports to Health Scrutiny Panel detailed an arrangement with the Local Authority from 1 April 19 to integrate additional services into the CityCare offer, however this has now been withdrawn with discussions ongoing regarding further integration opportunities specifically in relation to Better Care Funded (BCF) services.

- Another change to the contract requirements has been the introduction of the Local Incentive Scheme that sets out key outcomes to be delivered each year which are financially rewarded to the provider upon achievement. Such outcomes can include the active care planning of patients with long term conditions ensuring that patients

are progressing and meeting their agreed goals; patients remaining at home 91 days after a hospital inpatient discharge; reducing the number of patients who have falls etc.

What are the benefits of the new service model to a) provider and b) patient?

- The change in commissioning approach provides CityCare with the opportunity to work more flexibly, matching resources to the areas of greatest need to ensure delivery of a patient centred approach which looks at the patients as an individual rather than by condition.

- This more flexible commissioning style means that specialist practitioners will be embedded into the neighbourhood teams to provide a holistic approach to patient conditions, avoiding duplication and promoting consistent communication and support across the services. Promoting integration across primary, secondary and community organisations through the delivery of integrated care pathways such as diabetes, respiratory, where clinicians work across organisational boundaries. For example:

  The Integrated Respiratory pathway delivered by CityCare in partnership with NUH provides a unified approach across community and secondary care. As part of the partnership approach we have developed shared posts such as the re-admissions nurse.

  Employed by NUH the post works between the respiratory wards and community to jointly manage citizens that repeatedly readmit in a crisis due to their respiratory condition. Developing joint care plans which include management of anxiety (links to IAPT) which is known to be a major cause of unnecessary respiratory admissions so that the citizen knows what to expect, how to manage their condition and if necessary who to contact at times of crisis. Reducing duplication between teams, establishing shared prioritisation of care and consistent communication with the patient. This integrated approach has been a great success. The length of stay for patients admitted in crisis for respiratory conditions has reduced. 2015, 22.7% of patients discharged from NUH readmitted to NUH had a length of stay equal to or less than a day and this fell to 19.6% in 2016. The real example represents how this post works in practice:

  A 69 year old lady with COPD lives alone with no family locally and very anxious. Over a 12 month period she had been readmitted with respiratory issues 7 times. The readmission nurse identified that the admissions all occurred late on a Friday evening, as a 999 call with the patient presenting with severe anxiety. Working with EMAS colleagues as part of an integrated approach it was identified that when the paramedics arrived the patient would be waiting with overnight bag packed ready for admission. Using this knowledge the patient case was discussed by the MDT and a management plan agreed. This included ensuring the MDT we aware of the issues / management strategy and therefore able to respond in a co-ordinated and consistent approach. Referral to the Healthy Housing Coordinator, leading to the patient being rehomed to more suitable environment within supported living. Education and support to understand her condition and manage anxiety relating to her COPD. In the subsequent 12 months this lady has only had one hospital admission.

- A focus of the new delivery model will support patients to take control of their own condition, by providing them with the confidence, skills to practical tools to manage their own care. An example of this in practice is the MSK – physio self-management

website. The Site offers practical support and advice in the form of video demonstrations, exercise programmes tailored to specific MSK conditions.

- Patients (and Nottingham City as a whole) could benefit from the opportunities that delivered through Social Value which could include: on the job training and workforce development; links with colleges, universities and training Providers to promote apprentice schemes or befriending schemes; links with leisure facilities or walking groups (for patients/citizens and staff); links with slimming groups or healthy eating classes (for patients/citizens and staff); links with peer support groups; promoting active travel and providing salary sacrifice opportunities for staff to travel on public transport, for purchasing ultra-low emissions vehicles, or bike to work schemes; promoting electric or low emission vehicles for business use; utilising local suppliers for food, linen and other resources; promoting smoking cessation and delivering alcohol Identification and Brief Advice (IBA) (for patients/citizens and staff) etc. This will help to support and improve the health economy of the City, not just the health of its patients/citizens. The CCG welcomes innovation and creative thinking of how Social Value can be embedded in the contract.

What are the main mobilisation tasks?

- CityCare have continued their commitment to deliver safety, clinical effectiveness, caring and compassionate services to the people of Nottingham and Nottinghamshire.

- CityCare have been reviewing estates and estates utilisation to ensure that patients continue to benefit from convenient, accessible clinic venues; and that staff are located in buildings that are centralised, integrated and enabled. Some staffing bases may need to be changed to accommodate additional staff coming to CityCare from other providers as a result of the re-procurement.

- CityCare have an established relationship with the Patient Experience Group (PEG) who are active in engaging on current and new developments. The PEG group have been engaged throughout the procurement and mobilisation period to ensure that patient voices are heard and reflected in service models.

- The contract was awarded as a lead provider contract which means that CityCare has the opportunity of working with other organisations to provide integrated pathways and specialist input from experts to ensure that patients are supported in the best way possible. An example is end of life care where patients can benefit from local hospice support alongside clinical case management by CityCare. Another example is NUH where consultant input into services such as pain, long term conditions and care of the elderly ensures that patients only attend hospital when it is clinically appropriate. Some of the sub-contracts that CityCare are developing are new and some will continue from the previous contract.

- CityCare continually review their sub contract arrangements and often have contracts with organisations not for services but for products, such as continence products. These contracts are being reviewed and renegotiated where possible to ensure that CityCare get the best value in their purchases.

What engagement has been undertaken so far?

CityCare continues to involve patients and service users in helping us improve and develop our services through on-going feedback and engagement opportunities. We collect feedback from patients and service users following episodes of care and reflect on any learning from this alongside any information collated from complaints and concerns. Our Patient Experience Group (PEG) continues to meet regularly and we have involved members fully in discussion regarding the Out of Hospital contract. At the next PEG meeting in July we will be presenting the full range of services available. The meeting will also be attended by the Head of Engagement and Communications from the Clinical Commission Group (CCG), talking to PEG members about the CCG's financial recovery plan and its implications. We work closely with partners such as the CCG to ensure that information gained from consultation and engagement processes is shared and that we give a consistent message to patients, service users and the public.

One example of engagement has been around the development of the MOSAIC pathway which was supported by patient representatives focusing on areas such as liaison with the local Chronic Fatigue Syndrome patient group, providing an opportunity for our clinical team to discuss and receive feedback on clinical models and supporting the seamless transfer of care between providers, reducing anxiety amongst patients currently receiving services within secondary care.

What engagement/communication will be in place post July?

We are continuing to grow our participation of patients and service users as we develop and deliver Out of Hospital services. We will do this in conjunction with our partners across the health and social care system, avoiding duplication and ensuring that themes from feedback are shared and acted upon. For services that are new to CityCare, such as the delivery of the pain management pathway, we are beginning to link with networks of patient/service user groups to ensure that we are able to share clear information and to pick up on any concerns or suggestions for service improvement. We will build on our current structures to ensure that information regarding patient/service user experience is shared with the CityCare Quality Committee and Board. We will develop opportunities for co-production, with patients/service users and staff working together to develop and improve services

What are the risks to the timescale for 1 July 2018 implementation?

CityCare are managing and mitigating risks through the mobilisation phase and maintain a close working relationship with the Commissioners and other providers to ensure delivery by 1 July 18.

Kathryn Brown

Contracts Manager – Community Services

NHS Nottingham City CCG

Stephen Upton

Sustainability and Transformation Lead

Nottingham CityCare Partnership

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