Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review

for

Hull CCG

Service Specifications: Integrated Sexual Health Services, Urgent Care and Integrated Community Health Services

Version 1.0
April 2015

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

Clinical Senates are independent non statutory advisory bodies hosted by NHS England. Implementation of the guidance is the responsibility of local commissioners, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the review should be interpreted in a way which would be inconsistent with compliance with those duties.

Yorkshire and the Humber Clinical Senate
yhsenate@nhs.net

Date of Publication: February 2015

Version Control

Document Version	Date	Comments	Drafted by
Draft 0.1	13th February 2015	Draft based on Working Group comments	J Poole
Draft 0.2	2nd March 2015	Amended following further Working Group comments	J Poole
Final Version 1.0	15th April 2015	Final version following ratification by Senate Council at the March meeting.	J Poole

1. Chair's Foreword

1.1 The Senate thanks Hull Commissioners for the opportunity to review their proposals for the development of their urgent care, sexual health and community services. The Senate understands that the Clinical Commissioning Groups (CCGs) are pleased to have the opportunity to promote innovative approaches from the providers. The Senate recognises the value in this approach but felt that the open style of the specifications may lead to too simplistic an approach to the delivery of complex services and we recommend a further level of detail in order to ensure that the CCG commissions a service that meets the needs of its population.

2. Summary Recommendations

2.1 The Senate found it challenging to meet its brief in the absence of:

- details of the existing services and the context of the specifications
- detail within the specifications on the expected models of delivery
- clearly defined outcomes for the services and clearly agreed Key Performance Indicators
- requirements regarding governance, reporting and accountability

2.2 The Senate understands that the Clinical Commissioning Group (CCG) are pleased to have the opportunity to promote innovative approaches from the providers and to consider new models of service delivery and that the specifications are deliberately loose to encourage that innovation. The Senate recognises the value in this approach but felt that the specifications would benefit from a further level of detail in order to ensure that the CCG commissioned a service that met the needs of its population.

2.3 The Senate has developed its comments as far possible but was not in a position to fully meet its brief. It was difficult to comment on the gaps when so much of the service detail was unknown, much of the potential innovation is dependent on the intended locations and the model of service delivery and in many cases the outcome measures were not supplied.

2.4 The Senate therefore was not able to fully endorse the specifications as being able to procure a service that would meet the demands of the population they are expected to serve. We realise however that the specifications are still a work in progress and we hope the comments we have made are helpful to commissioners in their final stages of developing the procurement documentation.

3. Background

Current Position and Clinical Area

3.1 NHS Hull CCG is required to re-procure a number of community services that are currently commissioned through two main providers, following the transfer of community services from the former Hull Teaching Primary Care Trust under the *Transforming Community Services* programme. The procurement will be formally launched in April 2015 for new contracts to commence in April 2016.

3.2 A Prior Information Notice (PIN) informing the market of the procurement was published in September 2014. A clinical engagement exercise was undertaken with CCG member practices during October and November 2014 and a number of supplier engagement events were held in November 2014 to engage with potential providers of community services. The supplier engagement events in November 2014 attracted interest from 23 providers including both large existing community service providers as well as smaller

providers specialising in certain service provision. As a result of these exercises three Care Groups have been identified which will be procured as separate services.

3.3 The three Care Groups are:

I. Integrated Sexual Health Services
II. Urgent Care Services
III. Integrated Community Health Services

3.4 The value of these services is anticipated to be in the region of £30m. The CCG have developed a draft service specification for Integrated Sexual Health Services and a draft specification for Urgent Care Services. Integrated Community Health Services have been split into 4 specifications for the following aspects of care:

- Community Nursing & Condition Management
- Rehabilitation
- Intermediate Care
- Palliative and End of Life Care

Senate Role

3.5 In their review of the service specifications the Senate was asked to:

Review the detail of the draft service specifications and advise of:

- any specific gaps in service provision
- any opportunities for innovation that potential providers may be expected to submit
- any specific outcome measures that could be added

3.6 In addition to the service specifications, the CCG also shared their Strategic Plan 2014/15 - 2019/20.

3.7 Commissioners have advised that working with the Senate will help to ensure that the service specifications, published as part of the procurement process, are fit for purpose – clinically robust, clear in the aims and objectives, contain appropriate outcomes and Key Performance Indicators. The Senate advice is required by the end of February 2015 to inform the final version service specifications which are to be approved at the CCG Planning & Commissioning Committee on 19th March 2015. The final set of service specifications will be published as part of the Invitation to Tender (ITT) documentation for the CCG's community services procurement, formally commencing April 2015.

Process

3.8 The Senate first discussed working with Hull CCG in summer 2014. A further discussion in January 2015 confirmed that the specifications had now been developed and could be shared with the Senate. The Senate discussed the request to review the specifications at the Council meeting on 20th January. During that meeting, the Council recruited Council Leads for the 3 Working Groups to review sexual health, urgent care and community services specifications respectively. Assembly members were recruited to the 3 Working Groups following the Council meeting and the formal request to the Senate from Hull CCG was received on 23rd January with the specifications received on 30th January.

3.9 The Working Groups all commenced work on the review and each working group scheduled a teleconference to share developing thoughts in the week commencing 9th February. The 3 Working Groups also scheduled teleconferences with the commissioning leads week commencing 16th and the 23rd February to provide opportunity to clarify any questions prior to the development of the Senate reports.

3.10 The draft reports were finalised in the first week of March and sent to commissioners on 6th March for opportunity to comment. The Senate requested a week's extension to allow the Working Group members time to consider additional information received in the final week of February.

General Comments

3.11 In their reviews of all 3 sections, the Working Groups reported on the need to see more detail of the current services, including the activity and how this service is currently delivered. Without knowing the details of the existing services and more about the context of the specifications, it was difficult for the panels to understand the approach taken and address our brief. The Senate thanks the commissioners for sending the additional information to us.

3.12 We were also made aware during the course of our discussions, that the CCG had agreed not to be prescriptive about the services for procurement as they expect the provider(s) to provide innovation and scope for new locations or new models of delivery. The CCG felt that this enabled them to be clear on the objectives and outcomes of the service but allows bidders to describe their model of delivery along with any added value / innovation. The Senate is supportive of this approach, but in order to be open about the model of delivery, the CCG need to have clearly defined outcomes for the services within the specifications and clearly agreed Key Performance Indicators (KPIs) for the CCG to assess how well the service is being provided. The specifications made available to the Senate, however, did not contain the outcomes for the service or their KPIs as these were being developed separately. The specifications also did not contain the requirements regarding governance, reporting and accountability as we understand these are included in the NHS Standard Contract.

3.13 The Working Groups have therefore developed their comments as far as they can, in the absence of the information discussed, but the Senate was not in a position to fully meet its brief in terms of commenting on the gaps, the opportunities for innovation or the outcome measures. More broadly, the Senate was not able to fully endorse the specifications as being able to procure a service that would meet the demands of the population it is expected to serve. We hope the comments we have made however are helpful to commissioners in their final stages of developing the procurement documentation.

4. Recommendations (1)

Integrated Sexual Health Services

4.1 The existing contracts and services with the incumbent provider will end on 31st March 2016. Due to the procurement timetable, the CCG currently have the opportunity to look afresh at their sexual health services and make adjustments to the delivery of this service within this procurement process. The Senate understands that this is not a like-for-like procurement, meaning commissioners have reviewed existing services and pathways and re-written service specifications to reflect their new requirements. The CCG are pleased to have the opportunity to promote innovative approaches from the providers and to consider new models of service delivery. The Senate recognises the value in this approach but although the specification is deliberately loose to encourage that innovation, the Senate felt that the specification would benefit from a further level of detail in order to ensure that the CCG commissioned a service that met the needs of its population, particularly with regard to the following points.

4.2 The provider(s) will need to work collaboratively with community and secondary care providers and voluntary sector organisations to ensure patients have access to a choice of appropriate services to meet their needs and deliver streamlined pathways of care. The Senate however, could not see any requirement within the specification to ensure the providers will achieve the level of collaboration required to deliver that seamless service.

4.3 The specification is titled Integrated Sexual Health Service but this integration was not evident within the specification description. Nationally, integrated sexual health service is a term used to describe the integration of specialised contraception and Sexually Transmitted Infections (STI) services. There is no mention of the interface of this CCG commissioned service with the Local Authority (LA) commissioned specialised sexual health services. The Senate understands that this is a commissioner choice to give the providers the opportunity to scope new ways of working, however the Senate advises that the specification would benefit from containing more information to define the essential interface with these local authority commissioned services and describe the key clinical pathways.

4.4 In the way that the specification is currently written, without clear definitions of the full scope of services, the Senate felt that there was a risk that within the tender assessment there was opportunity for some elements of the service to fall between the 2 differing commissioning pathways. Although the Senate understands that there will be very specific questions asked about the integrated service during the tender process, it remains our recommendation that this is defined in more detail within the specification.

Specific Comments

4.5 The Working Group expressed some concern as to whether the section on community gynaecology has sufficient detail. As currently written, this may present an option for the provider to offer only a limited range of investigations which may be substandard to the requirements of the CCG.

4.6 The section on unplanned pregnancy and the early medical abortion service sets out the exclusion criteria. The Senate Working Group questioned why it states that the service will only take terminations over 9 weeks gestation. This may be a typing error and needs to be checked. There is limited reference to counselling services but this should be a priority of the service. No specific KPIs were included, but the Senate considers reduction in teenage pregnancy and reduction in overall termination rates to be included as well as KPIs specific to ongoing contraception and counselling advice.

4.7 The male sterilisation service states that a 24 hour emergency contact service will be required, but the Senate does not fully understand what will present as an emergency except for post-procedure complications which could be dealt with by the out of hours (OOH)/urgent care service. The Working Group also queries why commissioners had chosen a body mass index (BMI) of over 35 as the cut-off in the exclusion criteria.

4.8 The purpose of the male sexual dysfunction service is unclear. Without structured KPIs it is impossible to determine what the service is expected to achieve or why it is required.

Response to Questions

Any specific gaps in service provision?

4.9 Please refer to our earlier comments regarding the lack of information on the interface of this CCG commissioned service with the Local Authority (LA) commissioned specialised sexual health services. Please also refer to comments below regarding the KPIs and outcomes.

4.10 The specification does not include information about the intended governance, reporting and accountability but the Senate understands that the NHS Standard Contract will detail the provider's obligations around audit and governance.

4.11 The specification does not include information about the activity expected to be managed by each of these service specifications within a week/month/year or when appointments must be offered, but the Senate understands that this is provided separately to providers.

4.12 There is no detail within the specification on the workforce or intended skill mix, but the Senate understands that the commissioners expect that the providers will ensure that they have suitably qualified clinicians and specialists to deliver the services seamlessly.

4.13 Commissioners may wish to consider providing further information within the specification on:

- how the service will seek to address issues of equity and access particularly to marginal/vulnerable groups
- health promotion and disease prevention aspects
- safeguarding aspects (both child and adult, domestic violence, female genital mutilation) as currently these are not present
- how the provider will ensure medical information is shared effectively and confidentially
- counselling and contraception advice

- what safeguards could be put in place to minimize the risk of supplier induced demand for services
- how the service provision proposed addresses identified health needs for the target population. In order to assure value for money and cost effective commissioning of services, alignment of health needs and supply is an important consideration

Any opportunities for innovation that potential providers may be expected to submit?

4.14 The Senate Working Group did not feel that they were in a position to answer this question without having further detail on the service, as much of the innovation is dependent on the intended locations and the model of service delivery. We would also advise commissioners to consider clearly articulating the intended aim(s) of innovation as well as how they will assess any "innovations" that are subsequently proposed by bidders.

Any specific outcome measures that could be added?

4.15 The Senate thanks the CCG for sending separately the draft Key Performance Indicators and outcome measures. The KPIs received are only relevant to last year, demonstrating that the current provider has achieved the standards set by the commissioners and indicates that there has been greater than expected uptake of the service. However, there is no indication if the CCG wish to keep with the same KPIs or make changes for the new tender and therefore the Senate are still finding it difficult to assess the specification. The Working Group advises that currently the KPIs are mostly process type indicators and the CCG are advised to consider developing a fuller set of indicators, aligned more to service and health outcomes, reflecting the strategic intentions of the commissioner.

4.16 The Senate felt that the outcomes were better populated and described and welcomed mention of expectations for health education and sexual health screening to be offered to clients and the further detail of how these outcomes align to broader objectives. The Care Group outcomes however remain written in general terms and it would help to have more specific outcomes detailed, to define for example how the commissioners will define and intend to measure improved "access" or improved "choice". The Senate does not feel able to advise on bespoke outcome measures as we do not have the service detail which clarifies what commissioners want to commission. None of these measures make reference to how the provider will link with secondary care and it is not clear how they will align with strategic commissioning intentions.

5. Recommendations (2)

Urgent Care

5.1 The CCG are looking to re-contract their urgent care service for their population of 288,000. The Senate understands that the CCG do not wish to replicate their current services but are looking for providers who can deliver elements that these services cover but now under an Urgent Care model which bidders are asked to describe. Each bidder will therefore be expected to suggest a proposed structure for providing the commissioned care. As a minimum, patients will have access to a walk in facility for urgent needs (currently specified as Bransholme Health Centre which the CCG consider to be in a good location and surrounded by a large population). This is the only location specified as the CCG do not want to restrict bidders putting forward innovative options.

General Comments

5.2 The Working Group thanks the CCG for the additional activity figures provided. It would have been helpful if this allowed the Senate to compare each present site by activity/work load. It was therefore not possible to assess if all the sites are cost-effective. As a general observation, however, the Working Group questioned the need for so many centres within the current model for a population of 288,000 where many of these centres are less than 6 miles from the Emergency Department. In an urban area, selecting less sites may be cost efficient with minimal impact on access, but the CCG will be aware of the need to consider what transport mechanisms are used by patients to attend out of hours and if those centres are too few, whether this will put undue strain on home visit requests or on the ambulance service.

5.3 The Working Group questioned whether this Urgent Care Review will impact upon the care provided by the Acute Trust to patients from outside the HU1-9 post-code areas. It was not clear if there is an expectation that Hull and East Yorkshire NHS Trust (HEYHT) deals with patients from differing post codes differently or if it is already established local practice that inappropriate Emergency Department attendances are channelled to the co-located out of hours centre. Consideration needs to be given to how this will affect the ability of HEYHT to provide the same care to patients of different CCGs.

5.4 The specifications did not detail expectations around the workforce due to the commissioners' preference to leave out the detail in order to encourage innovation from the bidders. The Working Group did question the impact that these service changes will have on healthcare professionals training and advises that Health Education Yorkshire and the Humber is consulted as a stakeholder if this has not already been done.

Response to Questions

Any specific gaps in service provision?

5.5 The Working Group advises that commissioners:

- further consider the exclusion list within the specification. Face lacerations was raised as one example where commissioners may want to be more specific. The Working Group was unclear how the CCG would meet the needs of the "People presenting with intoxication alcohol/drugs" and "People presenting in an acute phase of mental illnesses who are currently listed in the exclusions". Automatically sending these patients to the Emergency Department is at odds with the vision of caring for the patient's need with a holistic system approach.
- provide further information on the pathways for patients with acute mental health needs
- prioritise the need for a strong communications strategy which is essential to help patients navigate through the proposals and to change behaviours and current practices. The Working Group felt that there is a risk of confusion for patients through the potential multiple sites where they can access services and questioned how these changes in service delivery are going to be made clear to patients and how they are going to be supported to change their behaviour. The CCG may want to consider what incentives the new provider(s) could have to encourage appropriate channelling of patients?
- expand on the advice expected to nursing and residential home centres

5.6 The Working Group understands that the governance and accountability framework for this service is specified within the NHS Standard Contract but the Working Group did question how patient safety concerns will be monitored, counted, reported, investigated and prevented. Commissioners will wish to consider the details of how incidents and the assessment of impact will be reported to commissioners.

5.7 The diagram on page 4 of the report appears very high level and a little simplistic. It does not contain information about how patients will be filtered out before presenting at an urgent care setting. The Working Group felt that this model ran the risk of resulting in a very busy urgent care centre when there are innovative ways of dealing with patients before they access the service.

5.8 The Working Group discussed with commissioners how the service will manage walk in patients who present at the wrong place and the mechanism for how patients can be re-defined at their entry points into the system. The Senate understands that patients will be allowed to “walk in” for their perceived urgent needs but this service is not intended to be a resource for patients with primary medical needs that can’t get an appointment with their GP. Walk in GP services are out of scope for this service/procurement. Although there are 2 objectives which cover this area within the specification, the Senate advises that commissioners may wish to give further consideration to this issue to ensure commissioners evaluate the detail of how bidders will manage this issue.

5.9 The Working Group advises that the specification needs to contain greater clarity on the pathways for life threatening conditions.

5.10 To ensure the success of the proposals the CCG will need to ensure that they have the engagement from their GPs. This need is acknowledged by the CCG during discussions and the detail of this engagement did not form part of the evidence provided to the Senate.

5.11 The Working Group understands that commissioners will expect bidders to describe how they would use technology for the service in their bid proposals and that there will be a specific question in relation to this in the assessment. Getting this technology right to share records across sites is key in delivering a seamless service to patients and commissioners are advised to ensure they give this sufficient consideration in their assessment.

Any opportunities for innovation?

5.12 The Working Group felt it was difficult to comment on this section in much detail as most of the opportunities for innovation will become clearer as the service is further developed in discussion with the bidders. The commissioners do have opportunities here for innovative use of estates and innovation in sharing of information and records. Commissioners also need to ensure that bidders are innovative in their approach to communicating the proposed new system with patients.

5.13 As discussed in the earlier section, the Working Group felt that commissioners need to consider innovative ways of dealing with patients before they access the urgent care services, for example community pharmacy and GP Practices. The Working Group was pleased that Emergency Care Practitioners are part of the community service and commissioners may wish to consider further the opportunities for using those with advanced skills, e.g. suturing, more innovatively within the proposals.

Any specific outcome measures that could be added?

5.14 The Working Group had some concern that the metric "reduction in minor A&E attendances" may be difficult to measure, particularly if this generates extra work on the acute provider side to try and consistently code cases according to whether they could/should have been assessed/treated/referred elsewhere. Commissioners may wish to consider whether the bidder will be able to impact minor Emergency Department (ED) attendances and what baseline data will be used for comparison. Owing to seasonal variation, at least 12 months of historical data will be required if this metric is to be applied fairly with matching months used for comparison. The Working Group also questioned whether with the national trend of rising ED attendances month on month "reduction in minor A&E attendances" is a realistic outcome. Also, because of rising ED attendances, the Working Group would suggest using proportional numbers of ED attendances (e.g. percentage) rather than absolute numbers. Due consideration will need to be given to historical data, and over the life of the contract, to ensure outcomes are appropriate and achievable.

5.15 Regarding suggested outcome NQR 2, the measure remains 'to be defined'. As the out of hours consultations will be shared with the appropriate practice electronically, the CCG may wish to consider this an opportunity to change the reference from "the next working day" to "the next day" as this is an opportunity to start normalising 7 days services.

5.16 There may be an opportunity to include a metric for patients that are triaged but not seen in the Emergency Department and then immediately attend the Urgent Care Centre. Commissioners may want to consider how many ED patients could be dealt with by primary care rather than the Acute Trust and assess the potential cost savings in this.

5.17 The CCG may wish to consider further outcomes which encourage integration of care as set out in their vision. Other possible area outcomes to consider are:

- the 4 hour target. It will be difficult to measure the 4 hour target especially if the patient is switching between areas of the service. Commissioners will need to consider how to accurately capture this
- how many transfers of care
- how many times re-triage patients
- equity of provision
- reduction in frequent attenders
- patient reported outcomes
- stakeholders experience of the service
- care plans followed
- liaison with other services on discharge e.g. mental health or social services. If integration of care is the aim, integration of care metrics could be used
- a metric to ensure that 111 is triaging correctly - what are their advice/referrals rates? Although it will be difficult for the bidders to be able to influence this easily, it may provide the motivation to encourage cross system integration (e.g. making the bidders accountable for the outcomes of partner 111 organisations that could lead to better collaboration)

Specific Comments

5.18 Page 3 – 3rd bullet point states that one of the key objectives of the service is to "Work in partnership with the wider urgent care system across primary, community, secondary health and social care to provide urgent care, support and advice to service users …" The Working Group suggests that the commissioners include more information about what this means, although we understand that commissioners intend to ask specific questions on this point in the tender evaluation.

5.19 The Working Group highlighted to commissioners that the specification currently reads that the public visiting Hull for any reason will not be able to access GP out of hours or Emergency Practitioner parts of the service. We understand that the population covered section is incorrect and that the rules on which CCG pays for urgent care need finalising for this service specification.

5.20 Page 3 – 5th bullet point. Commissioners have a proposal to provide telephone based clinical management for those clients triaged via 111 and need more assessment. The Working Group advises that this is explored within the tender process. We were unsure if the new service will just receive calls from NHS 111 and see them where they are directed or actually re-triage. NHS 111 may get patients to the safest place rather than always the most appropriate place. Extra triage by clinicians provides a means of re-sorting the patients and potentially downgrading a proportion of the calls but this requires resourcing. Another option is to change the NHS111 Director of Services (DoS) algorithm. Commissioners are advised to have in place some metrics to monitor and audit the dispositions over the initial period of the contract and to review the need to re-triage NHS 111 passed calls or accept the dispositions provided. Perhaps this could be explored in the discussion with the bidders or specifically addressed in the evaluation stage of the procurement.

6. Recommendations (3)

Integrated Community Health Services

6.1 Commissioners have the opportunity to re-tender for their community services and have agreed to divide their services into 4 specifications covering the following aspects of care:

- Community Nursing & Condition Management
- Rehabilitation
- Intermediate Care
- Palliative and End of Life Care

6.2 The Senate understands that commissioners have no preconception about the future form of the service and wish to encourage bidders to be innovative in their suggested models of care. Commissioners intend to commission this service on a lead provider model. Initially the Working Group had difficulty in understanding the concept that was being proposed given our lack of knowledge of the services currently in place and what this service was expected to deliver in relation to that. It would have been helpful to have more detail about the current position, where there are potential demographic 'pinch points' to focus service delivery and potential hub location.

6.3 The specifications are intentionally very light in detail on the services but in addition, 3 of the 4 specifications contained no outcome measures or KPIs. Clinical governance, IT and other elements of the service were also being handled in different work streams which were not shared with the Senate and we therefore found it challenging to provide insight into this work. Thanks to commissioners for sending activity data on their existing services and further contextual information which did help to fill some of those gaps in understanding.

General Comments

6.4 In general terms, the Working Group was supportive of the approach by commissioners, which was made clearer in the teleconference, in encouraging innovation and being open to new models of service. The specifications received, however, do not easily reflect the intentions of the integrated service and the Working Group would advise some amendments as commissioners further develop the tender documentation.

6.5 The commissioners intend to commission a single coordinating organisation with responsibility to deliver the whole list of individual services with options for subcontracting. We assume that other documentation will make this intention clear as this is not reflected in the specifications and providers will need to be aware that they will take responsibility for the whole package of services.

6.6 The preferred approach from the commissioners is to allow providers opportunity to propose the best way to deliver the individual services. In this context, the Senate had difficulty in understanding the split between the separate service specification documents. We understand that commissioners have had extensive discussion to agree upon this approach but we felt that there was more logic in having one single service specification or at least an additional document that sets out the concept of the "integrated service".

6.7 Each of these separate service specification documents contains a large list of services like deep vein thrombosis (DVT) and anticoagulation, home oxygen, podiatry, weight management, pulmonary rehabilitation etc. which on their own are large and complex enough to justify a separate service specification document. We understand that commissioners wish to avoid producing individual detailed service specifications for each service included in the project and to leave this to be proposed by the providers. Commissioners hope that this will avoid creating 'silos' of services and encourage providers to develop a holistic community service. The Senate are supportive of this approach, however commissioners have the ultimate responsibility for the potential outcomes of the services they commission and they should retain control on the essential characteristics of the services they purchase. The providers need to be aware of these characteristics in order to formulate their proposal. Providers will therefore need further text specifying what group of population should be covered, what is the expected volume of work, what is the expected access to the service (days of the week, waiting times), what quality standards are expected to be achieved and what outcome measures are expected to be reported. The Senate was assured that these elements will be in the package of tender documentation but this has not been referred to us and we are therefore unable to comment on this.

6.8 On reading the separate specifications the Working Group did note that there is a difference in style and level of detail in their presentation and they do not read as an "Integrated Service". If commissioners truly are avoiding the detail, then they may wish to consider whether there is a need for the detailed description of pathways like "Dietetic Service Pathway" or "Tier 3 Weight Management Pathway" as these should be left to the providers to propose.

6.9 The specifications do not contain detail on the required work-force and skill mix, how staffing will be structured and what programmes for training and continuous professional development will be adopted. The Senate understands that the commissioners want to commission a service based on deliverables and expect the bidders to propose the workforce detail.

6.10 The Working Group did discuss with commissioners the philosophy according to which the staff will be organised. The commissioners have a clear view that the services should be delivered in a patient focused and not in a conditioned focused way which means that the practitioners involved should be trained to deal with multi morbidity and not to be specialists in a single condition and a single procedure. The Senate agrees that this has the advantage of bringing simplicity to the system and reducing the number of visits and consultations.

6.11 Commissioners are advised, however, that the requirement for services to be delivered this way is made clear to any willing provider as this is not the only way to deliver the services and this philosophy is not shared by all providers. Such an approach requires different training and continues professional development of staff. For example, the service will need to make sure that a nurse dealing with a patient with diabetes, chronic obstructive pulmonary disease (COPD) and DVT has the skills to address all three issues. Commissioners will need to consider how staffing will be structured and what programmes for training and continuous professional development will be adopted. Having a community service with such a broad remit will have significant training implications for staff to manage the complexity and diversity and the Senate is unclear how this is going to be addressed.

6.12 In addition to physical hubs the service will require mobility of staff to allow visits and support of patients in their homes. It will be good if the principles along which the mobility of staff will be arranged are clear in the tender documentation.

6.13 The specifications also do not contain any proposals on the physical hubs for the delivery of the services. The Senate understands that there is an estates strategy that runs alongside this work and the commissioners are committed to some premises. It is not clear from the documents received how the commissioners will require that certain physical hubs are utilised for the delivery of the services by any successful provider. Commissioners will be aware that the conditions for such utilisation need to be made clear upfront and that they will need strong mechanisms for evaluating whether the detailed clinical services plans fit with the premises they are committed to and if their current estates plans are valid for the future.

Response to Questions

Any specific gaps in service provision?

6.14 The Working Group felt that commissioners may wish to consider the following points in the development of their specification:

6.15 The Working Group did remain concerned that the open style of the specifications may lead to too simplistic approach to the delivery of complex services with individual elements, for example podiatry or dietetics, getting overlooked or compartmentalised. An example given is that podiatry ranges from community based general practice, works within specialist services such as falls prevention through to acute based highly specialised services and works as part of a multi-disciplinary team in diabetes management in line with NICE guidelines, Vascular surgery teams, Orthopaedics, Rheumatology and Dermatology. In the context of these individual services the Senate found difficulty in understanding the service specification split. Currently podiatry and dietetics are only mentioned in one specification and the approach appears piecemeal as it remains unclear where there is the continuity of care and service continuity planning. Commissioners will want to consider when and how they will move away from the generalisation on the provision of services to how they will capture and assess those opportunities for innovation in individual services during the tender evaluation.

6.16 There is mention of carers support throughout the specifications but it is unclear if this will be through the 3rd sector or other means. There is some support available in Hull for carers but this is limited and the voluntary sector is fragile and cannot be relied upon to provide a service. There is much reference across the documents to working with the voluntary sector and the Senate raised some concerns on this approach given the fragility of many of these services and the lack of detail on those working arrangements. We are informed that how the provider intends to work with the voluntary sector will form part of the tender evaluation.

6.17 Although mental health services are not part of this procurement, the Working Group advises that commissioners consider the interface with this service and how they will evaluate the proposed pathways for the bidder to work alongside the mental health provider.

6.18 Outcome measures are only included within the therapy and rehabilitation specification, the Senate understands that other outcome measures are under development but currently this lack of detail remains a fundamental gap in the specifications.

6.19 Each of the services in this proposal will require a clinical governance framework and decision support including local guidelines, local pathways, protocols and access to specialist opinion to support the practitioners facing the patients. The Senate understands that this will be approved and documented within the NHS standard contract explaining the absence from this specification. It would seem appropriate for the specification to reference the intention to apply such a clinical governance framework that the successful provider will need to adhere to.

6.20 The Working Group also raised some questions about the stakeholder involvement in these proposals. We assume that there has been extensive work not shared with the Senate but from the information we have received there did not seem to be much reference to working with patient participation groups on service plans. The group also questioned whether commissioners may want to consider including Trades Union representatives on the project boards as they are key stakeholders in any organisational change process and can ensure a smoother uptake of change and activity. The group could also not see evidence of the

inclusion of Allied Health Professional (AHP) members on the Clinical and Professional Reference Group. Much of the development around falls, obesity, stroke care, and palliative care has AHPs at its core and their views need to be considered.

6.21 Integrated services like the one described in this proposal can function only if there is a free-flow of information between the different participants. The Senate understands that there is a broader work stream within Hull 2020 to develop the information infrastructure and we discussed with commissioners that the adequate flow of clinical information will not be possible without the commissioning of a fit for purpose IT portal. The Senate recommends that the service specification document makes reference to the strategy according to which free-flow of information will be secured and also recommends that the groups leading the IM and T developments contain clinical representatives.

6.22 The 5 Year Forward View calls for partnership and collaboration between health, statutory bodies, public health and voluntary sector organisations and co-delivery of services. There is reference to this in the Hull 2020 vision but commissioners may wish to ensure that this message is adequately conveyed within the service specifications.

Opportunities for Innovation

6.23 With so little detail on models of care, location, staffing or outcomes the Senate felt that they were not in a position to comment on the opportunities for innovation. The information management and technology (IM&T) solution and the patient focused staffing model are obvious opportunities. Further opportunities will emerge as commissioners develop the detail of the bids with the providers.

Any specific outcome measures that could be added?

6.24 The Senate was not provided with a full list of outcome measures upon which to comment.

Additional Specific Comments on the Therapy and Rehabilitation Specification.

6.25 Commissioners may want to consider the following additional comments:

- 3.2.1 It may be helpful to clarify consultant access in bullet point 8. There is no mention of the consultant after the general description and it is therefore unclear who is going to take charge and how this will happen in a timely manner considering long waiting times. Similarly ensuring quick access to a pain specialist or equivalent will improve the rehabilitation process.
- Bullet point 12. It would be helpful to specify how the 3 attempts (face to face, letter. telephone etc.) will be made and to document the reasons for any refusal
- Provision of the exercise programme should include hydrotherapy and access to the local swimming pool
- Page 10. Currently it is unclear what happens after final assessment. Commissioners will want to consider reducing hospital stay but also reducing readmission rate. Potentially the majority of the elderly will require some support after the therapy and one of the most helpful ways to approach this can be the provision of community support groups with access to therapist if need be. With reference to the 16 sessions it is unclear how intensive and spread out sessions these will be. It is also unclear if the patients could be re-referred to rehabilitation after they have been through the programme once.

7. Summary and Conclusions

7.1 The Senate understands that the CCG are pleased to have the opportunity to promote innovative approaches from the providers and to consider new models of service delivery and that the specifications are deliberately loose to encourage that innovation. The Senate recognises the value in this approach but felt that the open style of the specifications may lead to too simplistic approach to the delivery of complex services. The Senate recommends that the specifications would benefit from a further level of detail in order to ensure that the CCG commissions a service that meets the needs of its population.

7.2 From the evidence provided, the Senate is unable to fully endorse the specifications as being able to procure a service that would meet the demands of the population it is expected to serve. We realise however that the specifications are still a work in progress and we hope the comments we have made are helpful to commissioners in their final stages of developing the procurement documentation.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Integrated Sexual Health Services:

Senate Council Members

Dr Caroline Hibbert, Joint Medical Director, Hull and East Yorkshire Hospitals NHS Foundation Trust

Senate Assembly Members

Dr Christine Bowman; Clinical Director, Communicable Diseases & Specialised Medicine Directorate and Consultant Physician in GU and HIV Medicine, Sheffield Teaching Hospitals NHS Foundation Trust

Mr Lawrence Roberts, Consultant Obstetrician and Gynaecologist and Deputy Medical Director, North Lincolnshire & Goole NHS Foundation Trust

Co-opted Members

Dr Andrew Lee, Consultant in Communicable Disease Control, Public Health England

Integrated Community Health Services:

Senate Council Members

Catherine Wright, Allied Health Professionals Lead, Bradford District Care Trust

Senate Assembly Members

Peter Allen, Citizen Representative

Howard Lester, Specialist Podiatrist, Harrogate and District NHS Foundation Trust

Dr Syed Navqi, Psychiatrist and Carer Representative, Fieldhead Hospital

Rebecca Bently, Senior Nurse in Primary and Secondary Care, Hillside Bridge Health Centre

Dr Doytchin Dimov, Consultant Physician in Respiratory Disease, St James University Hospital

Dr Sameer Gupta, Consultant in Anaesthesia and Pain, Sheffield Teaching Hospitals NHS Foundation Trust

Dr John Coyle, Stroke Physician, York Teaching Hospitals NHS Foundation Trust

Mr Mahmoud Loubani, Cardiothoracic Surgeon, Hull and East Yorkshire Hospitals NHS Foundation Trust

Greg Fell, Consultant in Public Health, Bradford Metropolitan Borough Council

Urgent Care:

Senate Council Members

Dr Steve Ollerton, Clinical Leader, Greater Huddersfield Clinical Commissioning Group

Dr Andrew Phillips, GP & Deputy Chief Clinical Officer, Vale of York Clinical Commissioning Group

Senate Assembly Members

Sandy Gillan, Citizen Representative

Dr Pierre-Antoine Laloe, ST7 Anaesthesia, Hull and East Yorkshire Hospitals NHS Foundation Trust

Professor Graham Venables, Clinical Director, Strategic Clinical Networks, NHS England and Consultant Neurologist, Sheffield Teaching Hospitals NHS Foundation Trust

Co-opted Members

Dr David Tatham, Clinical Specialty Lead for Urgent Care, Bradford City and Bradford Districts CCGs

Appendix 2

COUNCIL AND PANEL MEMBERS' DECLARATION OF INTERESTS

Integrated Sexual Health Services:

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict
Dr Caroline Hibbert	Joint Medical Director	Hull & East Yorkshire Hospitals NHS Foundation Trust	20.1.15	Clinician in HEYT, the Trust providing secondary and tertiary care to the community services pathway under review	4.2.15	This is not being considered to be a significant conflict of interest as the conflict is limited to Caroline's role as an employee of Hull and East Yorkshire NHS Trust and Caroline's clinical duties are not within this area of service. Caroline has no pecuniary or non-pecuniary connections with the provider above her professional duties and therefore we can agree that she can participate in this work on behalf of the Senate
Dr Christine Bowman	Clinical Director	Sheffield Teaching Hospitals NHS Foundation Trust	9.2.15	Clinician in Sheffield Teaching Hospitals NHS Trust sexual health service, a Trust that may need to compete with Hull and East Yorkshire NHS Trust when their vasectomy services are put out to tender in 2016	9.2.15	This is not considered to be a significant conflict of interest. The tender process is not until 2016 and it is not known whether Sheffield Teaching Hospitals and Hull and East Yorkshire Trust will be competing for the tender for vasectomy services. The conflict is limited to Christine's role as an employee of Sheffield Teaching Hospitals NHS Trust and Christine has no pecuniary or non-pecuniary connections with the provider above her professional duties. We have therefore agreed that she can participate in this work on behalf of the Senate with this conflict noted.

Integrated Community Health Services:

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict
Dr Caroline Hibbert	Joint Medical Director	Hull & East Yorkshire Hospitals NHS Foundation Trust	20.1.15	Clinician in HEYT, the Trust providing secondary and tertiary care to the community services pathway under review	4.2.15	This is not being considered to be a significant conflict of interest as the conflict is limited to Caroline's role as an employee of Hull and East Yorkshire NHS Trust and Caroline's clinical duties are not within this area of service. Caroline has no pecuniary or non-pecuniary connections with the provider above her professional duties and therefore we can agree that she can participate in this work on behalf of the Senate
Mr Mahmoud Lubani	Cardiothorasic Surgeon	Hull & East Yorkshire Hospitals NHS Foundation Trust	30.1.15	Clinician in HEYT providing secondary care to the community services pathway under review	4.2.15	This is not being considered to be a significant conflict of interest as the conflict is limited to Mahmoud's role as a clinician. Mahmoud has no pecuniary or non-pecuniary connections with the provider above his professional duties and therefore we can agree that he can participate in this work on behalf of the Senate
Dr Sameer Gupta	Consultant in Anaesthesia & Pain	Sheffield Teaching Hospitals NHS Foundation Trust	21.1.15	Married to a GP who is Director of a company that may run a pain management service	4.2.15	You have informed the Senate that you are married to a GP who is Director of a Company that may run a pain management service although this company is formed, it is not yet operational. This company has not declared an interest. When the company does become operational and is intent upon tendering, you cannot participate in the Senate discussions however as the company is not yet operational and has not expressed an interest we have agreed with the Chair that you can participate in this work on behalf of the Senate with your conflict of interest noted.

Urgent Care:

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict
Dr Caroline Hibbert	Joint Medical Director	Hull & East Yorkshire Hospitals NHS Foundation Trust	20.1.15	Clinician in HEYT, the Trust providing secondary and tertiary care to the community services pathway under review	4.2.15	This is not being considered to be a significant conflict of interest as the conflict is limited to Caroline's role as an employee of Hull and East Yorkshire NHS Trust and Caroline's clinical duties are not within this area of service. Caroline has no pecuniary or non-pecuniary connections with the provider above her professional duties and therefore we can agree that she can participate in this work on behalf of the Senate

Appendix 3

TERMS OF REFERENCE

Template to request advice from the Yorkshire and the Humber Clinical Senate

Name of the lead (sponsoring) body requesting advice: NHS Hull Clinical Commissioning Group

Type of organisation: CCG

Name of main contact: Phil Davis

Designation: Senior Commissioning Manager

Email: philip.davis@nhs.net **Tel:** 01482 344747 **Date of request:** TBC

Please note other organisations requesting this advice (if more than the lead body noted above):

Not applicable.

Is the Senate being consulted for advice or as part of the formal assurance process?

The Clinical Senate is being consulted for advice.

Please state as clearly as possible what advice you are requesting from the Clinical Senate and what documentation you propose sharing with the Senate.

To review the detail of the draft service specifications and advise of:

- any specific gaps in service provision
- any opportunities for innovation that potential providers may be expected to submit
- any specific outcome measures that could be added

The CCG will share the CCG's Strategic Plan 2014/15 - 2019/20 plus 6 draft service specifications as follows:

Care Group 1: Integrated Sexual Health Services (1 specification)

Care Group 2: Urgent Care (1 specification)

Care Group 3: Integrated Community Health Services (4 specifications):

- Community Nursing & Condition Management
- Rehabilitation
- Intermediate Care
- Palliative and End of Life Care

Please state your rationale for requesting the advice? (What is the issue, what is its scope, what will it address, how important is it, what is the breadth of interest in it?).

The advice will inform the service specifications to be used as part of the CCG's re-procurement of a range of community services. The scope of the services includes sexual health services, urgent care services and a range of other community health services.

To ensure that the service specifications published as part of the procurement process are fit for purpose – clinically robust, clear in the aims and objectives, contain appropriate outcomes and KPIs.

The value of these services is anticipated to be in the region of £30m. The supplier engagement events in November 2014 attracted interest from 23 providers ranging including both large existing community service providers as well as smaller providers specialising in certain service provision.

What is the purpose of the advice? (How will the advice be used and by whom, how may it impact on individuals, NHS/other bodies etc.?).

The advice will be used to inform the final set of service specifications that will be published as part of the Invitation to Tender (ITT) documentation for the CCG's community services procurement formally commencing April 2015.

Please provide a brief explanation of the current position in respect of this issue(s) (include background, key people already involved).

NHS Hull CCG is required to re-procure a number of community services that are currently commissioned through two main providers (following the transfer of community services from the former Hull Teaching PCT under the *Transforming Community Services* programme). The procurement will be formally launched in April 2015 for new contracts to commence April 2016. A Prior Information Notice (PIN) informing the market of the procurement was published in September 2014. A clinical engagement exercise was undertaken with CCG member practices during October & November 2014 and a number of supplier engagement events were held in November 2014 to engage with potential providers of community services. As a result of these exercises three Care Groups have been identified which will be procured as separate Lots. The three Care Groups are: 1. Integrated Sexual Health Services, 2. Urgent Care Services and 3. Integrated Community Health Services. Draft service specifications for Care Groups 1 and 2 have been developed along with 4 specifications covering Care Group 3.

When is the advice required by? Please note any critical dates.

The advice is required by the end of February 2015 to inform the final version service specifications which are to be approved at the CCG Planning & Commissioning Committee on 19th March 2015.

Has any advice already been given about this issue? If so please state the advice received, from whom, what happened as a consequence and why further advice is being sought?

The draft specifications have been developed with clinical input from CCG Board GPs and have also been reviewed by the CCG Planning & Commissioning Committee at workshops held in January 2015.

Is the issue on which you are seeking advice subject to any other advisory or scrutiny processes? If yes please outline what this involves and where this request for advice from the Clinical Senate fits into that process (*state N/A if not applicable*)

The final service specifications will require approval at the CCG Planning and Commissioning Committee on 19th March 2015. The advice that is received from the Clinical Senate will inform the final service specifications.

Please note any other information that you feel would be helpful to the Clinical Senate in considering this request.

The CCG will require the Clinical Senate to manage any potential conflicts of interest that may arise in undertaking this work.

Please send the completed template to: joanne.poole1@nhs.net. *For enquiries contact Joanne Poole, Yorkshire and the Humber Clinical Senate Manager at the above email or 01138253397 or 07900715369*

Version 2.0 April 2014

Appendix 4

BACKGROUND INFORMATION

The following information was considered by the Senate for this review:

- Integrated Sexual Health Service Specification, draft 30/01/2015
- Urgent Care Service Specification, draft 30/01/2015
- Intermediate Care Service Specification, draft 30/01/2015
- Nursing Condition Management Service Specification, draft 30/01/2015
- Palliative and End of Life Care Service Specification, draft 30/01/2015
- Therapy and Rehabilitation Service Specification, draft 30/01/2015
- NHS Hull CCG Strategic Plan 2014/15 to 2019/20

The following additional information was sent to the Working Groups following the Senate request for further details:

- Care Group 1 - draft KPIs
- Care Group 1 – activity data
- Care Group 2 – activity data and location maps
- Care Group 3 – contextual information
- Care Group 3 – activity data