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Contract

NHS Norfolk Reablement and Recovery Pathway Window 2

NHS Norfolk & Waveney Integrated Care Board

F03: Contract award notice
Notice identifier: 2024/S 000-037428
Procurement identifier (OCID): ocds-h6vhtk-04a717
Published 19 November 2024, 4:56pm

Section I: Contracting authority

I.1) Name and addresses

NHS Norfolk & Waveney Integrated Care Board

County Hall, Martineau Ln

Norwich

NR1 2DH

Email

david.bailey1@nhs.net

Country

United Kingdom

Region code

UKH15 - Norwich and East Norfolk

Internet address(es)

Main address

https://www.improvinglivesnw.org.uk/about-us/our-nhs-integrated-care-board-icb/icb-contact/

Buyer's address

https://www.improvinglivesnw.org.uk/about-us/our-nhs-integrated-care-board-icb/icb-contact/

I.4) Type of the contracting authority

Body governed by public law

I.5) Main activity

Health

Section II: Object

II.1) Scope of the procurement

II.1.1) Title

NHS Norfolk Reablement and Recovery Pathway Window 2

Reference number

NW2024-82

II.1.2) Main CPV code

- 85100000 - Health services

II.1.3) Type of contract

Services

II.1.4) Short description

NHS Norfolk and Waveney ICB sought expressions of interest for the provision of a Discharge to Assess: Reablement and Recovery Pathway in Care Homes within Central Norfolk.

NHS Norfolk and Waveney ICB sought to commission 6 beds in a suitable Care Home to deliver a Reablement and Recovery pathway. This will form part of our Central Norfolk intermediate care bed model and be supported by Norfolk Community Health and Care NHS Trust (NCHC).

This pathway is for individuals registered to a Central Norfolk GP (ie; North Norfolk, South Norfolk and Norwich practices), who are 65 years and over with moderate cognitive decline and who are identified to require a short period of reablement and recovery in an appropriate bedded setting to enable discharge home/usual place of residence (UPOR) or suitable long term placement, following an Acute Hospital admission.

The pathway will include an in-reaching multi-disciplinary team (MDT) comprising; Physiotherapy, Occupational Therapy, Social Care and Primary Care with operational delivery through NCHC. An expected date of discharge will be agreed on admission, supported by a patient centred reablement plan together with weekly MDT meetings to enable recovery and progression of discharge plans.

The Contract will be for a period of 2 years and 4 months with the option to extend for up to an additional 1 year.
The service is priced at £1,200 per bed per week.

Prerequisites
The Care Home included in any bid must be within a 5 mile radius of the Norfolk & Norwich University Hospital.
The Care Home included in any bid are required to have six beds available (on the ground floor) from 1st December 2024.
The Care Home included in any bids must be registered with the Care Quality Commission (CQC) for the delivery of Dementia care.

II.1.6) Information about lots

This contract is divided into lots: No

II.1.7) Total value of the procurement (excluding VAT)

Value excluding VAT: £1,252,771.43

II.2) Description

II.2.2) Additional CPV code(s)

- 85144000 - Residential health facilities services

II.2.3) Place of performance

NUTS codes

- UKH1 - East Anglia

Main site or place of performance

Norfolk

II.2.4) Description of the procurement

This is a Provider Selection Regime (PSR) intention to award notice. The awarding of this contract is subject to the Health Care Services (Provider Selection Regime) Regulations 2023.

The broad outcomes required of the Central Norfolk Reablement and Recovery service are specified below:

• Provide a time limited (up to 6 weeks) period of bedded reablement and recovery, outside of a hospital environment, to promote independence and enable discharge home/ usual place of residence (UPOR) or to a least restrictive suitable bedded environment
• Reduce length of stay in Acute Hospitals
• Reduce potential for deconditioning
• Provide personalised care for all individuals accessing the service including delivery of a person centred reablement and discharge plan
• Delivery of reablement and care plan interventions for individuals on the pathway; agreed with the individual, their families, carers and the care home team
• Improve quality of life for individuals and their families/carers.
• Contribute to the reduction of avoidable re-admissions to hospital
• Improve professional relationships between care home staff, GP practices and MDT members
• Contribute to reduction in the number of pressure ulcers
• Contribute to reduction in the number of falls
• Streamline communication to enable patients to get appropriate non-urgent intervention
• Promote continuity of care by improving communication and handover to enable seamless transition from the pathway to relevant long-term care Providers

Project Deliverables

To deliver a Reablement and Recovery pathway within the designated N&W ICB commissioned care home beds, with a clear expectation that residents will remain on the pathway for up to 6 weeks and that the individual shall either return back to their own home/UPOR, with support if needed, or transfer into a suitable longer-term placement.

To support delivery of the pathway, Care Home Providers will be expected to provide a timely response and access to the commissioned beds for eligible individuals, proactively work with the individual and the in-reaching multi-disciplinary team (MDT) to enable progression of discharge plans and timely exit from the pathway.

The Central Norfolk HomeFirst Hubs will be responsible for sharing Transfer of Care (TOC) referrals with Care Home Providers for consideration. Care Home Provider requirements:

• During operational hours (Mon-Friday 08.00-18.00), Care Home Providers will respond within 2 hours of TOC receipt to identify whether or not the individual is provisionally accepted and/or outlining any additional information that may be required to make a decision.
• The Care Home's Registered Manager or nominated deputy may need to attend the Acute Hospital to assess the person face to face to ensure they can safely meet their needs. Where this is required the assessment and decision should be made within 48 hours of receiving the TOC Monday to Thursday and within 72 hours for TOCs received on a Friday.
• NB: Please note the intention to develop a Trusted Assessor role working with Care Home Providers and on their behalf to support timely decisions and transfer to the pathway in future, with the aim to transfer suitable individuals to the pathway within 48 hours of TOC referral. This also allows the opportunity to enable transfers 7 days a week. It is anticipated that this role will be part of the Central Norfolk HomeFirst Hub and operate 7 days a week to enable safe and effective transfers 7 days a week. The role will be developed with Care Home Providers, informed by the CQC Guidance on Trusted Assessors and Local Government Authority (LGA) Guidance on Trusted Assessors.
• Care Home Providers will receive a handover from the Acute Hospital ward or Hospital Discharge Team on the day of transfer. Wherever possible transport booking times will be shared to enable an estimated arrival time.
• Care Home Providers will temporarily register the person with an agreed Primary Care practice, within 24 hours of admission or as soon as possible for out of hours admissions.
• Care Home Providers will ensure the designated rooms are available for admitting individuals 5 days a week, Monday to Friday, during the contract period, with an intention to move to 7 day admissions including bank holidays, once the pathway is fully established and Providers are assured regarding quality of discharge information and transfers. Admission times will be dependent on the needs and safety of each individual with aim to transfer between 08.00-18.00.
• Care Home Providers will, when beds are available (Monday to Friday 08.00-18.00), admit individuals within 24 hours of an accepted TOC referral, unless otherwise jointly agreed with NCHC, the Central Norfolk HomeFirst Hub and Acute Hospital team arranging the discharge.

• Care Home Providers are required to build good working relationships with their aligned GP practice for the pathway and the in-reaching MDT.
• Care Home Providers will work with MDT members to support achievement of the outcomes specified within the individual's care and reablement plan.
• Care Home Providers will liaise effectively, sharing their professional insight, during weekly MDT meetings to inform planning, and be proactive in supporting the individual to return home/UPOR or new bedded care environment in a coordinated, safe, effective and timely manner.
• Care Home Providers will be expected to always have suitable staffing levels available to safely meet the needs of individuals on the pathway, which will include double assist care. People who are eligible for care will have varying levels of dependency and are likely to have both physical and cognitive/mental health needs.
• Care Home Providers will be able to provide temporary 1:1 support, if required, to safely manage short term escalations of behaviour e.g., linked to health changes or transition to a new environment. Where teams at the referring hospital, working proactively with Providers and the HomeFirst Hub team, identify if 1:1 support is anticipated in the short term to aid smooth transition to the pathway, it is at the Registered Manager's discretion whether the person's needs can be safely met and accepted onto the pathway. (NB. Patients requiring a high level of additional supervision are not suitable for this pathway).
• Care Home Providers must seek approval for funding when organising short term 1:1 support to manage short term escalation of behaviours while on the pathway. This should be in exceptional circumstances and detailed record keeping will be required
• Care Home Providers will ensure designated rooms are suitable to deliver the Reablement and Recovery pathway:
o Room size: All designated rooms must be of an appropriate size to accommodate full hoisting and or any relevant manual handling equipment, enable residents to navigate safely with walking aids including frames plus or minus assistance, and be large enough to enable double up care to be provided if needed.
o Room Location: needs to be downstairs or the Provider must have safety mechanisms in place to reduce risk of falls/injury in relation to stairs and access.

• The Provider must have access to a range of suitable equipment to support the needs of individuals on the pathway.

Aims and objectives of service

The aims of this service are to:

• Provide a responsive service, in order to support safe and timely hospital discharge for adults with moderate cognitive decline, who have identified short term reablement and recovery care and support needs.
• Provide quality care and support to all individuals on the pathway, through a person-centred approach.
• Ensure individuals have a comprehensive assessment and structured person-centred care

and reablement plan that involves active therapy or opportunity for recovery that is sustainable once the patient has returned home/UPOR.
• Deliver short term intervention to enable users to optimise their independence and enable discharge home/UPOR, adopting a HomeFirst approach
• Ensure continuity of care on transition into and from the pathway
• Provide effective care coordination and care navigation
• Reduce length of stay (LOS) in Acute Hospitals
• Reduce risk of deconditioning
• Prevent avoidable hospital admissions

II.2.5) Award criteria

Quality criterion - Name: Quality and Innovation / Weighting: 45

Quality criterion - Name: Integration, Collaboration & Service Sustainability / Weighting: 20

Quality criterion - Name: Improving access, reducing health inequalities and facilitating Choice / Weighting: 25

Quality criterion - Name: Social Value / Weighting: 10

Cost criterion - Name: Value / Weighting: 0

II.2.11) Information about options

Options: Yes

Description of options

This contract is for a period of 2 years and 5 months with the option to extend for up to an additional 1 year.

II.2.13) Information about European Union Funds

The procurement is related to a project and/or programme financed by European Union funds: No

Section IV. Procedure

IV.1) Description

IV.1.1) Type of procedure

Open procedure

IV.1.8) Information about the Government Procurement Agreement (GPA)

The procurement is covered by the Government Procurement Agreement: Yes

IV.2) Administrative information

IV.2.1) Previous publication concerning this procedure

Notice number: 2024/S 000-032398

Section V. Award of contract

A contract/lot is awarded: Yes

V.2) Award of contract

V.2.1) Date of conclusion of the contract

8 November 2024

V.2.2) Information about tenders

Number of tenders received: 1

The contract has been awarded to a group of economic operators: No

V.2.3) Name and address of the contractor

Redlands

Redlands House Care Home, 134 Reepham Road Hellesdon Norfolk, Norwich, NR28 0NA

Norwich

Country

United Kingdom

NUTS code

- UKH1 - East Anglia

The contractor is an SME

Yes

V.2.4) Information on value of contract/lot (excluding VAT)

Initial estimated total value of the contract/lot: £1,251,771.43

Total value of the contract/lot: £1,252,771.43

Section VI. Complementary information

VI.3) Additional information

This is a Provider Selection Regime (PSR) intention to award notice. The awarding of this contract is subject to the Health Care Services (Provider Selection Regime) Regulations 2023. For the avoidance of doubt, the provisions of the Public Contracts Regulations 2015 do not apply to this award. The standstill period begins on the day after the publication of this notice. Representations by providers must be made to the relevant authority by 3rd December 2024. This contract has not yet formally been awarded; this notice serves as an intention to award under the PSR.'

If you have wish to make a written representation regarding this intention to award notice please contact nwicb.enquiries@nhs.net.

The intention to award decision was made by the ICB Steering Group 8th November 2024.

There were no declared conflicts identified during in relation to this process.

The Key Criteria weighting for this services was as follows:

Quality & Innovation - 45%
Value - Pass/ Fail
Integration, Collaboration and Service Sustainability - 20%
Improving Access, Reducing - 25%
Social Value - 10%

The rationale for awarding to the preferred provider was that they have passed all pass/fail questions in the basic selection questionnaire and ranked as the highest scoring provider based on their overall Key Criteria score within this Provider Selection Process.

VI.4) Procedures for review

VI.4.1) Review body

NHS England

7&8 Wellington Place

Leeds

LS1 4AP

Country

United Kingdom

Internet address

https://www.england.nhs.uk//