Name of meeting: Calderdale and Kirklees Joint Health Scrutiny Committee
Date: 22 September 2014

Title of report: Calderdale and Greater Huddersfield Health & Social Care Strategic Review

Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**N/A – Report produced by Calderdale CCG & Greater Huddersfield CCG.**
Is it in the Council's Forward Plan?	**No**
Is it eligible for "call in" by Scrutiny?	**No**
Date signed off by Director & name **Is it signed off by the Director of Resources?** **Is it signed off by the Acting Assistant Director - Legal & Governance?**	**No – The report has been produced by Calderdale CCG & Greater Huddersfield CCG**
Cabinet member portfolio	**Health, Well-Being & communities**

Electoral wards affected: All

Ward councillors consulted: N/A

Public or private: Public

---

1. Purpose of report

1.1 To brief members of the Calderdale and Kirklees Joint Health Scrutiny Committee on the work that is being developed by Calderdale CCG and Greater Huddersfield CCG on the proposals for change across health and social care in Calderdale and Greater Huddersfield.

2. Key Points

2.1 Calderdale CCG and Greater Huddersfield CCG, in line with the national agenda and planning guidance are shaping proposals that will provide integrated care that is delivered at or closer to home.

2.2 This work is an important element of the wider transformation programme detailed in the Calderdale and Huddersfield Strategic Outline Case (SOC) which presented the case for changing the way NHS community and hospital services in Calderdale and Greater Huddersfield are provided.

2.3 The SOC describes a proposed future service model to support the changes that are required in the delivery of health and social care in Calderdale and Greater Huddersfield which includes: community locality teams; two specialist community centres; and two specialist hospitals (one delivering services for people that have an emergency or are acutely unwell and the other specialising in provision of planned hospital treatments)

2.4 In August 2014 the governing bodies of both CCG's agreed to adopt a phased approach to the new service model by continuing to develop and implement changes to community services and undertake consultation at a later date in relation to changes to hospital services.

2.5 Senior representatives from Calderdale and Greater Huddersfield CCG's will be in attendance at the meeting to brief the committee on the context and background to the proposals and provide an up to date position on the planned programmes of work.

2.6 Attached are reports from Calderdale CCG and Greater Huddersfield CCG which provide an overview of the work that is taking place in the transformational change programme.

2.7 It should be noted that each report contains similar information in areas that are common to both CCG's and has been produced with a view to address members from each authority. Subject to comments from the Committee the manner by which future information is submitted to the Committee will be refined to meet the requirements of the Committee as a whole.

3. Implications for the Council

This is a report for information.

4. Consultees and their opinions

Not applicable

5. Next steps

That the Committee take account of the information presented and consider the next steps it wishes to take.

6. Officer recommendations and reasons

That the Committee consider the information provided and determine if any further information or action is required.

7. Cabinet portfolio holder recommendation

Not applicable

8. Contact officer and relevant papers

Richard Dunne, Principal Governance & Democratic Engagement Officer, Tel: 01484 221687 E-mail: richard.dunne@kirklees.gov.uk

9. Assistant Director responsible

Julie Muscroft, Assistant Director: Legal, Governance & Monitoring

CALDERDALE CCG

REPORT TO THE JOINT CALDERDALE AND KIRKLEES HEALTH OVERVIEW AND SCRUTINY PANEL.

SEPTEMBER, 2014

RIGHT CARE, RIGHT TIME, RIGHT PLACE PROGRAMME

1.0 BACKGROUND

The Right Care, Right Time, Right Place Programme brings together the seven partners across Calderdale and Greater Huddersfield to develop proposals for transformational change across the health and social care economy of Calderdale and Greater Huddersfield. Significant change is essential because we want to ensure that everyone gets the right care at the right time and in the right place, whilst responding to the challenges of:

- An ageing population with increased needs;
- National shortages of key elements of the workforce that mean new service models are required
- Continuing to meet ever increasing external standards
- Significant financial pressures facing commissioners and providers.

As Commissioners, our contribution to the delivery of this change is set out in our five year strategy.

Our five year strategy is based on what the people of Calderdale have told us through our engagement. It sets out the aims we want to realise, the outcomes we expect to achieve, the Programmes of work we intend to deliver and the metrics we will use to measure our success.

In parallel with the development of our Strategy, three of our existing Providers have produced a jointly developed proposal for changing the way community and hospital services in Calderdale and Greater Huddersfield could be provided. They described their proposals in the form of a draft Strategic Outline Case (SOC), which was presented to members of both CCGs' Governing Bodies in January, 2014. It was presented to both the Kirklees and Calderdale Health and Wellbeing Boards (HWB) and Overview and Scrutiny Committees (OSC) in February and March. The Providers subsequently developed the Strategic Outline Case into an Outline Business Case (OBC). This Outline Business Case was lodged with the NHS Procurement Portal Bravo on the 23rd June. Our approach to its consideration is outlined in paragraph 7 below.

2.0 Introduction

We have used the engagement we have done over the past three years, including Call to Action and previous Right Care, Right Time Right Place engagement, to develop our Closer to Home proposals.

As well as influencing our proposals for the models of Health and Social Care that we need to commission, our engagement has also: confirmed the fundamental need for more

integrated care delivered in community and primary care settings; and provided feedback that the people in our communities will only gain confidence in our new model through experiencing the improvements for themselves.

Therefore, we know that we need to phase any implementation of change over at least five years. We also know that in making these changes we create an additional driver for change to the way our Hospital Services are configured. This would impact across Calderdale and Greater Huddersfield.

3.0 Our Five year Strategy and Two Year Operational Plan

Based on the needs of the population of Calderdale and what our Public and Patients have told us we have agreed 8 outcomes that we want to deliver over the five year period:

- Empowered citizens and resilient communities;
- Reduced Health Inequalities
- Improved Patient experience and perception
- Ensuring quality and safety in all we commission
- Reduced Preventable deaths
- Improved quality of life of patients with a long term condition or illness
- People are helped to recover from illness and injury
- Reduce reliance on unplanned hospital based care - by shifting to planned community services.

The plan is summarised below and demonstrates how the Closer to Home Programme provides the focal point for all our priority areas.

CALDERDALE CCG

REPORT TO THE JOINT CALDERDALE AND KIRKLEES HEALTH OVERVIEW AND SCRUTINY PANEL.

SEPTEMBER, 2014

4.0 Results of our engagement

At a population level we have conducted engagement in relation to: Call to Action; Right Care, Right Time, Right Place; the Providers' Strategic Outline Case; and our Commissioning Intentions. We have also engaged on specific programmes and projects as they have progressed. The key themes from Call to Action and previous Right Care, Right Time, Right Place and specific Programmes and Projects are detailed at Appendix A.

In summary, what our engagement has told us is that our communities want:

- Improved access to health services
- More services in the community
- All agencies working together to deliver Health and Social Care
- Improved Discharge planning and better resourced hospitals.
- Staff Training to improve communication and transparency
- Regular Check-ups - for people with chronic conditions
- Improved management of risk and safeguarding when people are unwell
- More education and information
- Support for Self Care and
- Investment in technology

We have used this engagement to inform our Proposals for Change. A report of findings has been produced which provides details and findings from all our engagement activity, including specific engagement with key stakeholders as part of our Care Closer to Home Programme. The Report of Findings has been published on the RightCareTimePlace website and used to further inform and update our Proposals for Change. We will also check to see if there are any gaps in our engagement that we need to address prior to finalisation of our proposals.

In addition, Calderdale Council has established a People's Commission that will give local people an opportunity to debate what services are needed now and in the future. We would seek to incorporate the views from The Commission as part of our Engagement Approach.

5.0 Proposals for Change

Based on the intentions in our five year strategy and the feedback from our engagement, we know that significant changes are required in order to ensure health and social care services are fit for the future. There is a national need to centralise key services to improve outcomes for patients. The Right Care Programme is overseeing proposals for what these future Community and Hospital services in Calderdale and Greater Huddersfield could look like. There are three interlinked pieces of work: Calderdale Closer to Home Programme; Greater Huddersfield Care Closer to Home Programme; and the In Hospital Model.

Community Services

The Calderdale Closer to Home Programme and The Greater Huddersfield Care Closer to Home Programme have both set out proposals for what our future Community Services could look like. The Greater Huddersfield proposals have been developed with North Kirklees CCG and Kirklees Council. These proposals continue the shift of both the services and the resources required to support unplanned hospital admissions to the delivery of more self-care and more integrated care delivered in community and primary care settings.

The Calderdale Draft Model for Closer to Home Draft model (Appendix B) provides an early view of the draft proposals for Calderdale. Whilst the high level model is unlikely to change substantially, detailed work will continue on the expectations around quality and outcomes. We are planning to further develop these proposals, including dialogue with commissioners in Calderdale MBC and links with the Better Care Fund, and also to reflect our most recent engagement and undertake any further engagement to address any gaps. We expect the CCG's Quality Committee to sign off our model by the end of September.

In-Hospital Services

Our requirements for In-Hospital Services are being developed jointly by Calderdale and Greater Huddersfield CCGs and will, in the first instance, be a set of joint standards. These joint standards set out the High level Outcomes we want to achieve, the scope of In Hospital Services and the standards that we want to apply to these Services. The scope of the services is set out at Appendix C. The standards are based on established best practice and are additional to and do not replace existing CQC, NICE, CQUIN and standard contract targets. We are currently assuring these standards through a quality assurance group comprising representation from both Calderdale and Greater Huddersfield CCG. We are in the process of establishing a joint Calderdale and Greater Huddersfield Programme Board, to oversee this work.

6.0 Approach to Commissioning of Community Services

It is intended that the commissioning of Community Services will be done in a phased manner, with the first phase comprising those services already provided in the community. We would then seek to add further services that are currently hospital based but could more appropriately be provided in the community.

We believe that integrated commissioning is necessary to ensure effective collaborative working across health and social care and in particular, ensure patients, service users and carers experience integrated care across health and care services. There are a number of services where we would seek to integrate our commissioning arrangements in line with the Better Care Fund (BCF) and our shared objectives of reducing demand for urgent and emergency acute hospital care and for permanent admissions to care homes, so enabling and supporting people to live in their own homes for as long as possible.

CALDERDALE CCG

REPORT TO THE JOINT CALDERDALE AND KIRKLEES HEALTH OVERVIEW AND SCRUTINY PANEL.

SEPTEMBER, 2014

National guidance in relation to BCF has identified four priority areas:

- Protecting social care services,
- 7-day services to support discharge and delayed transfers of care,
- Data sharing, including consistent use of the NHS number; and
- Joint assessments and accountable lead professional.

The previous national £1bn Payment for Performance framework has been revised so that the proportion of the £1bn now linked to performance is based solely on an area's scale of ambition in reducing total emergency admissions.

We have jointly agreed our Vision for the Better Care Fund with Calderdale Council:

We will have moved from reactive to proactive care
We will have prevented avoidable deterioration of peoples health and wellbeing and met their care needs at the right time and in the right place
Care will be holistic – looking after peoples physical, psychological and social care needs
'Everyone has a bed – and it's at home'

Seven Strategic Objectives together with supporting projects have been jointly designed with Calderdale Council to deliver our agreed vision and the aims of the Better Care Fund:

1 **Ensuring that people have a positive experience of care and enhancing quality of life for people with care and support needs**. (Integrated Single Point of Access (Gateway to Care); Weekend Single Point of Access to Intermediate Care (Gateway to Care); Self-Care Assistive Technology for Independent Living; Self-Care Hub including LD Hub)

2. **Enhancing quality of life for people with care and support needs as a result of long term conditions.** (Frailty; Targeted Prevention for Dementia; Carers Offer; Community Equipment (including the Loan Store); Home Improvement Agency; Handyperson Prevention Scheme; Disabled Facilities Grants for Adaptions; Preventative Home Support (CQC Registered Home Care)

3. **Ensuring that people have a positive experience of care and support through improving access to primary care services and Improving people's experience of integrated care.** (Case Management: Allocated Lead Professional Worker for 75+ in General Practice; Case Management: Social Work Assessments; Demographic Growth Pressures for Personal Budgets; Care Act (2014) new statutory duties Implementation and Review Costs)

4. **Delaying and reducing the need for care and support and helping people to recover from episodes of ill health or following injury**. (Residential Transitional Beds;

Intermediate Care Community Beds; Intermediate Supported Care (Heatherstones Reablement Unit); Intermediate Care Social Work; Reablement & Coordinated Support at Home; Community Support for Stroke Recovery)

5 **Delaying and reducing the need for care and support through reducing delayed transfers of care and reducing the number of permanent admission to residential and nursing care homes.** (Out of Hours Emergency Duty Urgent Assessment; A&E Physician; Complex Discharge Coordination; Early Supported Discharge for Stroke)

6. **Enhancing quality of life for people with care and support needs at end of life**. and

7. **Treating and caring for people in a safe environment and protecting them from avoidable harm and safeguarding adults who circumstances make them vulnerable and protecting from avoidable harm.** (End of Life Social Work; Home Hospice for End of Life; Hospice; Quality In Care Homes; ASC Capital - Telecare (Quest for Quality Scheme)

Underpinning all the Objectives is a further project for IT Enablement.

In areas where there is overlap between these key areas and our proposals for change, we would seek to commission in an integrated way.

7.0 Approach to Market

Approach to Market is the process by which the CCG decides on the most appropriate provider of services, but is not meant to imply that this is necessarily a competitive process. Irrespective of whether the CCG decides to re-commission competitively, the commissioner's requirements will need to be set out within formal Invitation to Tender (ITT) /Invitation to Commence Dialogue (ITCD) documents and the process to receive a formal response to the ITT/ITCD and a full and robust evaluation of whether or not the potential provider(s) will deliver the expected service, outcomes and benefits required. This will require the development of robust benefit realisation projections, evaluation criteria and standards along with appropriate weightings.

As part of our approach to market we need to consider the timing of when we should consider the Providers' Outline Business Case. This document was lodged with the NHS Procurement Portal Bravo in June but we delayed opening the document, because in a sense it has been produced and provided to the Commissioners outside of due procurement process. Following the publication of our proposed Service model, Hospital Standards; and Evaluation Criteria we have established a joint Greater Huddersfield/Calderdale Assurance Panel to consider the Providers' Outline Business Case. The members of this panel received a copy of the Providers' Outline Business Case on 8th September and met for the first time on 10th September to consider it in relation to our proposed service models, Hospital Standards and Evaluation Criteria. The Panel expects to have formed an initial view on the implications for the scope and phasing of our proposals for change by the end of September.

8.0 Approach to Evaluation

As outlined in our Approach to Market, regardless of whether we decide to use a competitive process, we will still set out our requirements (for both Community Services and In-Hospital Services) in a formal Invitation to Tender (ITT) / Invitation to Commence Dialogue (ITCD) process. We have drafted our high level evaluation criteria and these are set out at Appendix D.

9.0 Consultation

We know that significant changes are required in order to ensure health and social care services are fit for the future. Condition specific programmes of change started in 2012/13 and are continuing. One by one these changes, which are underpinned by a programme of engagement activities, contribute to our evolving community model. The changes to Community Services developed through our Care Closer to Home Programme continue this shift of services from the hospital to the community. Collectively, these changes mean that over the five years of our strategy we will need to make changes to the way our Hospital Services are configured. Change to the way our Hospital Services are configured can only be implemented following formal public consultation.

Both the Calderdale and Greater Huddersfield CCGs have decided to progress with their proposals for changes to Community Services prior to making any change to Hospital Services. This decision will allow us provide direct experience of an effective Community Model, demonstrate that we have listened to the public and allow us time to maximise the opportunity offered through the Better Care Fund.

We recognise that we will be required to demonstrate that we have conducted sufficient engagement in relation to our proposed changes to community services and that the potential for delay to changes to hospital services, increases the risk of a deterioration in the quality of services our hospitals are able to provide, prevents us from starting to address some current workforce issues and may require us to fund and resource double running of services.

10.0 Assurance Process

In support of our decision making, NHS England has a Strategic Change Assurance Process that will consider our proposed changes to Community Services and In-Hospital Services prior to any consultation exercise. The Strategic Change Assurance Process will also validate that these changes will bring improvement in quality, safety, effectiveness of care and that they are financially sustainable during transition and post transition. We have informally engaged with the NHS England process and plan to formally engage when we have completed our Options Appraisal. As part of the NHS England Strategic Change Assurance Process we will also engage with the Yorkshire and Humber Clinical Senate. The Clinical

Senate is a source of independent advice and guidance to commissioners to help them make the best decisions about healthcare.

11.0 Further work

We have set out above the engagement we have done, the changes we are proposing, our approach to the commissioning and procurement of these changes, our approach to Consultation and the Assurance Process that will support our work.

There is also a number of underpinning pieces of work that we will need to complete to support our Proposals.

We have commissioned work on the development of a Financial and Economic model that will produce a financial case for change to demonstrate the economic and financial sustainability of any proposed changes both during transition and post transition.

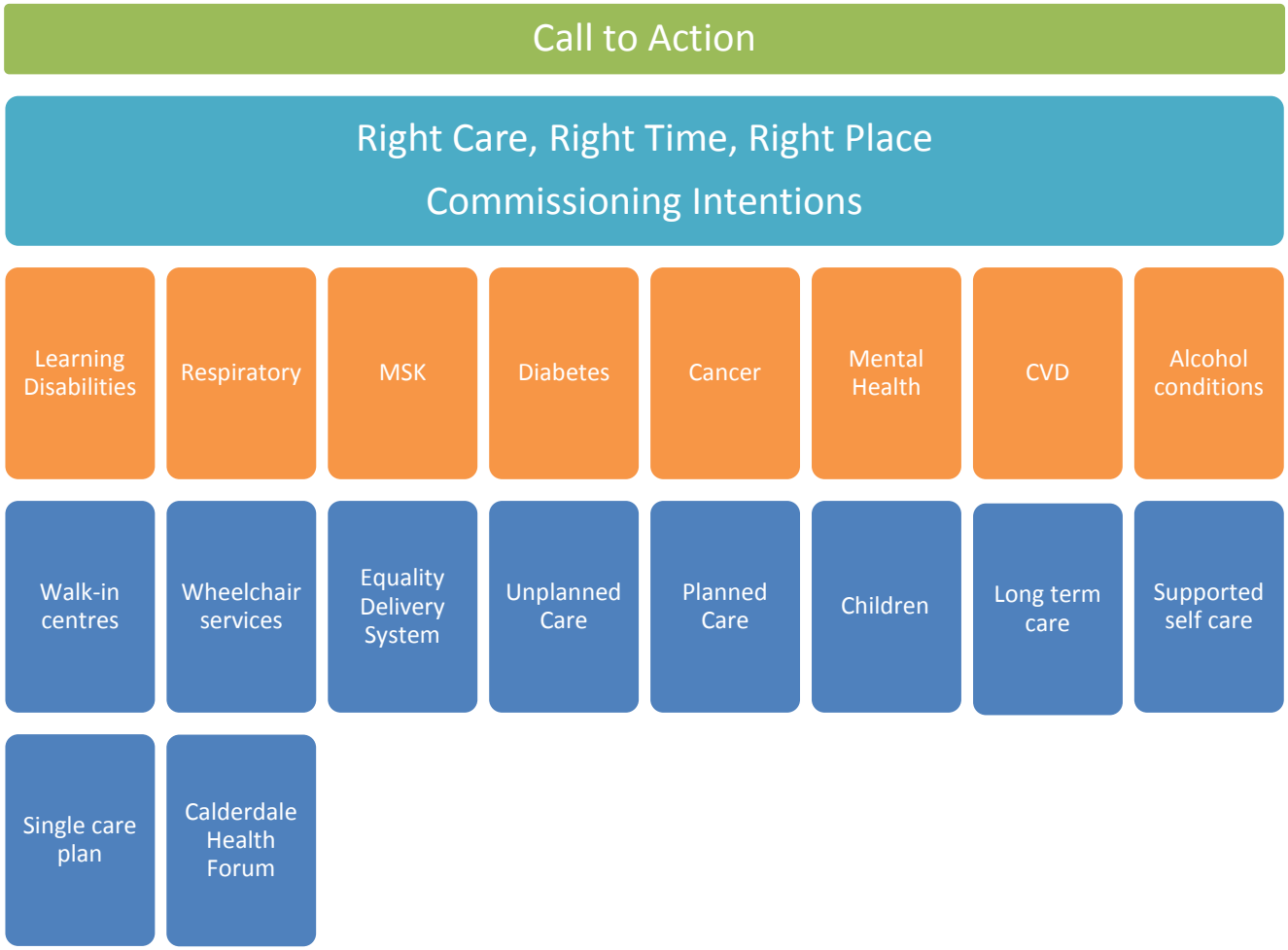
We will also need to undertake work to understand the implications for our Workforce, Technology and Estates.

Dr. Matt Walsh
Chief Officer,
Calderdale Clinical Commissioning Group.
10th September, 2014.

Appendices

Appendix A Key Engagement Themes
Appendix B Draft Closer to Home Model
Appendix C The Services covered by our In Hospital Standards
Appendix D High Level Evaluation Criteria

The Diagram below shows the areas of strategic level and service level engagement.



Overarching themes

The overarching themes that were raised across the engagment activites outlined above are as follows:

Improve access to health services. This included opening times and appointment availability, particularly aimed at GP practices and primary care.

- Awareness of building access issues to all staff, especially around disabilities
- One point of access for people with one or more long term conditions
- Longer appointment times for some people, spend more time with the patient and listen
- Improve home visits and bring GP services to community settings
- Reduce waiting times for appointments and change the booking system
- Have appointments at evenings and weekends, ring fence appointments for people who work
- Have specialist staff in GP practices

More services in the community, the public would like to see more staff working with and supporting local people in their own home and community.

- More health assistants, social workers and nurses
- Better home care
- Named community staff for individual people
- Better access to equipment to use in your own home
- More day care and respite care for carers

Working together, all agencies, not just health, should work together to improve health and wellbeing.

- Joint teams that are managed centrally, not just teams that work together
- Sharing of information and the ability to access a shared, patient owned record for those that need to
- Working with the third sector, as partners to improve health and wellbeing

Discharge planning and better hospitals. The public told us some of the things we should consider to improve our hospitals there was a lot of focus on discharge.

- Ensure that when people are discharged they have a robust plan that is backed up with a health and social care services 24/7.
- Ensure patients are fully recovered before they are discharged
- Assign a professional to keep regular daily contact in the first week, fund and use local VCS organisations to support the individual
- Train and support carers in their duties so they can manage more safely and effectively
- More staff in hospitals, under resourced
- Hospitals need to be clean and serve nutritional food to support recovery
- Bring hospital services into community settings

Staff Training including changing the culture of the NHS, communication and transparency.

- Improve communication with patients and ensure they understand their condition and treatment options and are able to make informed choices about their care
- Make the NHS transparent at all levels
- Train specialist staff (or have a matron lead)who understand different disabilities and mental health

Regular check-ups for people with Chronic Conditions including annual check-ups or possibly more frequent depending on the age and condition for everybody.

- To be offered a wide variety of health and wellbeing checks, many people described this as an MOT or health review
- Also a call for more targeted check-ups for those groups at particular risk

- More routine scans and screening
- Early diagnosis to ensure early intervention including self help

Manage risk and safeguarding, to the public this meant keeping people safe when they were unwell.

- Increase community staff and more regular house calls
- More nurses on medical elderly wards
- Make sure interpreters are available so people can understand information
- Provide more emotional and social support at home
- Prevent isolation, regular contact with local community
- Consistent staff and named key workers with skills

Education and information. All information from the NHS should be available in easy to understand formats and use a variety of different methods to reach the appropriate audience.

- There needs to be more information about how to maintain health and wellbeing and how to avoid preventable conditions
- More information on the services available and how to access them
- Education courses should be available for specific conditions and general health and wellbeing, preferably delivered by people with the condition themselves to provide peer support
- More education and information for young people – start at school, use Sure Start centres

Self Care, including prevention, was a theme arising from strategic as well as project specific engagement and included the following:

- Care that is personalised with the support of specialist staff; patients being able to access the right services at the right time
- Getting support in being healthy and to be encouraged to self care by providing access to information, advice and support with regards to diet, exercise, support groups/networks and contacts for ongoing support
- Ensuring patients are involved in the development of their care plan and informed so they know what to expect, who to contact and provision of ongoing care and support
- Involvement of wider networks such as carers and families and considering their needs
- 'Self Care' to support those who are well to ensure prevention – well-being courses for the community, particularly for young people
- Care navigators and co-ordinators to support individuals

Invest in technology. Use technology better and invest in future technology, especially for monitoring and sharing information between services and patients.

Keep Well, Stay Healthy | **Detect Problems Early & Prevent Deterioration** | **Keep Out of Hospital and Long Term Care** | **Manage Admission & Discharge**

Primary Care/General Practice

- **Develop the role of general practice in proactive co-ordination of care, particularly for people with long-term conditions and more complex health problems**
- **Ensure approach to delivery of primary care is holistic – addressing: physical, mental and social care needs in the round**

Function 1 -Information & Advice
Supported Self-Managed Care, Primary Prevention

Function 2 Early Intervention Services
Promoting independence & providing opportunities to empower people to make informed choices to enable them to manage

Function 3 -Multi-Disciplinary Working
Management of a holistic person centred approach is delivered across H&SC

Function 4 -Intermediate Tier/Urgent Response
Avoiding admission to long term care
Providing urgent/crisis support

Function 5 -Specialist Support
Consultants and specialist nurses working in the community
Expert advice & guidance

Function 6 - Supported Discharge
Focus on high quality expert decision-making as early in the process as possible
Enable decision makers have easy and rapid access to alternative services and diagnostics

Enabler 1	**Single Point of Access** – 7 day working accessible services
Enabler 2	**Single Assessment/Common Assessment**
Enabler 3	**Integrated Information Sharing** – including access to all key data and the use of risk stratification tools and Urgent Care Dashboard
Enabler 4	**Workforce Development and Skills** – trained and skilled workforce to deliver the right level of clinical, therapeutic and support services to work effectively
Enabler 5	**Estates**

DRAFT CLOSER TO HOME - PATIENT AND PROFESSIONAL VIEW ON THE COMMUNITY MODEL

FUNCTION 1 – INFORMATION AND ADVICE (Supported Self-Managed Care and Prevention)

PATIENT: I want support to enable me to get the right information, in the right format, which will help me to manage my condition.

PROFESSIONALS: To reduce passivity of receipt of health and social care when suffering from one of more long term condition and promote more self-responsibility for healthy living and prevention of deterioration

FUNCTION 2 – EARLY INTERVENTION

PATIENT: I want a range and choice of services, close to home, in a variety of settings which provide the appropriate support, advice and tools.

PROFESSIONALS: The appropriate use of self monitoring, telehealth, and soft intelligence from carers./health/social/3rd sector and neighbourhood care to intervene early in acute illness to maximise independence and prevent avoidable hospital admissions

FUNCTION 6 – SUPPORTED DISCHARGE

PATIENT: I want to be discharged from hospital when the appropriate services are in place with the right support around me.

PROFESSIONALS: To be confident that discharge only occurs when necessary support is in place for patient safety and confidence without the need to call the GP urgently after arriving home due to unmet need/poor discharge planning

FUNCTION 3 – MULTI-DISCIPLINARY WORKING

PATIENT: I want to tell my story once and have 1 point of contact. I want to know that information about me is shared appropriately across agencies, and where possible, see the same person for the course of my treatment.

PROFESSIONALS: Efficient and effective **SPA**, seamless working across integrated services with no duplication or confusion, generating confidence for professionals, patients and their families/carers

FUNCTION 5 – SPECIALIST SUPPORT

PATIENT: I want to see specialist staff closer to home, in a variety of settings, at a time to suit me, including weekends and bank holidays.

PROFESSIONALS: Prompt accessible use of specilaist clinicans face to face with patients in the home or clinics and by phone/email to primary and community clinicans for advice and guidance using systems that can be trusted by all

FUNCTION 4 – INTERMEDIATE TIER/URGENT RESPONSE

PATIENT: I want to feel safe when I am unwell and know I can access services 24/7

PROFESSIONALS: To have the confidence that prompt assessment and appropriate action will occur through good efficient team working using IT for good record keeping and ensuring the patient's comfort and safety

Emergency Department	Adult Accident and Emergency. Urgent Care Centre
Acute Medicine & General Medicine including services for older people	Acute Elderly medicine and Elderly assessment Service Stroke Cardiology Respiratory Oncology Haematology Neurology Gastroenterology Endoscopy General Medicine Medical day Case Rheumatology Rehabilitation Dermatology
Surgery	Acute and Complex Surgery Trauma Planned Inpatient Surgery Day Case Surgery
Paediatrics	Paediatric Accident and Emergency Department Paediatrics Neonatal Critical Care
Maternity Services	Complex Maternity Midwifery led maternity Gynaecology
Anaesthetics and Critical Care	Anaesthetics and Critical Care L2 & L3 Intensive Therapy Unit (ITU)
Diagnostics, Therapies and Pharmacy	Therapy Services Diagnostic Services

Group	No	Criterion
Clinical Safety and Effectiveness	1	Promotes service continuity/patient safety
	2	Improves service Quality
	3	Effective Utilisation of staff expertise
	4	Promotes innovation/best practice/transformational change
	5	Supports prevention/Health Promotion and Self Care
Service User responsiveness	6	Demonstrates Patient Focus
	7	Increase Patient Choice/Accessibility
	8	Demonstrates responsiveness to local need
Impact on Staff and Stakeholders	9	Acceptability to Key Stakeholders
	10	Develops Capacity
Integration with Local Authority / Social Care/ YAS Acute and Community /GPs Health Services/Third Sector	11	Supports Collaboration and Engagement
	12	Demonstrates a track record of partnership working with: Local Authority/ Social Care/ YAS/ Acute and Community Health Services/ GPs/ Third Sector
	13	Demonstrates sufficient flexibility to integrate/improve partnership working with Local Authority/ Social Care/ YAS/ Acute and Community/ GPs/ Third Sector
Financial Viability and Sustainability	14	Demonstrates financial Viability and sustainability
	15	Minimises financial risk
	16	Demonstrates planned savings
	17	Delivers productivity
Use of Estate across the economy	18	Demonstrates innovative use of Estates
Use of Technology and Data Sharing	19	Demonstrates optimisation of technology to improve service
	20	Effective data sharing across all partners

GREATER HUDDERSFIELD CCG

REPORT TO THE JOINT CALDERDALE AND KIRKLEES HEALTH OVERVIEW AND SCRUTINY PANEL.

SEPTEMBER, 2014

RIGHT CARE, RIGHT TIME, RIGHT PLACE PROGRAMME

1.0 BACKGROUND

The Right Care, Right Time, Right Place Programme was established to bring together the seven partners across Calderdale and Greater Huddersfield to develop proposals for change across the health and social care economy which would ensure that everyone gets the right care at the right time and in the right place, whilst responding to the challenges of:

- An ageing population with increased needs
- National shortages of key elements of the workforce that mean new service models are required
- Continuing to meet ever increasing external standards
- Significant financial pressures facing commissioners and providers.

As Commissioners, our contribution to the delivery of this change is set out in our joint Kirklees five year strategy and Greater Huddersfield CCG's two year Operational Plan.

Our plan is based on what the people of Greater Huddersfield have told us through our engagement. It sets out the aims we want to realise, the outcomes we expect to achieve, the programmes of work we intend to deliver and the metrics we will use to measure our success.

In parallel with the development of our Strategy, three of our existing Providers have produced a jointly developed proposal for changing the way community and hospital services in Calderdale and Greater Huddersfield could be provided. They described their proposals in the form of a draft Strategic Outline Case (SOC), which was presented to members of both CCGs' Governing Bodies in January, 2014. It was presented to both the Kirklees and Calderdale Health and Wellbeing Boards (HWB) and Overview and Scrutiny Committees (OSC) in February and March. The Providers subsequently developed the Strategic Outline Case into an Outline Business Case (OBC). This Outline Business Case was lodged with the NHS Procurement Portal Bravo on the 23rd June. Our approach to its consideration is outlined in paragraph 7 below.

2.0 Introduction

We have used the engagement we have done over the past three years, including Call to Action and previous Right Care, Right Time Right Place engagement, to develop our Care Closer to Home proposals.

As well as influencing our proposals for the models of Health and Social Care that we need to commission, our engagement has also: confirmed the fundamental need for more integrated care delivered in community and primary care settings; and provided feedback

that the people in our communities will only gain confidence in our new model through experiencing the improvements for themselves.

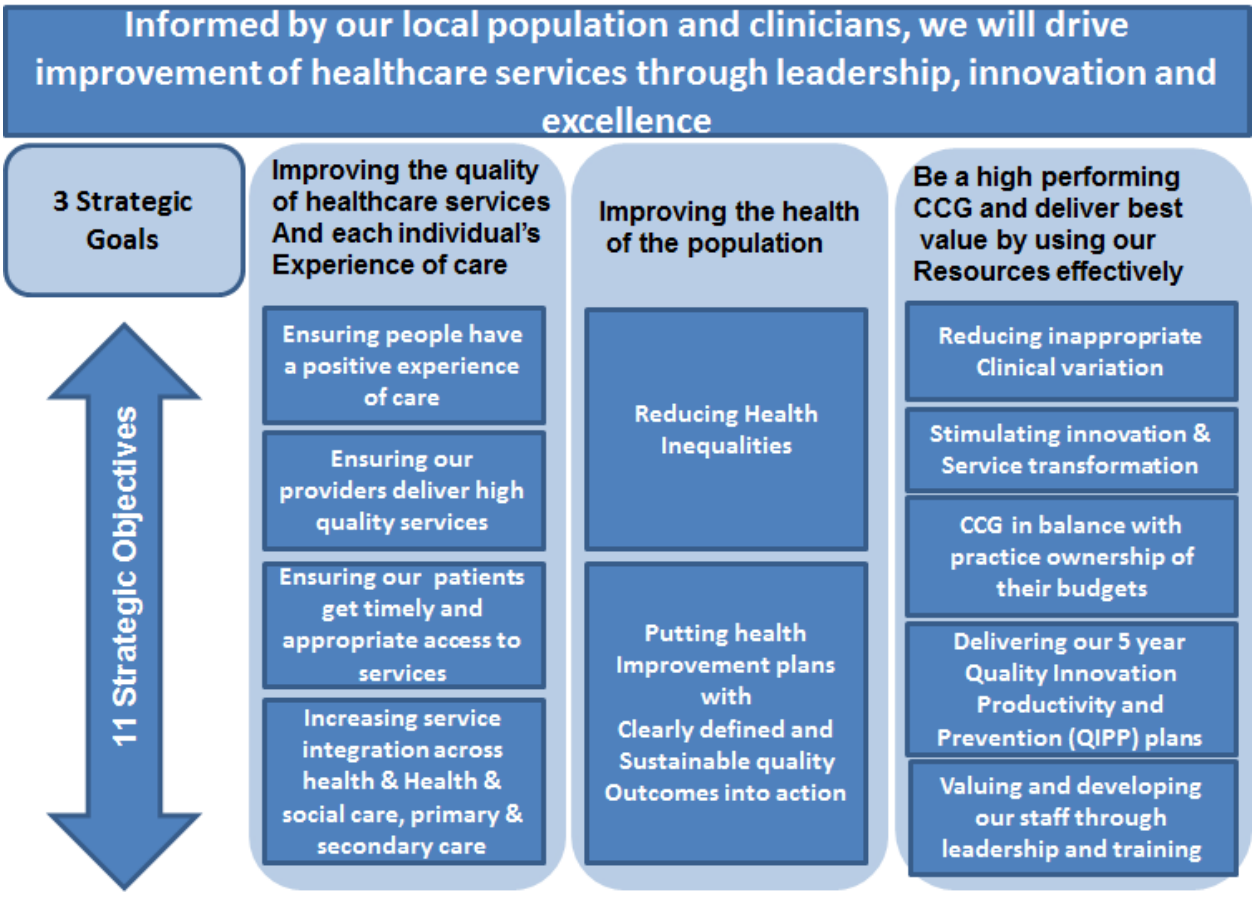
Therefore, we know that we need to phase any implementation of change over at least five years. We also know that in making these changes we create an additional driver for change to the way our Hospital Services are configured. This would impact across Calderdale and Greater Huddersfield.

3.0 Our Five year Strategy and Two Year Operational Plan

Our five year strategy, produced in collaboration with North Kirklees CCG and Kirklees Council, outlines how the health and social care system in Kirklees will be transformed over the next 5 years. Based on the needs of the population of Kirklees and what our Public and Patients have told us we have agreed 3 Strategic Programmes of work that we want to deliver over the five year period:

- Care Closer to Home
- Acute Services Reconfiguration
- Transformation of Primary Care

Underpinning the Five Year Strategy is GHCCG's two year Operational Plan which outlines the goals and objectives for the work we will undertake over the next two years. The plan is summarised below.



4.0 Results of our engagement

At a population level we have conducted engagement in relation to: Call to Action; Right Care, Right Time, Right Place; the Strategic Outline Case; and our Commissioning Intentions. We have also engaged on specific programmes and projects as they have progressed. The key themes from Call to Action and previous Right Care, Right Time, Right Place and specific Programmes and Projects are detailed at Appendix A.

In summary, what our engagement has told us is that our communities want:

- Staff training to impove communication and transparency.
- More education and information.
- Support for Self Care
- Regular check-ups - for people with chronic conditions.
- All agencies working together, to deliver integrated health and social care.
- Improve access to health services.
- Improved discharge planning and better resourced hospitals.
- Investment in technology.

We have used this engagement to inform our Proposals for Change. A report of findings has been produced which provides details and findings from all our engagement activity, including specific engagement with key stakeholders as part of our Care Closer to Home Programme. The Report of Findings has been published on the RightCareTimePlace website and used to further inform and update our Proposals for Change.

5.0 Proposals for Change

Based on the intentions in our five year strategy and the feedback from our engagement, we know that significant changes are required in order to ensure health and social care services are fit for the future. There is a national need to centralise key services to improve outcomes for patients. The Right Care Programme is overseeing proposals for what these future Community and Hospital services in Calderdale and Greater Huddersfield could look like. There are three interlinked pieces of work: Calderdale Closer to Home Programme; Greater Huddersfield Care Closer to Home Programme; and the In Hospital Model.

Community Services

The Calderdale Closer to Home Programme and The Greater Huddersfield Care Closer to Home Programme have both set out proposals for what our future Community Services could look like. The Greater Huddersfield proposals have been developed with North Kirklees CCG and Kirklees Council. These proposals continue the shift of both the services and the resources required to support unplanned hospital admissions to the delivery of more self-care and more integrated care delivered in community and primary care settings.

The Greater Huddersfield Draft Model for Care Closer to Home (Appendix B) provides a summary of these changes for Greater Huddersfield. In support of this model, a new specification for community services has been produced.

Greater Huddersfield CCG, jointly with North Kirklees CCG and Kirklees Council, has now established a Care Closer to Home Programme Board to take forward the re-commissioning of community services in line with this new specification. A key decision on the method we use to approach the provider market for these services will be made at a specially convened Governing Body on 24 September. Both the GHCCG and NKCCG Governing Bodies will meet at the same time to take a decision on this issue, reflecting the importance of our approach to integrated commissioning.

More information on approach to market is set out in paragraph 7 below.

In-Hospital Services

Our requirements for In-Hospital Services are being developed jointly by Calderdale and Greater Huddersfield CCGs and will, in the first instance, be a set of joint standards. These joint standards set out the High level Outcomes we want to achieve, the scope of In Hospital Services and the standards that we want to apply to these Services. The scope of the services is set out at Appendix C. The standards are based on established best practice and are additional to and do not replace existing CQC, NICE, CQUIN and standard contract targets. We are currently assuring these standards through a quality assurance group comprising representation from both Calderdale and Greater Huddersfield CCG. We are in the process of establishing a joint Calderdale and Greater Huddersfield Programme Board, to oversee this work.

6.0 Approach to Commissioning of Community Services

It is intended that the commissioning of Community Services will be done in a phased manner, with the first phase comprising those services already provided in the community. We would then seek to add further services that are currently hospital based but could more appropriately be provided in the community.

We believe that integrated commissioning is necessary to ensure effective collaborative working across health and social care and in particular, ensure patients, service users and carers experience integrated care across health and care services. There are a number of services where we would seek to integrate our commissioning arrangements in line with the Better Care Fund (BCF) and our shared objectives of reducing demand for urgent and emergency acute hospital care and for permanent admissions to care homes, so enabling and supporting people to live in their own homes for as long as possible.

National guidance in relation to BCF has identified four priority areas:

- Protecting social care services,
- 7-day services to support discharge and delayed transfers of care,
- Data sharing, including consistent use of the NHS number; and
- Joint assessments and accountable lead professional.

The previous £1bn Payment for Performance framework has been revised so that the proportion of the £1bn now linked to performance is based solely on an area's scale of ambition in reducing total emergency admissions.

In 2013, together with North Kirklees CCG and Kirklees Council we established the Integrated Commissioning Executive to provide a strategic oversight for health and wellbeing in Kirklees. This group has had a key role in developing and continuing to develop the mechanisms to operationalise the Better Care Fund. There are a number of subgroups which are responsible for developing action plans to take collaborative work forward in a number of key areas. These key areas are:

- Physical Wellbeing, Aging Well and Independence
- Children and Families Wellbeing
- Reducing Health Inequalities and Health Improvement
- Emotional and Mental Wellbeing and Independence

In areas where there is overlap between these key areas and our proposals for change, we would seek to commission in an integrated way.

7.0 Approach to Market

Approach to Market is the process by which the CCG decides on the most appropriate provider of services, but is not meant to imply that this is necessarily a competitive process. The Greater Huddersfield CCG Governing Body will decide at a meeting on 24 September whether to re-commission Community Services using competition or not. Irrespective of whether the CCG decides to re-commission competitively, the commissioner's requirements will need to be set out within formal Invitation to Tender (ITT) /Invitation to Commence Dialogue (ITCD) documents and the process to receive a formal response to the ITT/ITCD and a full and robust evaluation of whether or not the potential provider(s) will deliver the expected service, outcomes and benefits required. This will require the development of robust benefit realisation projections, evaluation criteria and standards along with appropriate weightings.

As part of our approach to market we need to consider the timing of when we should consider the Providers' Outline Business Case. This document was lodged with the NHS Procurement Portal Bravo in June but we delayed opening the document, because in a sense it has been produced and provided to the Commissioners outside of due procurement

process. Following the completion of a Market Sounding event and publication of our proposed Service model, Hospital Standards; and Evaluation Criteria we have established a joint Greater Huddersfield/Calderdale Assurance Panel to consider the Providers' Outline Business Case. The members of this panel received a copy of the Providers' Outline Business Case on 8th September and met for the first time on 10th September to consider it in relation to our proposed service models, Hospital Standards and Evaluation Criteria. The Panel expects to have formed an initial view on the implications for the scope and phasing of our proposals for change by the end of September. Our High Level Evaluation Criteria are set out at Appendix D.

8.0 Consultation

We know that significant changes are required in order to ensure health and social care services are fit for the future. Condition specific programmes of change started in 2012/13 and are continuing. One by one these changes, which are underpinned by a programme of engagement activities, contribute to our evolving community model. The changes to Community Services developed through our Care Closer to Home Programme continue this shift of services from the hospital to the community. Collectively, these changes mean that over the five years of our strategy we will need to make changes to the way our Hospital Services are configured. Change to the way our Hospital Services are configured can only be implemented following formal public consultation.

Both the Calderdale and Greater Huddersfield CCGs have decided to progress with their proposals for changes to Community Services prior to making any change to Hospital Services. This decision will allow us provide direct experience of an effective Community Model, demonstrate that we have listened to the public and allow us time to maximise the opportunity offered through the Better Care Fund.

We recognise that we will be required to demonstrate that we have conducted sufficient engagement in relation to our proposed changes to community services and that the potential for delay to changes to hospital services, increases the risk of a deterioration in the quality of services our hospitals are able to provide, prevents us from starting to address some current workforce issues and may require us to fund and resource double running of services.

9.0 Assurance Process

In support of our decision making, NHS England has a Strategic Change Assurance Process that will consider our proposed changes to Community Services and In-Hospital Services prior to any consultation exercise. The Strategic Change Assurance Process will also validate that these changes will bring improvement in quality, safety, effectiveness of care and that they are financially sustainable during transition and post transition. We have informally engaged with the NHS England process and plan to formally engage when we have

completed our Options Appraisal. As part of the NHS England Strategic Change Assurance Process we will also engage with the Yorkshire and Humber Clinical Senate. The Clinical Senate is a source of independent advice and guidance to commissioners to help them make the best decisions about healthcare.

10.0 Further work

We have set out above the engagement we have done, the changes we are proposing, our approach to the commissioning and procurement of these changes, our approach to Consultation and the Assurance Process that will support our work.

There is also a number of underpinning pieces of work that we will need to complete to support our Proposals.

We have commissioned work on the development of a Financial and Economic model that will produce a financial case for change to demonstrate the economic and financial sustainability of any proposed changes both during transition and post transition.

We will also need to undertake work to understand the implications for our Workforce, Technology and Estates.

Carol McKenna
Chief Officer,
Greater Huddersfield Clinical Commissioning Group.
10th September, 2014.

Appendices

Appendix A Key Engagement Themes
Appendix B Care Closer to Home Model
Appendix C The Services covered by our In Hospital Standards
Appendix D High Level Evaluation Criteria

The Diagram below shows the areas of strategic level and service level engagement. Commissioning Intentions is shown on this diagram to indicate its position as strategic level engagement, but our analysis of that engagement is shown in a separate Appendix

Overarching themes

The overarching themes that were raised across the engagment activites outlined above are as follows:

Staff Training including changing the culture of the NHS, communication and transparency.

- Improve communication with patients and ensure they understand their condition and treatment options and are able to make informed choices about their own care
- Make the NHS transparent at all levels
- Train specialist staff (or have a matron lead)who understand different disabilities and mental health

Education and information. All information from the NHS should be available in easy to understand formats and use a variety of different methods to reach the appropriate audience.

- There needs to be more information about how to maintain health and wellbeing and how to avoid preventable conditions
- More information on the services available and how to access them
- Education courses should be available for specific conditions and general health and wellbeing, preferably delivered by people with the condition themselves to provide peer support
- More education and information for young people – start at school, use Sure Start centres

Self Care, including prevention, was a theme arising from strategic as well as project specific engagement and included the following:

- Care that is personalised with the support of specialist staff; patients being able to access the right services at the right time
- Getting support in being healthy and to be encouraged to self care by providing access to information, advice and support with regards to diet, exercise, support groups/networks and contacts for ongoing support
- Ensuring patients are involved in the development of their care plan and informed so they know what to expect, who to contact and provision of ongoing care and support
- Involvement of wider networks such as carers and families and considering their needs
- 'Self Care' to support those who are well to ensure prevention – well-being courses for the community, particularly for young people
- Care navigators and co-ordinators to support individuals

Regular check-ups for people with chronic conditions including annual check-ups or possibly more frequent depending on the age and condition for everybody.

- To be offered a wide variety of health and wellbeing checks, many people described this as an MOT or health review
- Also a call for more targeted check-ups for those groups at particular risk
- More routine scans and screening
- Early diagnosis can ensure early intervention including self help

Working together, all agencies, not just health, should work together to improve health and wellbeing.

- Joint teams that are managed centrally, not just teams that work together
- Sharing of information and the ability to access a shared, patient owned record for those that need to
- Working with the third sector, as partners to improve health and wellbeing

Improve access to health services. This included opening times and appointment availability, particularly aimed at GP practices and primary care.

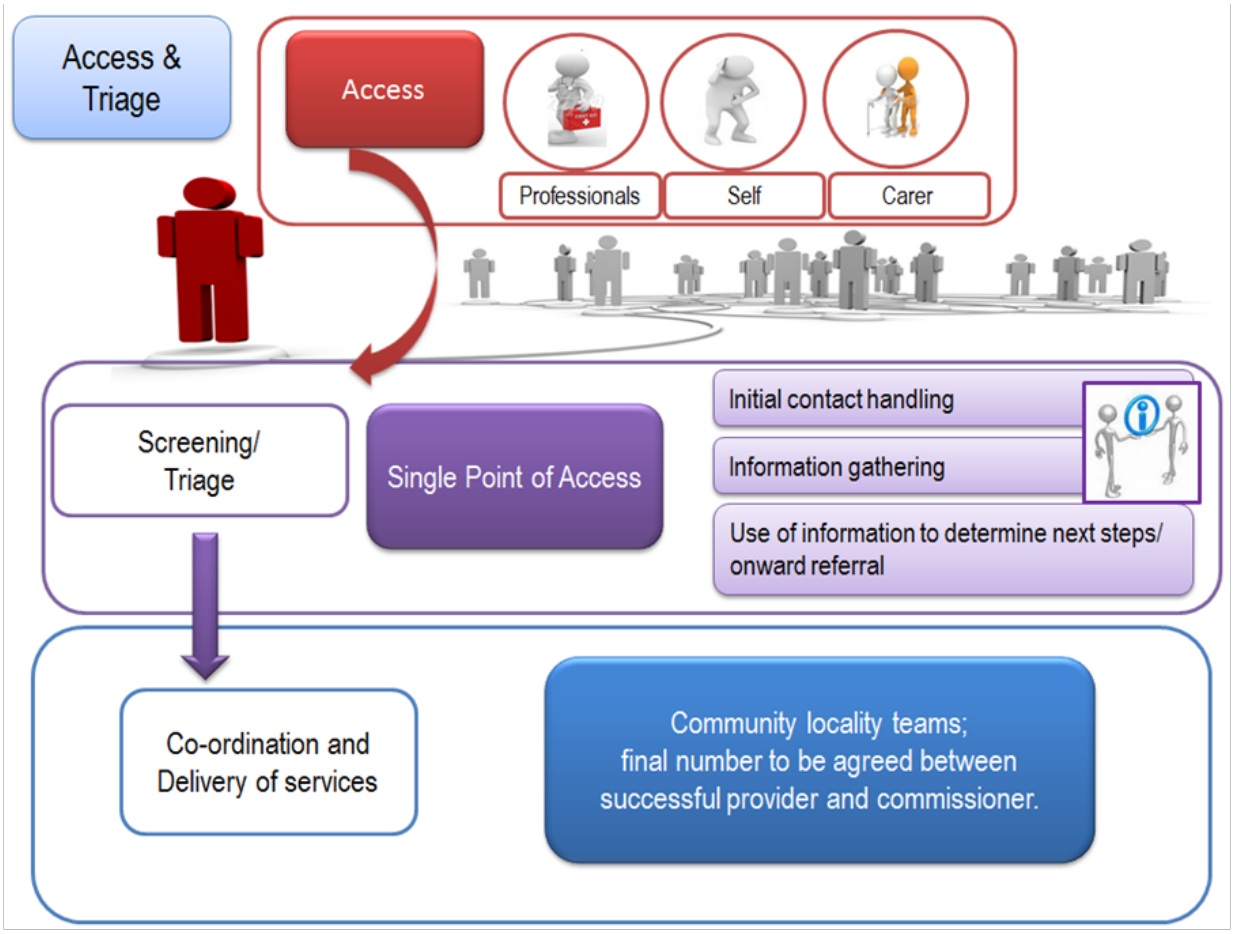
- Awareness of building access issues to all staff, especially around disabilities
- One point of access for people with a long term condition
- Longer appointment times for some people, spend more time with the patient and listen
- Improve home visits and bring GP services to community settings
- Reduce waiting times for appointments and change the booking system
- Have appointments at evenings and weekends, ring fence appointments for people who work
- Have specialist staff in GP practices

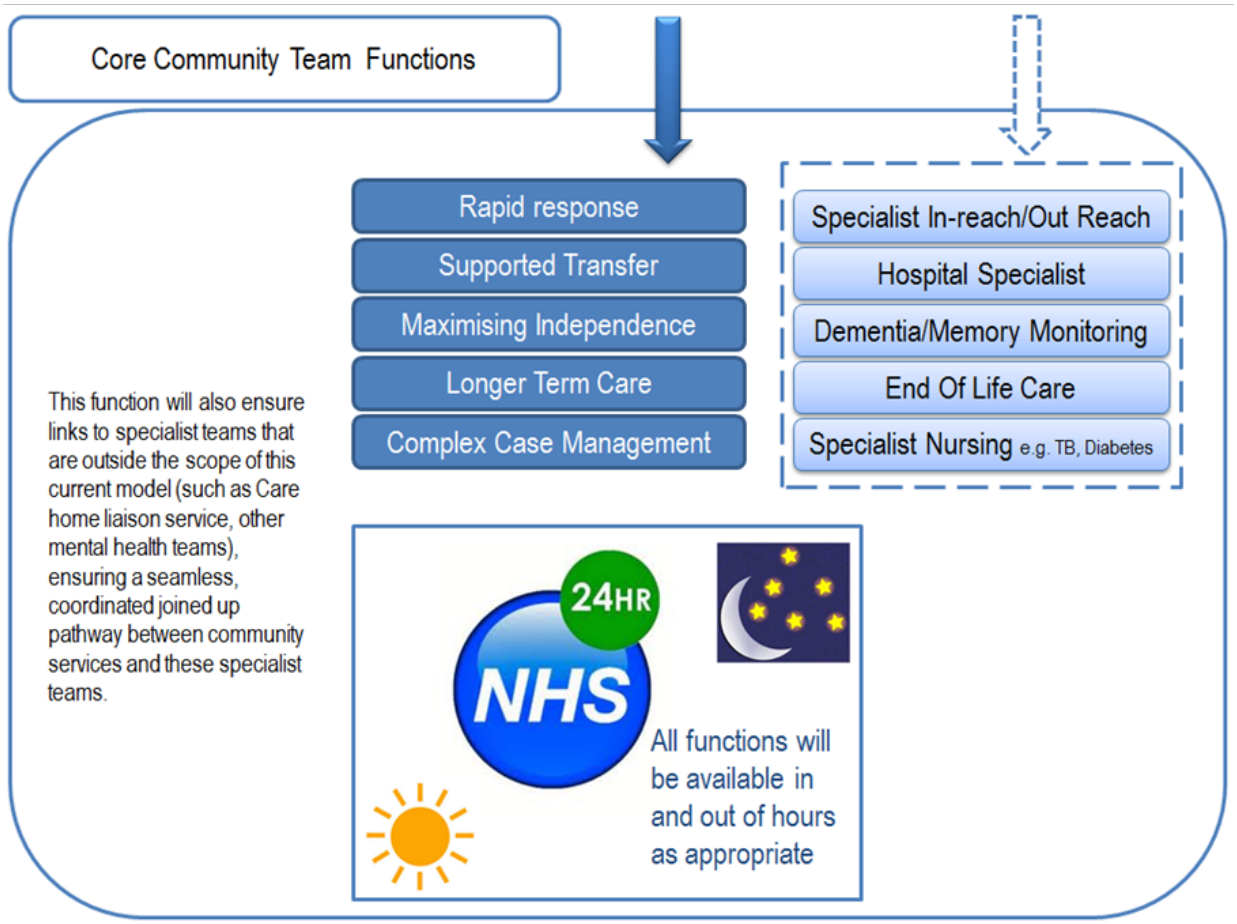
Discharge planning and better hospitals. The public told us some of the things we should consider for improving our hospitals and discharge planning was part of this.

- Ensure that when people are discharged they have a robust plan that is backed up with a health and social care services 24/7.

- Ensure patients are fully recovered before they are discharged
- Assign a professional to keep regular daily contact in the first week, fund and use local VCS organisations to support the individual
- Train and support carers in their duties so they can manage
- Improve staffing levels in hospitals and care homes
- Hospitals need to be clean and serving nutritional food to support recovery
- Bring hospital services into community settings and greater integration of care across pathways

Invest in technology. Use technology better and invest in future technology, especially for monitoring and sharing information between services and patients. This was raised during our strategic level engagement but also as part of our care closer to home work.


Access & Triage
Access
Professionals
Self
Carer
Screening/ Triage
Single Point of Access
Initial contact handling
Information gathering
Use of information to determine next steps/ onward referral
Co-ordination and Delivery of services
Community locality teams; final number to be agreed between successful provider and commissioner.


Core Community Team Functions
Rapid response
Supported Transfer
Maximising Independence
Longer Term Care
Complex Case Management
Specialist In-reach/Out Reach
Hospital Specialist
Dementia/Memory Monitoring
End Of Life Care
Specialist Nursing e.g. TB, Diabetes
This function will also ensure links to specialist teams that are outside the scope of this current model (such as Care home liaison service, other mental health teams), ensuring a seamless, coordinated joined up pathway between community services and these specialist teams.
24HR
NHS
All functions will be available in and out of hours as appropriate

Emergency Department	Adult Accident and Emergency. Urgent Care Centre
Acute Medicine & General Medicine including services for older people	Acute Elderly medicine and Elderly assessment Service Stroke Cardiology Respiratory Oncology Haematology Neurology Gastroenterology Endoscopy General Medicine Medical day Case Rheumatology Rehabilitation Dermatology
Surgery	Acute and Complex Surgery Trauma Planned Inpatient Surgery Day Case Surgery
Paediatrics	Paediatric Accident and Emergency Department Paediatrics Neonatal Critical Care
Maternity Services	Complex Maternity Midwifery led maternity Gynaecology
Anaesthetics and Critical Care	Anaesthetics and Critical Care L2 & L3 Intensive Therapy Unit (ITU)
Diagnostics, Therapies and Pharmacy	Therapy Services Diagnostic Services

Group	No	Criterion
Clinical Safety and Effectiveness	1	Promotes service continuity/patient safety
	2	Improves service Quality
	3	Effective Utilisation of staff expertise
	4	Promotes innovation/best practice/transformational change
	5	Supports prevention/Health Promotion and Self Care
Service User responsiveness	6	Demonstrates Patient Focus
	7	Increase Patient Choice/Accessibility
	8	Demonstrates responsiveness to local need
Impact on Staff and Stakeholders	9	Acceptability to Key Stakeholders
	10	Develops Capacity
Integration with Local Authority / Social Care/ YAS Acute and Community /GPs Health Services/Third Sector	11	Supports Collaboration and Engagement
	12	Demonstrates a track record of partnership working with: Local Authority/ Social Care/ YAS/ Acute and Community Health Services/ GPs/ Third Sector
	13	Demonstrates sufficient flexibility to integrate/improve partnership working with Local Authority/ Social Care/ YAS/ Acute and Community/ GPs/ Third Sector
Financial Viability and Sustainability	14	Demonstrates financial Viability and sustainability
	15	Minimises financial risk
	16	Demonstrates planned savings
	17	Delivers productivity
Use of Estate across the economy	18	Demonstrates innovative use of Estates
Use of Technology and Data Sharing	19	Demonstrates optimisation of technology to improve service
	20	Effective data sharing across all partners