REPORT TO THE JOINT CALDERDALE AND KIRKLEES HEALTH OVERVIEW AND SCRUTINY PANEL MARCH 2015

Right Care, Right Time, Right Place Programme update

1.0 BACKGROUND

The Right Care, Right Time, Right Place programme is the Commissioners' response to the Case for Change that was developed as part of the Strategic Services Review. From this Case for Change 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 are three interlinked pieces of work: Calderdale Care Closer to Home Programme; Kirklees Care Closer to Home Programme; and the Hospital Services Programme[1]. Collectively, these programmes are developing proposals for what the future Community services in Calderdale and Kirklees and the future Hospital Services in Calderdale and Greater Huddersfield could look like. These proposals will be implemented in three separate phases over the next five years:

Phase 1 - Strengthen Community Services in line with the new model of care.

Phase 2 - Enhance Community Services - which is likely to require more engagement.

Phase 3 - Hospital Changes.

2.0 INTRODUCTION

The aim of the Calderdale Care Closer to Home Programme is to define and commission the future model of community services for Calderdale. In recognition: of what people have told us through our engagement; the duplication and inconsistency in the current service delivery; and the need for more integration with Social Care, the programme is closely aligned with the Better Care Fund plans and focused on commissioning services that will result in fewer people being admitted to hospital. The Programme covers care provided to children, young people and adults.

The Kirklees Care Closer to Home (CC2H) is a flagship programme for both NHS North Kirklees CCG and NHS Greater Huddersfield CCG. The Care Closer to Home vision is for the development of integrated community-based healthcare services across Kirklees for all, from children and young people through to and including the frail, vulnerable and older people. It aims to make lasting changes to the Kirklees health and social care system to ensure that services are fit for purpose and sustainable in the future.

The aim of the Hospital services Programme is to define and commission the future model of Hospital services for Calderdale and Greater Huddersfield. Calderdale CCG and Greater Huddersfield CCG are working together in relation to Phase 3. We are clear that transformational change is needed in our hospital services to meet current and future

[1] There is also an inter-relationship with the Meeting the Challenge programme (which covers North Kirklees and Wakefield) that is looking at improving and modernising hospital services provided by the Mid Yorkshire Hospitals NHS Trust (MYHT) and services in the community; Kirklees Care closer to Home is integral to the success of the MYHT's clinical services strategy.

healthcare needs. We believe that we will gain public support for change when we can demonstrate that we have put in place enhanced and integrated community services that will meet local population needs. Our approach to demonstrating confidence that community services are working well is outlined later in this paper.

The purpose of this report is to update the joint Calderdale and Kirklees Health Overview and Scrutiny Panel on progress since it last met in September, 2014 in relation to these three programmes and our approach to demonstrating readiness for consultation.

3.0 CALDERDALE CARE CLOSER TO HOME PROGRAMME

Since the last update in September, 2014, NHS Calderdale CCG has taken significant steps forward in the development of the Care Closer to Home Programme. In particular, the CCG has:

- Finalised and agreed the community model and the scope of services in Phase One together with the supporting Key Performance Indicators.
- Approved the phase 1 specification and engagement assurance. The CCG Governing Body also agreed that its commissioning approach to phase 1 is to continue to work with current service providers to deliver the new ways of working in the phase 1 specification.
- Delivered three stakeholder events on 4th December (overall Model), 16th December (Single Point of Access) and 4th March (Upper Valley acceleration).
- Developed a Video and Case studies to support the communication of the model;
- Aligned the Care Closer to Home work with its work in relation to the Better Care Fund and QIPP Schemes as appropriate.
- Agreed and signed off the Engagement and Equality action plan for phase 1.
- Actively engaged our current community service providers on the new phase 1 Care Closer to Home specification.
- Presented the work done to date and next steps to the Calderdale Adult Social Care Overview and Scrutiny Committee at their January 2015 meeting.
- Submitted a successful expression of interest to NHS England to join the New Models of Care Programme (Vanguard) to be a lead site for the multispecialty community provider's model.
- Developed the supporting Care Closer to Home Governance structure: six Work Streams have been established to deliver the work: Primary prevention/healthy lifestyles; Supported self-managed care; Third Sector; Single point of access; Integrated Locality working; and Crisis Recovery.

An overview of the model and a list of services in scope are provided at Appendix A.

4.0 KIRKLEES CARE CLOSER TO HOME PROGRAMME

Since the last update in September, 2014, NHS Greater Huddersfield CCG and NHS North Kirklees CCG have also taken significant steps forward in the development of the Care Closer to Home Programme. In particular, the CCGs have:

- Finalised and agreed the community model and the scope of services in Phase One together with the supporting Key Performance Indicators.
- Approved the phase 1 specification and engagement assurance. Both CCG Governing Bodies also agreed that their commissioning approach to phase 1 is to re-commission services using a competitive dialogue procurement process.
- Aligned the Care Closer to Home work with its work in relation to the Better Care Fund and QIPP Schemes as appropriate;
- Launched the procurement on 20th October.
- Held a Bidder Event on 6th November
- Established and recruited a patient/carer panel which is an intrinsic part of the procurement and evaluation process.
- Involved Patients/carers in discussion and feedback session/s in relation to emerging bids
- Involved children and young people to further develop the children's elements of the model
- Completed the Pre-Qualification Questionnaire stage of the Procurement
- Presented the work done to date and next steps to the Kirklees Well-Being and Communities Scrutiny Panel at their December, 2014 meeting.
- Issued the invitations to participate in Competitive dialogue and held the Competitive Dialogue sessions with potential bidders.
- Received and evaluated the responses from potential bidders
- Notified bidders of the shortlist and issued the invitation to continue dialogue (ITCD).
- Started the dialogue sessions with bidders

An overview of the model is provided at Appendix B.

Calderdale CCG, Greater Huddersfield CCG and North Kirklees CCG, have also submitted their Phase 1 Care Closer to Home Specifications (three in total) to the Clinical Senate. In the draft report of findings that has been shared with Commissioners, the Senate is supportive of the proposals and their potential to provide excellent patient care closer to people's homes.

5.0 CALDERDALE AND GREATER HUDDERSFIELD - HOSPITAL SERVICES PROGRAMME

Calderdale CCG and Greater Huddersfield CCG are working together in relation to Phase Three. Since the last update in September, 2014 we have also made significant progress in relation to our work on Hospital services. In particular, we have:

- Agreed our hospital standards and the outputs and outcomes that we expect these standards to achieve.
- Established a Joint CCG Hospital Services Programme Board and agreed:
    - To produce a Commissioners' Future Model of Care in relation to Hospital Services that reflects our proposed changes to Community and our Hospital Standards.

- That in setting out this future model of care, we will work with our clinicians to establish the factors that affect the location of the provision of services and the currencies we will use to determine when it is safe and sensible to change the location of services.
- That we would engage the Clinical Senate in relation to both Hospital and Community Services.
- That we would continue our work in relation to the Case for Change.
- We will consolidate this work into a pre-consultation Business Case in 2015.
- We will continue to fulfil the requirements of the NHS England Assurance Process

- We have completed three clinicians' workshops.
  - On 20th November, clinicians from both CCGs, considered different models of care (the providers' OBC and the NHS England five year forward view), the standards we want to achieve from our services and agreed that there are a number of potential longer term solutions and that further work and discussion is required before the CCGs will be ready to outline any proposed changes to Hospital Services.
  - On 22nd January, clinicians from both CCGs developed Commissioners' thinking regarding the future provision of Hospital services.
  - On 24th February senior clinicians from CHFT and both CCGs held a strategic session to bring together our collective thinking to date as CCGs and as a provider to begin to develop what our ideal model for the future provision of hospital services could look like. We agreed that we would continue this collective dialogue in order to reach a position where we could express a consistent view from the local health economy on our future hospital services.
- A further joint CCG and CHFT clinicians' workshop is scheduled for 16th April.
- We have completed our work on our Financial Case for Change pending the development of proposals for changes to Hospital Services. In summary:
  - The NHS Nationally is facing a £30 billion financial gap by 2020/2021.
  - As Commissioners we face a £155 million financial gap over the next five years.
  - Provider efficiency savings of at least 4% over the next five years are needed to keep financial stability.
  - We are already making service and quality improvements through our QIPP schemes that are having a positive impact on:
    - reducing admissions as a proportion of A&E Attendance;
    - the number of patients with excessive lengths of stay and;
    - Delayed discharges.
  - We have allocated a total of £28.5 million to the CCGs' Better Care Fund Programmes.
  - Phase One of the CCGs' Care Closer to Home Programmes comprises services with a current value of £44.6 million.

- We expect these programmes collectively to reduce the number of emergency admissions by 1700 in 2015/16 and to contribute a potential £14 million saving by 2018/19.

- Work is progressing to identify, baseline and set ambition for metrics which would allow us to track the progress towards the outcomes we have described in our hospital standards.
- A development session scheduled with members of the: Joint Overview and Scrutiny; Kirklees Scrutiny and Calderdale Scrutiny Committees for 29th January was cancelled at the request of the Scrutiny chairs due to the weather. The session has been rescheduled for 17th March.
- In addition, the People's Commission has published its report which contains a number of recommendations regarding the future provision of primary, community and secondary care.

6.0 DEMONSTRATING READINESS FOR CONSULTATION

Our work is informed by the NHS England Change Assurance Process. We continue to fulfil those requirements in parallel to this work, and expect to be able to demonstrate readiness for consultation during 2015. Once we have demonstrated that we are 'ready for consultation' we will determine when that consultation should commence. In making that determination we will consider a number of factors which collectively would provide confidence that Community Services are working well.

The individual factors have not yet been established or agreed with respective CCG Governing Bodies, but collectively, both Calderdale CCG and Greater Huddersfield CCG will be seeking to demonstrate improvement in Community Services by establishing answers to the following questions:

1. Are fewer People going into Hospital?
2. Are people who are admitted into Hospital spending less time in Hospital?
3. Are people satisfied with their experience of Hospital Care?
4. Are more people being managed within Community Services?
5. Are people satisfied with their experience of Community Care?
6. Are people safe?

Calderdale CCG has developed a performance framework that will enable it to measure the impact of the changes it is making in Community and provide confidence that Community Services are working well. The framework comprises dialogue with providers to ensure clarity on the CCG's expectations, strengthened governance arrangements to drive effective delivery of the specification; and a performance dashboard comprising a small number of indicators that reflect the strategic direction of travel in terms of: activity; cost; and quality and safety.

At its Governing Body meeting in August 2015, Calderdale CCG will be asked to agree an approach to the future commissioning of community services, based on evidence that the

strategic direction set out in its 5 Year Plan is being delivered. Particularly a reduction in avoidable hospital admissions and an increase in community-based activity.

Greater Huddersfield CCG has also developed a performance framework that will enable it to measure the impact of the changes it is making in Community and provide confidence that Community Services are working well. The framework comprises: Service Standards and Quality Requirements underpinned by a comprehensive set of indicators (that cover: clinical effectiveness; performance and productivity; quality and safety; and Patient experience) and supported by Governance and reporting requirements to drive delivery of these standards and requirements.

At its Governing Body meeting in May 2015, Greater Huddersfield CCG will be asked to agree contract award for the future provision of these services.

It has been agreed that from these performance frameworks a small number of common indicators would be taken which would enable the Hospital Services Programme Board to have confidence that Community services are working well.

As outlined above, the indicators and the number which we choose to measure have yet to be determined, but it is likely that they will be a summarised aggregate of a number of the indicators being used across both CCGS. For Calderdale CCG the indicators would evidence the extent to which the existing provider is making changes to Community Services and the extent to which existing QIPP plans are delivering change and for Greater Huddersfield CCG the extent to which mobilisation of community services and existing QIPP plans are delivering change.

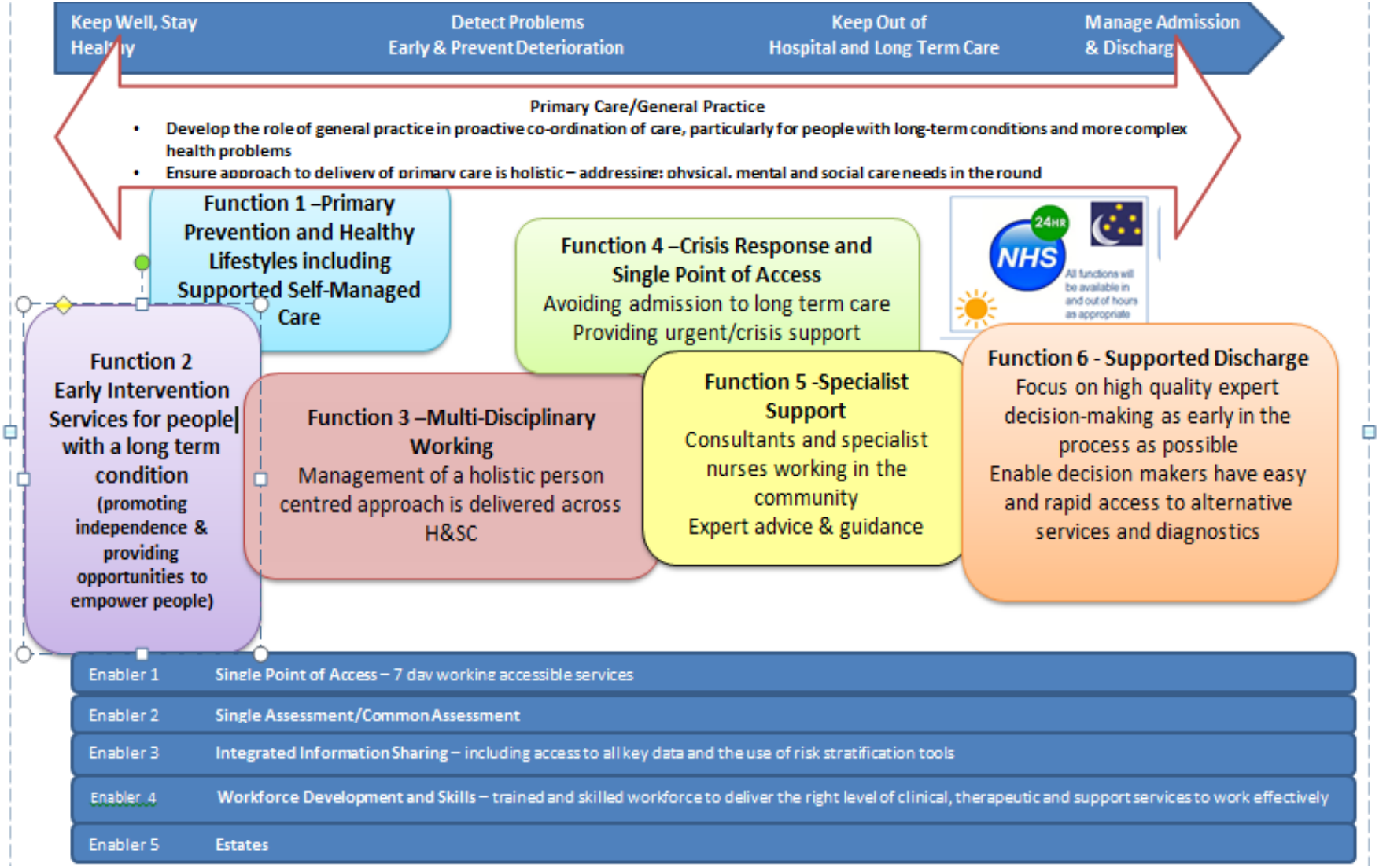
7.0 NEXT STEPS

- In May 2015, Greater Huddersfield CCG's Governing Body will be asked to agree contract award for the future provision of phase one of community services.
- In August, 2015, Calderdale CCG's Governing Body will be asked to agree the approach to the future commissioning of phase one community services
- We are developing our approach to pre-consultation engagement and expect to have finalised our proposals by June, 2015.
- We are developing our Quality and Safety Case for change which, together with our Financial Case for change, will form a key element of our pre-consultation business case.
- We expect to demonstrate readiness for consultation during 2015

Jen Mulcahy, Programme Manager
12th March, 2015

Appendix A

Overview of The Calderdale Care Closer to home Model



Appendix A

Calderdale CCG – list of services in Phase one

Service Areas	Service Lines included in Phase 1 and Brief Description	Children and/or Adults	Interdependencies included in Phase 1
Cancer	• **Children's contacts**	C	
Cardio Vascular	• **Cardiac Nursing** - Inpatient and outpatient services • **Cardiac Rehabilitation** - Various exercise programmes • **Heart Failure BNP** - Brain natriuretic peptide (BNP) - A natriuretic peptide test can indicate the severity of your heart failure • **Stroke, Early Supported Discharge** - Intensive multi-disciplinary rehabilitation for patients returning home from hospital following a Stroke. Aim to help patients to leave hospital more quickly and return to their own homes so to maximise independence as quickly as possible after their stroke.	A A A A	
Dermatology	• **Community Provision (GPSWI's & Nurses)**	A	
Diabetes	• **DAFNE** - Dose Adjustment For Normal Eating (DAFNE) is a way of managing Type 1 diabetes • **DESMOND** - Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) is a UK NHS training course for people with type 2 diabetes • **Diabetic Foot Screening** (new and follow up) • **Nurse Liaison** - Including specialist nurse. Services in hospital and community setting provide a joint specialist clinics for antenatal care and young people	A A A C&A	
End of Life	• **GSF Facilitator** - Gold Standards Framework (GSF) Care Home Facilitator • **MacMillan Benefits Advisor** - Providing financial assessments, assisting with completion of benefit applications, providing benefits advice and financial help • **MacMillan Rehab Team** - As part of a multi-disciplinary team to promote well-being and independence and maximise quality of life • **Palliative Care** - Treatment to patients who are no-longer responsive to curative treatment. No specialist palliative care beds in the Trust and patients remain under the care of their GP or supervising consultant.	A A A A	• End of Life Care – Out of Hours (A) – Pilot providing out of hours palliative support provided at home
MSK	• **Clinical Psychology (Chronic Pain Management Programme)** - Specialised pain clinics provide chronic pain treatment and relief. Dedicated pre-operative assessment service at CRH • **MSK Service** - Assessment and treatment for people with musculoskeletal disorders and pain problems • **Spinal and Lower Limb including** development of upper limb, and pain management -Mon - Fri & weekend. emergency respiratory physiotherapy 24/7	A A A	
Mental Health	• **Community MH Teams** • Memory Monitoring Service - Assessment and diagnosis of dementia and ongoing support and information to people with memory problems • Out Patient Psychiatric Liaison	A A A	• IAPT – Improving Access to Psychological Therapies (A) Provides talking therapies and interventions to people depression and anxiety • RAID – Rapid Assessment

Appendix A

Service Areas	Service Lines included in Phase 1 and Brief Description	Children and/or Adults	Interdependencies included in Phase 1
			Interface & Discharge(A) -
Ophthalmology	• **Vision Screening**	A	
Respiratory	• **Asthma Respiratory Nurse** - Asthma Clinic • **Children's closer to home project** • **Pulmonary Rehabilitation & Support** - To improve the well-being of people who have chronic (ongoing) breathing problems • **Respiratory Nursing** - Advise on the care management of any patients with respiratory problems	C&A C A A	
Therapies	• **Community Rehab** - Outpatient rehabilitation service commonly in the patient's home, treatment may be carried out in the centre, or continue at home. Monitoring and support after a period of rehabilitation or discharge from hospital. Treating patients with a physical rehabilitation need. Seeing patients in their own homes following hip and knee replacement surgery. • **Dietetics** - Referrals or on-ward. Advises people on what to eat in order to lead a healthy lifestyle or to achieve a specific health-related goal. • **Occupational Therapies** - Community based - Therapists assess patients situation at home and help to identify ways to overcome difficulties • **Physiotherapy** - Flexible and responsive service treating patients in their own home to restore movement and function when someone is affected by injury, illness or disability. • **Podiatry** - Various clinics including, general treatment clinics, biomechanical assessments and orthotic manufacture and shoe clinics, rheumatology, sports and orthopaedic clinics, hospital outpatient and diabetic clinics, child health clinics, basic foot care clinics • **Speech and Language** - **Children's**: Working with children, parents and other relevant professionals in the most appropriate setting to help reduce the impact of their difficulty on their physical, social, emotional and educational development **Adult**: Part of a multidisciplinary team diagnosing, assessing and addressing the needs of those individuals with communication and swallowing problems with input into a wide range of clinical environments	A C&A C&A C&A C&A C&A	
Community Generic	• **Community Matrons** - Provides a case management approach for patients with complex conditions / LTCs identified as being very high intensity users of unplanned secondary and Primary care - includes case finding, assessment, personalised care planning interventions • **Community Paediatrics** – aims to minimise the adverse effects of disease. Provides primary care in the community and general practice settings • **District Nursing** - Provision of a comprehensive nursing service to housebound patients including all aspects of fundamental nursing care, complex wound care and palliative/end of life care • **Epilepsy Nurses -** • **General Nursing Services for Children** • **Intermediate Care Services including; Falls, and IMC Beds** –support and independence service to three nursing homes and 1 residential home (46 beds) • **Monovette Needles** Safety needles for blood collection • **OPAT** (outpatient parenteral antibiotic therapy) - Administration of intravenous antibiotics in the community	A C A A C A A A	• Quest for Quality in Care Homes – MDT & Assistive Technology (A) -

Appendix A

Service Areas	Service Lines included in Phase 1 and Brief Description	Children and/or Adults	Interdependencies included in Phase 1
	• **Phlebotomy** (community and hospital) - in-patient and out-patient blood sample- taking service available in some clinics and surgeries within the community • **Single Point of Access (SPA)** and extended SPA for the model – current access for Intermediate Tier Services and Intermediate Care Beds. To be extended from April 2015 • **Specialist Nurses** e.g. ○ Colorectal (Colon, rectum) (C&A), ○ Enteral Feeding (feeding directly into the stomach) (C) ○ Multiple Sclerosis, Parkinsons (Degenerative neurological conditions) (A) ○ Stoma (surgically created opening on the abdomen) (C), ○ Tuberculosis (curable bacterial infection) (C) • **Virtual Ward/Frailty** - An expansion of emergency care providing confidence to clinicians and enabling patients to be returned home whilst awaiting on-going investigations.	A&C A C&A A	
Other Generic	• **Continence** - Provides specialist advice to GP practices, community nursing teams and other health and social care staff and provides staff training in continence care. Also responsible for managing the home delivery service for continence products **(adults)** • **Early Supported Discharge Schemes** - Referrals from social workers • **Enhanced Services** • **Hearing Aids & Counselling; Assessment, Filling, Follow-up and Repairs** • **Hearing Aid Costs** • **Hearing Aid – Audiology** • **Local Enhanced Services** – range of services provided by general practice or the community, such as, Phlebotomy, treatment room etc • **Outpatient attendances** – range of attendances provided in the hospital where hospital stay is not required • **Podiatry Decontamination** - Decontamination of reusable podiatry instruments • **Tissue Viability** - Preventing pressure ulcers	C&A A A A A A C&A A	• Vasectomy (A) • Wheelchairs (C&A)

Appendix B

Overview of The Kirklees Care Closer to home Model and list of services included.

The Care Closer to Home model of care was developed following extensive engagement with the public across Kirklees, colleagues from primary, community, secondary and social care sectors, and the voluntary sector. Key characteristics of the model are:

- Improved primary and community care providing the right care at the right time in the right place
- Provision of services in the community that promote independence and wellbeing for patients so they can support themselves by exercising self-management, choice and control
- Integrated high-quality services at times required to meet the needs of the community
- Providing more planned care earlier thereby reducing reactive, unscheduled care
- Care provided as one coherent package, with a focus on individuals and helping people to get better

Both Greater Huddersfield CCG and North Kirklees CCG are strongly committed to commissioning health services that are delivered closer to people's homes or within their homes, and which ensure fewer people are admitted to hospital. This is what local people have told us they want.

While there is some local variation across the two CCG areas, common elements of the programme include:

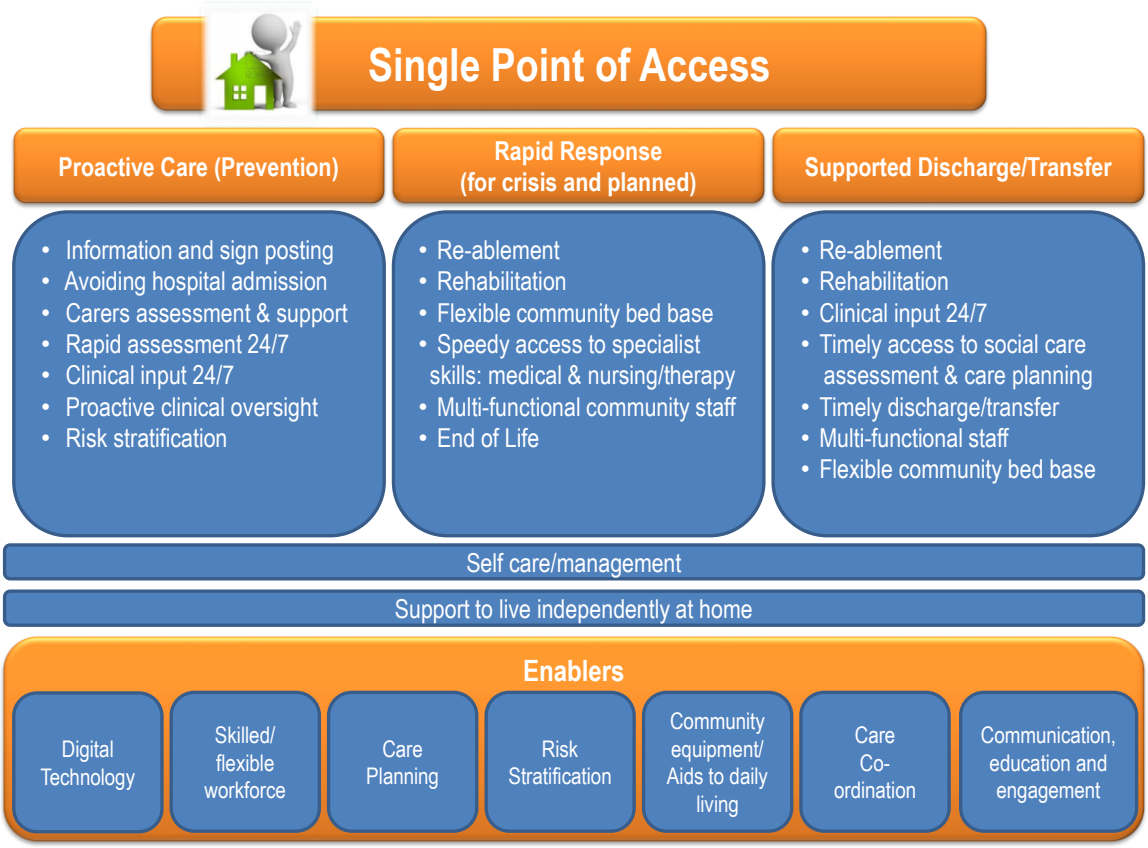
- Risk assessment to identify people who are most vulnerable and most likely to be admitted to hospital
- Proactive care management by multi-disciplinary teams
- High quality local information and support to enable people to manage their own condition and access the most appropriate care
- Person centred care delivered through a single assessment process and single care plan 24/7
- Care at or near home wherever possible.

The programme focuses on services for people with identified needs which impact on their health and well-being, including those with disabilities and long-term conditions, those in vulnerable groups, and those with palliative and end of life care needs, for example:

- Community beds
- Specialist community nursing (adult and children)
- Community therapy – occupational, physiotherapy, speech and language
- Podiatry
- Early supported discharge
- Intermediate care

5. Scope of Community Health Services

The full list of services in scope for both CCG's is represented pictorially below and provided as a list later in this Appendix.



Both CCGs are already delivering elements of this model through pilot schemes across a range of services which support hospital avoidance, including:

- Extension of the hospital avoidance scheme
- Expansion of mobile response team
- Extended care homes support
- Extended support to specialist palliative care
- Psychiatric liaison service

The Care Closer to Home model will ensure a greater emphasis on people taking charge of their own health and care, where appropriate. It will also look at existing buildings and community facilities such as health centres and GP surgeries to see where services can be provided. This will be developed through the procurement process and through the life of the contract.

Appendix B

Kirklees Care Closer to Home - List of Services in Scope.

The services[2] in scope are:

Common Services across Kirklees

- Single Point of Access & Care/Wellbeing Navigation
- Long Term Conditions Case Management (inc. care co-ordination, complex case management)
- Intermediate Care Services
- Speech and language services for adults (Phase 2 for Greater Huddersfield)
- Community rehab services (incl. community consultant)
- Acute occupational therapy services (Phase 2 for Greater Huddersfield)
- Community occupational therapy services
- Adult physiotherapy services
- Community Care including district nursing and community matrons
- Early Supported Discharge Services (including stroke and COPD)
- End of Life incl. Facilitator (to be renamed)
- Care Home Educator
- Children's Community Nursing & Therapy incl. nurse provision YOT/LAC/PRS (Therapy is Phase 2 for Greater Huddersfield)
- Cardiology community based provision inc. Cardiac rehab, heart failure specialist/rehab (Cardio investigations and Cardiac rehab is Phase 2 for Greater Huddersfield)
- Podiatry incl. diabetes mentorship and podiatry provision
- Diabetes DESMOND educators
- Specialist nursing service (incl. Tissue Viability, Epileptic, MS, Continence)
- Community respiratory specialist services (including Home Oxygen assessment & contract monitoring, Community COPD service and specialist nursing services)
- Pulmonary rehabilitation
- TB specialist service
- Older peoples Mental Health (inc. community MH, liaison services, admiral nursing, dementia memory monitoring)

Greater Huddersfield Specific Services

- Day Surgery Services
- MSK / elective orthopaedic services / pain management (Phase 1 Community MSK services and minor hand surgery provision, Phase 2 for Elective Orthopaedic Services)
- Plastics Neurology
- Dermatology
- Diabetes including community DSNs
- Hospital at Home
- Podiatric surgery
- Adult Mental Health (Phase 2)

North Kirklees Specific Services

- Fragility assessment and management
- Falls
- Care Home Clinical/Medical Support

[2] Described as they are currently known 2014