Public Document Pack

Assistant Director, Governance and Monitoring
Julie Muscroft

Governance and Democratic Services
Civic Centre 3
High Street
Huddersfield
HD1 2TG

Tel: 01484 221000
Direct Line: 01484 221000
Fax: 01484 221707
Please ask for: Richard Dunne
Email: richard.dunne@kirklees.gov.uk
Monday 6 June 2016

Notice of Meeting

Dear Member

Calderdale and Kirklees Joint Health Scrutiny Committee

The **Calderdale and Kirklees Joint Health Scrutiny Committee** will meet in the **Council Chamber - Town Hall, Huddersfield** at **3.30 pm** on **Tuesday 14 June 2016.**

This meeting will be webcast live.

The items which will be discussed are described in the agenda and there are reports attached which give more details.

Julie Muscroft
Assistant Director of Legal, Governance and Monitoring

Kirklees Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair/Clerk of their intentions prior to the meeting.

The Calderdale and Kirklees Joint Health Scrutiny Committee members are:-

Member

Councillor Viv Kendrick
Councillor Andrew Marchington
Councillor Elizabeth Smaje
Councillor Julie Stewart-Turner
Councillor Adam Wilkinson - Calderdale Council
Councillor Jane Scullion - Calderdale Council
Councillor Marilyn Greenwood - Calderdale Council
Councillor Chris Pearson - Calderdale Council

Agenda
Reports or Explanatory Notes Attached

Pages

1: Minutes of Previous Meeting

1 - 26

To approve the Minutes of the meeting of the Committee held on 22 March 2016, 6 April 2016 and 19 April 2016

2: Interests

27 - 28

The Councillors will be asked to say if there are any items on the Agenda in which they have disclosable pecuniary interests, which would prevent them from participating in any discussion of the items or participating in any vote upon the items, or any other interests.

3: Admission of the Public

Most debates take place in public. This only changes when there is a need to consider certain issues, for instance, commercially sensitive information or details concerning an individual. You will be told at this point whether there are any items on the Agenda which are to be discussed in private.

4: Deputations/Petitions

The committee will receive any petitions and hear any deputations from members of the public. A deputation is where up to five people can attend the meeting ad make a presentation on some particular issue of concern. A member of the public can also hand in a petition at the meeting but that petition should relate to something on which the body has powers and responsibilities.

5: Care Closer To Home

29 - 92

Representatives from Calderdale and Greater Huddersfield Clinical Commissioning Groups, Calderdale and Huddersfield NHS Foundation Trust and Locala Community Partnerships will outline the work that is taking place to strengthen community services across Calderdale and Kirklees.

Contact: Richard Dunne, Principal Governance and Democratic Engagement Officer – 01484 221000

6: Primary Care Services

93 - 94

Representatives from Calderdale and Greater Huddersfield Clinical Commissioning Groups and Calderdale and Kirklees Local Medical Committees will be in attendance to comment on the role of General Practice and wider Primary Care Services in the proposed future model of care for hospital services in Calderdale and Greater Huddersfield.

Contact: Richard Dunne, Principal Governance and Democratic Engagement Officer – 01484 221000

7: Adult Social Care and Public Health

95 - 110

Representatives from Kirklees Council and Calderdale Council will be in attendance to comment on the role of Adult Social Care and Public Health in the hospital reconfiguration proposals and outline the impact and implications of the proposals for these services.

Contact: Richard Dunne, Principal Governance and Democratic Engagement Officer – 01484 221000

8: Calderdale and Kirklees Joint Health Scrutiny Committee Project Plan

The Committee will discuss and agree its plans for future meetings and activities.

Contact: Richard Dunne, Principal Governance and Democratic Engagement Officer – 01484 221000

Contact Officer: Richard Dunne Tel. 01484 221000

CALDERDALE AND KIRKLEES JOINT HEALTH SCRUTINY COMMITTEE

Tuesday 22 March 2016

Present:
Councillor Robert Barraclough
Councillor Howard Blagbrough
Councillor Martin Burton
Councillor Malcolm James
Councillor Andrew Marchington
Councillor Elizabeth Smaje (Chair)
Councillor Molly Walton
Councillor Adam Wilkinson

In attendance:
Majid Azeb – GP Member Calderdale CCG
Anna Basford – Calderdale & Huddersfield NHS Foundation Trust (CHFT)
Gemma Berriman - CHFT
David Birkenhead - CHFT
Alan Brook – Calderdale CCG
Mark Davies - CHFT
Rory Deighton – Healthwatch Kirklees
Dr Phil Foster – NHS 111 Clinical Director Urgent Care
Brian Hughes – NHS England Locality Director, West Yorkshire
David Hughes – GP Member Greater Huddersfield CCG
Colin McIlwain – Interim Director West Yorkshire Urgent and Emergency Care Network
Carol McKenna – Greater Huddersfield CCG
Jen Mulcahy – Calderdale CCG & Greater Huddersfield CCG
Steve Ollerton – Greater Huddersfield CCG
Julie O'Riordan - CHFT
Victoria Pickles - CHFT
Catherine Riley – CHFT
Andy Simpson – Yorkshire Ambulance Service
Professor Chris Welsh – Chair Yorkshire & the Humber Clinical Senate
Janet Youd - CHFT
Richard Dunne – Principal Governance & Democratic Engagement Officer Kirklees Council
Mike Lodge – Senior Scrutiny Support Officer Calderdale Council

1 Minutes of previous meeting

RESOLVED – That the minutes of the meeting of the Committee held on 22 February 2016 be approved as a correct record.

2 Interests

No interests were declared.

3 Admission of the Public

The Committee considered the question of the admission of the public and agreed that all items be considered in public session.

4 Deputations/Petitions

The Committee received deputations from the following people regarding the Proposals for the provision of Hospital Services in Calderdale and Greater Huddersfield: Helen Kingston, Rosemary Hedges and Cllr Mark Hemingway.

5. Clinical Senate Review of the Future Model of Hospital Services and NHS England Assurance Process.

The Committee welcomed Professor Chris Welsh Chair Yorkshire and the Humber Clinical Senate and Brian Hughes NHS England Locality Director West Yorkshire to the meeting.

Mr Welsh outlined the key areas of responsibility of the Clinical Senate that included details of the Senates membership; the mechanisms that were followed for carrying out reviews; and the guidance for reporting.

Mr Welsh informed the Committee of the timescales for the Senates involvement in the review of the Calderdale and Greater Huddersfield hospital services proposals.

Mr Welsh stated that Senate had recognised the need for change; that it supported the strategic direction that was outlined in the proposals and the Senate felt that the centralisation of some services that delivered care for patients with serious conditions was entirely appropriate.

Mr Welsh informed the Committee that the Senate had identified a number of concerns that included: a lack of detail in the proposals at the review stage; the effectiveness of the required integration of services in primary, hospital and community care; and the development of network services across West Yorkshire

Mr Welsh stated that the Senate was ready to review the detailed proposals if requested although no further requests had yet been received.

Mr Hughes outlined the key areas of responsibility of NHS England West Yorkshire that included its responsibility in an assurance capacity for health service change proposals.

Mr Hughes informed the Committee of the NHS England 4 key tests for service change and outlined its role in the Calderdale and Greater Huddersfield hospital services change programme and the timetable that had been followed in the assurance process.

Mr Hughes explained in detail the work that had been undertaken by NHS England to check and analyse the proposals against the 4 key tests that included taking account of the view of the Yorkshire and the Humber Clinical Senate.

In response to a question from the Committee on whether the Clinical Senate had been asked to comment on the capacity of the community services programme to support the proposals Mr Welsh stated that the Clinical Senate had been invited to look at the specification for community services but not the resources.

A Committee question and answer session followed that covered a number of issues that included:

- The process that would be followed for reviewing the risks that had been identified by the Clinical Senate.
- An overview of the post consultation assurance process.
- The Clinical Senate's support of an extensive public consultation.
- The benefit of having an independent clinical view of the proposals.
- The need to ensure that the integration of the whole system was in a position to support the proposals.
- The importance of primary care in the integrated service.
- The national and local challenge of having the availability of workforce to effectively deliver the changes.
- The importance of taking patients directly to the places that provided the specialist treatment.
- The influence of the NHS 5 year forward view and the Keogh report on urgent and emergency care services on the proposals.
- The role of NHS England post consultation.
- The role of the West Yorkshire Urgent and Emergency Care Network in reviewing the proposals and assessing the impact on the West Yorkshire network.
- The recognition at national level of the challenges that local health service providers faced.
- The work that was being done to develop local and regional Sustainability and Transformation plans.

RESOLVED:

(1) That all attendees be thanked for attending the meeting.

(2) That the Committee's supporting officers be authorised to liaise with attendees to obtain any information that had arisen from the discussion.

6. West Yorkshire Urgent and Emergency Care Network

Mr McIlwain informed the Committee of the background to the Network that included its structure; membership; and the reasons why the Network had been established.

Mr McIlwain stated that one of the primary objectives of the Network was to help organisations in West Yorkshire to progress the key actions outlined in the Urgent and Emergency Care Route Map.

Mr McIlwain explained that another key aim of the Network was to ensure that there was a consistency in standards of service and that they complied with national guidance.

Mr McIlwain explained the purpose of a Vanguard and outlined details of the Network's Vanguard programme that included four work streams Primary Care, Hear, See and Treat, Mental Health and Acute Care.

Mr McIlwain informed the Committee of the work that was being undertaken on the Hear, See and Treat work stream which included the integration of the ambulance and 111 services and the Mental Health work stream which included the development of a shared mental health outcomes framework.

Mr McIlwain stated that the Network would also be looking at how the urgent care centres and the emergency centre proposed in the changes to hospital services in Calderdale and Greater Huddersfield aligned with national draft standards and how the services would contribute to the network as a whole.

A full Committee question and answer session followed that covered a number of issues that included:

- The importance of the network looking at the West Yorkshire footprint of urgent care centres and emergency care and its longer term sustainability including local workforce challenges.
- The work being undertaken on developing preventative measures to reduce demand on acute hospitals.
- An explanation of how the performances of Trust's were monitored.
- An overview of the role of primary care services in the new model.
- The need to move more resources into primary care services to support the new model and address the needs of the local population.

RESOLVED:
(1) That Colin McIlwain be thanked for attending the meeting

(2) That the Committees supporting officers be authorised to liaise with the West Yorkshire UEC network to obtain any information that had arisen from the discussion.

7. Yorkshire Ambulance Service and NHS 111 Service

Mr Foster informed the Committee that the standardisation of services across the region was important and included a clear pathway for people who wished to receive advice or seek treatment.

Mr Foster explained that the Vanguard workstream that was looking at standardising patients healthcare records across West Yorkshire was an important element of the planned improvements to the NHS 111 service offer and would also help to transform the way that paramedics treated patients.

Mr Foster informed the Committee of the challenges that the Yorkshire Ambulance Service (YAS) faced in retaining advanced paramedics who were an attractive resource for other health providers.

Mr Foster stated that to try and combat this issue all providers across the West Yorkshire footprint had agreed to develop a common workforce plan to ensure that each part of system was sharing the appropriate workforce and not just focusing on the recruitment of employees which would result in resources being moved from one area of the region to another.

Mr Foster outlined the work that was being done to integrate the 999 emergency services and the NHS 111 service as part of the Hear, See and Treat Vanguard workstream.

Mr Foster explained how the NHS 111 service operated which included an explanation of the process that was followed to assess a call and direct the person to the most appropriate place to deal with their need.

Mr Foster outlined details of the clinical advisory service that was also part of the Hear, See and Treat workstream and aimed to ensure that people who used the NHS 111 service could get advice at the right level.

Mr Foster informed the Committee that the development of the NHS 111 service was ongoing and explained that nationally there was a lot of working being done on assessing how the 111 service could integrate with primary care both in hours and out of hours.

Mr Foster explained that NHS 111 also wanted to start measuring the whole patient pathway to assess the effectiveness of the whole system and to measure the time it took from the initial contact to the patient receiving definitive care.

A full Committee question and answer session followed that covered a number of issues that included:

- The benefits to having a standardised patient healthcare record that would be developed to provide appropriate and relevant information for the end user.
- The benefits of sharing information that was already available such as the risk assessment registers that were held in GP practices.
- A question on the capacity of NHS 111 to deal with sufficient enough enquiries to reduce the numbers of people going direct to hospital.
- The challenges facing NHS 111 in accommodating the increased demands on the service and the trend for higher volumes of calls to take place during late night and early morning.
- The work that was being done to integrate the various IT systems across the system.
- An explanation of the process that NHS 111 would follow to book appointments at the Urgent Care Centres or GP practices.
- The need for consideration to be given to supporting patients who required transportation to an Urgent Care Centre.
- The desire to ensure that there was a consistency in the services being provided by Urgent Care Centres across the region.
- The work that was being done to establish a NHS 111 service provider network.

RESOLVED:
(1) That attendees be thanked for attending the meeting.
(2) That the Committees supporting officers be authorised to liaise with attendees to obtain any information that had arisen from the discussion.

8. Urgent Care; Emergency and Specialist Emergency Care; and Intensive Care Unit

Mr Azeb outlined the current location of services at the two hospital sites that included details of common services that were available at both sites and those services that were specific to each site.

Mr Azeb informed the Committee of the location of services under the new proposals that included a detailed explanation of the proposed urgent care centres and the services they covered.

Mr Azeb informed the Committee of the proposed location of the emergency centre that included details of the staff resources; an explanation of the services that would be available; and details of the new paediatric emergency centre

Mr Azeb stated that the Acre Mill site in Huddersfield would be the location for the new hospital for planned inpatient surgery and outlined details of the facilities that would be available.

Mr Azeb explained that the new proposals were in line with national thinking and the Keogh review on urgent and emergency care services and that the proposals were based on a clinical model that would deliver high quality and safe services for patients.

Mr Azeb outlined the key benefits of the proposed model that included undisturbed planned care and significantly fewer cancellations; a consultant and senior doctor led service; and an improved working environment for employees.

Mr Ollerton explained the process that would be followed in the event that a very sick person presented at the Huddersfield Urgent Care Centre that included the procedure for transferring a patient to the Calderdale based Emergency Care Centre.

In response to a committee question Mark Davies provided a detailed explanation of how the Urgent Care Centre would be staffed and the skills and knowledge of the doctors and nurses.

In response to a committee question the Committee was informed that the exact model for the work force had not yet been fully developed and that the doctors who would be providing the services at the Urgent Care Centres would require wide generalist knowledge.

A full committee question and answer session followed that covered a number of issues that included:

- The improved outcomes for patients having an early intervention by a senior consultant.
- An overview of a similar reconfiguration that had taken place in Northumberland.
- An explanation of the services that would be available at the Urgent Care Centres.
- The need for commissioners and health providers to improve their communication methods to help improve the public's understanding of the proposals.
- An overview of the challenges that the Trust currently faced that included: meeting the required A&E standards; recruitment of doctors; retention of staff; the safe staffing of overnight rotas; and access to senior decision makers.
- An example of how the centralisation of one service had led to a significant improvement in mortality rates and the quality of patient care.
- Details of where evidence that the centralisation of services helped to improve patient outcomes could be found.
- The plans to rotate staff working at the Urgent Care Centres so that they would benefit from ongoing supervision and support from experienced clinicians.

- The standards of competency that staff working in the Urgent Care Centres would be required to follow and the advantages of having dedicated staff working and developing skills in specific disciplines.
- The work that was still to be done on modelling the workforce that would be required to support the proposed configuration of hospital services.
- The benefits that operating an emergency centre at one site would have in reducing reliance on middle grade locum doctors to cover the overnight rotas.
- Clarification on the plans for the Todmorden and Holme Valley Health Centres.
- An overview of the expected numbers of attendances at the Urgent Care Centres and the Emergency Care Centre.
- The need to analyse the impact of the new model for community services on reducing the numbers of people being admitted to hospital.
- An explanation on how centralising the expertise of clinicians would lead to earlier decision making and improve the outcomes and quality of care for patients.
- An overview of the approach that was taken in modelling the bed capacity.
- The impact of winter pressures on the Trust's bed capacity.
- Details of the diagnostic facilities that would be available across the two sites and clarification that the intensive care unit would be expanded and located at the Calderdale site.

RESOLVED:
(1) That attendees be thanked for attending the meeting.
(2) That the Committees supporting officers be authorised to liaise with attendees to obtain any information that has arisen from the discus

9. Date of Next Meeting

RESOLVED:
That the date of the next meeting be confirmed as 6 April 2016.

CALDERDALE AND KIRKLEES JOINT HEALTH SCRUTINY COMMITTEE, 6th April 2015

PRESENT: Councillor James (Chair)
Councillors Barraclough, Blagbrough, Burton, Marchington, Smaje, Walton, Wilkinson

IN ATTENDANCE:
Dr Alan Brook, Chair of Calderdale Clinical Commissioning Group (CCCG)
Julie Lawreniuk, Chief Finance Officer, CCCG and Greater Huddersfield CCG
Jen Mulcahy, CCCG and Greater Huddersfield CCG
Julie Dawes, Director of Nursing, (Calderdale and Huddersfield NHS Foundation Trust (CHFT)
Kristina Arnold, Assistant Divisional Director Surgery and Anaesthetics, CHFT
Dr Martin DeBono, Divisional Director Families and Support Services, CHFT
Anne-Marie Henshaw, Associate Director of Nursing and Head of Midwifery, CHFT
Dr Heshan Panditaratne, Clinical Director Radiology, CHFT
Anna Basford, Director of Transformation and Partnerships, CHFT
Catherine Riley, Assistant Director Strategic Planning. CHFT
Mike Lodge, Senior Scrutiny Support Officer, Calderdale Council
Richard Dunne, Principal Governance and Democratic Engagement Officer Kirklees Council
Deborah Tynan, Committee Administrator, Calderdale Council
Dr Matt Walsh, Chief Officer, CCCG
Penny Woodhead, CCCG and Greater Huddersfield CCG

1 INTERESTS
No interests were declared.

2 ADMISSION OF THE PUBLIC
The Committee considered the question of the admission of the public and agreed that all items be considered in public session.

3 DEPUTATIONS/PETITIONS
The Committee received deputations from the following people regarding the proposals for the Provision of Hospital Services in Calderdale and Greater Huddersfield: John Garside, Chris Owen and Dr Hutchinson.

4 MINUTES OF THE MEETING HELD ON 9TH MARCH 2016
IT WAS AGREED that the Minutes of the meeting of the Calderdale and Kirklees, Joint Health Scrutiny Committee meeting held on 9th March 2016 be approved as a correct record.

5 FUTURE MODEL OF CARE
The Senior Scrutiny Support Officer submitted a written report providing Members of the Joint Committee with the context to the discussions with Calderdale and Greater Huddersfield Clinical Commissioning Groups, Calderdale and Huddersfield NHS Foundation Trust and other key health stakeholders on the proposals for the future provision of hospital services in Calderdale and Greater Huddersfield, particularly with regard to planned services, maternity services, paediatric services and diagnostics.

Calderdale and Greater Huddersfield Clinical Commissioning Groups had published a Pre-Consultation Business Case (PCBC) that set out their case for transforming

health services in Calderdale and Greater Huddersfield. Included in the PCBC was a description of the in-hospital future model and an outline of the services that were included in the scope of the in hospital services programme. The evidence used at this meeting would be used to inform the Joint Committee's assessment of the proposals and recommendations it may choose to make to the Clinical Commissioning Groups.

The Committee welcomed representatives from the Calderdale and Huddersfield NHS Foundation Trust (CHFT), Calderdale CCG and Greater Huddersfield CCG to the meeting.

Planned Care

Dr Alan Brook advised that the proposals would include an acute site and state of the art unit at Acre Mill in Huddersfield with the opportunity for plenty of cases to be seen at both sites. The following services would be available at both hospital sites: outpatients, midwifery, urgent care, therapies, diagnostics and day surgery. There would be 120 beds available at Acre Mill for planned surgery.

Members commented on the following issues:-

- There are plans for an acute unit at Calderdale and a planned surgery unit at Huddersfield, How many planned operations will go to the planned hospital and how many will go to the acute unit? In response, Ms Rutherford advised that patients from the acute unit would be moved to the planned unit if they required a long period of rehabilitation. There were plans for 3000 inpatients to the planned unit and 10,500 patients to the acute unit.

- Where are the intermediate care beds? In response, Dr Brook advised that Huddersfield patients would be transferred to the planned care site even if they are operated on in Halifax.

- The planned care model is working on fewer outpatient appointments, the Care Closer to Home model is therefore crucial to these plans. Is Care Closer to Home able to meet these demands? In response, Dr Brook advised that Care Closer to Home wasn't able to meet demands yet and had been given high priority. There were lots of potential developments and there was a five year timeframe to improve the service.

- What will happen if a procedure goes wrong and a person needs emergency care? in response, Dr De Bono advised that in the current model if a person needs emergency care then they are transferred to acute care. Patients can be transferred to other hospitals now depending on the type of care they need.

- Has there been an increase in mortality rates or poor patient outcomes? In response, Dr De Bono advised that the outcome data is similar and in some cases better. There had been no patient harm and in some instances patients had received better care.

- Would preventative care leaving plans be produced for patients? In response, Dr Brook advised that there would be a thorough process to ensure that all

patient information was collated and then a discharge plan would be sorted before the patient was admitted to hospital.

- There is mention in the report of unnecessary follow up appointments which would be reduced. Why were they arranged? In response, Dr De Bono advised that they were working with primary care so that follow up cases could be referred to them so that they happened in the local community.

- Local GP's were already stretched to capacity. How would they accommodate the follow up appointments? In response, Dr Brook advised that GPs would be given help to meet the additional appointments. Some appointments would be made with nurses who had specialist skills. There would be electronic patient notes and communication between the hospital and GP surgeries will be easier. This will enable GPs to liaise with the hospital about a patient. There will be a wider follow up team available. Members were advised that a one stop shop appointment system would be developed to reduce follow up appointments and staff in primary care would be trained and developed to carry out more work and provide more care in the community.

- If patients in the acute unit are going to be moved to planned, how will they be accommodated in the planned unit? Will this create blockages in the system? Will beds in the planned unit be used for this? In response, Members were advised that the modelling profile would look at lengths of stay and that the figures had been added in to the capacity for the planned unit. Planned care would not be used for blocked beds and more patients would be moved to day care.

- Will people still have a choice of where to go for treatment? In response, Members were advised that patients will have a choice where to go for day care services. There would be no choice for planned and elective treatments, in these instances patients would be offered only one hospital.

- Are the key assumptions about the length of stay and reducing numbers based on evidence? Had the models been tried and tested? In response, Members were advised that the evidence looks at a wide range of data depending on the procedure and the recovery model. Being in hospital was not always the best place for a patient. The models had been tested and three days was a well established basis for stays with 90% of patients staying in hospital for three days or less.

- Was the electronic patient record a sustainable and successful system? In response, Dr De Bono advised that the EPR had been introduced in October/November 2015. This area was one of the first in this country to get an electronic record system. The system would not be available countrywide. This had been a major piece of work.

- Would rehab be available on the two sites? In response, Dr Brook advised that high risk cases at Calderdale would go to rehab and a planned procedure would be followed.

- Would the operating theatres for planned care at Huddersfield be used to treat acute patients? In response, Members were advised that there would be eight operating theatres at Calderdale which would be running longer days.

- What time would patients be expected to attend at the planned and acute units? Patient arrival time would depend on their case. Plans were being made to move some cases to the afternoon. Dr De Bono advised that the pre-assessment procedure had been improved and was now done the day before an operation. This meant that patients arrival times could be staggered. Planned surgery would only be carried out on the acute site if intensive care, high dependency care or specialist surgery was needed.

- How are the changes to services being communicated with the public? In response, Dr De Bono advised that the process was outlined in the leaflet. All decisions would be based on improving care. Ms Rutherford advised that a leaflet was being produced which would make the position clearer. Dr Brook advised that the position was that there would be no duplication of procedures over the two sites.

- Patients were already being transferred between hospital sites. How many births had there been whilst a patient was being transferred from one hospital to another? How many patients had died or been adversely affected when being transferred between hospital sites? In response, Mr De Bono advised that births and harm had been monitored and there had been no births whilst a patient was being transferred. The reconfiguration of the maternity service in the past had reduced the risk. There had been one incident when a patient had come to harm when being transferred, however, this had been due to a delay in transfer rather than the transfer itself.

- The number of outpatient appointments at Todmorden would increase, however, there would be no funding for Vanguard available. How would this affect Todmorden? In response, Dr Brook advised that Vanguard funding was not crucial to the process and would only allow projects to move quicker. Todmorden would provide the ability to test and adopt a model of care which would be used in other areas.

<u>Maternity Services</u>
Dr Brook advised that there were no proposals to change the maternity model. In future there would be other specialities available.

Members commented on the following issues:

- Has there been an increase in the number of home births? In response, Dr De Bono advised that every pregnant woman was offered a choice based on risk and that would continue. There would be two birth centres. Home births would not be refused if the risk was low, even though the support required was more intensive.

- Would there be more or less obstetricians? In response, Mr De Bono advised that there were no plans to increase the number of obstetricians and no plans to extend the service.

- The maternity unit in Huddersfield was state of the art. In response, Mr De Bono advised that he was very proud of the birthing unit at Huddersfield which provided a service for low risk pregnancies and had delivered 500 babies in the last year. Antenatal services were also provided.

- Women with low risk pregnancies could choose to go to Huddersfield, however, complicated pregnancies were referred to Halifax. Will that still happen? In response, Mr De Bono advised that this would still be the process, however, some women with high risk pregnancies still wanted to have their baby at Huddersfield and they would be supported in their decision.

- Can the current aspirations be met with the current staffing demand? It was believed that the aspirations for the service could be met by the current staff. The hospital was seen as an attractive place to work. Dr De Bono advised that the changes to the maternity service started eight years ago and risks would continue to be reduced.

- Would there still be 24 hour consultant cover available in maternity? In response, Dr De Bono advised that currently 98 hours of consultant care was provided and there were no plans to move from this. A consultant was available, if required, for the rest of the time and this was covered on a rota system.

- There were plans in the future to investigate all stillbirths. What was done now? In response, Mr De Bono advised that there had been a lot of work carried out over the last three years to reduce the number of stillbirths and the number had reduced significantly. This work would continue.

<u>Paediatric Services</u>
Dr Brook advised that there was a lack of a specialised paediatric service in the area and the proposals included the installation of a paediatric unit at Calderdale. This would be a major improvement.

Members commented on the following issues:-

- There was a need to raise awareness of what parents should do in an emergency situation. What would the provision be for children under and over the age of five? In response, Dr Brook advised that children were more transportable, however, people would be encouraged to use an ambulance. The 111 telephone service were able to filter cases and parents were being encouraged to ring for advice before taking action. Children under five should be directed to emergency services.

- Was a review of the 111 service being carried out in the area? In response, Dr Brook advised that the 111 service was monitored and quality assured. There were regular surveys and requests for patient experience.

- There needed to be a stronger message about the 111 telephone service. In response, Dr Brook advised that the 111 telephone service was right for non-urgent advice, however, all urgent and emergency cases should contact 999.

- What was the situation regarding consultant cover for paediatrics? In response, Dr De Bono advised that the data for paediatric care and had found that cases dropped off after 10pm. At the moment cover was available until 8pm, however, this would be extended. Currently there was a well established nurse practitioner model in place with two accident and emergency paediatric consultants.

- Was there a traffic light system for paediatric cases? In response, Dr Brook advised that 90% of paediatric cases are dealt with by General Practice. People needed to be given the confidence to deal with things themselves.

- A planned new hospital in another area would have a child assessment unit. Why was this not included in the plans for Huddersfield and Halifax? In response, Dr Brook advised that the paediatric unit would operate 24/7 and children would be taken there for assessment. One of the main anxieties in paediatric care was that children would be taken in the wrong direction. People needed to be directed to the right service. Dr De Bono advised that a paediatric assessment unit was already in place.

- Why can't there be a paediatric unit at both sites? In response, Dr De Bono advised that there was a staffing issue with a shortage of paediatric medical staffing. It would not be viable to have a paediatric unit at both sites. Dr Brook advised that they wanted poorly children to be moved sooner rather than later and children should not be kept in planned care.

- A paediatric assessment unit had been sustainable in Wakefield. In response, Dr De Bono advised that there was a paediatric observation unit at Huddersfield and Halifax. It would be a struggle to maintain two paediatric units medically. Medical cases were currently transferred to Huddersfield. The present configuration did not provide cover for in-patients needing paediatric care. The model we had needed to be developed.

<u>Diagnostics</u>
Dr Panditaratne advised that there was diagnostic equipment and qualified staff on both sites. Personnel would be moved to whichever hospital held the machinery. This would be determined when it was decided what services would be covered on each site.

- Was there adequate staffing available? In response, Dr Panditaratne advised that staff would be halved in some areas, however there would be parallel rotas with provision to provide full support. There was a national shortage of radiologists, two new radiologists had been appointed and there were plans to appoint more. Reconfiguration was needed to keep the service running.

- Would there be opportunities for diagnostic services to move out to local areas with the introduction of Care Closer to Home? In response, Mr Panditaratne advised that diagnostic services were available in local areas now and systems were linked now. This would not change.

- Would the data analysis continue? In response, Mr Panditaratne advised that this would continue and results would be available quicker.

- Would haemotology at Huddersfield be moving? In response, Mr Panditaratne advised that haemotology would not be moving, however, there were be new tests carried out. Mr De Bono advised that the pathology unit had been designed to support acute care and this would not change. This service would be centralised and rationalised.

- Had staff been consulted on the changes? In response, Ms Riley advised that members of staff had been invited to contribute to the consultation process and staff drop in sessions had been set up.

- Services were needed to support admissions in the acute unit. Where would they be situated? In response, Mr De Bono advised that there was already a split model for acute care across the two sites. The blood bank would be rationalised.

- Some hospitals were using off-shore companies to analyse test results. Would this be considered? In response, Mr Panditaratne advised that a company called TNC which operated from Australia was already doing this work and every Trust used companies such as this. Dr Brook advised that a lot of diagnostic work was already carried out in local communities such as blood pressure checks.

IT WAS AGREED that all attendees be thanked for attending the meeting and addressing questions.

6 CONSULTATION UPDATE

Formal consultation of the Calderdale and Greater Huddersfield CCGs on their proposals for hospital reconfiguration began on 15th March 2015. The CCGs attended the meeting and updated the Joint Committee on how the consultation was progressing.

Members commented on the following issues:

- Sessions in Huddersfield had been better attended than those in Halifax. How was this being addressed? Members were advised that there had been greater attendance to the sessions in Huddersfield. The survey responses had provided an even balance between the two areas. Communications would be sent out.

- Would responses be weighted? In response, Members were advised that there were no plans to weight responses, there would be an overall analysis of the responses received.

- In the main there were two themes coming through from the comments received, these were transport and Accident and Emergency services. Was the whole message of the changes to the hospitals getting through? In response, Dr De Bono advised that people had picked up on these two key themes. It was important that people also looked at the changes as a whole. Dr Brook advised that the fact that these meetings were looking at all the changes was appreciated.

- How will the number of calls and petitions be reported? How were replies dealt with? How are GP's and clinicians being consulted? How are young people being engaged in the consultation process? There had been no exact specification in respect of the petitions. There had been a number of sessions in practices in Huddersfield where the proposals had been discussed and GPs had been given a supply of consultation material so that they could answer questions. There had been a good number of young people at the event which was held at the college and an offer had been made to return in the future. There had been a series of one to one interviews with consultants who in the main had expressed overwhelming support for the proposals. The vast majority of nurses also supported the proposals. Dr Brook advised that GPs in Calderdale had been involved in the consultation process, they had attended presentations and had been invited to challenge the proposals.

- Thousands of people had demonstrated about the proposals but were not attending the meetings. The discussions seemed to have been narrowed down to the closure of the Accident and Emergency unit in Huddersfield and it was clear that people didn't know the full message.

- The consultation was not getting the message across and there were concerns that any recommendations made by this Committee will not cover everything. The changes proposed would result in long term changes. An independent body would be analysing the results. People were being encouraged to attend sessions and give their views.

IT WAS AGREED that the progress be noted.

7 COMMITTEE WORK PROGRAMME AND FUTURE ACTIVITY

The Committee Joint Chair reported orally that the date of the next meeting had been arranged for Tuesday 19th April at 3.30pm.

IT WAS AGREED that the date of the next meeting be noted.

Minutes of the meeting of the Calderdale and Kirklees Joint Health Scrutiny Committee held on Tuesday 19th April 2016

Members:
Councillor M James, Calderdale Council, Joint Chair (In the Chair for this meeting), Councillors H Blagbrough, M Burton and A Wilkinson (all Calderdale Council) and Councillors R Barraclough, A Marchington, E Smaje (Joint Chair) and M Walton (all Kirklees Council)

Officers:
Mike Lodge, Scrutiny Support (Calderdale Council) and Richard Dunne (Kirklees Council)

Clinical Commissioning Group (CCG):
Dr Matt Walsh and Carol McKenna, Chief Officers, Calderdale CCG and Greater Huddersfield CCG), Penny Woodhead and Jen Mulcahy.

CHFT
Catherine Riley

Healthwatch:
Rory Deighton, Director at Healthwatch, Kirklees

Unison:
Natalie Ratcliffe

West Yorkshire Ambulance Service (YAS):
Andy Simpson

Calderdale Council
Councillor Barry Collins, Deputy Leader of Calderdale Council and Cabinet Member for Regeneration and Economic Development
Kate Thompson, Lead for Corporate Projects

Kirklees Council
Councillor Peter MacBride, Kirklees Cabinet Member with responsibility for Regeneration, Transportation and Regional Matters
Richard Hadfield, Head of Strategy and Design

1 Members interests

Cllr Elizabeth Smaje declared an interest as a member of the West Yorkshire Combined Authority Transport Committee

2 Admission of the public

There were no items to be discussed in private

3 Deputations / Petitions

The Chair invited members of the public to make their deputations. There were five deputations in person from members of the public at the meeting:

- Dr Adnan Muhamed
- Paul Coney

- Jenny Shepherd
- David Himelfield
- Rosemary Hedges

The Chair thanked them for their contributions

Items for discussion

4 Future model of Care – Trade Unions

Natalie Ratcliffe (Unison) introduced this item. She thanked the Scrutiny Committee for inviting the unions to make representation. Whilst acknowledging good relations generally with the Trust there is no doubt that there will have to be significant job reduction - in spite of recruitment difficulties in certain specialist areas. The CCG and the Trust say that consultation has taken place but the unions challenge that view. The CCG / Trust have asked staff to participate as public in the consultation process and whilst they may have met with certain groups, front line staff have not been consulted. This is apparent from the union's own survey. Survey results shown that of the 1500 returns 93.5% say that the removal of A&E from Huddersfield is not the safest option. 6.95% agree with the proposal. Scrutiny Committee members can have the full survey details to look at the responses including comments from the staff which include responses such as:

- I have been nursing for 38 years – I am not aware of anyone who agrees with these proposals
- This is too large an area to be dealt with by one A&E
- There will be longer blue light runs
- YAS does not have the capacity to deal with this change
- How will staff get to the new A&E if they don't have their own transport
- Waiting times are already 4-6 hours
- CRH is already at capacity
-

Responses for the proposal included comments:

- Experience in another area of the country (Cornwall) where this system is in place demonstrates that it can work
- This could attract and retain more staff

At the public meeting senior clinicians were challenged. This proposal relies on a home contract model. Locala are very concerned about a performance contract. Recruitment is already difficult. What arrangements are there regarding re-location, job remodelling? What consideration has been given to staff who work on the far side of Kirklees in Holmfirth who do not have their own transport? In summary the CCG have not involved the staff early enough in the process.

Question from a Councillor: With regard to consultation – these statistics are in conflict to what we have been told in earlier meetings. We had been assured that there was wide spread support for the change. The staff do not appear to have been consulted adequately – what has been the process?

CHFT: Staff have been encouraged to get involved as members of the public. They have access via email, there have been staff drop-in sessions and more will be arranged. Management have met with staff teams and all staff have been encouraged to get involved. 1-1 discussions have been carried out with consultants and there have been regular talks

with the staff-side forum. We recognise that the union have said there hasn't been enough consultation and so more questionnaires have been sent out.

Question from a Councillor: Are you still saying that the majority of staff support the proposal

CHFT: We need to review this in the light of the Union survey results

Councillor: It is important that you resolve this difference of views – we need a consultation picture that is clear

Natalie Ratcliffe: We are happy to share the survey results with the Trust. The grass roots staff are not being engaged and many are frightened to say something. This is why we carried out the on-line survey

Question from a Councillor: It concerns us that staff feel they can't speak out. What is the CCG view regarding the survey?

CCG: These are shocking percentages – we weren't aware of this. The clinical model was designed with senior doctors in the trust. Senior clinicians are comfortable with the safety and the design.

Councillor comment: We suggest that the Trust and the Union have further discussions regarding the consultation process for staff. Also, when reviewing the consultation returns there should be data showing how many were from staff. Where can staff return their contribution?

CHFT answer: paper copies are available in the work place and there is a post box for them to use, also a free post address

Question from a Councillor: More information regarding the proposed staffing levels v. the number of staff leaving – how do you intend to get the reduction in posts as described in your case

CHFT: On average, 15% leave the trust annually. By not replacing, turn over will reduce the staffing levels sufficiently so that compulsory redundancy should not be required

Question from a Councillor: However, you already have staff shortages in some areas – how will you balance the numbers overall

CHFT: Within emergency care we have lost 2 consultants and a third is leaving - reasons cited because the 2 site model that we are currently operating is not good enough. We would increase retention if we could give better care. We are doing everything we can to recruit - developing posts to make them more attractive as well as changing work patterns

Question from a Councillor – you say in the document that you will have to reduce staff, yet you have areas that are currently understaffed – how will you balance this?

CHFT: We don't replace like for like when people leave – we recruit for future work force needs and future working practices.

Question from a Councillor – staff relocation issues, change management, retaining staff with relevant skills to go into the new model, staff involvement with the change process – for example moving from acute care to primary care – where are the unions involved in all this?
Natalie Ratcliffe: We should have been involved from the start.

CCG: Workforce development is a key strategy, especially in practice based primary care. We need to invest in the general practices and train staff for them.

Question from a Councillor: how is it made clear that this is a pathway for staff – how will this work across the patch – it is likely to be a lengthy process.

CCG: There is an order to the progress of events – if the new model is taken up after the consultation process then we can start discussions about how we move the services out to the practices. This will be phase two – which will trigger a series of events and start career development over the next 5 years. Once we get the green light we can develop the opportunities – staff can transfer into the community.

Question from a Councillor: Yet the Trust is already beginning to model the workforce?

CHFT: We have already got an established community division in the workforce

Question from a Councillor: There is anecdotal evidence that the model does not relate to the consultation – how have front line staff views been taken into account?

CHFT: Divisional teams have held open forums with regard to the development of the 5 year plan – these have gone to the directorates for peer challenge and up through the structure. Verbal feedback confirms that staff have been involved.

Natalie Ratcliffe: we need more engagement with union officers as well as the staff side reps.

CCG / CHFT: We will add this to the next meeting.

Question from a Councillor: How do you see communication moving forward?

Natalie Ratcliffe: Some change needs to take place. We want to work with the Trust – there are elements that we don't agree with and staff are saying the same. There has definitely been a communication breakdown that needs fixing.

Question from a Councillor: Is it envisaged that the work carried out by the Trust will be largely the same as now or would a significant amount be moved to the private sector?

CCG: Work takes into account people's right to choose. Contracts are in place to support choices. There has been a small steady drift of elective work to the independent sector. NHS care is delivered free at the point of need. The value of work in the independent sector on behalf of the NHS is 5% of the overall spend. There are contractual arrangements in place to take care of this. We want to create a hospital offer that people will choose – to deliver the quality that people want to access.

CHFT: Our ambition is the same. Plans are to keep the community service as local as possible. The new planned care site will be superior to some in the independent sector. Referring GP's offer choice - patients prefer the NHS hospitals where the waiting times are preferable. The planned care facility should be more attractive

CCG: The planned care model will mean fewer cancellations.

Question from a Councillor: We need a better understanding of the staffing numbers in the document. Of the 900 anticipated job losses – how much of this will be in 'back office' functions – labs etc rather than front line? Are you transferring the employment of those who

carry out this kind of work outside the Trust to other organisations or will you improve current practice?

CHFT: Currently half of the posts filled by agency staff. We are also looking at new technology to become more efficient.

Question from a Councillor: Several questions need answers: how will you achieve the reductions - more detail is required. For example, currently your documents show 145,000 patients across both A&E sites planned to rise to 170,000 in 2021 – how does this fit with an overall reduction in staffing. We are having difficulty in understanding seeing how the numbers stack up and how they relate to staffing and locums. Your projected 5 year plan increases patient numbers – how will you support this with reduced staffing? We have no confidence that this looks viable.

CHFT: The Trust agreed to re-confirm the staffing figures.

5 Future Model of Care – Transport Issues

The meeting was attended by Councillor Barry Collins, Deputy Leader of Calderdale Council and Cabinet Member for Regeneration and Economic Development and Councillor Peter MacBride, Kirklees Cabinet Member with responsibility for Regeneration, Transportation and Regional Matters, Kate Thompson, Lead for Corporate Projects, Calderdale and Richard Hadfield, Head of Strategy and Design, Kirklees Council.

Cllr Barry Collins: Proposals to upgrade A629 are in line with the flagship policy to improve road connectivity and become a healthy, active borough – improvements to train and bus services are all linked. The A629 project will take 4-5 years to complete – should have a major effect on reducing congestion, improving air quality – particularly at Bradley Bar, Elland by-pass and Ainley Top. The main problem is route from Huddersfield to Halifax - once complete there will be perceivable gains, especially at Salterhebble Junction. There are improvements planned at the Calder and Hebble Junction to alleviate the situation and improve ambulance access. We are also looking at routes around north Halifax. The scheme is designed to improve connectivity and journey times – it will also give employment growth opportunities.

Cllr Peter MacBride: This was a planned road improvement project – it is not linked with the hospital plans. The main beneficiaries will be those who travel from Huddersfield to Halifax. There will be marginal effects on journey times. The major works are planned to commence in 2021 to be completed by 2025 – there will be an attempt to get the programme advanced but there is no guarantee.

Cllr Barry Collins: Some enabling works will start this summer.

Kate Thompson:

- Phase 1 to start end of July 2016 - enabling works at Salterhebble. Main civils work to start Summer 2018
- Phase 2 – Halifax town centre – 2017-2021
- Further phases - timetable to be agreed
- Final phase – Ainley top - Huddersfield, after 2021. Bringing the project forward will depend on the funding streams

Question from a Councillor: Any comments from West Yorkshire Ambulance Service?

YAS: There is a lot of public concern about the Elland bypass – this is no different to other arterial routes in Leeds or Bradford – there are no problems navigating these roads.

Question from a Councillor: Any comments from bus services?

WYCA: We haven't been consulted about these hospital plans. There will be a varied, disproportionate impact. How we can help depends on the issues – but we don't know what they are. There are a number of options available eg managing the link services between the sites. Funding is a concern – current funding has been reduced by 25% for 2016-2017. Councillors should note that the 503 service is entirely commercial - any increase (or not) in service after the improvements to the A629 will be a commercial decision by the operator. Where there have been similar road improvements on the A65 in Leeds there has been no response by the commercial market to increase the services.

Question from a Councillor: Reduced journey times on the A629 are to be welcomed – but there will be road works for the next 6-7 years which will impact on journey times. Is there an analysis regarding patient outcomes in the medium term when considering this?

CCG: There is no analysis on the impact of the road works – we have only just found out about this – but we welcome the scheme.

Kate Thompson: We have not been consulted by the CCG or CHFT – we are ready to work together.

Question from a Councillor: Bus services change over time. Please confirm whether services to Barnsley from Huddersfield have reduced over time?

WYCA: Since the insolvency of the service provider the services have reduced

Question from a Councillor: The assessment regarding journey times was done in 2014. Is this relevant now? Is it as robust as it could be?

CCG: The report is as it is. We are not aware of any significant changes since the report was completed.

Question from a Councillor: Where is the up to date information – we need up to date information about services, especially evening services.

CCG: We have recognised that travel on public transport could be an issue and we have set up a special consultation / discussion about this – especially how it is likely to affect visitors. We are also looking at planned appointments and the use of choose and book systems.

Question from a Councillor: Choose and book is fine for the initial appointment but follow up appointments are made by the various clinics for outpatients – how will this be managed?

CHFT: We are looking at moving outpatients into localities. Also at how appointments can be negotiated. Outpatients and diagnostics will be at both hospital sites.

Question from a Councillor: Journey times are a real issue – for example for people living in Flockton / South Kirklees / North Calderdale – there will be real difficulties. In HD8 currently the Ambulance Service has the lowest response rates in West Yorkshire – how will this affect them?

YAS: Using modelling, we will need an extra 10,000 hours over the region. We anticipate a reduction of 0.6% in response times.

Question from a Councillor: Who will bear the cost of the 10,000 hours?

CCG: We anticipate discussion about this – the costs have not been quantified.

Question from a Councillor: There are issues about waiting times at the A&E location

YAS: The current turnaround time is 20-30 minutes. With the new model we anticipate this will reduce to less than 15 minutes

Question from a Councillor: What are the differences between the extra hours required across the two sites?

YAS: We estimate overall in the region of 10,000 hours. If the central A&E was at Huddersfield this would be 8,500 – if Halifax around 9,500.

Question from a Councillor: What is the impact of longer journey times on clinical outcomes? Is there any assessment of the possibility of improved outcomes of going to one better centre against the possible increase in journey time to get to it?

YAS: There is evidence in other areas that by centralising acute surgery there were improvements. There have been changes to the children's services - all go direct to Calderdale now – not aware that more children have come to harm. We know that taking a major trauma to a centre of excellence gives a better outcome and far outweighs the additional risk that would be caused by extra journey time.

Question from a Councillor: There must be a point where the risk is reached?

CCG: There is a consensus that 45 minutes is the optimum time. Response time to the emergency is important – to get the paramedics there first. No doubt there is a tipping point. Re-configuration has worked in other clinical areas. First responders getting to the scene and beginning treatment started is fundamental.

Question from a Councillor: What about the 'golden hour'?

CCG: Treatment should be started within the golden hour, which would be at the scene.

Question from a Councillor: Most traffic has to go through Ainley Top – what impact will this have on extra journey time?

Kate Thompson: Current modelling has been around the current traffic flows. We need to design this change into the scheme. We are also talking to Highways England about an additional 24a junction on the M62 which could take traffic away.

Question from a Councillor: What is the significance of the 45 minute journey time?

CHFT: anything over that would be considered very significant.

Question from a Councillor: Has the YAS modelling considered the 'golden hour', getting treatment started, journey, handover time to hospital staff, turnaround time and readiness for the next call, end location of the ambulance which could be Huddersfield / Calderdale / Pinderfields – how have you modelled the back fill required in order that you can continue to meet response time?
YAS: All of the above have been used to come to the 10,000 hours figure. We have actively modelled activity and we believe 10,000 hours will fill the gap.

Question from a Councillor: Rapid response teams often get there first – how many extra will you need?

YAS: The job cycle has increased – not the activity. Rapid response stay in the area after a call out – there will be no impact on those resources.

Question from a Councillor: Will you expect to use more St. John's ambulances or will you be able to reduce dependency on these?

YAS: We currently use St John's ambulances and private sources. The plan is to increase YAS resources and staffing and move away from these providers.

Question from a Councillor: If one centre has to go on divert – where will you go and will they be able to cope?

YAS: In the last 6 years there has not been a divert – and this centralised system will be more efficient so even less chance of a divert. It would be a very last resort – but there are plans in place should this happen.

Question from a Councillor: Have you discussed capacity requirements that you will need at CRH?

YAS: Yes we know what is needed and have been in discussions about this.

CCG: Further discussion will take place about the location of ambulances after they leave the site.

Question from a Councillor: Are plans in place in case of a major emergency from Syngenta (or similar engineering site) or the like?

CCG: When we know what we are going to deliver we will develop emergency plans. We need to deliver resilience and a better service – we have to improve emergency services. We have plans to improve care at home and in the community and so reduce the need to transport to hospital.

Councillor: We need these figures again – they don't match the aspiration to providing local care.

CCG / YAS: The figures reflect what we are doing now.

CCG: We had discussions with Sygenta - they have their own emergency response teams.

Question from a Councillor: What account has been taken over future planning – where the houses / industry is likely to be?

CCG: We are open to suggestion as to how we engage with local authority planning in the future.

Question from a Councillor: When do you intend to establish your travel / transport group?

CCG: We are looking at this, but don't want to set up anything before the decision is made

Question from a Councillor: Have any timings been calculated for blue light runs?

YAS: Not as such – the modelling takes this into account.

Cllr Collins: When the proposals were first made we set up a People's Health Commission. We spoke to YAS, pharmacists, GP's, hospitals and unions. We took the position that we wanted to see a proper balance between both hospitals. Important to consider what's best for the people of Kirklees and Calderdale. Given the background created by current government and the strength of public feeling we need to find the best solution

Councillor: The Jacob's report (journey time report) needs updating.

Rory Deighton (Healthwatch): Journey times are of a concern. We also need more explanation about proposals around treatment closer to home.

Future Model of Care - Patient Flow

CCG: We are working on data around the impact on neighbouring trusts – we have shared information and will continue to work with them

Question from a Councillor: We want to see this – also the other details asked for – flow of people between Barnsley Trust and Kirklees – and the impact on other routes. Are you talking to all neighbouring trusts?

*CCG: W*e will have completed the data collection by June.

Future Model of Care - Estate:

Question from a Councillor: With reference to the PFI and the proposed changes to the CRH site – what is the risk if the PFI provider will not agree? What are the risks of not getting planning permission to build the required extensions?

Question from a Councillor: Who owns the Acre Mill site in Huddersfield? How will you deal with the backlog of work at HRI – how will you finance this going forward?

CHFT: The site at Acre Mill is owned by a joint venture company. We did not have the condition survey from HRI before we started the report. The major issue is one of capacity of existing services (electrical / gas / water) – they are all at full capacity - any extension would mean a new sub-station.

Update regarding the consultation process

CCG: So far carried out 440 hours of consultation time and information events. 356 people have attended the information events. 2 public meetings, continuing surveys – still receiving them. Returns are low considering the size of the population.

The public meetings are only one method. The information sessions have been well populated with specialists who have helped people to understand the rationale behind the proposals.

Member of the public question to the Joint Committee: Please could we have access to the reports you are working from – can these come into the public domain? The Chair noted this request.

Chair – noted

The meeting closed at 6.45pm

This page is intentionally left blank

KIRKLEES COUNCIL

COUNCIL/CABINET/COMMITTEE MEETINGS ETC
DECLARATION OF INTERESTS

Name of Councillor

Item in which you have an interest	Type of interest (eg a disclosable pecuniary interest or an "Other Interest")	Does the nature of the interest require you to withdraw from the meeting while the item in which you have an interest is under consideration? [Y/N]	Brief description of your interest

Signed: …… **Dated:** ……

NOTES

Disclosable Pecuniary Interests

If you have any of the following pecuniary interests, they are your disclosable pecuniary interests under the new national rules. Any reference to spouse or civil partner includes any person with whom you are living as husband or wife, or as if they were your civil partner.

Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner, undertakes.

Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses.

Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -

- under which goods or services are to be provided or works are to be executed; and
- which has not been fully discharged.

Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

Any tenancy where (to your knowledge) - the landlord is your council or authority; and the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -
(a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and
(b) either -

the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

Kirklees COUNCIL

Name of meeting: Calderdale and Kirklees Joint Health Scrutiny Committee
Date: 14 June 2016

Title of report: Right Care, Right Time, Right Place Programme Update

Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**No**
Is it in the Council's Forward Plan?	**No**
Is it eligible for "call in" by Scrutiny?	**Not Applicable**
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 to provide the context to the Committee discussions with Calderdale CCG; Greater Huddersfield CCG; North Kirklees CCG ; Locala Community Partnerships and Calderdale and Huddersfield NHS Foundation Trust**
Cabinet member portfolio	**Prevention, Early Intervention and Vulnerable Adults**

Electoral wards affected: All

Ward councillors consulted: N/A

Public or private: Public

1. Purpose of report

1.1 To provide members of the Calderdale and Kirklees Joint Health Scrutiny Committee (JHSC) with an update on the work that is being undertaken on the Care Closer to Home (CC2H) programmes in Calderdale and Kirklees.

2. Key Points

2.1 Clinical Commissioning Groups (CCG's) in Calderdale and Kirklees in line with the national agenda and planning guidance have been shaping proposals for care at or closer to home.

2.2 This work is an important element of wider transformation programmes that are being developed across the district that are based on the acute trust footprints.

2.3 Representatives from CCG's in Calderdale and Kirklees, Calderdale and Huddersfield NHS Foundation Trust and Locala Community Partnerships will be in attendance to provide the Committee with an update on the first two phases of the Care Closer to Home (CC2H) programmes to include:

- Progress on the Upper Valley (Calderdale) Vanguard and its implications for CC2H;
- Details of services that are included in the CC2H programme and those that are scheduled for inclusion in the later phases of the programme;
- The contribution that CC2H will make to the proposed future arrangements for hospital services;
- How the CCG's will assess the contribution of the CC2H programme in reducing demand on the hospitals;
- How health and social care will work together to reduce hospital admission, re-admission and discharge waiting times.

2.4 A report produced by the CCG's that covers the areas above is attached for information.

3. Implications for the Council

None at this time.

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 221000 E-mail: richard.dunne@kirklees.gov.uk

9. Assistant Director responsible

Julie Muscroft Assistant Director: Legal, Governance & Monitoring

REPORT TO THE JOINT CALDERDALE AND KIRKLEES HEALTH OVERVIEW AND SCRUTINY PANEL JUNE 2016

Right Care, Right Time, Right Place Programme update

1.0 BACKGROUND

The Right Care, Right Time, Right Place programme commenced public consultation on proposed future arrangements for hospital and community health services on 15th March 2016. The Consultation will run until 21st June, 2016.

In support of the decision to proceed to consultation the CCGs produced a Pre-Consultation Business Case (PCBC) which sets out: why change is needed; what our engagement has told us; the changes we are proposing; the impact of the proposed changes (including reports from the Clinical Senate; A quality Impact Assessment; and an Equality Impact Assessment); the modelling and analysis of the options and the options Appraisal. This document together with the Consultation Plan was shared with the Joint Scrutiny Panel in January, 2016.

Following the decision to proceed to Consultation, the CCGs have used these documents to produce the Consultation Materials. The Consultation Document, Summary and Survey, together with the PCBC and supporting documents in the form of a Travel Analysis outlining the impact for patients and the analysis undertaken to understand the implications for the Yorkshire Ambulance Service have been made available on the rightcaretimeplace website.

In parallel to the CCGs' consultation, the Joint Calderdale and Kirklees Health Overview and Scrutiny panel is conducting a series of meetings, each considering different elements of the CCGs' proposed changes. These meetings have, so far, considered: The need for change; the Future model of care (in relation to Urgent and Emergency Care; Planned Care; Maternity Services; Paediatric Services; and Diagnostics); and Patient accessibility including impact on surrounding acute trusts and the Yorkshire Ambulance Service.

The meeting on 14th June will be considering: Care Closer to Home; Implications for Social Care; and Public Health.

2.0 INTRODUCTION

The purpose of this report is to provide an update from Calderdale CCG and Greater Huddersfield CCG in relation to:

- Progress to date on Care Closer to Home Phases 1 and 2
- Progress on the Upper Valley (Calderdale) Vanguard and its implications for Care Closer to Home
- Detail on services that are already included in the Care Closer to Home and that are scheduled to be included in Care Closer to Home.
- The contribution that Care Closer to Home will make to the hospital reconfiguration

- How the CCGs will assess the contribution of the Care Closer to Programmes to reducing demand on the hospitals.
- How Health and Social Care will work together to reduce admissions, re-admissions and discharge waiting times.

Both the Calderdale Care Closer to Home Programme and the Kirklees Care Closer to Home programmes are also subject to separate Scrutiny arrangements by Calderdale Council and Kirklees Council respectively. In order to reflect the overlap of Scrutiny arrangements both CCGs have produced separate reports in relation to their Care Closer to Home Programmes. The Calderdale Report is attached at Appendix A. The Greater Huddersfield report, attached at Appendix B, was initially produced for Kirklees Overview and Scrutiny Committee on behalf of Greater Huddersfield CCG, North Kirklees CCG and Locala Community partnerships.

3.0 PROGRESS TO DATE ON PHASES ONE AND TWO

The progress made to date in relation to Phase One of both Care Closer to Home (CC2H) Programmes is detailed in the attached reports. For Calderdale CCG this is set out at Appendix A to the Calderdale CC2H report and for Greater Huddersfield this is set out at Section 8 in the Kirklees CC2H report.

As referenced in both CC2H reports, progress in relation to Phase two of both CC2H programmes is dependent on the outcome of Consultation. The proposed future arrangements are set out in the Consultation Document on page 36. For ease of reference, the proposals are also set out at Appendix C.

The questions in relation to Community Services are on Page 9 of the Survey.

4.0 PROGRESS ON THE CALDERDALE VANGUARD AND IMPLICATIONS FOR CC2H.

Calderdale CCG's CC2H Programme sought and successfully received Vanguard Status in 2015. As outlined in the report attached at Appendix A, the CC2H programme and the Calderdale Vanguard are one and the same programme not separate programmes. The progress in relation to services at Todmorden Health Centre is set out in the section which is headed 'Care Closer to Home – Our plans for 2016/17.

5.0 DETAIL ON SERVICES ALREADY INCLUDED AND SCHEDULED TO BE INCLUDED IN CC2H

The services that are already included the CC2H programmes is detailed in the attached reports. For Calderdale CCG this is set out at Appendix A to the Calderdale CC2H report and for Greater Huddersfield this is set out at Section 5 in the Kirklees CC2H report.

As referenced in both CC2H reports, services proposed to be scheduled in Phase two of both CC2H programmes is dependent on the outcome of Consultation. The proposed future arrangements are set out in the Consultation Document on page 36. For ease of reference, the proposals are also set out at Appendix C.

6.0 THE CONTRIBUTION THAT CC2H WILL MAKE TO THE HOSPITAL RECONFIGURATION

From the outset, these programmes of work have been aimed at improving health outcomes and reducing an over-reliance of our system on unplanned hospital care. The proposed future arrangements for hospital services are inextricably linked with the improvements in patient care, and delivery of care closer to home initiatives.

We know from what our engagement has already told us that:

- As many services as possible should be close to home in local settings such as a GP practice with improved waiting and appointment times
- Services that are coordinated and wrap around all the persons needs involving a range of partners and agencies
- The right staff. With the right skills that are caring and competent and treat people with dignity and respect
- Services that are properly planned and that are appropriately staffed and resourced, have the right equipment and maintain quality
- More information available about health conditions and more communication about what is available to ensure people can make choices and have support to self-manage health care
- Services that everyone can access including clean comfortable buildings aimed at the right target audience, appropriate information and staff that represent the community they serve.
- Any barriers to parking, travel and transport addressed with a clear plan which takes account of diversity and locality
- Improved communication between all agencies involved in a person's care and treatment including better communication with young people
- Services that are responsive and flexible - particularly in an urgent care situation
- Reduce delays in getting the care and treatment required and improving waiting times
- Technology that people can use to reduce travel times and unnecessary journeys – particularly for young people
- Support for mental health across all services

A key focus of the CC2H work has been to shift the balance from unplanned and avoidable hospital admissions, to planned, integrated care provided in community and primary care settings which would deliver prevention and self-care at scale and provide the opportunity to reduce health inequalities by the implementation of services that are bespoke to communities.

We have confidence that the changes we are proposing will have a positive impact on: Non elective admissions for both Emergency long stay (EMLS) and emergency short stay (EMSS); Ambulatory Care sensitive conditions and Conditions not usually requiring admission.

The proposed capacity for future hospital arrangements incorporates the agreed reductions (CIP and QIPP) in avoidable emergency admissions in the patient cohorts (frail/elderly, ambulatory care sensitive conditions, people with long term conditions).

7.0 HOW THE CCGS WILL ASSESS THE CONTRIBUTION OF CC2H

Calderdale CCG has set out how they will assess the contribution of CC2H at Appendix B to the Calderdale CC2H report. Greater Huddersfield CCG has set out the benefits realisation approach in section 8 of the Kirklees CC2H report.

8.0 HOW HEALTH AND SOCIAL CARE WILL WORK TOGETHER

Health and Social care are already working together to reduce admissions, re-admissions and discharge waiting times.

The Health and Social Care Act 2012 places a duty on CCGs to promote integration and NHS England guidance clearly articulates the need to integrate health and social care services to improve the effectiveness, safety and quality of services for patients. The introduction of the Better Care Fund provides for the pooling of health and social care resources to jointly commission services.

The specific initiatives which are already being progressed and those which could be included in phase 2 of CC2H are referenced in Section 5 above.

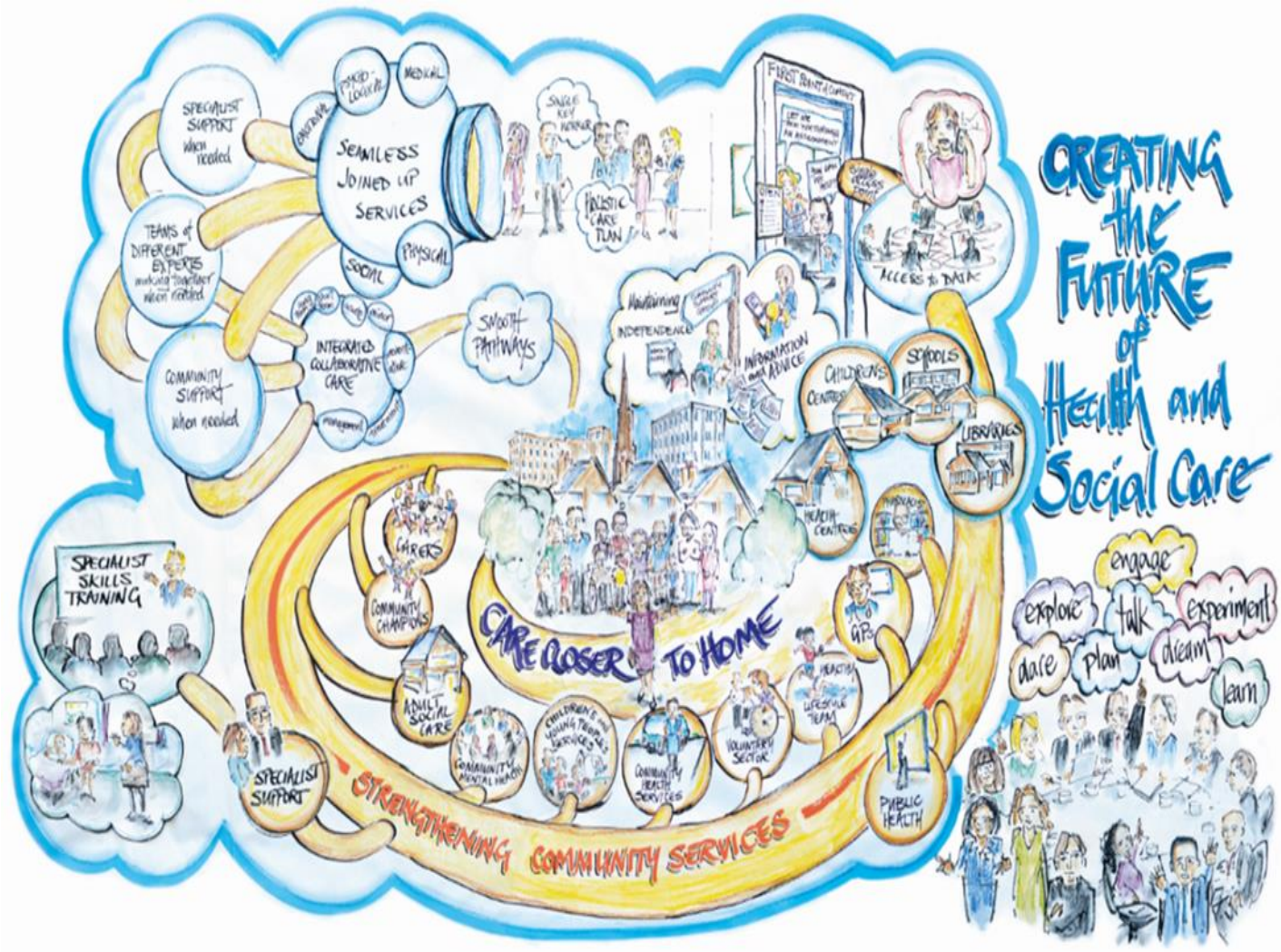
For Calderdale CCG, the CC2H and Better Care Fund (BCF) plans are aligned and the BCF continues to be used as a vehicle to develop integrated commissioning models with Calderdale Council. In addition Calderdale CCG is also working closely with partners on the Health and Wellbeing Board to develop the Local Transformation Plan (LTP) for Children and Young People's Emotional Health and Wellbeing.

Greater Huddersfield CCG is an equal partner, with North Kirklees CCG and Kirklees Council in an Integrated approach to commissioning across Adults and Childrens Health and Social Care and Public Health. The Integrated Commissioning Executive (ICE) which is made up of senior commissioners from across the Council and CCGs is leading this work

Both CCGs plans for integration will also be clearly articulated in the Strategic Transformation plans for both Calderdale and Kirklees which are due for submission on 30 June.

Jen Mulcahy,
Programme Manager, NHS Calderdale CCG and NHS Greater Huddersfield CCG
3rd June, 2016

NHS
Calderdale
Clinical Commissioning Group



Care Closer to Home (CC2H) in Calderdale

Update to JOSC – June 2016 (v3.0)

1.0 Purpose of the Report

The purpose of the report is to provide JOSC members with an opportunity to consider the following information:

(a) High level context for the development and delivery of Care Closer to Home (CC2H) in Calderdale, including an overview of the evidence considered by the CCG's Governing Body in August 2015 (Appendix B)

(b) An update on the implementation of CC2H since its initiation in 2013/14 and our plans for further work during 2016/17 (both detailed in Appendix A).

(c) An articulation of our approach to commissioning CC2H since its inception, and plans for its re-commission in 2017.

(d) The role of social care in the delivery of CC2H and the hospital change programme.

(e) The role of primary care in the delivery of CC2H and the hospital change programme.

2.0 High Level Context

Set against a backdrop of; high incidence in a number of key conditions: respiratory, cardiovascular and cancer, issues with premature loss of life and health inequalities, an increasing population of over-65s and young children, pressure on acute care and national fiscal challenges, it was clear that radical change was required to ensure our system is resilient and sustainable into the future. The need for transformation was underpinned by a number of factors which are present within the Calderdale health community – some of which are articulated below:

- Equitable and easy access to services is challenged by geography and demographics.
- Patients have told us of their desire to improve self-management, especially for long-term conditions, and to reduce dependency and social isolation. They want more holistic care plans and integrated ways of working.
- There is a potential to maximise community estate e.g. community buildings/libraries to support better community offers and support the sustainability agenda.
- There are significant workforce challenges and the need to change culture and ways of working.
- There is a requirement to make long-term financial savings which make the system viable and sustainable.

In July 2011, the CCG (in shadow form) developed its first vision and a set of values. These were set out in the CCG's first 'Commissioning Plan for 2012/13'. The Plan set out the CCG's intent to commission care closer to home and the programmes of work which would be delivered during our first year as a CCG (2012/13). From the outset, these programmes of work were aimed at improving health outcomes and reducing an over-reliance of our system on unplanned hospital care.

The CCG continued to articulate this ambition in its 5 Year Plan published in 2014/15, and One Year Plans for 2014/15, 2015/16, and most recently for 2016/17.

3.0 Strategic Context for CC2H

The 5-year strategic direction outlined by the CCG is underpinned by the delivery of four critical and interlinked pieces of work:

- Calderdale Care Closer to Home Programme (our Calderdale Vanguard)
- Calderdale Health and Wellbeing Strategy
- Calderdale Primary Care Strategy
- Hospital Services Programme *with Greater Huddersfield CCG*

Implemented in three inter-related phases over the next five years:

Phase 1	Strengthen existing community services in line with the Five Year Forward View
Phase 2	Further enhance community services – by creating new care models (focusing on prevention and supported self-care), new organisational forms and strengthening the role of primary care. Formally consult the public on hospital change and CC2H (phase 2 services)
Phase 3	Delivering the hospital changes and organisation change needed to make our system safe and sustainable

We are currently in Phase 2 and we are in formal consultation about both the second phase of CC2H and the configuration of future hospital care.

4.0 Implementation of CC2H since 2013/14

The long term trends facing the NHS in England have seen greater volumes in both emergency care and elective activity, with emergency admissions increasing by 2.9%.

The key focus of the CC2H work has been to shift the balance from unplanned and avoidable hospital admissions, to planned, integrated care provided in community and primary care settings – delivering prevention and self-care at scale. The work we do seeks to deliver the triple aim of; improving health, improving care and improving value.

In Calderdale, we believe that the work we have done with our partners on CC2H has had a significant impact on our growth in emergency admissions. The table below summarises this position for Calderdale compared to the national picture. It indicates that the rate of growth in Calderdale has been less than half that of the rate experienced nationally.

Volume of Emergency Admissions, 2014/15 to 2015/16:

	Calderdale	England
2014/15	22,313	5,497,523
2015/16	22,563	5,656,112
% change	1.12%	2.9%

Appendix A sets out a comprehensive view of CC2H initiatives and service developments undertaken during; 2013/14, 2014/15 and 2015/16, and our plans for 2016/17. The benefits of the initiatives we have developed and commissioned have been articulated in line with our triple aim.

5.0 Our Approach to Commissioning CC2H

In August 2015 the Calderdale CCG Governing Body agreed an approach to commissioning services included in or aligned to services that would be provided as part the scope of Care Closer to Home in Calderdale.

It was recognised at that time that there were two significant issues that influenced the approach and that these influences would continue into the future, these being the developing work around 'Right Care, Right Time, Right Place' and the Calderdale Multi-Specialty Community Provider Vanguard project. The view taken at that time was that it was not possible to adequately specify the model of care required within Calderdale until work associated to do so in both of these programmes was completed.

The Governing Body were of the view that the absence of a clear service model including those services to be included; and/or the emerging development of commissioner and provider relationships resulting from the Vanguard process; made it difficult to determine the benefit to either patients or the taxpayer of embarking on the re-commissioning of contracts for services that would fall due within the short term i.e. up to the end of March 2017.

As a result of this decision the CCG has maintained its approach to commissioning these services through a number of ways: extension and/or of existing contract terms; short term direct contract awards; and grants to third sector all of which focussed on extending arrangements and maintaining continuity of provision of the services to patients until the end of March 2017.

At this point in May 2016, it is clear that although work on developing the new service model has progressed it is clear that it is not yet ready to be launched to stakeholders, not least as significant elements of the model are dependent on the outcome of the consultation

currently underway on hospital re-configuration. The outcome of the consultation is not expected until October 2016.

There is a hierarchy of concerns that the CCG must take into account as we work our way through to the sign off of a specification and a procurement approach in relation to these sorts of services.

First we will need to deliberate on the outcome of consultation, and what that dialogue has told us about the views of the people who we serve about the content of Care Closer to Home and the phasing of delivery.

Second, we need to ensure that we have determined the ability of existing providers to deliver to the existing service specification, the quality of that delivery and the willingness of our existing market to work collaboratively to any new service specification that we might wish to use as the basis of delivery.

Third, we must pay due regard to procurement legislation and ensure that any decision that we take in relation to the securing of Care Closer to Home services is compliant and defensible, should there be a market challenge.

It is extremely unlikely as we stand that this process could be completed to allow an April 2017 commencement. A more realistic view is assuming that the service model is completed within the next two months with an October 2017 start being possible. A paper will be submitted to the Calderdale CCG governing body in the autumn which will map out the issues and risks, and make recommendations on the timeline and the likely consequences for contractual arrangements from April 2017. Subsequent to that, it is likely that the CCG need to review its contracts, grants and agreements to determine the action required to both maintain continuity of service to patients, assess the quality of provision and determine its commissioning approach for each e.g. extension, variation and/or the use of short term contract procurements to cover the period up to the agreement and commissioning of a new specification.

6.0 Role of Social Care in CC2H and Hospital Change.

The Health and Social Care Act 2012 (2012 Act) places a duty on CCGs to promote integration. It specifically states that CCGs have a duty to ensure that the provision of health care services is integrated with the provision of health related services and social care services.

The '*Everyone Counts: Planning for Patients 2014/15 to 2018/19'* guidance issued by NHS England clearly articulates the need to integrate health and social care services to improve

the effectiveness, safety, and quality of services for patients. The introduction of the Better Care Fund from 2015/16 onwards is a significant step towards achieving this and clearly signals that the pooling of health and social care resources to jointly commission services is the national direction of travel.

The health and social care landscape is changing fundamentally and rapidly with greater integration between health and social care being both the national and local direction of travel. Better integration has the potential to deliver better care and services, make better use of resources and facilitate progression of local transformation.

Our CC2H and Better Care Fund (BCF) plans are aligned and we have continued to use BCF as a vehicle to develop integrated commissioning models with Calderdale Council. We have also worked closely with partners on the Health and Wellbeing Board to develop the Local Transformation Plan (LTP) for Children and Young People's Emotional Health and Wellbeing.

Our plans for integration will be clearly articulated in the Calderdale STP which is due for submission on 30 June.

7.0 Role of Primary Care in CC2H and Hospital Change

The CCGs Primary Care Strategy is a critical element of our plans to transform our local system and deliver both CC2H and our hospital change programme. Whilst the Strategy focuses on general practice, it gives a clear steer about the importance of working with wider primary care providers and other stakeholders.

We know that General Practice is at the heart of a wider system of integrated out-of-hospital care in Calderdale, and we have strengthened the links between primary care, community health services, acute care, Social Care, third sector organisations and Community Pharmacy West.

Based on authoritative sources such as the Kings Fund and the British Medical Association (BMA), the Strategy expresses the need for new models of primary care that can deliver 'primary care at scale'.

General practice by definition entails a high degree of integration, offering a comprehensive service that deals with the health of the whole person in the context of their socio-economic environment. Primary care is therefore fundamental to the success of the CC2H model. An increasingly important part of general practice is the treatment and management of long term conditions, which form a large proportion of our local opportunity to reduce avoidable admissions. Beyond the direct provision of care, GPs' role as the gateway to more

specialised treatment means that they play a crucial role in facilitating the smooth transition for patients across organisational boundaries.

It is recognised nationally that patients who receive continuity of care in general practice have better health outcomes, higher satisfaction rates and the healthcare they receive is more cost effective. Improving access to general practice is the first step for most patients in diagnosing and treating health problems and this is identified as the highest priority within our strategy, along with reducing variation across pathways.

Our strategy articulates that good access to general practice matters for patients and for the health system. Prompt diagnosis and treatment are important in achieving the best health outcomes for those patients whose conditions will not get better on their own. The strategy recognises national evidence that higher rates of continuity within general practice will also have an effect on other parts of the healthcare system, producing savings in prescribing, hospital referral, hospital admissions and the use of A&E.

Research has estimated that in 2012 13, 5.8 million patients attended A&E or walk-in centres because they were unable to get an appointment or a convenient appointment in general practice. National Audit office estimated that a typical consultation in general practice costs £21, whereas hospitals are paid £124 for a visit to A&E.

Within Calderdale we have seen the establishment of a GP Federation (the Pennine GP Alliance) which represents all 26 practices in Calderdale and 100% of the local population. The Alliance provides an important vehicle to facilitate the shift of services into primary care and community settings - delivering innovation that benefits patients and delivers value for money. We believe this is an important feature of our ability to delivery change at scale within general practice locally.

Care Closer to Home in Calderdale – An overview (App A)

Care Closer to Home - 2013/14

2013/14 saw the CCG start to work with its partners to deliver CC2H:

(a) Tackling the impact of loneliness in older people

The CCG and Calderdale Council jointly invested nearly £1 million to tackle the problem of loneliness, because in Calderdale

- 11,520 people aged over 65 live alone
- About 30% feel lonely
- 12% feeling trapped in their home.

In its first year the programme worked with established community organisations and development trusts across Calderdale to start to strengthen existing support across a range of community-based schemes. The aims of the initiative were to:

- Enhance bespoke activities in local communities;
- Build on existing local voluntary sector and neighbourhood initiatives.
- Have 4 community 'hubs' (North Halifax Health Alliance, Halifax Opportunities Trust, Elland & District Partnership and Hebden Bridge Community Association)
- Support local community workers, voluntary groups, health and council partners to deliver the project aims.
- Mainly focus relies on voluntary and community sector.
- Support a key priority of the Health and Well-being Board; links to the Better Care Fund, part of wider Care Closer to Home Strategy, links to sustainability agenda.

Benefits of the work:

- **Reduced utilisation of hospital services:** reduces reliance on hospital and other formal care services
- **Improved health:** reduces falls and episodes of depression
- **Improved care:** reduces medication reliance and cost
- **Improved value:** reduce utilisation of primary care services and increases use of their sector provision.

(b) Improved Services for people with learning disabilities

The CCG and Calderdale Council committed to working together to review and improve local services for people with a learning disability

We gathered views and actively engaged with service users, families and carers as well as the statutory and 3rd sector in Working closely with local providers we planned a new Calderdale model for Learning Disabilities.

We commissioned a number of new supported living services. This has enabled 10 people to move back into Calderdale so far, so that they can be closer to their families and support networks

A key principle is that services are in place to support individuals to remain in the community close to home and families.

Benefits of the work:

- **Reduced utilisation of hospital services:** reduced unplanned admissions by keeping people independent and well at home
- **Improved health:** supported people in communities closer to home
- **Improved care:** integrated service offers around the needs of individuals
- **Improved value:** reduced expensive out of area placements

(c) Developed a Support Independence Team (SIT)

The CCG and Local Authority commissioned this service to deliver joint a assessment service via a single point of access (Gateway to Care). The team consists of; therapy crisis intervention, falls prevention, Out of Hours Homecare, Out of hours District Nursing community, rapid response and re-ablement

Its aims are to support people to remain at home and independent for as long as possible. This reinvestment improved the quality of care provided to patients in the communities.

"As busy GPs we love single point of access services and Gateway to Care is a great example of this. There is now no duplication of services and communications and record-keeping is much more efficient. All contacts with the team are dealt with in a professional and courteous manner and I feel this is a flagship service moving forwards."

"Hi – I had to text to thank you properly for all you have done today, the relief is indescribable, my mum is very happy that she will be visited four times a day for now and our family has had a great weight taken off its mind . Thanks for everything."

Benefits of the work:

- **Reduced utilisation of hospital services**: reduces the risk of an avoidable acute admission to hospital
- **Improved health**: promotes early supported safe discharge from hospital of individuals to their own home or into an intermediate care bed
- **Improved care:** ensures the safety, dignity and privacy of the individual, maximise independence and optimise mobility to reduce continuing dependency on care and support services
- **Improved value**: preventing avoidable admissions to long term care

(d) Developed our flagship Quest for Quality in Care Homes programme – phase 1

Improving the quality of care in care homes was one of the first priorities of the CCG. Working closely with the Local Authority, the first phase focused on assistive technology.

We supplied technology (telehealth monitoring and telecare) to 25 nursing and residential care homes in Calderdale. Summerfield House in Halifax was the first nursing home to have Telecare installed.

Further phases continued in the following two years.

Benefits of the work:

- **Reduced utilisation of hospital services:** supported the reduction in unplanned admissions (see phase 2)
- **Improved health:** supported a reduction in falls.
- **Improved care**: additional support for care homes to delivery better patient care across a range of conditions
- **Improved value:** supported a reduction in unplanned admissions (see phase 2)

(e) Supporting people with Respiratory Conditions at home

Respiratory conditions are one of the most prevalent long-term conditions affecting people in Calderdale. 24 tele-monitoring systems were installed initially in the homes of those with COPD

This work was part of a programme work aimed at reducing mortality and avoidable admissions for those with a long term conditions

Benefits of the work:

- **Reduced utilisation of hospital services:** reductions in number of admissions and average LOS for some patients, Supporting early discharge
- **Improved health:** improvement in patient's perceptions of their empowerment/being more in control of their care, Enabling early intervention, Improving self-management
- **Improved care:** early identification of potential exacerbations, prompting early treatment, Preventing future complications for those who haven't yet started to access extensive healthcare, Improving medication compliance
- **Improved value:** reductions in number of admissions and average LOS for some patients

"Its very good, informs the nurses how I feel every day, I feel as though they are keeping an eye on me day-to-day. I have a pulse oximeter also and that is also very

helpful, I take my readings each day and write them down."

"I feel supported, like someone is monitoring me. It is a huge confidence boost for me. A life-saver. Thank you for letting me have it."

Care Closer to Home - 2014/15

2014/15 saw the CCG accelerated the implementation of Care Closer to Home with its partners. We:

- Produced a CC2H Specification and set this within provider contracts with clear links to delivery of our Better Care Fund (BCF) Plans.
- Saw our acute provider (CHFT) develop a new clinically-led division within its structure to oversee and drive forward delivery of Care Closer to Home – with strong links to the work of the new GP Federation.
- Strengthened relationships with 128 health-related providers in the third sector.
- Brought together providers within a new CC2H Implementation & Innovation Hub.
- Continued to implement new models of care such as the Quest for Quality in Care Homes; a new model of respiratory care; initiatives to tackle social isolation and loneliness;
- Commissioned a new Palliative Care Collaboration between Health, Marie Curie and Overgate Hospice providing out-of-hours support and care to people with palliative care needs;
- A new Child Health Care Closer to Home pilot in North East Halifax – bringing together; CHFT, GPs, and Children's Community Nurses delivering paediatric clinics in the community at a Children's Centre.
- Worked with our third sector providers to deliver new models of Social Prescribing – supporting health and social care to access a different menu of support for patients.
- Continued to strengthen current integrated health & social care intermediate care

More detailed examples of implementation of CC2H are set out below:

(a) Health Connections – supporting Third sector organisations

The Health Connections Programme was commissioned by the CCG from Voluntary Action Calderdale to provide support to the third sector on:

- **Capacity Building** – organisational development and resilience.
- **Safeguarding and Equalities** – policy development and implementation ongoing professional development of staff.
- **Partnership working** – facilitation of partnerships, networking to encourage partnerships.
- **Engagement** – building community assets (engagement champions), undertaking engagement, supporting network development.
- **Grants** – small and partnership grants via Calderdale Community Foundation, large grants directly from Calderdale CCG.
- **Patient Reference Group (PRG) development** – support for practice managers and PRG members.

In 2014/15 this delivered

- increased levels of quality in frontline organisations particularly around safeguarding and equalities
- Clear demonstrations of the value that the Voluntary and Community Sector (VCS) can bring to improving health outcomes.
- Increased delivery of health outcomes via grant investment, particularly around mental health, drugs and alcohol, obesity and diabetes.
- Increased partnership working between VCS groups – particularly around older people, BME, mental health and dementia.
- Increased number of PRGs operating effectively in Calderdale
- Improved reach into local communities.
- Increased and more effective engagement with local people in local communities.

Benefits of the work:

- Strengthened capacity and capability of the sector to enable providers to proactively support delivery of CC2H
- The sector has been able to pilot and test new initiatives to improve outcomes
- The sector is able to evaluate and learn from the progress made, sharing insights across the sector via VAC
- Enhanced resilience across the sector through partnership and integrated ways of working
- Population has access to a wider range of services to help support their needs closer to home
- The sector is a recognised and valued asset in Calderdale that is able to play an effective role in the development of new models of care.

(b) New Service for people with Respiratory Conditions – a new community team

The CCG invested significantly in the commissioning of a fully integrated service from CHFT. Its aims were to improve outcomes for people with respiratory disease and reduce avoidable hospital attendances and admissions. It will be managed through a single point of access. Key features include:

- 7 day service
- Nurse-led community clinics
- Multi –disciplinary teams
- 'Hot Clinics' - daily specialist clinics
- Post-discharge home visits and regular contact with the patient to monitor their condition

In addition, for children we asthma, personalised supported self-management plans are being developed with the child and their family – shared with their school and/or nurseries. We are aiming to expand this approach to include activity clubs.

Benefits of the work:
This year saw development of the new model and therefore the impact was not felt until subsequent years. From a relatively early stage we had a high level of patient satisfaction with a 95% survey completion rate and 75% of patients giving a positive view of their experience of the new service.

(c) Palliative care Pilot

The pilot was aimed at creating:

- More comprehensive advanced care planning and early identification of patients at the end of life;
- Better care coordination across the pathway;
- Better planning to prepare for discharge and organise appropriate packages of care within the community; and
- Increased support to help people stay at home and avoid admissions to hospital, particularly out of normal working hours.

Four partner organisations; Calderdale CCG, Marie Curie Cancer Care, Overgate Hospice and CHFT launched a new out of hours specialist palliative care service in Calderdale.

Case Study: Multi-disciplinary team working: A young patient with pancreatic cancer was visited by the team one evening to help them to manage their symptoms of uncontrolled nausea and vomiting. The out of hours palliative care team supported an out of hours GP by advising on the appropriate type and course of anti-sickness medication based on the patient's condition and the medicines they were already taking. The palliative care team and GP agreed to make a joint visit to the patient's house so the GP could prescribe and provide the medication with the additional support of the expert team. The treatment worked and the patient's symptoms quickly settled

so they were able to feel more comfortable.

In order to further strengthen palliative and end of live care we significantly increased CCG funding for Overgate Hospice.

Benefits of the work:

- **Reduced utilisation of hospital services:** Reduced unplanned and inappropriate hospital admissions to hospital by 245 YTD in 2015/16.
- **Improved health:** Improved quality of life by reducing stress and anxiety and providing quality EoL care at home.
- **Improved care:** More patients dying in their preferred place of death. Improved access to specialist nurses and to information.
- **Improved value:** Reduced costs associated with admissions avoided, GP Callouts and Verification of Death by £171,490 YTD in 2015/16.

(d) Quest for Quality in Care Homes - phase 2

The Quest for Quality in Care Homes' initiative which began in 2013/14 had grown and had been fully implemented across 25 Calderdale Care Homes. This work was focused on 3 high impact changes:

- **Telecare in care homes** – care home staff request equipment that they feel would benefit residents. Largest deployment of telecare into care homes in the UK, supporting safety - wireless sensors around the home which detect risks e.g. falls.
- **Telehealth** monitoring in the care homes – testing vital signs of residents in the care homes (up to 500 people)
- **MDT working** – commissioning of an integrated social and clinical approach to support anticipatory care planning

The service:

- Supports care homes to treat non-urgent illnesses and manage long-term conditions
- Clinicians to access live clinical records in the care homes;
- 7 day working

- Reduces unplanned demand on GPs;
- Reduces avoidable hospital attendances, admissions and readmissions;
- Reduces the number of avoidable ambulance call-outs
- Enhances end of life care
- Enhances quality of care
- Maximises independence and dignity

Benefits of the work:

- **Reduced utilisation of hospital services:** 25% Reduction in emergency admissions, down by 25% year-on-year at March 2015, 26%. Reduction in hospital stays, down 26% year-on-year at March 2015. Hospital

bed days used down 16% year-on-year at March 2015

- **Improved health:** Supported residents to improve their overall health status, particularly in relation to long-term conditions.
- **Improved care:** Care home staff feel more supported and empowered. Improved medication compliance and reduction in missed doses
- **Improved value:** £456,166 Reduction in cost of hospital stays, 58% reduction in GP care home visits to Quest for Quality care homes.

(e) New Services for People with Mental Health Problems

In 2015/16 we made significant additional investments into mental health services. The CCG are working with partners and stakeholders to develop a system wide approach to transformation that supports individuals in the community

One of the main pieces of work was the redesign of rehabilitation and recovery services. Working with the local authority we aim to reshape and strengthen services in the community underpinned by a new community rehab and recovery team. This work is with partners in the NHS, the 3rd sector and private sector and will develop stay well and provide flexible and responsive specialist services where and when needed.

We also:

- Increased funding for Crisis Resolution Team to support 24/7 service.
- Invested additional funding and support to improve Child and Adolescent Mental Health Services to improve emotional health and wellbeing in Secondary Schools

Benefits of the work:

- **Reduced utilisation of hospital services:** reduce the need for hospital admission and minimise the length of stay where an admission to hospital for an individual is appropriate.
- **Improved health:** improve outcomes for children with mental health conditions
- **Improved care**: provide crisis services 24/7
- **Improved value:** reductions in hospital utilisation.

(f) Other Improvements

During 2015/16 we also made additional investment into:

(i) Wheelchair services – additional funding to support improvements in service provision.

Benefits of the work:

- **Improved health:** promotes independence and mobility
- **Improved care:** Improved environment and facilities for service users to access.
- **Improved value:** Access to clinic rooms extended to 5 days per week. Increased storage facilities and workshop has improved efficiency.

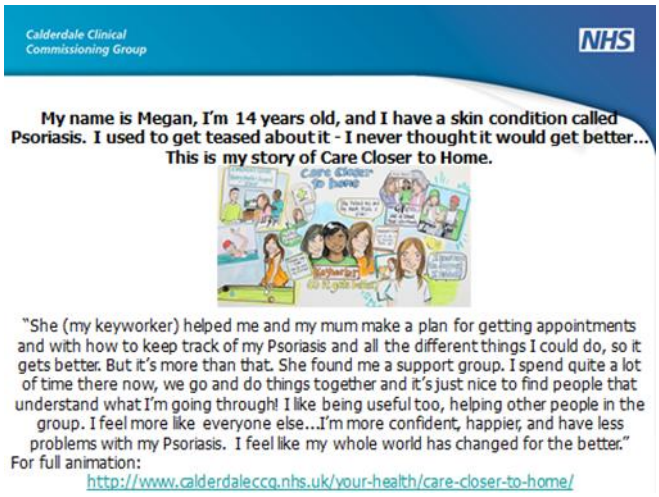
(ii) Musculoskeletal services (MSK) – investment in new upper limb service in the community.

Benefits of the work:

- **Reduced utilisation of hospital services**: reduced inappropriate referrals into secondary care orthopaedics by 18% for upper limb pathways
- **Improved health**: reduced the long term impact of MSK-related conditions
- **Improved care**: increase continuity of care in primary care and community setting
- **Improved value**: reduced costs associated with outpatient secondary care attendances

(g) CC2H Animations

The CCG produced its first animation which described the compelling story of Care Closer to Home – its impact on our population and our partners. We built on the success of this approach by using the experiences of people living across Calderdale to illustrate how lives can be improved through the changes we were planning. Megan's story has been brought to life as an amination.



Care Closer to Home - 2015/16

2015/16 was focused on strengthening community services in advance of consultation on hospital change – this was our year of formalising Phase 1 of CC2H.

We sought and successfully received ***Vanguard status*** for our CC2H work and subsequently received support from NHSE for the work we are doing. Highlights were:

- We were shortlisted for a Health Service Journal award for the work being carried out as part of **Quest for Quality in Care Homes**.

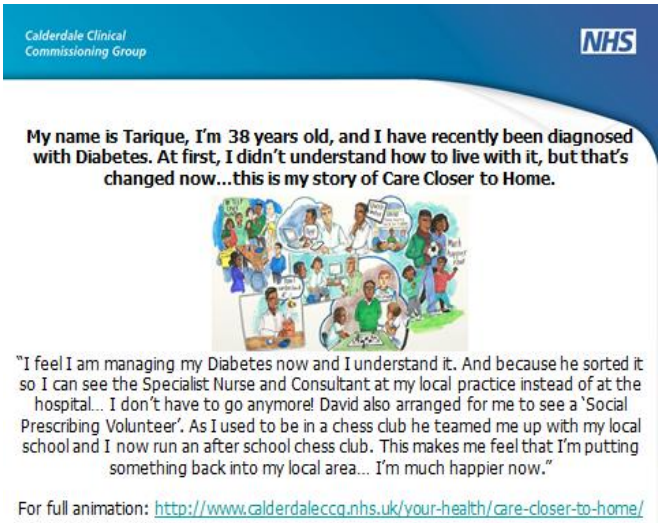
(a) Diabetes Service in the Community

The Level 3 diabetes services began on 1st December 2015 in the majority of GP practices. The service provides enhanced care and support for adults with diabetes stabilised on injectable therapies, some of whom previously received their care at the hospital. This included investment in new diabetes specialist nurses.

Benefits of the work:

- **Reduced utilisation of hospital services:** Reduced outpatient activity and unplanned admissions to hospital
- **Improved health:** Better control/management of condition, reduced complications
- **Improved care:** Improved experience through reduction in variations in care. Up-skilling of primary care staff
- **Improved value:** Reduced costs associated with emergency admissions

We animated a Calderdale case study to show the benefits from this work:



(b) New Heart Failure pathway

We implemented pathways and guidance for heart failure and atrial fibrillation which align to NICE guidance and best practice. We commissioned pathways for AF patients in primary care. This meant that 257 patients (6% of patients with an AF diagnosis) are now on more appropriate anticoagulation treatment for their condition in the community

Benefits of the work:

- **Reduced utilisation of hospital services:** Reduced unplanned admissions to hospital by 8.2% overall (12.5% AF, 9.8% HF, 2.8% Stroke).
- **Improved health**: Contributed to the reduction in risk of Stroke by identifying patients with AF and given anticoagulation treatment/control.
- **Improved care**: improved identification of AF cases and reduction in treatment gap.
- **Improved value:** Reduced costs associated with unplanned admissions by £193k in year.

(a) COPD Services at Home

Tunstall telehealth systems were installed in the homes of 24 people with COPD to undertake daily readings of their vital signs. These are monitored by the CHFT Specialist Respiratory Nurses. The benefits are:

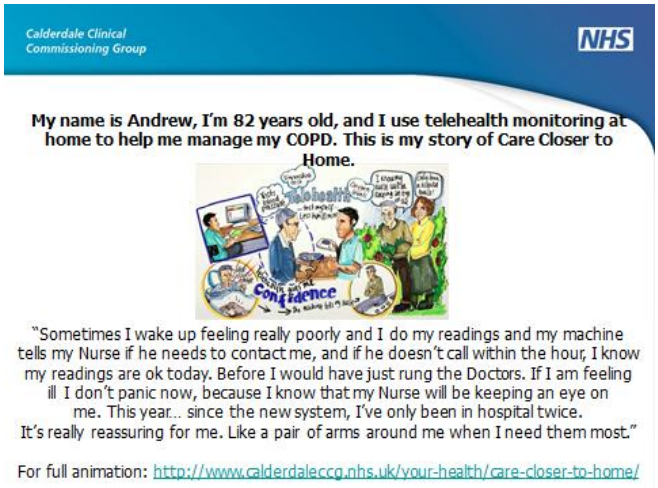
Preparation for an assistive technology procurement with a model that includes the continuation and expansion of this COPD service.

The new model will include telehealth monitoring technology to support Early Supported Discharge, and additional long-term conditions, for example; Heart Failure.

Benefits of the work:

- **Reduced utilisation of hospital services:** Prevented hospital admissions/ length of stay
- **Improved health:** Improved self-management/reduced anxiety, Enabled early intervention, Prevented future complications for those who hadn't yet started to access extensive healthcare
- **Improved care:** Improved medication compliance
- **Improved value:** Supported the COPD Specialist Nurses' workload to ensure them to be more effective and focus proactively on those at most risk.

We developed a new animation based on a real Calderdale case, which showed the benefits of technology for COPD:



(b) Quality For Health (QFH)

Quality for Health (QFH) is a new innovative quality assurance system for the third sector, developed by Voluntary Action Calderdale and endorsed by Calderdale CCG.

It is the only quality assurance system in the country designed to support VCSEs to demonstrate the quality of the outcomes of their health services through rigorous external assessment and is a vital tool in the supporting the sector to deliver local health services for local communities.

The system measures outcomes based evidence across nine quality areas supported by a range of measurable indicators ncluding Service user experience, effectiveness, equality and diversity, outcomes and impact

Benefits of the work:

- Quality - VCS providers have an outcomes based framework (QFH) to demonstrate the quality of the services it provides
- Assurance - provides the basis to assure commissioners and providers on the quality of service
- Uptake 49 VCS providers in Calderdale (and over 90 VCS provider outside Calderdale) are signed up to QFH
- Regulation - Increasing recognition of QFH by NHS England and CQC

(c) Transforming care for people with learning disabilities

One of our priorities is to ensure that the delivery of CC2H meets the needs of the most vulnerable of our residents including those people with learning disabilities (LD)

The CCG is working with the local authority to develop services in the community in line with the transforming care national agenda.

Calderdale are part of the Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Transforming Care Partnership

Calderdale CCG has invested in the development of a new health pathway for people with learning disabilities and a new community model has been in place for 12 months. This new service and the plans to work with the local authority to commission a crisis facility in Calderdale should help to reduce the need for people with a learning disability to have long stays in specialist hospitals. The progress of this work is overseen by Transforming Care Partnership Board with clear reporting systems and governance arrangements for each of the CCGs.

Benefits of the work:

- **Reduced utilisation of hospital services**: a reduction of in-patient beds by up to 50% over this period.
- Improved health:
- **Improved care:** reduce the need for people with a learning disability to have long stays in specialist hospitals.
- **Improved health:** Supports people to live independently and locally.
- **Improved value:** Shift from unplanned hospital activity to planned community based activity.

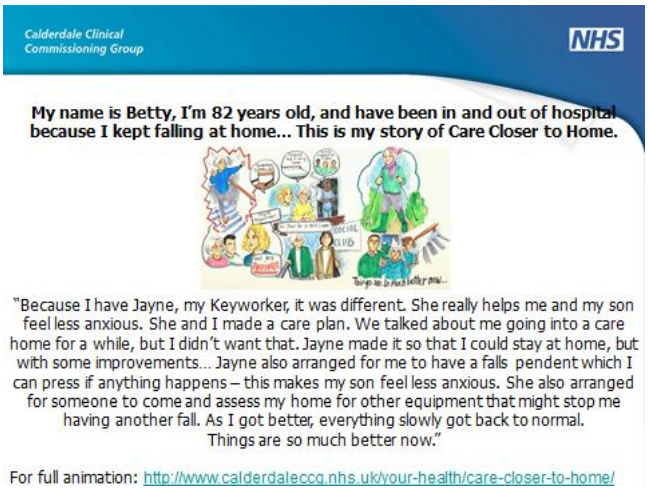
(d) Continuing Healthcare Hospital discharge Team (CHCDT)

A new team of 3 nurses, 2 social workers and an administrative support worker, overseen by a lead nurse and a social worker team leader was initially formed as a pilot with BCF funding.

Throughout 2015/16 this team became embedded as part of the discharge process within Calderdale and Huddersfield

Foundation Trust (CHFT). As a result of the teams' experience and knowledge, those patients who met the eligibility criteria for continuing healthcare (CHC) and their families, now have a much more positive experience and a reduced length of stay in hospital.

We developed an animated cast study to show how the plans we have developed will benefit people in Calderdale:



(e) Mental Health - Parity of Esteem

We continued to build on our work with partners supporting people with mental health problems. We have:

- Developed and begun to implement our local action plan to deliver the Crisis Care Concordat.
- Developed the new multi-agency Mental Health Innovation Hub and tested the mental health elements of all programmes for parity of esteem
- We have developed new links with third sector providers through the Mental Health Matters forum

We developed an animated case study to show the benefits of the work we had been doing:

(f) New Care Home Model

Work is being led by the CCG and LA with other partners to:

- Ensure that the current system is as resilient and effective as possible
- Develop a new model of care provision for Calderdale built upon best practice and learning from other areas.
- This will ensure that we have the right care and support to support people in the community.
- This work will be undertaken in conjunction with work being developed by the SRG to look at the demand and capacity requirements for home care and intermediate care.

Benefits of the work:

- **Reduced utilisation of hospital services**: builds community capacity and supports the timely discharge of patients out of hospital
- **Improved care:** ensures that providers are able to deliver the very best care in local homes
- **Improved health:** ensures care home residents are able to access an appropriate the range of services in order to maintain their health and well-being.
- **Improved value:** reduce LOS for patients in hospital and support reductions in permanent admissions to care homes.

(g) Other community investments

Specific investments during the year have been in the following new services for people in Calderdale:

- **Quest for Quality in Care Homes** – **phase 3** – we continued funding for care homes in Calderdale to improve the quality of the care they provide – through new technology and a new community-based multi-disciplinary

team. We saw a reduction in hospital admissions with a saving of £800k.

- **End of Life Care** – we continued funding for the programme aimed at educating health professionals around good palliative care provision and also providing dedicated out of hours crisis intervention/community nursing service.

- **Mental Health** – we continued investment into:

  - Early Intervention in Psychosis (EIP) services in the community

  - Mental Health Liaison Team based in A&E at the acute hospital to provide mental health advice, support and signposting to services where appropriate

  - Crisis Resolution Team to support 24/7 service in the community

- **Child and Adolescent Mental Health Service (CAMHS)** – Additional investment to support the service and Autism Spectrum Disorder backlog.

- **Respiratory** – continued additional investment of 6 specialist respiratory nurses in the community as part of Care Closer to Home.

- **Asthma** – investment in an additional specialist nurse to support patients in the community and to reduce avoidable hospital admissions.

- **Heart Failure** – invested in an additional specialist nurse to support patients in the community and to reduce avoidable hospital admissions.

- **Musculoskeletal services (MSK)** – continued investment in new upper limb service in the community.

- **Personal Health Budgets (PHB) -** People eligible for CCG Continuing Healthcare funding are now entitled to ask for a personal health budget. 23 people have now taken this opportunity and report that it has made a positive difference to their lives.

- **Third Sector** – continued support for a wide range of third sector organisations in Calderdale to enable them to develop and strengthen the services they deliver.

Care Closer to Home - Our Plans for 2016/17

Our plans for 2016/17 are focused on implementation of Phase 2 of CC2H. The focus of these plans will be heavily influenced by the outcome of the current formal public consultation. At this stage are plans are focused around the

movement of services out into community – particularly those services that have been traditionally provided in hospital for example out-patient services, some diagnostic services, therapy services. These include:

- Services for children & young people
- Frailty services
- Long Term Conditions (Children and Adults)
  - Respiratory
  - Cardiovascular Disease
  - Diabetes
- Musculoskeletal services

As an indication of scale - the total cost of avoidable emergency admissions conditions in 2014/15 was £8,800,000 for Calderdale residents**.**

- Ophthalmology
- Dermatology
- Diagnostics
- End of life care
- Community-based First Point of Contact
- Integrated Community services
- Rehabilitation

The focus of the work will be delivery of the 'triple aim' – improving health, improving care, improving value. This will include continuing the reduction the current high level of avoidable admissions going into our two local hospitals.

In addition we have secured funding for 16/17 for quest, and agreed 17/18 procurement for assistive technology

The chart below ranks the rate of avoidable emergency admissions for all CCG's in England. Calderdale is ranked in the 4th quartile nationally and is higher than the national average.

Other plans for 2016/17 include:

(a) Prevention at Scale

Delivery of a new joint prevention strategy focused on; nutrician, smoking, physical exercise.

(b) Supported Self-Managed Care

Delivery of information and support to help people manage their own care.

(c) New integrated community model

Delivery of a new integrated model of locality community services build around general practice, delivering MDT working and shared records. This includes the development of a first point of contact.

(d) New Service at Todmorden Health Centre

Following the commissioning of spatial planning work, we have developed plans to strengthen services provided at the centre,

particuarly: third sector services, out-patient activity and walk-in services.

High Level View of Evidence for Delivery of CC2H	
Submission to Governing Body – August 2015	Appendix B

Theme	Interpretation of Evidence
1. Processes	▪ We have documented at a high level the CC2H chronology. This shows that the plans for CC2H started with the inception of the CCG in 2011 and have been a feature of every strategic and operational plan written by the CCG since that point. ▪ Whilst the introduction of the specification is a key part of the work, as it sets out our expectations within a contractual framework, this was one step on the delivery journey rather than a defining one. ▪ We have clarity on the huge amount of service improvement work that has been done to date in implementing the model, and the work that will follow next. The information on service improvement work has been shared with the Governing Body as points throughout the last 3 years. Year
2. Engagement	▪ The CC2H model has been developed using the stakeholder information gathered since 2012 – this can be evidenced by the alignment of the key engagement themes and the CC2H model itself (as set out in the specification – available on the CCG's website). ▪ During 2015 a gap analysis of patient engagement was undertaken and further engagement work is being completed in order to mitigate any important engagement gaps for Phase 2 of CC2H. ▪ In developing the services models for the CCGs 7 clinical priorities, the engagement themes as well as specific engagement feedback have been used to shape future models. ▪ We have considered the 15 recommendations made by the People's Commission, and we believe that each of the recommendations made relating to CC2H are captured within our plans. As a result of the recommendations we have picked up the need to do more work on transport as part of our work-plan for 2015/16. ▪ We have welcomed the opportunity for continued dialogue with the Adult Overview and Scrutiny Committee (OSC) regarding CC2H and Vanguard. We have carefully listened to their views and taken these on board as part of the development of the CC2H and Vanguard programmes. We will continue to meet with OSC and have committed to attending a further meeting in October to provide an update.
3. Quality & Safety	▪ Data shows that we are having an impact on the quality of care provided to patients as the result of our work on CC2H and 7 clinical priorities. However, it also shows that there are areas where we will

	need to seek further quality improvements over the life of the CC2H programme. The overview of high level outcomes in section 6 also provides a view on improvements to date and opportunities to be addressed as part of the next phase of CC2H. ▪ The Clinical Senate were very supportive of the process and scope of CC2H. Their encouragement for us to work in partnership on the development and delivery of CC2H are evidenced throughout the material. ▪ The patient stories captured provide a powerful understanding of the benefits we have started to see from the CC2H work – particularly from some of our more long-standing programme, such as Quest for Quality in Care Homes.
4. Finances	▪ The financial case for change developed by the CCG clearly sets out how transformational system change is needed to deliver a more financially resilient system. CC2H is seen as a critical part of this transformation, and therefore its delivery is inextricably linked to financial stability. ▪ The 7 clinical priorities that are being addressed through CC2H have generated the majority of our QIPP efficiencies over the last 2 years. Going forward CC2H is a key factor in delivering financial efficiencies that the CCG can then re-invest in models of care that improve health and well-being. ▪ The elements of CC2H focused on prevention, healthy lifestyles and supported self-care are important in making changes to population health that will deliver a more financially resilient system – reducing demand and dependency, and strengthening independence and recovery.
5. Relationships	▪ The BCF Plan submitted in 2014 is clearly aligned to delivery of the CC2H – it provides an important enabler for strengthening joint commissioning between the CCG and CMBC, and an important vehicle for delivering the integrated models described in the CC2H programme. The Plan evidences the common views held by the two organisations about the future service models, and the role CC2H plays in delivery of this aspiration. ▪ There has been considerable investment of both funding and time to ensure the third sector are able to maximise their role in delivery of CC2H, and there is evidence of their growth in terms of capacity, capability and knowledge of the CCG's commissioning intentions relating to CC2H ▪ The CCG has shared the CC2H model widely with key providers and

	stakeholders to ensure that its commissioning intentions are clear – ensuring that providers are able to respond to those intentions now and in the future. ▪ Vanguard provides an important and unique opportunity to bring together partners and accelerate CC2H in Calderdale – particularly focused on testing how new models of commissioning, payment and provision can be used to implement CC2H. Our status as a Vanguard site also validates the CC2H plan which was submitted in our proposal.
6. System Metrics	▪ There are significant demographic pressures – with a forecasted 6.5% increase in population – particularly children and older people ▪ For premature death we have a challenging 15% reduction to deliver in 5 years – but the first year's delivery is positive. ▪ There are opportunities to reduce health inequalities by the implementation of CC2H services that are bespoke to communities based on need rather than the current one-size-fits-all approach. ▪ We have seen a 5.9% reduction in emergency admissions from April 2012 to March 2015. ▪ There has been an increase in community nursing activity from 2013/14 to 2014/15, and an improvement in quality related to the care of patients with leg ulcers during the same period.
7. Enablers	There is evidence that the CCG, working closely with its partners are developing new ways of working to enable the system to maximise opportunities from the CC2H Programme, particularly: ▪ Developing an Estates Strategy that will deliver important opportunities to deliver CC2H through the maximising of community estate and contribute to the sustainability agenda ▪ Working with partners to develop a workforce strategy that will identify actions to mitigate some of the current workforce issues, particularly those in primary and secondary care. ▪ Developing a IT and Digitisation strategy that will seek to maximise the opportunities related to; supported self-care, sharing electronic records, telephony, telehealth and telecare. ▪ The CCG is seeking engagement from local transport providers in order to ensure that patient transport systems enable the full implementation of CC2H – this is a new element of work

NHS North Kirklees Clinical Commissioning Group

NHS Greater Huddersfield Clinical Commissioning Group

Locala Community Partnerships

Greater Huddersfield and North Kirklees Clinical Commissioning Groups and Locala Community Partnerships

Care Closer to Home in Kirklees

Report to Overview and Scrutiny Committee

April 2016

1. Purpose

The purpose of this document is to provide a summary report by North Kirklees Clinical Commissioning Group (NKCCG), Greater Huddersfield Clinical Commissioning Group (GHCCG) and Locala Community Partnerships (Locala) on the implementation of the Care Closer to Home (CC2H) service in Kirklees.

The first part of this report will provide the Overview and Scrutiny Committee with a summary of the CCGs' process to procure the CC2H services and an overview of the mobilisation of the contract which was undertaken jointly between the CCGs and the successful lead provider, Locala Community Partnerships.

The second part of this report will provide the OSC with a summary of Locala's model for CC2H, an update on implementation to date, including the impact and benefits of the new model for patients and professionals.

This paper is designed to provide background to support an Overview and Scrutiny Committee panel taking place on 12 April 2016. The focus of this session will be the following:

- How the new model is working (including management of risk)
- Patient stories and case studies
- Relationship between Care Closer to Home and acute hospital reconfigurations.

2. Background - developing the service model

2.1. Approach

Greater Huddersfield Clinical Commissioning Group (GHCCG) and North Kirklees Clinical Commissioning Group (NKCCG) embarked upon a joint procurement using a competitive dialogue process to commission a lead provider model contract for Care Closer to Home (CC2H) services across Kirklees.

Care Closer to Home is the vision for the development of integrated community based health care services across Kirklees for children and young people through to and including the frail, vulnerable and older people. The service will primarily focus on those people with identified health needs which impact on their health and well-being, due to differing disabilities, long term conditions, those in vulnerable groups and meeting the needs of individuals with palliative and end of life care needs.

The aim of this procurement was to source a lead provider via a competitive dialogue process to provide CC2H services across GHCCG, NKCCG and Kirklees as a whole.
The objectives of the service are:

- Improved primary and community care providing the right care in the right place, at the right time, first time;
- Self-care and self-management of conditions, to give individuals confidence, knowledge and information about support to look after their own conditions and prevent exacerbations;

- Integrated high-quality services at times required to meet the needs of the community;
- A reduction in reactive, unscheduled care - doing more planned care earlier;
- Care that is coordinated across providers as one coherent package of care, with a focus on individuals; helping them to get better and get on with their lives.

The programme was split into several phases:

- Specification development
- Pre-procurement
- Procurement and evaluation
- Mobilisation and transition to business as usual

2.2. Specifications

Both CCGs developed specifications to outline the outcomes and key elements of the model of care required. There joint requirements in the core model including a Single Point of Contact and integrated community teams within localities wrapped around general practice to meet the needs of local populations. Both specifications were outcomes based and these outcomes had been defined by local people in each area.

The key outcomes identified by the CCGs to be met through the Care Closer to Home contract are:

North Kirklees

- Care is co-ordinated and seamless
- Nobody is kept in hospital or residential care unnecessarily
- Care is cost effective and within available budgets
- People are supported and in control of their condition and care, enjoying independence for longer
- All staff understand the system and work in it effectively
- Unpaid carers are prepared and supported to care for longer

Greater Huddersfield

- I'm seen at the right time by the right person
- More of my care happens nearer to home
- Me and my carers know how to manage my health and wellbeing
- Everyone involved in my care knows my story

Whilst the two specifications were cohesive in their aims for the core service, there were some different requirements according to the particular need of each area and population, e.g. delivery of some planned services in Greater Huddersfield such as MSK which were out of scope within North Kirklees. In addition, Greater Huddersfield identified a further set of services which may become part of a Care Closer to Home service in Phase II, linked to the movement of further services from secondary care supporting the Right Care, Right Time,

Right Place programme. By including these services within the specification, this gives the CCG the option to move these services under the new CC2H contractual arrangements without undertaking a further full procurement exercise. However, each of the services identified is subject to consultation as part of the Right Care, Right Time, Right Place programme and subsequent decisions on the best way to deliver these services in the future. As such, no decisions have been made about the delivery of these services in the future.

There are a core set of Key Performance Indicators (KPIs) for the contract which cover both specifications and these are linked to the outcomes described by both CCGs.

Both CCGs identified an incentive scheme which would represent 5% of the overall contract value for each CCG. The successful lead provider is required to evidence achievement the KPIs associated with the incentive scheme in order to obtain the funding. This replaced the use of CQUINs associated with previous contracts. Given the different priorities for each local population and CCG, each CCG identified its own incentive scheme.

3. Care Closer to Home programme and procurement

3.1. Overview

A full overview of the development of the programme and the procurement process, including timelines, can be found at Appendix 1.

Table 1 below identifies the key milestones in the implementation of the new contract.

Table 1

Milestone	Planned Completion Date	Actual Completion Date
Contract Award*	24/05/2015	24/05/2015
Contract complete and signed	11/09/2015	30/09/2015
Contract commencement	01/10/2015	01/10/2015

* Contract award was planned for end April / early May 2015, the contract award date was determined by availability of Governing Bodies to make the decision in parallel to award the contract.

3.2. Programme Delivery Assurance

Programme delivery assurance was completed through the following mechanisms:

- Programme Initiation Documentation at each phase of the Programme identifying objectives and deliverables, signed off by the SRO at each stage
- Weekly attendance at SRO's Senior Management Team meeting to update the senior team on progress
- Regular Programme Boards (monthly throughout procurement and mobilisation)

- Task and finish groups and other governance structures to support progress, assess quality, risks and outputs
- Weekly flash reports and monthly highlight reports to assess progress against milestones and key risks
- All programme outputs/ deliverables were assured by governance structure at the appropriate level including clinical and management representation
- Regular reporting to external scrutiny bodies including Health and Wellbeing Board, Overview and Scrutiny Committee and other programmes such as Meeting the Challenge
- In addition, although unplanned, the challenge of the unsuccessful bidder to Monitor regarding the procurement process provided external assurance on the rigour of the procurement process with Monitor choosing not to launch an investigation upon review of the comprehensive evidence provided

3.3. Governance, reporting and management

Governance and oversight throughout was provided by the Senior Responsible Owner (SRO) and the CC2H Programme Board which met monthly throughout the programme. Whilst the structure beneath the Programme Board evolved during the process, a series of sub-groups acting in a task and finish capacity provided the forums to manage the significant levels of work and activity.

A risk, issues and lessons learned register was maintained throughout the programme and key risks and issues highlighted and reviewed by the programme board.

Reporting was managed via a weekly flash report updating all stakeholders on the progression against key milestones during the previous week and activity planned for the following week. This was reduced to a fortnightly basis after contract commencement, during November 2015.

A monthly highlight report was also produced and shared with the Programme Board, Health & Wellbeing Board and other external forums e.g. the Meeting the Challenge Programme operating within the Mid-Yorkshire footprint.

Regular reports were also produced as required for scrutiny bodies including OSC and JHOSC.

3.4. Overall approach

The approach to procurement was an innovative approach and was a departure from the traditional procurement methods deployed in the past. The CCGs made the decision to re-commission services in their areas using a competitive dialogue procurement process.

Competitive dialogue is a public-sector tendering option that allows for bidders to develop alternative proposals in response to the CCGs' outline requirements. Only when the proposals were developed to sufficient detail were tenderers invited to submit competitive bids.

It aimed to increase value by encouraging innovation and to maintain competitive pressure in bidding for this complex contract. The approach made it easier to confirm that "all necessary elements" are in place before bids are submitted, resulting in more robust tenders. Active

dialogue prevented the possibility of misinterpretation by either the tenderer or the CCGs and hence cost escalation later in the contract. For bidders, the process provided a better information flow, together with the opportunity to test the CCGs requirements through a progressive development of their proposal.

This process allowed the CCGs to:

- Build upon market engagement work and avoid, where possible, any repetition/ duplication
- Retain a flexibility to explore solutions
- Balance/trade-off outcome and overall cost
- Undertake an iterative, two way dialogue
- Satisfy the various procurement and competition responsibilities

The CCGs determined the weightings to be used at final tender stage as follows:
70% quality/technical
10% outcome delivery
20% commercial envelope

These criteria were established jointly by both CCGs in line with their models of care and objective of improved patient outcomes. They were also designed to allow the selection of the bid that represented the most economically advantageous tender to the CCGs, rather than lowest price alone. The most economically advantageous bid was judged to offer the optimum combination of service capability and quality.

3.5. Contract Award

Following evaluation and the moderation process, the CCGs' Governing Bodies met in parallel and made the decision to award the contract. The successful and unsuccessful bidder were notified and a 10 day standstill period was entered.

During the standstill period, concerns were raised by the unsuccessful bidder about the process to which the CCGs collectively responded. The unsuccessful bidder indicated it was not satisfied with the response received and indicated the intention to refer to Monitor. Both CCGs made the decision to continue with contract award and a formal announcement of contract award was made on 7 July 2015 and the mobilisation process formally commenced.

The CCGs received notification of the unsuccessful bidder's complaint to Monitor on 19 August 2015. The Programme Director with CCG leads led a number of discussions with Monitor regarding the process and provided further information where required. Monitor notified the unsuccessful bidder and CCGs that it would not be launching an investigation into the complaint on 16 September 2015.

4. Mobilisation

4.1. Approach

The CCGs' approach to the mobilisation phase was to provide dedicated resource to support the programme on a day-to-day basis through a delivery lead with oversight and continuity provided by the Programme Director. The delivery lead was responsible for managing the governance structure to support mobilisation, ensuring the input of key stakeholders and that key milestones and deadlines were met to ensure the service would go live on 1 October 2015. The delivery lead also provided the main interface between the CCGs and Locala on an ongoing basis working with both commissioners and provider to unblock issues.

Support for contract development was provided by the Contract Mobilisation Advisor to provide specialist advice and input.

Locala identified its own mobilisation lead to work closely with the commissioners' delivery lead and governance structures to ensure the process was harmonious and avoided any unnecessary duplication.

4.2. Constraints

The mobilisation phase was reduced from the planned May – October timeline due to the extended standstill period and the delay in awarding the contract until July 2015 which reduced the available mobilisation period to approximately 10 weeks.

4.3. Timeline

The phasing of mobilisation and implementation was proposed by Locala and agreed by the CCGs through the mobilisation governance structure.

Following formal contract award, Locala quickly highlighted that due to compressed timescales, the SPC could not be mobilised for 1 October and proposed a revised date of 1 December 2015. The key deliverables and milestones for the CCG to lead were as identified and delivered as identified in the table below.

Stage	Deliverable	Timescale
Mobilisation	Set-up governance structure and work streams	31/07/2015
	KPIs developed	30/09/2015
	LIS (NKCCG) developed and finalised	30/09/2015
	Specifications finalised	30/09/2015
	Contract developed (Including SDIP, DQIP and all particulars)*	30/09/2015
	Joint mobilisation plan developed and agreed	14/08/2015
	Joint communications plan developed and	

	agreed	
	Contract signed	14/08/2015
	Contract commencement	30/09/2015
	Developed and finalised contract and quality management governance structure	01/10/2015
	Lessons learned review	11/12/2015
		21/12/2015

*Service Development and Improvement Plan (SDIP) and Data Quality Improvement Plan (DQIP).

There were a number of activities to take place between October – December 2015, notably the transfer of services from incumbent providers as part of the agreed phased process and the SPC go live. During this first 100 days of the contract, the mobilisation structure was maintained and development work on the contract and quality management structure to take effect from 1 January 2016 was undertaken.

During this period there was a focus on:

- Supporting the transfer of remaining services from incumbent providers on a phased basis between October and December
- Quantifying the impact financially for the CCG as a result of the disparity between service descriptors held and service provision by the trust
- Developing more detail to support the Service Development and Improvement Plan (SDIP) in specific pathways / areas
- Developing contract and quality management structures, terms of reference and establishment of governance
- Supporting ongoing engagement and communications activities jointly between CCG and Locala, most notably to support the SPC go live
- Development and baselining activity to support the LIS in North Kirklees
- Scoping phase II in more detail with RCRTRP programme team and in conjunction with Calderdale CCG
- Establishing interim contract management routes via the Finance and Contracting group
- Supporting ongoing engagement activities e.g. patient panel, ERS 2 event
- Facilitating handover and identifying business as usual roles and responsibilities
- Gathering lessons learned through a survey to all those who participated in the procurement and / or mobilisation phase and reflection process through programme board.

3.4 Lessons Learned

An overview of the lessons learned have been shared within each CCG and with Kirklees Council to inform future procurement and mobilisation exercises, particularly those in collaboration between commissioning partners.

3.5 Contract Management

The new contract management structures took effect from 1 January 2016 and the CC2H programme was officially closed. An overall Joint Contracting and Clinical Quality Board was established between across the two CCGs to manage the contract. This board is supported by local groups in each of Greater Huddersfield and North Kirklees to escalate issues relevant to local populations.

These groups actively monitor performance through an agreed set of key performance indicators (KPIs) included in the contract, the local incentive schemes and the service developments outlined in the service development and improvement plan (SDIP) included within the contract.

4 Engagement

Significant engagement was undertaken as part of the development of the Care Closer to Home model of care. Engagement continued throughout the competitive dialogue procurement process and mobilisation phase. This group will continue to meet for a period following programme closure to support ongoing communications and engagement activity related to Care Closer to Home.

Key activities included:

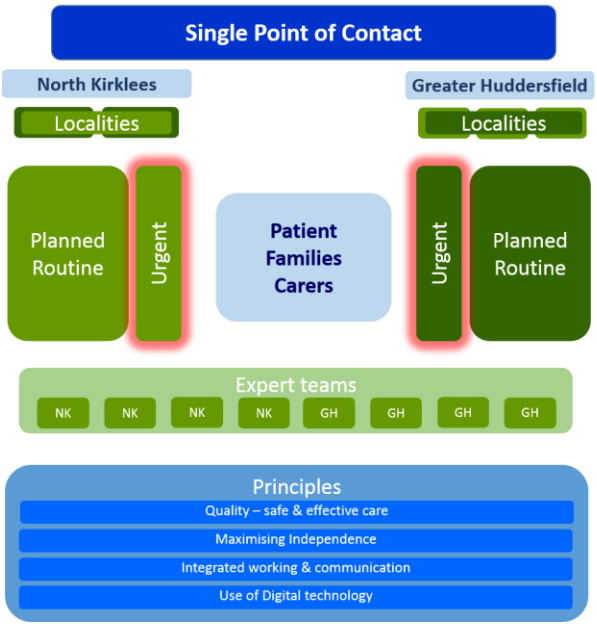
- Key stakeholder events during market engagement
- The establishment of a patient/carer panel which was an intrinsic part of the procurement and evaluation process which gave a strong voice to patients and carers throughout the process
- Patients/carers to took part in discussion and feedback session/s in relation to emerging bids
- Establishment of a Communications and Engagement task and finish group during the procurement and mobilisation process
- Updates provided to key partners/stakeholders including Health and Wellbeing Board, Health and Communities Scrutiny Panel, and elected representatives
- Updates to clinicians and other providers during mobilisation when procurement process had been completed and conflicts were no longer a barrier
- Development of joint communications and engagement plans between CCGs and Locala during mobilisation and joint implementation of a number of activities to support awareness of the CC2H model
- Development of an assurance framework to support the lead provider in ongoing engagement and consultation work as further service change is identified.

Part Two – The Locala model and implementation

5. The model

5.1. Overview

The Locala model for Care Closer to home is detailed in the diagram below.



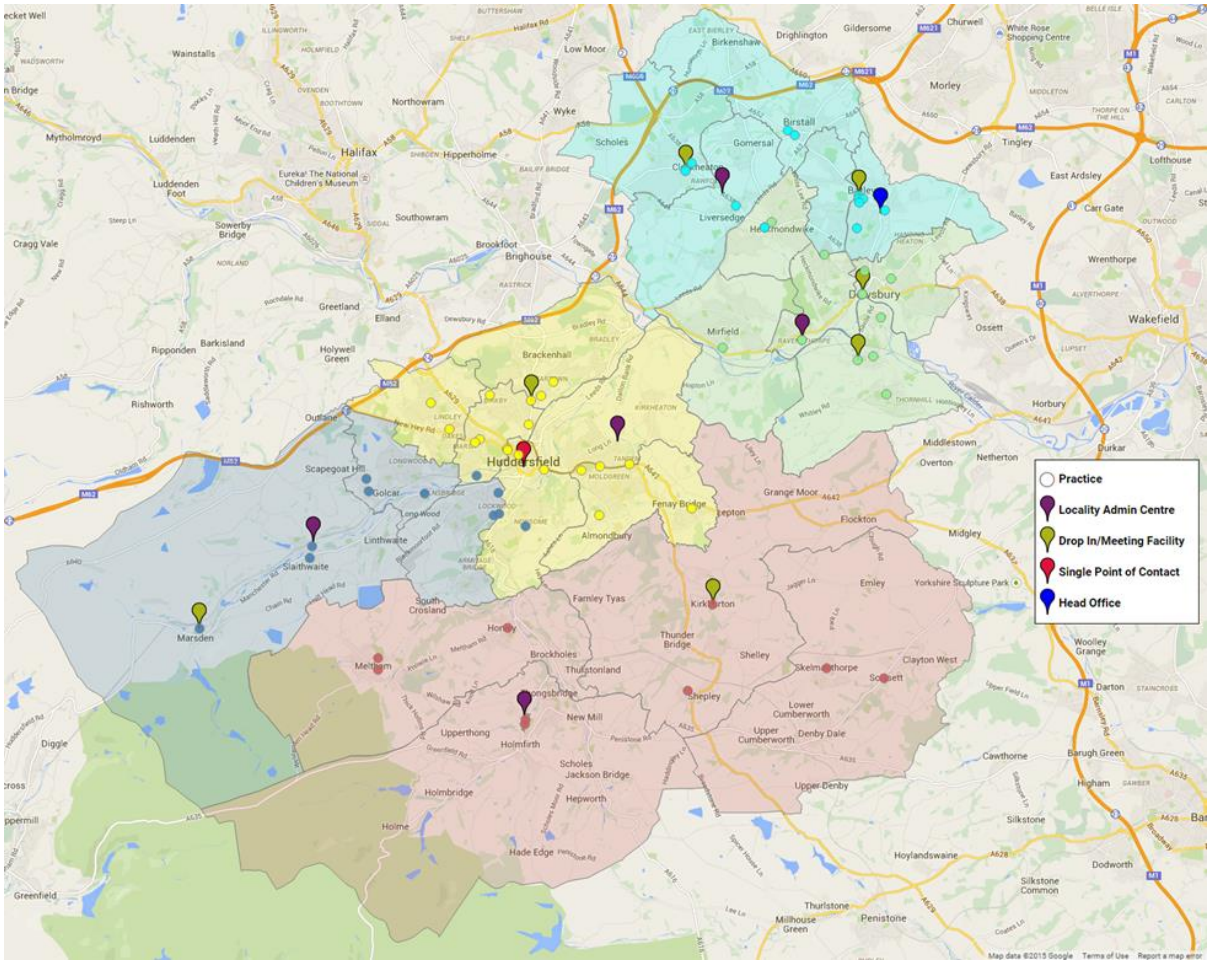
	Description	What it means for patients	What it means for primary care
Single Point of Contact	The place where activity is coordinated 0300 304 5555	A central place to get the answers I need. Clinicians that advise on my care.	Find the answers to questions quickly, make referrals & sign posting.
North Kirklees / Greater Huddersfield – Localities	ICCTs are configured into localities, 2 in NK, 3 in GH.	There is a consistent team able to respond to needs	ICCTs are geographically based and linked to practices.
Planned Routine / Urgent / Patient Families Carers / Urgent / Planned Routine	ICCTs core people include nurses, therapists, social care (LA employed), older people mental health. Planned routine care is ring-fenced from urgent care which responds to need within 2 hours. Each ICCT has a link nurse with a GP practice.	Patients get preventative, comprehensive & consistent care from trained professionals who understand their condition & history. Care is coordinated and patients know their carers. When there is a crisis, the response is swift	Care is coordinated and communicated with general practice. General Practice will know who their link nurse is and be part of collaborative care. When there is a crisis general practice can rely on a comprehensive response.
Expert teams	Clinical teams that provide expert care for specific conditions across Kirklees	Patients can get access to specialised care close to home by clinicians.	Access to the expert team is simple care is comprehensive and communicated
Principles	Maximising Independence – supporting patients to understand & manage their condition. Integrated working – working with all disciplines no barriers & communicating Digital – where it helps us it	Patients understand their condition, know what to do to live healthy lives. The right person understand the patients condition & care is provided in the right place. Convenient access to information and services	Patients are more independent and require less services. Your link clinician & ICCT enhance primary care support for patients. Digital allows sharing of information & greater efficiency.

5.2. Key aspects of the model

A core part of the model is a 24/7 Single Point of Contact (SPC) – with a single telephone number for: new appointments, changing appointments and queries from patients and carers. This telephone centre, with clinicians and administrative colleagues, is there to take referral calls from: patients/carers; GPs; colleagues in the locality team including social care and home care; and Yorkshire Ambulance Service. This team screens and triages new referrals on behalf of the locality teams, prioritising service delivery and communicating effectively to the locality team the appropriate time band for delivery.

SPC's responsibility is to ensure that referrals are allocated, directly overnight and through the locality teams 8am to 10pm, and also providing feedback to the referrer providing them with reassurance that urgent matters are being appropriately managed. A common criticism of the previous process and service was that GPs did not know when a crisis situation had been made safe, as they usually only received feedback at the point of discharge.

The majority of the workforce has been organised into five localities across Kirklees which are configured using a wide range of factors including our knowledge, experience and population needs. Each locality has one team of clinical colleagues from nursing and therapy backgrounds, managing both the urgent and routine work. These teams will work with other colleagues from GP practices, social care, mental health, expert teams, and voluntary/ third sector organisations to provide integrated support for patients and their carers. There are five of these integrated teams across Kirklees as illustrated in the map below.



Locality	Colour on Map
Batley and Spen	
Dewsbury and Mirfield	
Colne Valley	
Dearne Valley	
Huddersfield North and South	

To supplement the locality teams, 'Expert Teams' have been established for those services not appropriate to be managed directly within the locality team, providing specialist support and knowledge. These are managed where possible on a North Kirklees and Greater Huddersfield basis. Only where expertise is very limited are these teams managed Kirklees wide. A key aspect of these services is to support through communication and education the SPC and locality team workforce.

Going for a different mix of skills in the workforce, meaning there will be more highly skilled specialists and more non-registered but trained, multi-skilled colleagues. This will mean that the teams have the right skills to meet the needs of each patient.

A key approach is spending much longer with the first appointment to really get to know the patient, what they need and put clear plans in place that will enhance the quality of care. This means that they get the right sort of ongoing support, which in most cases will mean fewer follow up appointments. We're be focusing on the whole person – holistic care - not just looking at a wound for instance but at the patient's general health, wellbeing and lifestyle which may contribute to their condition.

The Locala workforce has been trained to coach patients to play a more active role in decisions about their care. This supports patients, providing them with information about their condition and the actions they can take to improve their health. This is called 'Maximising Independence'.

Staff are provided with digital technology that helps them do their job more efficiently and effectively. For example, providing access to great quality clinical information in the patient's home to support care; and offering video appointments where appropriate and increasing this considerably in coming years. This means staff can talk to and see their patient via their laptop from the comfort of their home or at work, saving time and effort and travel costs.

Locala is developing much closer relationships with the Council's Social Care teams, South West Yorkshire Partnership HNS Foundation Trust - particularly in providing elderly mental health services - GP Practice teams, our local hospitals and organisations such as Milen Care, Age UK, the Denby Dale Centre and Kirkwood Hospice. These organisations will work in a more joined up way to ensure all teams know what each other is doing and when. A key component for successful integration is sharing information, to enable a single core assessment and a shared care plan. The multi-disciplinary teams within Locala have worked collaboratively to develop a core assessment. This has been trialled within a number of services and is now being rolled out across all Adult Services included in the CC2H portfolio, and will help reduce duplication. This will ensure staff have all the details they need about a patient, so they won't have to go over the patient's details with them time after time, saving the patient and the staff member time.

6. Managing risk

The delivery of the CC2H model is governed by the systems and processes in place to identify, manage and monitor risk in Locala generally. These cover risks at all levels within the organisation at an individual patient/ clinical team level colleagues are encouraged to use the incident process to raise any issues, near misses. These are monitored by their line management and quality manager colleagues to ensure trends are identified and actions put in place to prevent/ reduce any re-occurrence.

All colleagues have mandatory safeguarding training compliance with this is monitored, and colleagues are encouraged to raise any issues with the expert safeguarding support in Locala. Clinical teams all have processes in place to ensure regular supervision of colleagues. At a service level operational managers and clinical team leaders are encouraged to identify any risks, these and the mitigating actions are reviewed through a governance structure that depending on the severity of the risk ultimately reports to the Locala Board.

7. Benefits

The Care Closer to Home service will support the development of better healthcare services within the community with an emphasis on care being closer to people's homes or within their homes. It will also ensure a focus on services that help patients' recovery and promote independence.

The lead provider is responsible for ensuring that community care is much better co-ordinated across Kirklees. They will provide some of these services directly as well as using other organisations, including the community and voluntary sector to provide care as appropriate.

The key benefits that will be achieved during the life of the contract are:

- Implementing a coherent approach to person centred health and social care assessment that focuses on helping people be as independent as they can be to get on with their lives;
- Putting in place evidence based, seamless, health and social care services that result in an offer of one coherent care package for an individual and their carers;
- A more proactive approach to care/case management of individuals which focuses on hospital admissions avoidance, planned discharge and monitoring and reviewing those most at risk; Ensuring high quality local information and advice are available to people when they need it and in a format that they can use so that they better understand their conditions, how to manage themselves and when to ask for support;
- Focussing our health and care services on those more at risk by looking at our combined data and intelligence and applying recommended approaches to risk stratification; and
- Offering integrated high-quality services at times required to meet the needs of the individual rather than services (i.e. 7 days and in some cases 24hours).

8. Implementation update / benefits realisation

Given the scale of the Care Closer to Home implementation, following initial contract mobilisation, there is a period of implementation and embedding of services. The table below gives an overview of this process from now until December 2016 in the three core elements of the service model (Integrated Community Care Teams, Specialist / Expert Teams and Single Point of Contact) which will support achievement of outcomes for patients.

Present Position	By June 2016	By December 2016
Integrated Community Care Teams (ICCTs) • ICCT working in Localities, development in planned and unplanned teams - working closely with primary care. • **Individual case studies available of how CC2H Model is helping reduce hospital stays.** • Memorandum of Understanding discussions with Practices and introduction of Link Practitioners to attend MDT meetings. • Clinical Leadership programme commenced for all ICCT managers. Review and refresh CCTH model with all staff groups. • Service improvement plans in place to move service areas forward. • Training needs addressed in the integration of skills within the unplanned teams • Review of utilisation of admin roles • 24/7 working implemented along with Lone working policy • One core template introduced and utilised by all staff areas in Locala.	• **Evidence available we are making a difference – reduction in hospital bed days. Need to have real time (or at least timely) information re attendance/ admissions by service – ideally with NHS number to enable cross checking.** • **Evidence of integrated working – to enhance care coordination. Information continuity developed through integration of systems from primary, community and secondary care. (S1, Emis, Edis and Symphony)** • Clearview accessible down to individual and team level at locality levels. • Skills framework operational for band 5 nurses • Skills framework available for Community Matrons role and full understanding of their clinical lead role within ICCTs. • Long Term Condition training updates integral to Locala training schedule • CC2H Patient panel involved in review of and further development of CC2H services.	• CC2H Phase 2 - Enhance community services – which is likely to move more services closer to home. **Support to Phase 2 of 'Right care right time right place' - Hospital changes** • Support training needs of staff for development of roles and succession planning • Realisation of core skill mix within localities with increased highly skilled qualified staff and increased emphasis on highly skilled unqualified staffing. • Continued work on skills framework at all grades, so that all staff have the basic competences for their role i.e. prescribing, which could take 18 months to 2 years. • Evidence of ongoing developments in the use of technology to provide quality care to patients in their homes.

• S1 training and robust induction programs introduced for new and existing colleagues. • Skills framework developed for band 5 and Community Matron role. • **Locala is not currently able to see hospital attendance/admission data until 2-3 months later & only very general then so can't tell where we are doing well, where we have not been involved or where we can improve.**	• Clinical leadership embedded	
Specialist Teams • Expert teams developed – Some excellent work with Respiratory – increase pulmonary rehab, increase community clinic capacity. • **Started review of CVD with view to getting Heart Failure as a 'one stop approach' – opportunity to help efficiency within CHFT.** • Starting Integrated MSK discussions keen to look at Upper Limb & Hip pathways to potentially mirror work within Calderdale – good links via CCG with management team. • **Developing In-reach team and need for greater acceptance of roles within CHFT.** • Procurement of Continence products commenced • Negotiation of SLAs with secondary care • Specialist therapy teams in Greater Huddersfield are now fully integrated into Locala, utilising the available technology and S1. Staff have moved from HRI into Mill Hill • Standalone therapy teams have been integrated	• **In-reach teams and ICCTs working closely with secondary care and primary care to facilitate admission avoidance and reduced length of stay.** • **Maximising Independence work within secondary care commenced.** • Specialist therapy teams will be working consistently across the organisation. • Therapy integrated pathways with localities with demonstrate a patient centred approach avoiding duplication where possible • Recruit to Multiple Sclerosis Specialist Nurse Post. • Deliver Long Term Condition training to ICCTs. • Work with PALS to support early referral to exercise programmes supporting lifelong changes. • **Exploring opportunity for 'one stop' - heart failure clinic for early diagnostics.**	**Full integration with In Reach team and support to follow up of patients discharged to ensure reduction in readmissions.** **Patients will move seamlessly between locality and specialist services. One story for each patient**

into the specialist's team reducing the majority of single points of failure. • The significant waiting list in Speech and Language Therapy (SALT) is reducing quickly. A redesigned SALTs service is unlikely to experience this type of issue in the future. • Robust referral pathway embedded for OPAT. Virtual Ward Rounds with Microbiology.		
Single Point of Contact (SPC) • SPC went live 1.12.15 • Successful recruitment of staff. Initial implementation went and achieved the target of calls answered within 90 seconds. • Experienced problems with high demand of calls as a result of introducing Podiatry. Rotrvm (call technology) capabilities continue to be explored and developed to cope with increasing demands as new services are introduced. Triage of calls introduced and implementation of a staff planning tool resulting in system settling back down. • Team Leader with Call centre experience advertised • Team working well together - full utilisation of clinical skills. • Robust action plan implemented to get back on track.	• SPC ensuring the patient referrer tells their story once, triages care and navigates care. More electronic referrals received from both S1 and EMIS Practices. Electronic referrals received from all referrers. • Team leader and clinical leads in post. • All Locala service areas now into SPC as per plan. • Near to target of 80% calls answered in 90 seconds • Positive Patient opinion feedback received • Audit of Algorithms and full integrated working with ICCTs • Evidence of the impact SPC is having on frontline demand • Integration of SWYPFT SPC • Full, real time reporting on call time waiting	• Recruitment continues and internal rotation of clinical staff developing to ensure skills maintained • Working with all service areas to continually evaluate and identify areas to expand service provision. • SPC established to enable timely and easy access to the right service through single assessment process and documentation • Improved patient, carers and families experience of the service. • Improved experience of all staff who provide and interact with the service • Services are responsive to individual patient need and provide value for money and are performance managed to improve patient outcomes. • Use innovations in IT systems that enable

	available on Rostrvm and available in Clearview	information sharing and developments, telehealth systems will also, where appropriate, be utilised to support patient care. • Develop Virtual contacts to reduce frontline demands

8.1. Benefits for patients

The new Care Closer to Home model is already having an impact for patients, demonstrated by the case studies below.

Case Study: Demonstrating how integration/ Multidisciplinary working within Locality Teams is benefiting patients

Patient had been in hospital several weeks and had muscle wastage and therefore temporarily bed bound. Referral sent to Locality Unplanned team for Rapid Response carer support. Physio from Locality Unplanned team went out to assess health, social and therapy needs. OTs and physios from the unplanned team followed up with exercise and therapy. Within 4 weeks the patient was out of bed and using the stairs. Prior to CC2H, referral to Single Point of Access would have resulted in visit by District Nurses, who would then have had to refer to social care and therapy services, resulting in duplication and delay for the patient.

Having the ability to utilise unplanned team and integrated working resulted in health, social and therapy needs being assessed within 24 hours and support offered and delivered more quickly.

Case study: Respiratory patient demonstrating maximising independence.

When Janet was first diagnosed with emphysema she was very frightened and anxious about her condition and felt powerless. Cathy worked closely with Janet to develop an emergency care plan and teach her the skills to manage the condition. Janet now knows how to plan her medication, what to do in in an emergency and how to monitor signs and symptoms. Janet also knows how to do breathing exercises and pace her activities.

Janet has since helped inspire others, through being an active member of exercise group PALS where she supports other patients who live with long term health conditions. More

9. Monitoring

The specifications designed for CC2H articulate the ambition for services and outcomes for patients. The key performance indicators (KPIs) finalised during the mobilisation process are currently being used as a mechanism to monitor the delivery of the contract by the CCGs, through a joint contracting and quality management structure composed of both CCGs and Locala.

These KPIs are linked to the over-arching outcomes identified and are monitored through the local and joint contract management structures described in section 3.5.

10. Links to other transformation programmes

For both CCGs, Care Closer to Home is intrinsically linked to the other major transformation programmes – primary care and acute hospital reconfiguration.

Operationally, the model supports close working with primary and secondary care with a particular focus on collective working to ensure any unnecessary admissions to hospital are avoided and when patients are admitted to hospital, they are supported to be discharged back home as soon as safely possible.

Both CCGs have produced strategies for primary care; in North Kirklees this has been approved by the Governing Body and in Greater Huddersfield, the strategy will be reviewed at the meeting on 13 April 2016 for approval. Areas for joint working have already been identified across the two CCGs in implementing these strategies and both seek to address issues of inequality of access, provision and quality for patient and focus on closer working between primary care and a number of partners, including community services. Both strategies will be presented to the Health and Wellbeing Board.

North Kirklees and Greater Huddersfield are at different stages of their acute hospital reconfigurations. For North Kirklees, the Meeting the Challenge programme is well established in implementation and there is currently a process of scrutiny and assurance to assess whether any aspects of the reconfiguration can be brought forward from the planned timeline. For Greater Huddersfield, the proposals for the reconfiguration of the Calderdale and Huddersfield Foundation Trust (CHFT) footprint are currently at the stage of public consultation.

For both programmes there is currently a focus on review and assurance, included within this is the impact of Care Closer to Home. For both programmes, the assurance processes through Governing Bodies and Joint Health Overview and Scrutiny panels will provide the rigour to ensure that the impact of Care Closer to Home is considered for both Right Care, Right Time, Right Place and Meeting the Challenge. In Calderdale and Huddersfield there is a dedicated Joint Health Overview and Scrutiny Committee planned to specifically review the impact of Care Closer to Home in relation to the Right Care, Right Time, Right Place proposals.

Appendix 1

Programme Background Overview

During August 2014, GHCCG and NKCCG, working across the Kirklees footprint commenced a programme of work to procure and implement a new model for community services, Care Closer to Home. This followed a short piece of diagnostic work undertaken during July 2014 to identify the readiness of each CCG to commence the programme of work and the potential for a collaborative process.

The objective of the programme was to support the CCGs' programme of work to bring services out of acute settings, into the community and closer to home. The new service was required to be in place by 1 October 2015 as existing contractual arrangements ceased on 30 September 2015 and had already been subject to extension. This dictated the timelines for procurement and contract award.

Specific deliverables and timelines are detailed under the relevant headings in sections 3.3 and 4.

The first meeting of the CC2H Programme Board on 5 September 2015 formed the start-up meeting for the programme agreeing objectives and timeline with a decision from the board that procurement of CC2H services was required.

Programme performance

The deliverables and achievements of the programme are identified below:

- Development of specifications for Care Closer to Home services linked to the objectives and desired outcomes of each CCG
- Competitive dialogue process was delivered within 7 months
- Robust procurement process which stood scrutiny from Monitor
- Developed clear processes to manage conflicts of interest
- Recruited and utilised non-conflicted clinicians to ensure clinical involvement throughout the process
- Utilised ongoing stakeholder engagement – establishment of a patient panel which had involvement throughout the process
- Lead Provider for the specified service in place with appropriate sub-contractual relationships to support service delivery
- Comprehensive signed contract before 1 October (including comprehensive SDIP, DQIP and particulars)
- Service mobilised for 1 October with jointly agreed plans to phase commencement of other services
- Agreed set of KPIs and timescales for reporting which link back to identified outcomes
- Agreed local incentive scheme for North Kirklees following contract award
- Jointly agreed mobilisation and communications plans between provider and commissioners
- Supported the transfer of services from incumbent to new provider in a phased and pragmatic way

- Gathered and reflected upon lessons learned for future procurement and mobilisation exercises
- Commenced scoping and planning to progress Phase II in Greater Huddersfield
- Fostered partnership working and joint approach to carry through into contract management
- Established and maintained a governance structure throughout to ensure clear decision making and escalation as well as ensuring progress was tracked
- Establishment and maintenance of programme documentation for each phase of the programme to identify clear objectives and deliverables.

Pre-procurement

The table below identifies the key timelines for pre-procurement activities.

Stage	Deliverable	Timescale
Pre-procurement	Decision to procure (Programme Board) Decision to procure (Joint Governing Body Meeting) Decision to procure final (NKCCG Governing Body and GHCCG Governing Body)	05/09/2014 10/09/2014 24/09/2014
Pre-procurement	Workstreams established: Finance, estates, contracting and HR Communications, engagement and equality Quality, Clinical safety & workforce Local steering groups in both Greater Huddersfield and North Kirklees	03/10/2014

Approach

In order to support the CC2H programme, governance arrangements were established as outlined above. This included the establishment of a CC2H Programme Board with the Chief Officer, GHCCG as SRO for the Programme and Chair of this Board. Existing groups were revised and terms of reference refreshed to support the process and new task and finish groups established.

Following discussion between and within the CCGs and advice from Monitor, the Programme Board took the decision to undertake a procurement process for Care Closer to Home services on 5 September 2014. This was agreed by the respective Governing Bodies and finalised as part of a Governing Body in parallel meeting on 24 September 2014.

At this point it was clear that a number of clinicians involved in the process were conflicted as a result of making the decision to procure a new Care Closer to Home service. A series of processes were put in place to ensure that conflicts of interest were managed within both CCGs. Non-conflicted clinicians were recruited to support the process.

Procurement

The table below identifies the key procurement timelines.

Stage	Deliverable	Timescale
PQQ	Provider engagement PQQ live PQQ decision	29/09/14 – 16/10/14 20/10/14 – 24/11/14 03/12/14 – 12/12/14
Invitation to Proceed to Dialogue (ITPD)	ITPD pack development Dialogue ITPD Live ITPD Decision	20/10/14 – 12/12/14 06/01/15 – 21/01/15 12/12/14 – 30/01/15 12/02/15 – 02/03/15
Invitation to Continue Dialogue (ITCD)	ICTD pack development Dialogue ITCD Live ITCD Decision	12/12/14 – 02/03/15 09/03/15 – 13/03/15 02/03/15 – 16/04/15 24/04/15 – 01/05/15

Market engagement

Bids were sought for three lots:

Lot	Services included
Lot 1	Greater Huddersfield CCG services
Lot 2	North Kirklees CCG services
Lot 3	Kirklees wide (GHCCG and NKCCG) combined

The procurement was launched on the 20th October and a Bidder Event was held on the 6th November where 24 providers attended (Details of the providers who attended can be found in Appendix B). The purpose of the event was to:

- Share the CCGs' visions for Care Closer to Home
- Introduce Bidders to the Competitive Dialogue procurement process
- Provide Bidders with the procurement timeline
- Top Tips for Bidders responding to the opportunity
- Provide an opportunity for Bidders to meet and network with a wide range of potential providers from all sectors to facilitate alliances etc.

The procurement was launched on the 20 October and a Bidder Event was held on the 6 November where 24 providers attended. The purpose of the event was to:

- Share the CCGs' visions for Care Closer to Home
- Introduce Bidders to the Competitive Dialogue procurement process
- Provide Bidders with the procurement timeline
- Top Tips for Bidders responding to the opportunity
- Provide an opportunity for Bidders to meet and network with a wide range of potential providers from all sectors to facilitate alliances etc.

The PQQ closed on the 24th November 2014 with the following PQQs submitted:

Lot	Services Included	Bids Received
Lot 1	Greater Huddersfield CCG services	1 PQQ received
Lot 2	North Kirklees CCG services	No PQQ received
Lot 3	Kirklees as a whole (Greater Huddersfield CCG and North Kirklees CCG combined)	2 PQQs received

As evidenced above there was insufficient competition to proceed the procurement for Lot 2, North Kirklees CCG services. A decision was made by both CCGs to progress on a Kirklees-wide basis (i.e. Lot 3).

Invitation to Participate in Dialogue (ITPD)

The Invitation to Participate in Dialogue ("ITPD") was issued on 12 December 2014 to all bidders short-listed following the PQQ evaluation and was the first of two stages to the competitive dialogue.

The Competitive Dialogue was split in to two stages:

Stage One: Invitation to Participate in Dialogue (ITPD)

Stage Two: Invitation to Continue Dialogue (ITCD) and to submit a final tender

At Stage One, bidders were invited to submit their response to a series of questions which were evaluated against the award criteria set out below. Following evaluation, a maximum

of 2 bidders who meet the minimum threshold of 50%, were Invited to Continue In Dialogue (Stage Two). At this stage bidders were given the opportunity, in accordance with the process set out below, to discuss the commissioning organisations needs for the Service and the Bidder's possible solutions.

Stage Two involved further dialogue and an invitation to submit a Final Tender was issued to all the bidders still remaining in the process, inviting them to submit their final Bid. These Final Tenders were be evaluated against the award criteria with the intention of awarding a contract or two contracts for a single service to one provider for most economically advantageous tender.

The main objectives of the dialogue sessions are for both parties to obtain an understanding of the optimum solution for the CC2H service across Kirklees. This will be obtained via the presentation and the open dialogue.

The sessions gave the providers the opportunity to test their ideas with commissioners and assisted them to complete their responses to the questions for the evaluation phase of the Invitation to Participate in Dialogue (ITPD) stage of the procurement process and informed the content for the next stage of the procurement process.

Question themes within the procurement linked to the award criteria included:

Themes
1. Service Delivery Local Demographics Integration With Social Care/VCS/Primary Care Innovation Lead Provider Arrangements Prevention/Self Care/Personalisation Links to Admissions Avoidance
2. Service Capability Operating Model Workforce Plans Addressing Skills Gaps Assessment Of Resource Levels
3. IT & Service Infrastructure Clinical System Interoperability Information Governance Virtual Consultations Shared Records Assessment Of The Current Use Of Premises And Future Plans Estate Utilisation
4. Engagement & Ongoing Management Ongoing Patient And Carer Engagement Equality & Diversity
5. Mobilisation Implementation Plans

6. Commercial (including Contracts, Finance & Estates) Performance Management & Dashboards
7. Outcome Delivery Incentivisation PHBs

Invitation to Continue in Dialogue (ITCD)

Following evaluation both bidders were invited to continue in dialogue and dialogue sessions were held during March 2015.

Final submissions were evaluated and moderation took place following this. The highest scoring bidder was identified and information passed to each of the CCG's Governing Bodies for a decision.

Contract Award

Stage	Deliverable	Timescale
Contract Award	Governing Body decision in parallel to award contract	13/05/2015
	Standstill period commenced	13/05/2015
	Unsuccessful bidder challenge received	18/05/2015
	Initial response to unsuccessful bidder concerns	22/05/2015
	Formal contract award announced by both CCGs	07/07/2015
	Complaint to Monitor issued by unsuccessful bidder	19/08/2015
	Monitor notified no further action would be taken / no investigation launched	16/09/2015

Following evaluation and the moderation process, the CCGs' Governing Bodies met in parallel and made the decision to award the contract. The successful and unsuccessful bidder were notified and a 10 day standstill period was entered.

During the standstill period, concerns were raised by the unsuccessful bidder about the process and the Procurement Delivery Manager gathered, reviewed and appropriately redacted a full range of documentation to respond to the concerns raised which resulted in an extended standstill period whilst this information was obtained. A chain of correspondence was entered with the unsuccessful bidder and legal advice sought by the CCGs.

The unsuccessful bidder indicated it was not satisfied with the response received and indicated the intention to refer to Monitor. Both CCGs made the decision to continue with contract award and a formal announcement of contract award was made on 7 July 2015 and the mobilisation process formally commenced.

The CCGs received notification of the unsuccessful bidder's complaint to Monitor on 19 August 2015. The Programme Director with CCG leads led a number of discussions with Monitor regarding the process and provided further information where required. Monitor notified the unsuccessful bidder and CCGs that it would not be launching an investigation into the complaint on 16 September 2015.

Glossary

CC2H – Care Closer to Home

CCG – Clinical Commissioning Group

OSC – Overview and Scrutiny Committee

JHOSC – Joint Health Overview and Scrutiny Committee

CQUIN – Commissioning for Quality and Innovation payments

CHFT – Calderdale and Huddersfield Foundation Trust

CVD – Cardiovascular disease

DQIP – Data Quality and Improvement Plan

Emis – Clinical system used by some general practices

GHCCG – Greater Huddersfield Clinical Commissioning Group

GP - General Practitioner

ICCT – Integrated Community Care Team

ITCD – Invitation to Continue in Dialogue

ITPD – Invitation to Participate in Dialogue

ITT – Invitation to Tender

MDT – Multi-disciplinary team

NKCCG – North Kirklees Clinical Commissioning Grouip

PQQ – Pre-qualification questionnaire

S1 – SystmOne (clinical system used by Locala and some general practices)

SPA – Single Point of Access

SPC – Single Point of Contact

SDIP – Service Development and Improvement Plan

SpN – Specialist Nurse

SRO – Senior Responsible Owner

SWYPFT – South-West Yorkshire Partnership NHS Foundation Trust

Extract from the Consultation Document (page 36) Community Health Services

What would be the impact?

Our proposed changes would deliver more care closer to where people live, in GP surgeries and health centres and this would include some services that have previously been provided in hospital, including routine outpatient appointments and diagnostic tests (such as x-rays and blood tests). The services we are looking at are set out below.

Calderdale

- **Children and young people** – more paediatric clinics in community settings.
- **Frail older people** – Expanding a scheme called Quest for Quality in Care Homes (see page 37) to the remaining 14 care homes in Calderdale.
- **Long term conditions –** Respiratory – services for children with asthma and adults with chronic chest problems. Heart disease – services for people with heart failure, angina and atrial fibrillation. Diabetes – services for when people with diabetes become unwell.
- **Musculoskeletal** – planned orthopaedic care, rheumatology, physiotherapy and hospital based pain management.
- **Ophthalmology** – vision screening, community based optometry, cataract assessment and follow-up, ocular hypertension (OHT) follow-up.
- **Dermatology** – provision of specialist/acute services.
- **Diagnostics** – radiology and pathology.
- **Other services**
  End of life care, more services for frail older people, children with complex needs and people with long term conditions and delivery of rehabilitation beds in a community rather than acute hospital setting.

Huddersfield

- **Therapies**
  Speech and language therapy, occupational therapy and physiotherapy – delivery of outpatient therapy in a community based setting.
- **Children's services**
  Community nursing services for children, community paediatric services and specialist nurses – delivery of community children's services as a primary/community based service rather than an acute-led service.
  Speech and language therapy, occupational therapy and physiotherapy – delivery of outpatient therapy in a community based setting.
- **Other services**
  Rehabilitation beds – delivery of rehabilitation beds in a community rather than acute setting.
- **Diagnostics –** radiology and pathology

Questions

We would like you to think about how these proposed changes would impact on you and your family. We want to know what worries you/ what you don't like. Also what you do like and if there is anything else

you would like to tell us or that we have missed. At the end of the survey we ask if you agree or disagree with our proposed changes, if they will have a negative impact on you and any ideas about travel, transport and parking. The survey is attached or you can complete it on line at www.rightcaretimeplace.co.uk. If you need a hard copy please ring **01484 464212**.

For further information about the Care Closer to Home programmes in Calderdale and Greater Huddersfield, go to http://www.calderdaleccg.nhs.uk/your-health/care-closer-to-home/ and http://www.greaterhuddersfieldccg.nhs.uk/home/

Kirklees COUNCIL

Name of meeting: Calderdale and Kirklees Joint Health Scrutiny Committee
Date: 14 June 2016

Title of report: Primary Care Services

Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**No**
Is it in the Council's Forward Plan?	**No**
Is it eligible for "call in" by Scrutiny?	**Not Applicable**
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 to provide the context to the Committee discussions with Calderdale and Greater Huddersfield CCG's and representatives from Calderdale and Kirklees Local Medical Committee's**
Cabinet member portfolio	**Prevention, Early Intervention and Vulnerable Adults**

Electoral wards affected: All

Ward councillors consulted: N/A

Public or private: Public

---

1. Purpose of report

1.1 To provide members of the Calderdale and Kirklees Joint Health Scrutiny Committee (JHSC) with the context to the discussions on Primary Care Services.

2. Key Points

2.1 Primary Care will be a key element in the work that is being done to transform the ways that health services are delivered as set out in the NHS Five Year Forward view.

2.2 A fundamental element of the proposed changes to hospital and community services in Calderdale and Greater Huddersfield is to strengthen community services. The success of these services will require Primary Care to work in collaboration with the Care Closer to Home (CC2H) and Urgent Care agendas.

2.3 Representatives from Calderdale and Greater Huddersfield CCG's and Calderdale and Kirklees Local Medical Committee's (LMC's) will be in attendance to outline the role that General Practice has to play in contributing to the proposed changes to hospital services to include:

- How GP's have been involved in the design of the proposals;
- The role of GP's in Urgent Care Centres;
- LMC's views on the proposals to include:
  - The role of GP's in helping to take demand out of the hospital system;
  - The impact of the proposals on GP's;
  - The impact of the CC2H programme on GP's

3. Implications for the Council

None at this time.

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 221000 E-mail: richard.dunne@kirklees.gov.uk

9. Assistant Director responsible

Julie Muscroft Assistant Director: Legal, Governance & Monitoring

Name of meeting: **Calderdale and Kirklees Joint Health Scrutiny Committee**
Date: **14th June 2016**
Title of report: **Public health in Calderdale**

1. Purpose of report

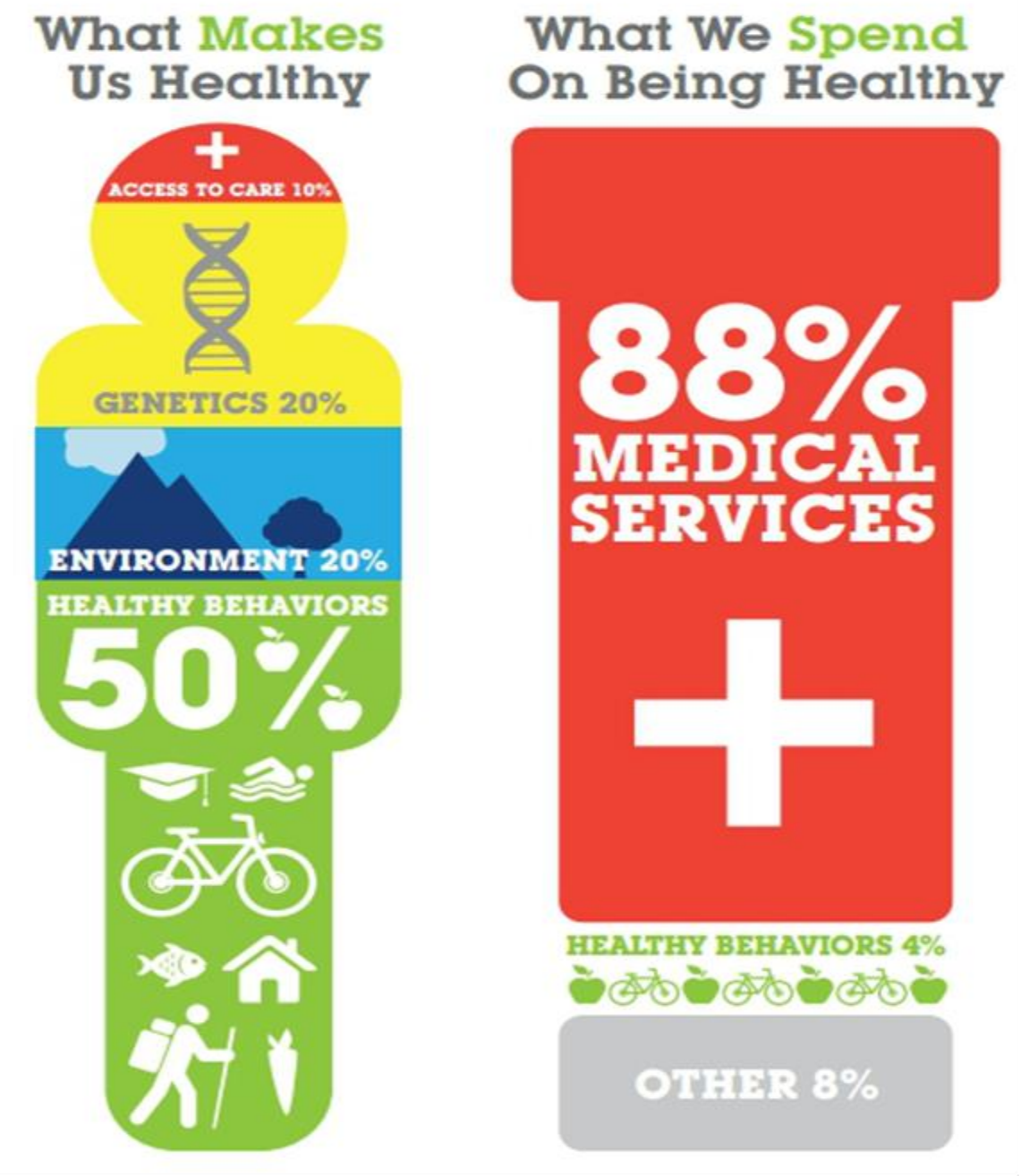
To provide the Panel with information to help them assess

1) The contribution of the hospital reconfiguration proposals to improving health outcomes people living in Calderdale
2) The contribution that public health initiatives will make to "taking demand out of the system"
3) The alignment of the hospital reconfiguration proposals with the Calderdale JSNA and the priorities identified in the Calderdale Wellbeing Strategy

1.1 The contribution of the hospital reconfiguration proposals to improving health outcomes people living in Calderdale

Calderdale CCG has fully engaged with the Council and its partners on these proposals to date and we expect this to continue through the implementation. Health indicators will need monitoring if the reconfiguration rolls out and plans will need to be adapted where necessary to ensure the best possible services for our population.

The reality of the impact of hospital reconfiguration on the health of the population is expected to be small. The academic research indicates that health services only contribute between 10-20% of health outcomes in our population. The key determinants of the health of our population are mainly located within environmental and health behaviour domains.



1.2 The contribution that public health initiatives will make to "taking demand out of the system"

The first argument in the NHS 5 year Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health.** Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded – and the NHS and social care is on the hook for the consequences.

The reality is that public health budgets - currently the only dedicated resource for prevention - has and will continue to be reduced over the next few years.

Efficiencies in public health spend have been realised recently as more rigorous approaches to procurement and service specifications have been implemented. However the majority of the resources in public health continue to be spent on treatment services. i.e. alcohol and drug services , sexual health services .

System wide public health interventions have demonstrated success in reducing demand. The teenage conception strategy has shown a 50% reduction in teenage conceptions over the past 10 years or so. Smoke-free legislation in public and work places has been associated with reduced acute myocardial infarction (heart attack) occurrence by 13% on average from international evidence. (1)

There is a great deal more that can be done. For example, the Chief Medical Officer believes that - like the smoking ban - minimum unit pricing of alcoholic drinks would save lives within a year. According to estimates in a Government consultation paper, a 45p minimum unit price would result in a reduction in consumption across all product types of 3.3%, leading to 5,240 fewer crimes per year, a reduction in 24,600 alcohol-related hospital admissions and 714 fewer deaths per year after ten years. (2)

At a more local level oral health continues to cause both pain and distress amongst children. The NHS routinely collects data on tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under. There were 306 admissions between 2011/12 and 2014/15 (so approx. 77 per year) with a rate of 1052.4 per 100,000. Better dental hygiene, the consumption of less sugar and fluoridation of water supplies would all impact on these preventable causes of admission.

Specific public health initiatives that contribute to “taking demand out of the system” include:

Demand caused by obesity, alcohol, smoking – public health commission a range of programmes to help people tackle behaviours that contribute to poor health and increase the likelihood of needing services. A “wellness” model has been re-procured that will deal holistically with a range of lifestyle choices that impact on health and wellbeing rather than traditional single issue services allowing us to support people with a range of issues in one place and make more efficient use of resources as well as increase the chances of helping individuals achieve real change.

Social isolation and loneliness – Calderdale CCG and Calderdale Council have embarked on a major intervention to reduce the harm caused by social isolation. Various estimates have put the health harm of isolation at the same level of risk as smoking 15 cigarettes per day. The programme is being evaluated by the University of Lincoln and is due to report within the next two months. Moves to strengthen community services will support broader ranging interventions which reduce population health harm.

Active Borough Calderdale, the Council in partnership with public voluntary and private sector partners has embarked on a major programme to increase levels of physical activity across the borough. If 40- 79 year olds undertook the levels of activity needed for health then the benefits would include; approximately 160 premature deaths per years would be avoided; there would be 25 fewer new cases of breast cancer; and 17 fewer new cases of colorectal cancer. (3) In the long term there be a large reduction in dementia cases and costs borne by social care would be dramatically reduced.

The paper submitted to the Joint Committee by Kirklees outlines the case for work on ambulatory care sensitive conditions (ACSCs) which are conditions where effective community care and case management can help prevent the need for hospital admission.

1.3 The alignment of the hospital reconfiguration proposals with the Calderdale JSNA and the priorities identified in the Calderdale Wellbeing Strategy

The Calderdale Wellbeing Strategy sets out the outcomes needed for wellbeing across our population. Calderdale Health and Wellbeing Board is in the process of revising the Strategy in the light of new guidance, the introduction of Sustainable Transformation Plans and the clear direction of travel to have more integrated commissioning and delivery of health, social care and public health.

The Wellbeing Strategy sets out a range of outcomes, the reconfiguration proposals may help deliver these and has a particularly important role in relation to

- Having the best possible start in life
- Development of positive health behaviours and good health
- Enhancing self-care and resilience

The most recent update of the JSNA (see www.calderdale.gov.uk/jsna) highlights increasing life expectancy and increasing healthy life expectancy for some, but significant inequalities in health outcomes are increasing. Inequalities in health are demonstrated by the differential rates of use of hospital services. Strengthening community-based early intervention and preventative services will support a reduction in inequalities.

Paul Butcher
Director of Public Health

References

1 The effects of smoke-free legislation on acute myocardial infarction: a systematic review and meta-analysis

BMC Public Health BMC series 2013 **13**:529

2 Home Office, A consultation on delivering the Government's policies to cut alcohol fuelled crime and anti-social behaviour, November 2012, chapter 5

3 Public Health England Health Impact of Physical Inactivity 2013

Kirklees COUNCIL

Name of meeting: **Calderdale and Kirklees Joint Health Scrutiny Committee**
Date: **14th June 2016**
Title of report: **Implications for social care and public health in Kirklees**

Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**No**
Is it in the Council's Forward Plan?	**N/A**
Is it eligible for "call in" by Scrutiny?	**N/A**
Date signed off by Director & name **Is it signed off by the Director of Resources?** **Is it signed off by the Assistant Director (Legal Governance and Monitoring)?**	**Richard Parry Director for Commissioning, Public Health and Adult Social Care.** **3rd June 2016** **N/A** **N/A**
Cabinet member portfolio	**Prevention, Early Intervention and Vulnerable Adults**

Electoral wards affected: **All**
Ward councillors consulted: **N/A**
Public or private: **Public**

1. Purpose of report

To provide the Panel with information to help them assess

1) The level of engagement of Kirklees Council in the Strategic Review that led to the proposals for hospital reconfiguration
2) The implications of the development of specialist hospitals for hospital discharge arrangements, hospital social work teams, reablement services etc.
3) The contribution that social care services can make to the implementation of a specialist hospital model.
4) How will health and social care work together to reduce admissions, re-admissions and discharge waiting time
5) The impact that hospital configuration will have on Kirklees social care services
6) The current workforce issues that will impact on the delivery of social care services
7) The contribution of the hospital reconfiguration proposals to improving health outcomes people living in Greater Huddersfield
8) The contribution that public health initiatives will make to "taking demand out of the system"
9) The alignment of the hospital reconfiguration proposals with the Kirklees JSA and the priorities identified in the Kirklees Joint Health and Wellbeing Strategy

2. Key points

2.1 Engagement of Kirklees Council in the Strategic Review that led to the proposals for hospital reconfiguration

The Health and Wellbeing Board has received regular updates on the development of the Calderdale and Greater Huddersfield Strategic Review, the development of the Strategic Outline Case and more recently progress with the Right Care Right Time Right Place programme.

There has been protracted and repeated engagement with senior officers from the Council over the lifetime of the Strategic Review. For example senior officers have been invited to attend the Calderdale & Huddersfield Strategic Review Programme Executive. More recently social care has been much more actively engaged around the current proposals.

The Council recognises that this is a complex set of changes and there have therefore been a wide range of stakeholders involved. The intention has clearly been to enable the maximum amount of engagement, however at times this resulted in too many meetings for the Council to be able to engage effectively.

2.2 The implications of the development of specialist hospitals, the contribution that social care services can make to the implementation of a specialist hospital model and how health and social care work together to reduce admissions, re-admissions and discharge waiting time

The Council is working with a wide range of partners to deliver more integrated services. Some of the most significant services are

- **Reablement service**
  Council staff work alongside physiotherapists and occupational therapists to support people for a period of up to six weeks to relearn daily living skills and to regain abilities and confidence in their own home. The aim is to reduce avoidable hospital admissions, support timely discharges and prevent re-admissions.
- **Intermediate care**
  Based in Moorlands Grange, Netherton and Ings Grove, Mirfield the intermediate care services is delivered by Council and Locala staff following an assessment by a health or social worker at home or in hospital people who have mobility, dietary or emotional needs and who need support to help them regain or adapt their day-to-day living skills. The aim is to make sure that people who would otherwise be admitted to hospital, or who need to be in hospital for a long time, remain as independent as possible, reducing or delaying the need for long-term care.
- **Hospital avoidance team**
  Based in each of the main hospital sites the Hospital Avoidance Team work with emergency department staff and community nurses to ensure people presenting at A&E have a pathway to services to avoid admission (where medically appropriate) after treatment/ exploratory tests. Social care assessments are also available seven days a week to support discharge from hospital and intermediate care.
- **Mobile response service**
  The Mobile Response service supports Carephone users by providing an alternative response to Telecare alerts when Carephone officers are unable to get in touch with family or named emergency contacts, or where family are unable to respond. Operating 24/7, responders intervene in circumstances where it is

considered that the request for help does not require any of the emergency services to attend. The service reduces in emergency YAS callouts; preventing unnecessary hospital admissions, helping to manage the demand for intensive people based services alongside improving service user's health & wellbeing through the promotion of self-care, choice & control.

- **Kirklees Integrated Community Equipment Service**
  The service is jointly commissioned by the Council and both CCGs and provides a truly integrated approach to ensuring frontline staff from across health and social care can ensure their clients are getting the equipment they need as quickly as possible.
- **Integrated Community Care Teams**
  Locala and the Council have been working closely together for a number of years to develop Integrated Community Care Teams (ICCTs), bringing together health & social care services. The model was initially implemented on a 'pilot' basis with a full review/audit taking place in 2014 which helped shape the further development of an integrated model. The core services involved are shown in Appendix 1.
  The early stages of implementation of the ICCTs was managed through a joint programme management structure with key people from across Locala & Adult Social Care. Whilst a great deal has been achieved in terms of delivering services in a more co-ordinated way and minimising duplication there is still work to be done to improve, including the operation of the Integrated Night team which is made up of nursing and social care staff delivering unplanned and some planned interventions.
  This work in now being led by the Integration Board, which has officers from the Council, CCGs, Locala and South West Yorkshire Trust. The aim is to further develop ICCTs, linking the Care Closer to Home contract, and the Council's Early Intervention & Prevention programme. The current focus is on developing a 'pilot' locality team.

Commissioning

The current integrated commissioning arrangements with the CCGs were established in September 2013. Since then a significant amount of work has been undertaken by the 3 organisations, through the Integrated Commissioning Executive and the Integrated Commissioning Groups which sit underneath this. The Chief Officer Group has overseen this work.

Proposals for strengthening these arrangements were endorsed by the Health and Wellbeing Board in May 2015. The focus is development and implementation of the Better Care Fund plan, continuing care, nursing and care home provision, mental health commissioning, children's commissioning, and performance and intelligence.

Each of these areas now has an action plan that identifies the priority areas of work along with actions, timescales and responsibilities for taking these forward. In addition, each of the Integrated Commissioning Groups are identifying areas where further pooling and aligning of resources has the potential to improve the commissioning of services for the benefit of the residents of Kirklees.

Better Care Fund

The Better Care Fund, a national programme to support the integration of health and social care including a requirement to pool funds in a Section 75 Agreement, has been a major focus over the last 18 months. The BCF includes a range of schemes covering

- Preventative services including; support to voluntary and community sector organisations; self-care, alcohol liaison workers
- Intermediate Care
- Aids to Daily Living: including Kirklees Integrated Community Equipment Service, Assistive Technology and adaptations
- Carers Support
- Community Health Services
- End of Life Care
- Mental health (inc Psychiatric Liaison Services)
- Supporting Social Care.

Discussions locally about the Better Care Fund have highlighted the need to evaluate the impact of existing schemes more thoroughly. We have invested in a pilot project with Care Trak that can draw together both NHS and social care data for the first time to support this. This has also enabled us to start resolving some of the Information Governance issues, although there is still more work to be done to ensure the necessary data flows both for commissioning and care planning and co-ordination for individuals.

A key focus of activity to ensure we deliver the commitment under the Better Care Fund in 2016/17 will be developing more integrated and effective approaches to

- Named care co-ordinators, individualised care plans & case management
- Intermediate care, reablement and rehabilitation

The BCF Plan also identifies the importance of strengthening the links between the Integrated Commissioning arrangements and the local System Resilience Groups (SRGs) for both Calderdale/Huddersfield and North Kirklees/Wakefield. Especially around patient flows and delayed transfers of care.

Urgent care and transfers of care

The Calderdale and Huddersfield SRG, which has representatives from the Trust, CCGs and the adult social care has developed an action plan to implement the High Impact Change Model for Delayed Transfers of Care (see appendix 2).

This builds on the work that the local partners, including adult social care, have been doing as part of the Emergency Care Improvement Programme (ECIP) with the Emergency Care Intensive Support Team (ECIST) to deliver the changes set out in 'Safer, faster, better: good practice in delivering urgent and emergency care'. There have been a series of Improvement Programme events and this has enabled partners to look at ways of improving joint working arrangements between health and social care in acute settings and internal social care systems.

2.3 The impact that hospital configuration will have on Kirklees social care services

Whilst there was extensive work done on modelling the impact of the changes on the NHS system, as yet there has been no detailed analysis of the impact on social care delivery and the funding implications of the proposed changes.

Without this work being done it is only possible to comment on the more obvious operational impacts, these include

- Splitting the social care customer base over two sites makes it more difficult and costly to manage, for example we will need to ensure a social work presence at both sites, plus the increased mileage, travel time etc.
- Assessors often leave the hospital base to visit clients at home due to Safeguarding, Admission Avoidance and Reviews. If Assessors are traveling to and from Halifax to Huddersfield a number of times daily/ weekly this will cause a significant reduction in assessment hours.
- The Hospital Avoidance Team currently take people home from A&E at HRI, which means they are away from the site for around an hour on average. Obviously, taking people home from CRI will increase this significantly.
- Local care homes and care providers come into hospital to complete assessments on the wards for complex patients before discharge, if Kirklees providers were to travel further to assess Kirklees residents this process will become more drawn out and probably increase delays.
- Managing a larger proportion of Kirklees residents at Calderdale Royal will have some risks because due to working onsite with a different host Local Authority. This has already been our experience working at Pinderfields in Wakefield. Although this experience has shown that whilst it is more challenging it is possible.
- There is a high risk of losing staff due to relocation if their working base becomes Halifax as meant people applied for their current posts to work in the area they live in order to achieve a certain work life balance not to work out of area.

2.4 The contribution of the hospital reconfiguration proposals to improving health outcomes people living in Greater Huddersfield

Greater Huddersfield CCG has, through continuous engagement with partners, given assurance that they expect no negative impact on health outcomes for their population and that new arrangements will be monitored closely to ensure this remains the case. It is clearly stated that the aim of the reconfiguration is to improve standards of care.

The new model of service delivery has described urgent care facilities in Huddersfield that the Kirklees population will be able to access if they have a need that requires immediate attention. The intention is that all emergencies will travel to Calderdale where there will be the right level of expertise to deal with that level of need. Contribution to the improvement in health outcomes will depend on the right people accessing the right service at the right time with the right level of expertise to address their needs. There is evidence across the country that centralisation of services improves patient care and their outcomes.

Given the willingness of Greater Huddersfield to engage with the Council and its partners on these proposals to date we expect this to continue through the implementation so that impact on our population can be monitored and plans adapted where necessary to ensure the best possible hospital services for our population.

2.5 The contribution that public health initiatives will make to “taking demand out of the system”

Public Health works across all 3 levels of prevention – preventing people needing health and social care by keeping them healthy and well, reducing the need for health and social care intervention when people are identified as having a health or social care need and delaying the need for complex care packages. A lot of this is

done by working in partnership with health and social care colleagues to understand population needs and what works.

The challenge we face is that we need to focus enough on prevention, in order to have a real impact on future demand while dealing with the immediate challenges we face now in terms of taking demand out of the system from people who already have health and social care needs. Specific public health initiatives that will contribute to "taking demand out of the system" include:

Self-care – there is a wealth of evidence that supporting people to take more control of their health, their long term condition or their care leads to greater independence and people using services in a different way. In Kirklees we have built up a comprehensive programme over the past 10 years that gives people with a long term condition a range of individual and group based options to give them the skills and knowledge they need to do this. Public health have also worked closely with both CCG's and Locala to embed a culture of maximising independence and supporting self-care in the delivery of community services and care closer to home.

Demand caused by obesity, alcohol, smoking – public health commission a range of programmes to help people tackle behaviours that contribute to poor health and increase the likelihood of needing services. The proposal for the future is to develop a "wellness" model that will deal holistically with a range of lifestyle choices that impact on health and wellbeing rather than traditional single issue services. This will allow us to support people with a range of issues in one place and make more efficient use of resources as well as increase the chances of helping individuals achieve real change.

Healthy Ageing – as people get older the likelihood of them needing health and social care services increases and it is therefore important to focus on healthy ageing. In terms of "taking demand out of the system" public health is coordinating work on falls prevention and the development of a falls pathway with colleagues from the CCG and acute sector. Work has been ongoing for some time on nutrition and hydration in older people with a particular focus on improving standards in care homes through education and training of staff. Both falls and dehydration are common causes of hospital admission that can, in many cases, be avoided.

Ambulatory care sensitive conditions (ACSCs) are conditions where effective community care and case management can help prevent the need for hospital admission (see table below). Emergency admissions for ACSCs cost the NHS £1.42 billion annually. Influenza, pneumonia, chronic obstructive pulmonary disease (COPD), congestive heart failure, dehydration and gastroenteritis account for more than half of the cost, and those aged 75 years and over are most at risk. Influenza and pneumonia account for the largest proportion of admissions and expenditure - many of these cases are vaccine-preventable[1]. Reducing levels of obesity, alcohol misuse and smoking, improving confidence of people to take control of their long term conditions and focussing on healthy ageing, including amongst the frail elderly, can all have a positive impact on reducing demand caused by ACSCs.

[1] Kings Fund (2012) Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf

The 19 ambulatory care-sensitive conditions

Vaccine-preventable	Acute
1. Influenza and pneumonia	11. Dehydration and gastroenteritis
2. Other vaccine-preventable conditions	12. Pyelonephritis
Chronic	13. Perforated/bleeding ulcer
3. Asthma	14. Cellulitis
4. Congestive heart failure	15. Pelvic inflammatory disease
5. Diabetes complications	16. Ear, nose and throat infections
6. Chronic obstructive pulmonary disease (COPD)	17. Dental conditions
7. Angina	18. Convulsions and epilepsy
8. Iron-deficiency anaemia	19. Gangrene
9. Hypertension	
10. Nutritional deficiencies	

2.6 The alignment of the hospital reconfiguration proposals with the Kirklees JSA and the priorities identified in the Kirklees Joint Health and Wellbeing Strategy

The Kirklees Joint Health and Wellbeing Strategy sets out a clear direction of travel to more integrated commissioning and delivery of health, social care and public health. This reflects a clear national political consensus about the need to create a more coherent, person centred health and social care system that focusses on moving care closer to home wherever possible and promoting independence and prevention. The JHWS sets out a range of outcomes, the reconfiguration proposals could help deliver many of these, but has a particularly important role in relation to

- Having the best possible start in life
- Development of positive health behaviours
- Enhancing self-care and resilience
- People feeling safe and include in their care

The JHWS also sets out a range of 'system change priorities'. Again the reconfiguration proposals can make a contribution to many of these, but ones of particular importance to how the proposals are developed and implemented include

- Being person centred, taking a holistic view of the individuals, valuing their strengths and involving them in creating solutions, increasing their sense of control over the life and their care
- Creating a clear way for individuals to navigate through services and systems
- Co-ordinating care that also recognises and supports informal carers
- Providing consistent and appropriate quality information
- Using consistent messages and language across services and organisations
- Improving quality of and access to services and reducing variation
- Being evidence based in outcomes and what works
- Minimising the unintended consequences of service changes
- Prioritising according to need and impact
- Eradicating duplication
- Using a shared approach to digitisation
- Building a workforce that is adaptable and that can span health and social care

The most recent update of the JSA overview highlights the positive steps in increasing life expectancy and increasing healthy life expectancy, but the major challenges of more people ageing with multiple long term conditions, the levels of obesity and poor mental health and the significant inequalities in health outcomes particularly for those people living in poor social and economic circumstance. It sets out a number of key challenges which the hospital reconfiguration proposals could make a significant contribution to:

- The need to focus on prevention and to intervene early
- Narrowing the inequality gap
- Enabling people to start, live and age well
- Improving resilience and enabling healthy behaviours

2.7 Implications for the Council

The Council and NHS partners have committed themselves to developing a more integrated approach to the commissioning and delivery of health and social care services.
There is now a national expectation that there will be an integration plan by 2017 which will be implemented by 2020. Whilst there has been significant progress on many fronts this report highlights the range of opportunities to widen and deepen integration across Kirklees.

2.8 Consultees and their opinions

Not applicable

2.9 Officer recommendations and reasons

That the contents of this report are noted**.**

2.10 Cabinet portfolio holder recommendation

Not applicable.

2.11 Assistant directors responsible

Keith Smith
Assistant Director for Commissioning and Partnerships

David Hamilton
Assistant Director

Rachel Spencer-Henshall
Director of Public Health

Appendix 1: Integrated Community Care Teams core services

N.B Not exclusive list

Appendix 2:
Calderdale and Greater Huddersfield SRG: Implementing high impact changes – managing delays in the transfer of care from hospital beds (Huddersfield/Kirklees footprint)

Change 1: Early Discharge Planning.

Actions to be taken	a) Complete development of an integrated discharge model business case and agree with all partners including strengthening the role of primary care b) SRG to agree case and funding (Q1) c) Implementation Plan for new model agreed by DTOCB (Q1) d) Begin implementation of relevant recommendations from the January 2016 ECIP report (Q1) e) Implementation of operational SAFER bundle activity in CHFT and with partners as necessary (Q1) a) Ensure all partners are sighted on plans to integrated health and social care teams to support discharge (Q1)
Leadership	TOC Board
Measurement	• Provisional discharge dates set upon admission (non-elective care) - % to be locally agreed. • 100% of discharge dates are set prior to admission for (elective care) • Patient experience KPIs to be confirmed • Delivery of KPIs in business case for integrated model • Delivery of KPIs/ECIP recommendations

Change 2: Systems to Monitor Patient Flow

Actions to be taken	a) Continuation of work to strengthen flow information in advance of an agreed system (Q1) b) Further development of proposals to new system to manage flow – as discussed at SRG (Q1) c) Agreement on system BI and informatics support needed for current and future system (Q2) d) Being implementation of relevant recommendations from the January 2016 ECIP report (Q1)
Leadership	TOC Board
Measurement	• Performance data available for DTOCB and SRG • New system in place and supporting improvement

Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector

Actions to be taken	a) Build on current processes are in place for tracking and action planning the number of outstanding assessments; the list should reflect new cases daily and how many days existing cases have been waiting and how many cases were completed and taken off list previous day (Q1) b) Ensure process in place to tackle long waits an integrated health and social care focus group and action plan for each case with clear discharge dates as a matter of priority (Q1) c) Complete development of an integrated discharge model business case and agree with all partners (Q1) d) SRG to agree case and funding (Q1) e) Implementation Plan business case agreed by DTOCB (focus on initiation of MDTs and Discharge to Assess) (Q2) f) Commence delivery of relevant recommendations from the January 2016 ECIP report (Q1) a) Implementation of operational SAFER bundle activity in CHFT and with

	partners as necessary (Q1)
Leadership	TOC Board
Measurement	• Number of joint MDTs taking place • % patients covered by joint MDT working • % MDTs with community/third sector involvement • No/% of patients discharged to assess

Change 4: Home First/Discharge to Assess

Actions to be taken	a) Continue work to strengthen current joint reablement services, including strengthening KPIs, response times and capacity and demand analysis (Q2) a) Confirm SRG views on involvement in the national programme "Shared Lives" (Q1) b) Further work to be done with care homes who are unresponsive to requests to speed up assessments in hospital – linked to contractual levers where possible (Q1) a) Pilot discharge to assess with care homes in Calderdale (Q2)
Leadership	TOC Board Care Homes work-stream in Kirklees
Measurement	% people discharged into joint reablement services and no. of days taken for discharge to take place % people in receipt of joint reablement still at home 91 days after discharge %care home assessments undertaken in hospital within 48 and 24 hours of agreement to discharged % assessments undertaken at home/care homes rather than hospital % people discharged home % people admitted into permanent residential/nursing care

Change 5: Seven-Day Service

Actions to be taken	a) Confirm current 7DS offer locally through local stakeholder event delivered by NHSE Improvement Team (Q2) b) Confirm progress with negotiation of staff contracts for health and social care (Q2) c) Confirm progress on provider negotiation on homecare assessment and re-starts at weekends (Q2) d) Full action plan to be agreed to delivery on 7DS national expectations, with recognition of current acute site constraints (Q2) a) Take learning from public consultation on acute configuration (CHFT footprint) and agree the future care model (Q3)
Leadership	SRG agreement on governance and leadership required
Measurement	• Contractual monitoring of 7DS delivered across a range of providers • Response time for 7DS already in place • KPIs and timelines developed within system plan • KPIs and timelines developed for hospital change programme in line with consultation

Change 6: Trusted Assessors

Actions to be taken	(a) Agreement to develop to "trusted assessor" arrangements based on good practice elsewhere (Q1) (b) Implementation timelines agreed and shared with SRG (Q2)
Leadership	TOC Board
Measurement	To be agreed with the TOC Board as part of implementation plan

Change 7: Focus on Choice

Actions to be taken	(a) DTOC Board to keep a watching brief on Policy implementation and issues and escalate to SRG as needed (Q1)

	(b) Develop SOP confirming expectations around the pace of delivery interventions for those whose discharge is delayed – this will be updated regularly with latest guidance codes and will reflect changes in daily weekly and monthly reporting recommendations (Q2) (c) Strengthen links between CHFT and voluntary sector who can support post/on discharge and ensure staff are fully aware of offers – via CC2H plans (Q2) (d) Update on SHFT to SRG as part of evaluation of winter schemes (Q1) (e) Feedback to SRG on implementation of new Discharge Policy, including impact on LOS (Q2) (f) Ensure third sector play a key role in the development of emerging new care models (Q2)
Leadership	TOC Board CC2H Contract Board
Measurement	• LOS for medical patients • Reductions in long lengths of stay • No of third sector organisations involved in integrated discharge planning/% patients covered • KPIs for patient and family satisfaction with discharge • Reductions is SIs related to poor discharge planning

Change 8: Enhancing Health in Care Homes

Greater Huddersfield/Kirklees footprint	
Current Rating and rationale	Level 3: Care Home Pilot in place Stimulating the market and creating resilience is currently a challenge for Local Authorities and CCGs and we have capacity issues in step-up/step down/intermediate care beds and nursing and EMI beds. Agreed focus locally includes the need to also strengthen the home care market in order to support flow. *Caveat on level 3 is the need to test quality and safeguarding plans are in place within care homes*
Actions to be taken	(a) Ensure shared learning across the two different care home models (Q1) (b) CCG and CHFT working to establish any joint opportunities to develop a new approach to community beds (Q1) (c) SRG work-stream is established but there is a need to strengthen planning, reporting and challenge (Q1) (d) CCG working with CMBC working at a place-based level to develop a short, medium and long-term plan to strengthen the care home and home care markets. Implementation Plan to be agreed SRG (to include other elements of this plan including discharge to assess and improving speed of assessments (Q2)
Leadership	SRG through Care Home Work-stream CC2H Board for place-based work
Measurement	• Care Home Pilot dashboard • Variation in admissions by individual care homes • Patient experience improved • Reductions in care home SIs