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.

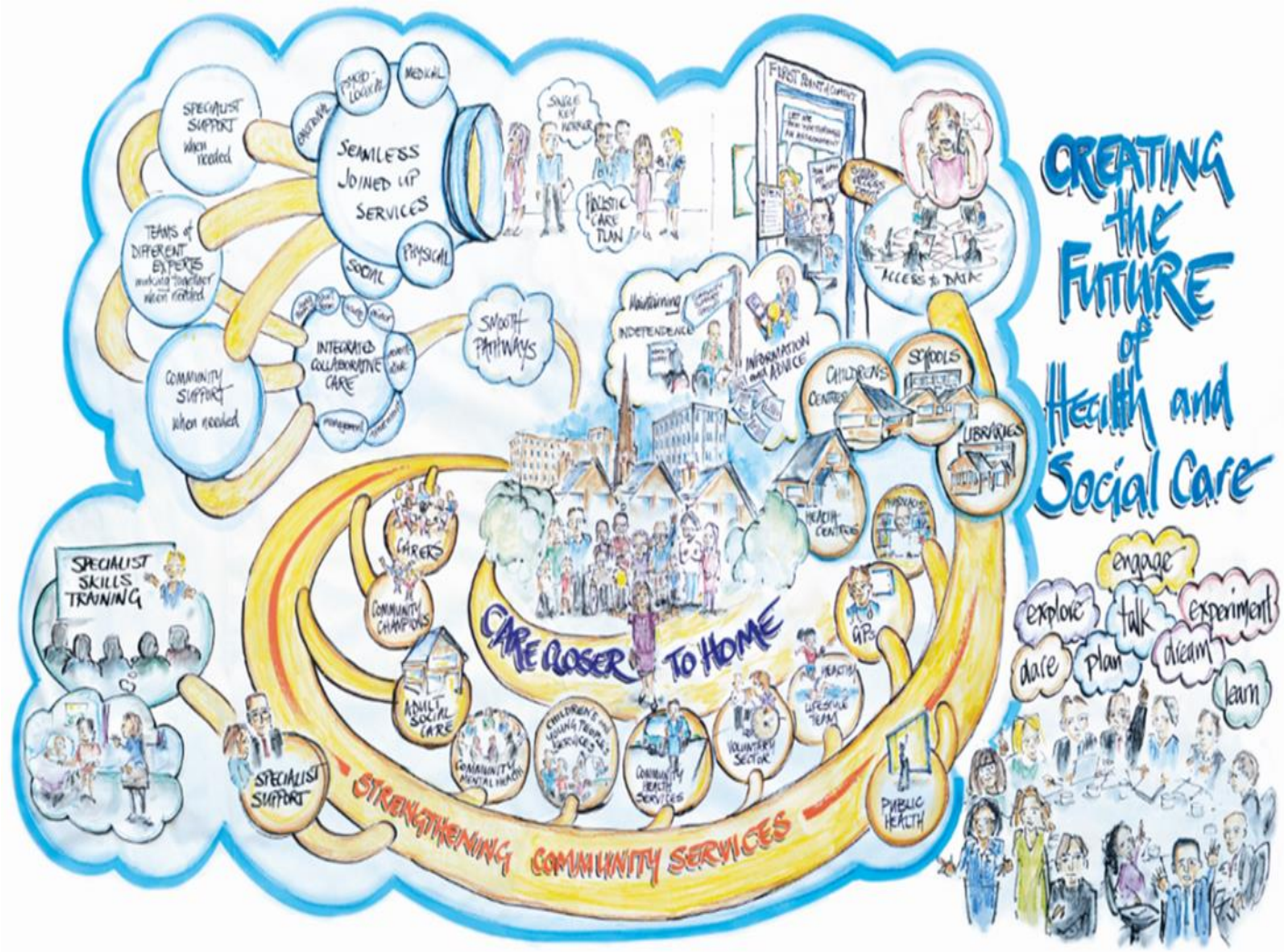
For Calderdale CCG, the CC2H and Better Care Fund (BCF) plans are aligned and the BCF continues to be used as a vehicle to develop integrated commissioning models with Calderdale Council. In addition Calderdale CCG is also working closely with partners on the Health and Wellbeing Board to develop the 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)

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

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.

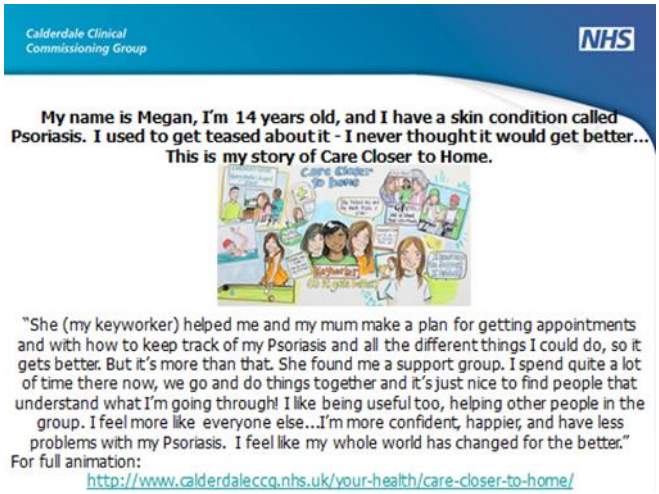
(ii) Musculoskeletal services (MSK) – investment in new upper limb service in the community.

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**.

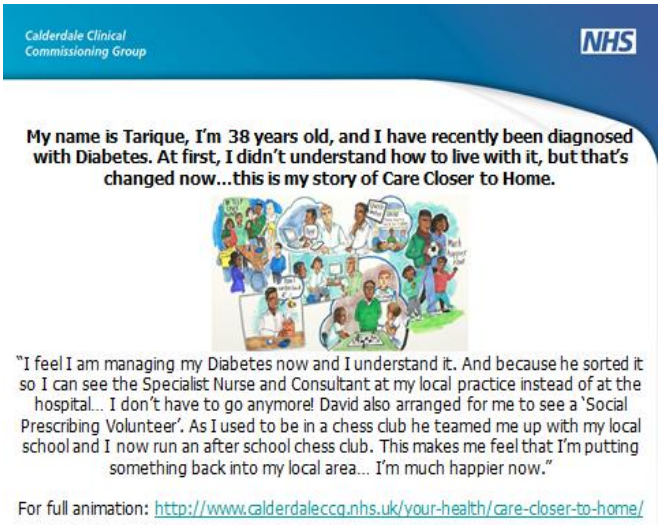
(a) Diabetes Service in the Community

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:

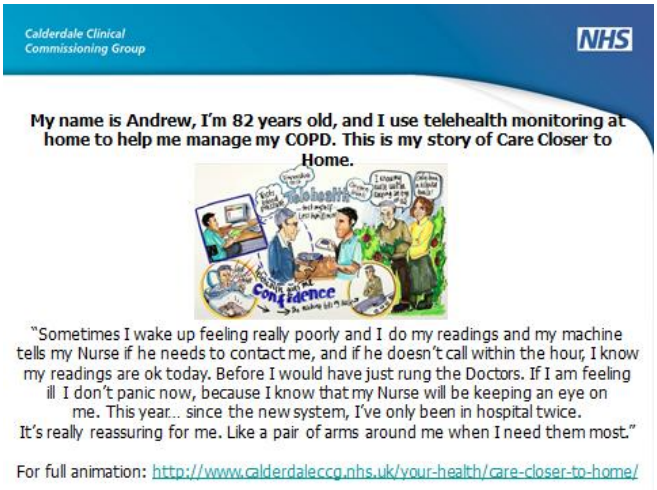
Preparation for an assistive technology procurement with a model that includes the continuation and expansion of this COPD service.

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.

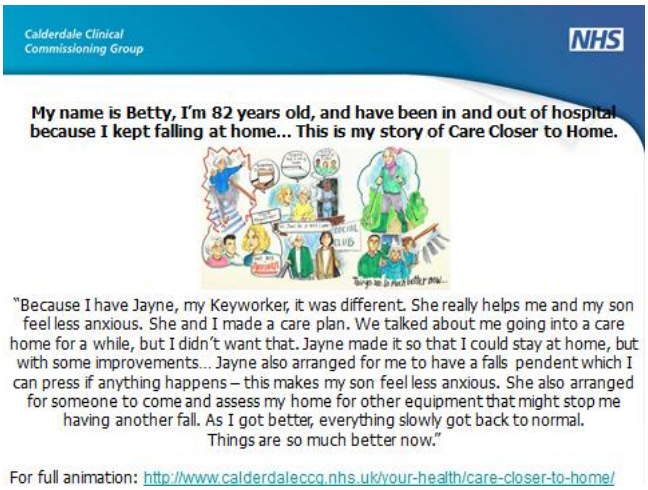
(d) Continuing Healthcare Hospital discharge Team (CHCDT)

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
		11/12/2015
	Lessons learned review	
		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:

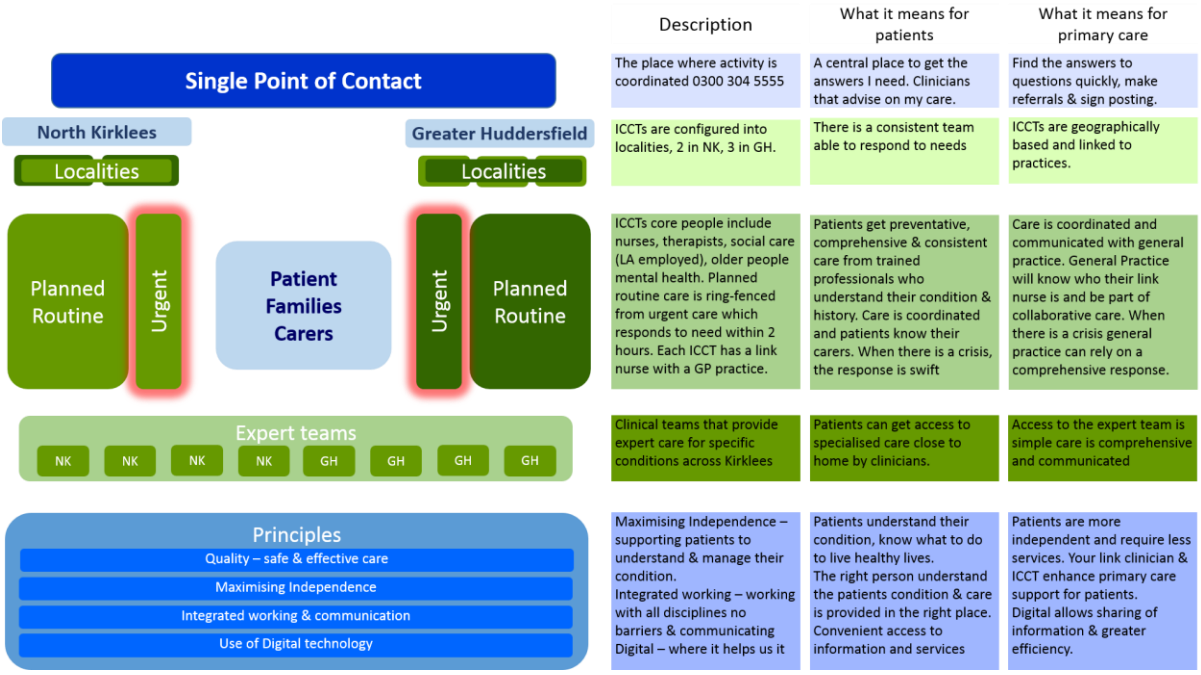
- Key stakeholder events during market engagement
- The establishment of a patient/carer panel which was an intrinsic part of the procurement and evaluation process which gave a strong voice to patients and carers throughout the process
- Patients/carers to took part in discussion and feedback session/s 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.

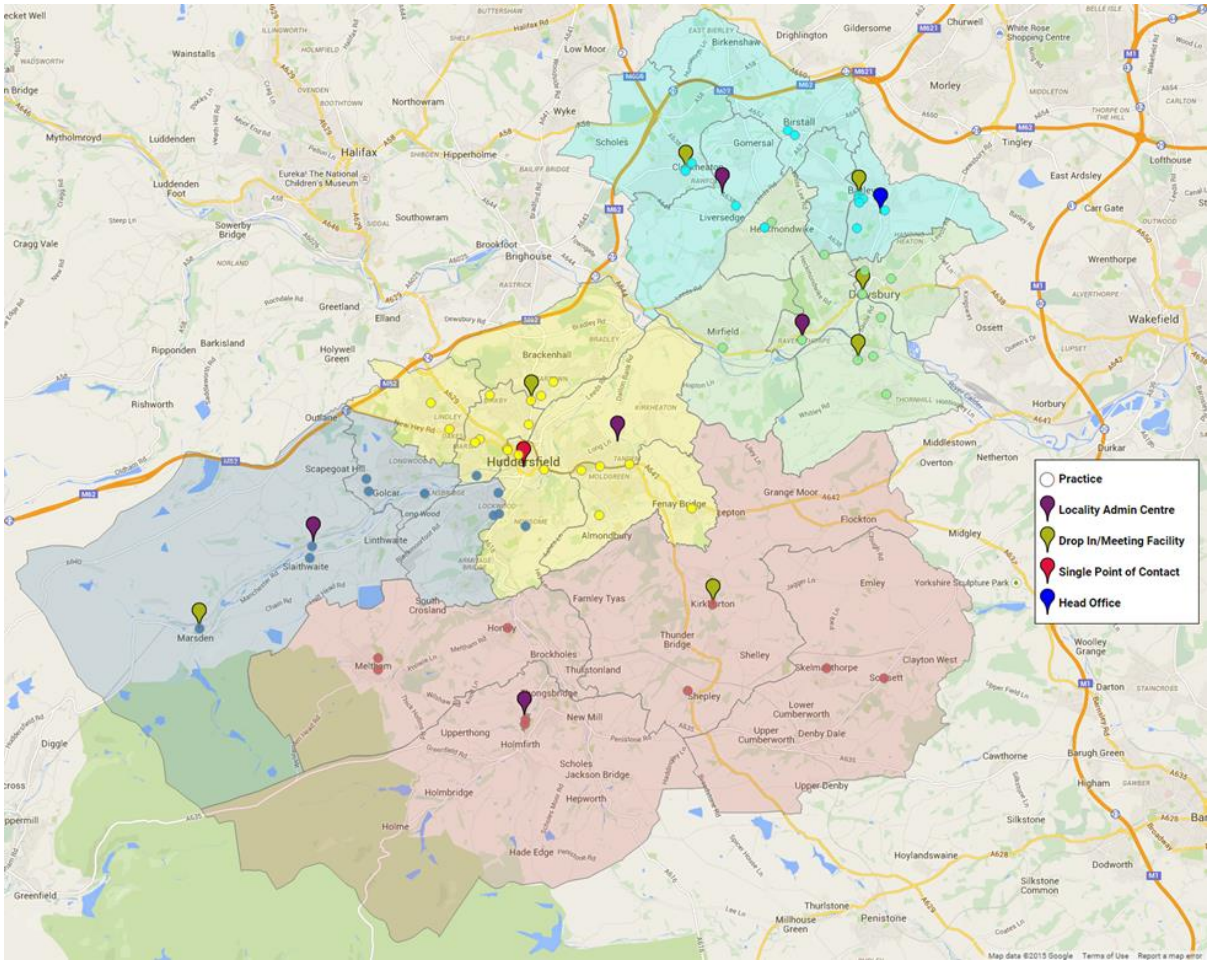


5.2. Key aspects of the model

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).

APPENDIX B

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

APPENDIX B

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

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- 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/