Future Arrangements for Hospital and Community Services in Calderdale and Huddersfield

Progress Report for the Secretary of State for Health and Social Care – January 2019

1. Background

Calderdale and Huddersfield NHS Foundation Trust (CHFT) has two DGH sites, Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH), located 5 miles apart in Huddersfield and Halifax. There is a compelling quality and financial case for change in the local health system.

Work to develop a safe and sustainable model of hospital and community care in Calderdale and Huddersfield has been underway since July 2012. Formal public consultation on proposed future arrangements took place during 2016. In September 2017 the Calderdale and Kirklees Joint Health Scrutiny Committee referred the proposals to the previous Secretary of State for Health and Social Care, his recommendations and the advice of the Independent Reconfiguration Panel (IRP) were published in May 2018. This set out that further work focussing on out of hospital care, hospital capacity and the availability of capital funding was required by the NHS before a conclusion could be reached.

During the summer of 2018 significant work was therefore undertaken by local NHS organisations working with NHS England and NHS Improvement and engaging the Chairs of the Joint Health Scrutiny Committee, Health and Wellbeing Boards, and the Local Medical Committees to develop an enhanced proposal for the future model of care. The enhanced proposal sought to ensure the best possible clinical outcomes for patients within available resources and to address the issues identified by the IRP in their report. An update describing the enhanced proposal (and the stakeholder engagement undertaken that informed this) was sent to the Secretary of State for Health and Social Care on the 9th August 2018.

On the 10th September 2018 the Secretary of State confirmed that he was pleased that rapid progress had been made with the active involvement of stakeholders and that he would welcome a further update on local discussions and progress being provided by the end of January 2019.

On the 7th December 2018 the Department of Health and Social Care (DHSC) confirmed that capital funding of £196.6m had been allocated to support implementation of the enhanced proposal and that this was included as part of the Government's major multi-year £2.9 billion funding package of additional capital investment in the NHS to provide better service models for patients, integrate care services and renew ageing facilities.

2. Purpose

The purpose of this report is to provide an update for the Secretary of State for Health and Social Care. The report:

- describes the proposed model of hospital care that was developed in August 2018 to address concerns raised by the IRP regarding hospital capacity;
- provides an update on the development of care closer to home / out of hospital capacity;
- provides an update on the development of digital technology to support delivery of the proposed model of care;
- confirms the capital investment requirement and the expected impact of the proposed model of care to deliver recurrent system revenue savings;
- describes the next steps and timeline for moving forward;
- describes the on-going plans to ensure stakeholder and public involvement.

3. The proposed model of hospital care

The proposed future model of hospital services in Calderdale and Greater Huddersfield will support and enable delivery of the vision and ambitions described in the NHS Long Term Plan. Digital technology will have a central role in transforming services supporting more people to have care at, or closer to home complemented by a hospital model that provides essential clinical adjacencies and the critical mass required to sustain staff recruitment, ensure quality and deliver revenue savings.

The proposed model will make use of both existing hospitals. Both sites will provide 24/7 A&E services and a range of day-case, outpatient and diagnostic services - although where possible services will be delivered in the community and closer to people's homes. The total number of hospital beds will remain broadly as they are now whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care. Enhanced Digital Health capability such as the electronic patient record and patient portals will enable 'real-time' review and advice on patient's care to be provided by specialist staff where required.

Tertiary services will continue as now to be provided in Leeds and at other specialised service providers.

The Hospital Service plan in more detail:

- Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) will both provide 24/7 consultant-led A&E services. As is the case now this will mean a 24/7 presence of middle grade Emergency Doctors on each site and Consultant staff on-site for a proportion of each day with 24/7 on call responsibility.

- The A&E at CRH will receive all blue light emergency ambulances for patients that have serious life-threatening conditions and all patients likely to require hospital admission following triage by the Yorkshire Ambulance Service. The A&E at HRI will receive self presenting patients. All patients requiring acute inpatient admission will be transferred by ambulance from HRI to CRH. Digital technology will ensure that specialist advice will always be available across both sites and therefore creating more service resilience and enhancing patient safety;

- CRH and HRI hospitals will both provide medically led 24/7 urgent care and will be able to treat children 5 years and older with minor illness or injuries and those children considered to have minor illness after triage by 111. Children who are more seriously ill, have serious injury or under 5 years old will be quickly triaged, stabilised and if necessary, transported to CRH. Paediatric emergency care and all inpatient paediatric services will be provided at CRH.

- 24/7 anaesthetic cover will be provided at HRI to enable the safe delivery of accident and emergency services. As is the case now this this will mean a 24/7 presence of middle grade Anaesthetists, and Consultant staff on-site for a proportion of each day with 24/7 on call responsibility.

- Critical care services, emergency surgical and paediatric surgical services will be provided at CRH;

- Physician-led inpatient care will be provided at HRI. This is for people who do not require the most acute clinical inpatient healthcare but do require extra support whilst arrangements are made to meet their future needs;

- The total number of hospital beds will remain broadly as they are now whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care.

- Extended ante-natal, intra-partum and post-natal care will be provided in the community where possible and choice will be offered in relation to where the birth takes place.

Midwifery led maternity services will be provided on both hospital sites. Consultant led obstetrics and neo-natal care will be provided at CRH.

- Planned surgery and care will be provided at HRI. Patients that require complex surgery or it is known that they will require critical care after surgery will be treated at CRH.

An overview of the proposed service configuration is shown below:

Huddersfield Royal Infirmary

- 24/7 A&E and clinical decision unit
- 24/7 urgent care centre
- 24/7 anaesthetic cover
- diagnostics
- planned medical & surgical procedures
- outpatient services and therapies
- midwifery-led maternity unit
- physician-led step-down inpatient care.

Calderdale Royal Hospital

- 24/7 A&E and clinical decision unit
- paediatric emergency centre
- 24/7 urgent care centre
- 24/7 anaesthetic cover
- diagnostics
- critical care unit
- inpatient paediatrics (medical and surgical care)
- outpatient services and therapies
- obstetrics & midwifery led maternity care
- acute inpatient medical admissions and care (e.g. respiratory, stroke, cardiology).
- acute emergency and complex surgery services

The proposed model will sustainably address quality, operational and workforce challenges and deliver a number of expected benefits that include:

- Local access to urgent and A&E services at both hospital sites;

- Maintaining the total number of hospital beds broadly as they are now whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care;

- Ensuring paediatric medicine and surgery are co-located on one site facilitating the provision of shared senior paediatric and surgical care for children and young people. This will enable the Royal College standards for Children and Young people in Emergency Care settings to be met.

- A single critical care unit will enable consolidation of the specialist medical and nursing critical care workforce and improve outcomes for patients by ensuring timely senior decision making.

- The reconfiguration of acute inpatient medicine onto one site will reduce the need for the transfer of acutely unwell inpatients across sites. This will improve the safety, experience and outcomes of care.

- The provision of planned surgery and medical procedures at one site will support improved access and reduce waiting times for planned treatment and surgery by minimising the risk of disruption from emergency admissions.

- Consolidation of all blue light ambulance attendances will enable the Trust to improve patient access to the right clinical expertise and better meet the Royal College of Emergency Medicine workforce recommendations. This will improve the likelihood of survival and a good recovery for patients that have life-threatening conditions.

- The realignment of services across the two sites will enable the Trust to deploy staff more efficiently and support meeting standards around 7-day working in the future and the ability to provide specialty rotas. In turn this will reduce workload pressures on staff and impact favourably on the Trust’s ability to recruit and retain staff reducing the current reliance on temporary staffing.

4. Further work to develop care closer to home

Significant progress has already been made in both Calderdale and Kirklees in the development and delivery of care closer to home. In Calderdale, as a consequence of our strengthened partnership approach operating between the CCG, the Local Authority and CHFT, we have completely transformed the system's performance on Delayed Transfers of Care (DTOC) and have moved from being amongst the weakest performing systems nationally to being consistently amongst the best. We have done this by making a positive choice to prioritise the agenda, and by creating a leadership narrative which is focussed upon ensuring that we are working together in order to reduce the harm that we do to people, increasing the potential for people to go back to their own homes, maintaining independence and reducing deconditioning. Our focus has not been just on the DTOC number, it has been on improving care and improving teamwork by using patient level data to drive system performance.

Greater Huddersfield CCG (along with its neighbour North Kirklees CCG), became one of seven national Intensive Support Sites during 2018/19, with the intention of increasing GP retention and therefore strengthening our out of hospital workforce. Through this programme, we are building support for practices, for example by increasing the number of training practices in the Kirklees area, and for individual GPs through GP mentorship, coaching and leadership development. This programme is also supported by wider system initiatives, such as work to understand the impact on workload at the interface between primary and secondary care. These initiatives are in addition to significant investment by NHS England to attract new GPs to practices, including providing more training places and an international programme.

In both Calderdale and Kirklees, networks of GP practices have been brought together, to serve and design care for 'localities'[1] of 30,000-50,000 people, in line with the NHS Long Term Plan. This structure is expected to form the basis of community care and public health service provision within both places providing a place-based framework for Health and Social Care where organisations work together and share resources to deliver holistic person-centred care. The aim is to make it easier for people to access care when closer to home, with a consistent and high quality experience for patients as they move between different parts of the integrated system.

The current plans, and those of the wider system, for out-of-hospital care, would more than absorb the forecast 5% increase in hospital usage from demographic growth.

To significantly improve the care and population health management out of the acute setting, a wider transformation of services is required. Health systems around the world are moving

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[1] Calderdale CCG tends to refer to Localities and Greater Huddersfield CCG to Primary Care Networks. Both terms refer to a population of 30,000-50,000 people around whom out-of-hospital care and public health programmes will be designed. Care within localities is shaped by networks or collaborations of GP practices. The populations of each locality are defined by the joint population served by these networks of primary care practitioners.

to a model of care outside of the hospital that integrates all primary care, community, mental health and social care services. Best-performing systems fully integrate their services (including nursing, social care and community care) within their localities, co-locating front-line staff within integrated community hubs. This approach enables better co-ordination of care, and better identification and provision of appropriate packages of care to patients according to their individual need. This improved care means people do not have to go to hospital so frequently and once there can leave it more quickly. This delivery model would enable us to deliver all of the components of integrated care systems, tailored as appropriate to the needs of our individual patients.

As care in Calderdale and Kirklees is redesigned around the localities, there is an opportunity to follow best-performing out-of-hospital systems in the UK and worldwide, by designing packages of care around the needs of the population and joining up and co-locating delivery of community, primary and social care services through teams that comprise a range of staff such as GPs, mental health professionals, pharmacists, district nurses, community geriatricians, dementia workers and Allied Health Professionals such as physiotherapists and podiatrists/chiropodists, joined by social care and the voluntary sector.

The West Yorkshire and Harrogate Integrated Care System has supported the CCGs to undertake detailed capacity modelling to compare the existing models of care closer to home with examples of best practice and to quantify the future community and primary care workforce and facilities capacity that will be required. The best of these integrated care systems in both England and internationally have 20-40% fewer non-elective bed days per head of population than Calderdale and Greater Huddersfield CCGs. These systems, starting from a similar baseline, have in a number of cases made these improvements through substantial transformations of their services over 4-6 years.

From the evidence base, set out in detail in the report, the CCGs have set an aspiration to reduce non-elective bed days for the population by 30% over 5 years. This would make Calderdale and Greater Huddersfield CCGs some of the best-performing areas in the UK for this measure. A summary of the report is provided at Annex A.

This modelling will inform future CCG investment decisions in primary and community services to address demand pressures, enable workforce expansion, and develop new services to meet the needs of the population. The total number of hospital beds will continue to remain broadly as they are now whilst these integrated services are developed in the community and until we can demonstrate a sustainable reduction in the demand for in-patient hospital care.

The CCGs will continue to work closely with Kirklees and Calderdale Health and Wellbeing Boards and local stakeholders to progress the plans for development of care closer to home.

5. Update on the development of digital technology

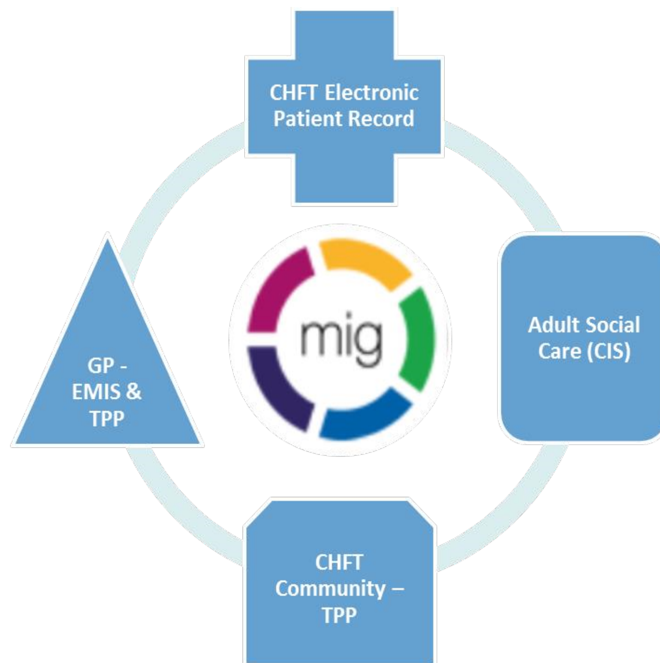
The development of digital technology in Calderdale and Huddersfield over the last few years has been significant which means CHFT is now one of the most digitally advanced Trusts in the country. CHFT, in partnership with Bradford Teaching Hospitals Trust, has successfully implemented the Cerner electronic patient record across well over a third of the population of the West Yorkshire & Harrogate Health and Care Partnership footprint. In addition to this and as a part the West Yorkshire Association of Acute Trusts programme work has been undertaken to develop a regional imaging collaborative as well interoperability across laboratory information management systems, some of which involves national genomics testing on behalf of NHS England.

CHFT has some of the highest utility of the national electronic staff record (ESR) and has been successfully using an app for recruitment for bank staff for several months as well as leading the way nationally on implementing the K2 Athena maternity patient record and recently the same system went live in Leeds Teaching Hospitals Trust again providing consistency of approach in West Yorkshire.

Working in partnership with commissioners and fellow providers, CHFT has been able to demonstrate progress when measured against NHS England's Digital Maturity Assessment resulting in a movement to joint third of the 41 groupings in England.

Digital technology is currently enabling clinicians to access and interact with 'real-time' patient records and care plans wherever they are. This will enable and amplify the patient benefits that are associated with the proposed changes to the configuration of hospital and community services. Our aim is to ensure that staff and patients have access to the right information and data, at the right time, to optimise the delivery of effective, safe, high quality care. To achieve this, we are working towards enabling our digital systems to talk to each other, so that data can flow seamlessly across health and care settings.

- Since August 2018 the Trust has used the Cerner Health Information Exchange (HIE) and the Medical Interoperability Gateway (MIG) to enable 'real-time' patient information to be shared across GP practices and the hospital. All GPs in Calderdale and Greater Huddersfield can now view the hospital electronic patient record in their system of choice (SystmOne and EMIS) - this is a real time view and not via a separate portal. Hospital clinicians can also now view the GP record for all Calderdale Patients within the hospital Cerner electronic patient record and this is technically enabled to 'go-live' for Greater Huddersfield patients in February 2019. Calderdale Community Service staff can also view the Calderdale GP record for both SystmOne and EMIS. Work has also commenced to progress digital inter-operability with the Calderdale Social Care System via the MIG. This development will enable integration of the adult health and social care records in the future. The progress being made to connect digital health and care systems is illustrated below;



- continued to expand the use of technology to transform out-patient services and deliver virtual clinics;

- implemented a digital ECG management system that means ECG carts are now fully integrated with the electronic patient record. This has improved the efficiency of requesting ECGs and enabled the immediate availability of digital ECG test results for clinical review;

- implemented digital blood tracking system (Haemonetics) that means all blood products are barcoded and identifiable. This system will improve safety and efficiency and in the future will enable the safe remote vending of blood products across the two hospital sites.

Work in Calderdale and Huddersfield is also being progressed to develop digital health solutions such as telecare, telehealth tele-monitoring & direct booking of appointments from 111 to GPs.

The Yorkshire and Humber Local Health and Care Record Exemplar programme will support the continued expansion of the use of technology to facilitate the co-ordination of patients' care and provide detailed analytics and reporting to support future improvements to care.

6. Capital investment and the expected impact to deliver recurrent revenue savings

During the summer West Yorkshire & Harrogate Health and Care Partnership supported the CHFT bid for the national capital funding prioritisation process and agreed these proposals as its top priority. The Partnership is confident that these proposals fit with the overall strategy

for the development of better health and care services for West Yorkshire and Harrogate as a whole.

In December 2018 the DHSC confirmed that 100% public capital funding of £196.6m had been allocated to support implementation of the enhanced proposal with £22m of this available for use up to 2022/23 and the remainder thereafter. .

The capital funding will be used for:

- £20m investment at HRI to enable adaptation of existing buildings and to address the most critical backlog maintenance requirements enabling the continued use of some of the HRI existing site.

- £177m for expansion and new build at CRH.

Since August 2018 the Trust has undertaken further work to provide assurance that the proposed developments can be contained within the overall funding envelope and that changes to assumptions such as inflation in building costs and fees have been taken into account.

The Trust carries a high risk in terms of the condition and reliability of buildings at HRI. Some are not clinically fit for purpose and without capital injection there is a high risk of failure of critical estate services and consequent impact on service delivery. An updated 6 Facet Estate Survey is currently being undertaken to assess the condition and reliability of the buildings and the engineering services infrastructure at HRI and this will inform prioritisation of the £20m investment on this site.

Work has also been undertaken to assess the financial (net present cost and equivalent annual cost) and non-financial benefits of the proposed service and estate model compared to continuing the existing service model and, in relation to the capital funding source. This has demonstrated that the proposed service model provides economic (VFM) advantage compared to the existing service model.

The proposed future model also demonstrates overall affordability for the investment and will enable the Trust to return to financial balance earlier than under the existing service model. This financial modelling work is currently being refreshed to take account of updated 2019/20 NHS tariffs and financial planning assumptions.

7. <u>The next steps and timeline for moving forward</u>

Following the DHSC confirmation in December 2018 that capital funding of £196.6m has been allocated to this development it has also been confirmed that approval of a Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) by NHS Improvement, DHSC, Ministers and HM Treasury will be required.

The SOC, OBC and FBC will need to be approved by CHFT Trust Board prior to submission to NHS Improvement and letters of support from CCG Governing Bodies, NHS England, and the West Yorkshire & Harrogate Health and Care Partnership Chief Executive will also be required at each stage of approval of the business cases. The content of the SOC, OBC and FBC will take account of Her Majesty's Treasury (HMT) Green Book guidance on appraisal and evaluation and the supplementary Guide to Developing the Project Business Case (2018) and guidance from NHS Improvement.

Based on these requirements and the associated governance processes the table below provides an indicative outline timeline for this development. This timeline will require the effective management of existing estate and clinical service risks over this period and is reliant therefore on the assumption that these risks do not escalate at a faster rate. Opportunities to expedite the timeline will also be explored if it is possible to do so whilst ensuring robust governance and stakeholder involvement.

Stage	Submitted to NHSI	NHSI, DHSC, Ministers & HMT Approval
SOC	April 2019	December 2019
OBC	February 2020	October 2020
FBC	January 2022	September 2022
Commence Build	January 2023	
Complete Build	January 2025	

8. West Yorkshire & Harrogate Health and Care Partnership

The ICS has supported the developments in Calderdale and Huddersfield throughout this process in a material and meaningful way:

- All organisations across the partnership made investment in Calderdale and Huddersfield the number one priority for capital bids in the last round. This helped secure funding for the system.
- The ICS has funded additional work to develop the models that will be required to support more people within communities and accelerate the development of local care networks.

- The ICS is playing a lead role in the LHCRE programme, which is both supporting the work within Calderdale and Huddersfield, and learning from the work to inform progress across the whole region
- The ICS has been fully involved in recent local scrutiny discussions, as well as political discussions at a local and national level.

This submission continues to be fully endorsed by the ICS.

9. <u>Plans to ensure stakeholder and public involvement.</u>

It is planned to continue to fully engage and involve local people, key stakeholders and the Joint Health Scrutiny Committee in the next steps to deliver the proposed future model for hospital services across Calderdale and Greater Huddersfield. This will be an ongoing process throughout the decision-making timeline described in section 7.

We will continue to work closely with the Kirklees and Calderdale Joint Health Scrutiny Committee. An informal workshop and meeting took place in July and August 2018 and the proposals were discussed at the formal public meeting of the Joint Committee that took place on 7th September 2018. Since then further informal meetings with the Joint Committee were held on 1st October, 5th Novemberand 22nd January 2019. A formal public meeting of the Joint Committee is scheduled for the 15th February to further discuss the proposals.

There has also been on-going engagement with Calderdale and Kirklees Councils.

"Calderdale Council has supported the proposals and agreed that they are wholly consistent with the Council's strategic intent and plans. The Council has confirmed it will take all necessary action to work with the local health system to realise the full impact of the investment and the delivery of a sustainable health and social care system in the future. This work fits with Calderdale's 2024 Vision and its focus in delivering the best health and care for local people as a part of Calderdale Cares."

"Kirklees Council recognises that there are quality, cost and sustainability pressures across the whole health and care system and that change will be required to address this. These pressures face all the healthcare providers that support Kirklees residents and considering only one of these providers will not result in the best solution for Kirklees. The configuration of services delivered by CHFT cannot be considered in isolation from those delivered by Mid Yorkshire Trust which also experiences pressures, has re-configured services but will need to further re-configure including those services currently delivered in Kirklees. The Council believes that the exact configuration of services should be determined through a comprehensive review of all health and social care services and facilities across Kirklees

including community provision because we know that a number of our community facilities are not ideal. This process should be supported by a single plan for Kirklees rather than individual organisations planning in isolation from each other. The Council considers that there is scope for operational and financial efficiency if the 2 acute providers that serve Kirklees were to collaborate and work together to re-configure services within Kirklees. This feels to be much more in line with the concept of an ICS than the current approach of organisational silos.

Whilst the Council welcomes investment into local health services and recognises that there are some urgent short term estates issues, the Council would not want to see investment in solutions that constrain future change, particularly knowing that the re-configuration proposals made by CHFT are only a short term solution and not a sustainable long term plan. The Council also believes that significant investment is required in prevention, staying well and helping people to manage their own health conditions effectively. This includes investment in community health care services, social care and voluntary sector capacity, all of which have seen significantly less focus and investment than the primary, mental health and acute care sectors. It is helpful to see that the NHS 10 Year Plan recognises this and we welcome the opportunity to work with local commissioners and providers to make this happen"

The revised hospital model is an evolution of the proposals informed by previous engagement and the significant public consultation undertaken in 2016.

There are a number of areas where the proposed model is therefore unchanged from that which was previously the subject of public consultation (this includes: urgent care; maternity and midwifery services; paediatrics; planned surgery; acute inpatient medical care; critical care; acute and complex surgery, and; outpatient services).

Where changes have been made to the proposed future hospital service model this has sought to respond to the views of stakeholders and to the recommendations of the IRP. The key changes are: the continued provision of 24/7 consultant-led A&E services at both sites; the provision of physician-led inpatient care at HRI, and; a commitment to maintain the number of hospital beds broadly as they are now whilst services are developed in the community.

The approach to engagement will be inclusive and will include a range of opportunities for the public and stakeholder groups to provide their input and insight particularly around:

- Development of the services

- Co-design of the environment and development of the sites including car parking
- The use of digital technology

We will continue to target the involvement of groups protected under the Equality Act to ensure that the needs of these groups are understood, and due regard is had to advancing equality in developing, making decisions about, and delivering the proposed changes to services in Huddersfield and Calderdale. The protected groups that will be targeted are:

- Age – specifically children and young people, older people, and frail elderly
- Gender
- Disability
- Ethnicity representative of the demographics of Greater Huddersfield and Calderdale
- Religion and religious belief
- Sexual orientation
- Transgender
- Pregnancy and maternity
- Carers

All engagement activity will be informed by local data to ensure that we are engaging with the right people, and equality monitored to assess the representativeness of the views gathered during the engagement process. An Equality Impact Assessment will be prepared.

The engagement activity required to deliver the next stages of development will be co-created at an initial stakeholder event during the Spring 2019. This event will be used to support the design of specific involvement activities and describe the communication material required to support the approach to ensure that local people remain informed and/or involved in the next stage of development for hospital services. The engagement will therefore take place in two stages:

Stage 1 (Spring 2019) - Stakeholder involvement in developing the action plan for engagement and associated communication material.
Stage 2 (Following the stakeholder event and then ongoing throughout the decision making process) - Delivering the action plan to involve a wider audience of local people.

The Trust and the CCGs will engage, involve and respond to the Kirklees and Calderdale Joint Health Scrutiny Committee in progressing these developments.

Annex A

1. BACKGROUND

In both Calderdale and Kirklees, integrated community and primary care services are being developed to meet the different levels of need of the local populations. Community based services will be led by multidisciplinary teams of health and care professionals, working together to meet the needs of people who have short-term health needs, individuals with long term conditions and those requiring specialist care for severe or complex needs.

These services will be delivered over populations of 30,000 to 50,000 people in a way that makes it easier for people to access care when closer to home, with a consistent and high quality experience for patients as they move between different parts of the integrated system.

This work builds on strong existing working relationships between the GPs, community services and both Kirklees and Calderdale local authorities. Calderdale CCG has worked with Calderdale Local Authority to produce a Single Plan for Calderdale within the overarching vision of 'Calderdale Cares'. The system's strategy is to deliver an integrated, locality based, health and care offer, driven by population based commissioning and primary care led. Building on the CCG's existing approach to primary care development and Care Closer to Home approach the aim is to improve care and quality of services and move the provision of care from unplanned to planned care, and the location from hospital to community. Development and delivery of the plan is overseen by the Health and Wellbeing Board. Greater Huddersfield CCG and North Kirklees CCG have worked with Kirklees Local Authority to produce the Kirklees Health and wellbeing plan. The vision for the Kirklees health and social care system in 2020 is: "No matter where they live, people in Kirklees live their lives confidently and responsibly, in better health, for longer and experience less inequality." This place based system of care will include social care, community services and Primary Care initially and develop to include mental health, voluntary and other services and support in the future.

2. INTRODUCTION

In September 2018, with support from the West Yorkshire and Harrogate Health and Care partnership, Calderdale and Greater Huddersfield CCGs commissioned a piece of work, the aim of which was to:

> 'To be able to clearly quantify the impact of interventions in primary and community care on reducing demand in acute settings, by being more rigorous about: which interventions work; how we could standardise their application; and the utilisation of underpinning data driven modelling to give confidence in delivery.'

Subsequent to this, a report has been produced for the CCGs that describes in detail the plans for out of hospital services and what their potential impact on acute hospital services could be. The report provides important information to support the development and delivery of the Calderdale and Kirklees place based plans.

3. SUMMARY

The report identifies:

1. The baseline position, the likely impact of currently planned pathway-based changes and the risks to their successful implementation.
2. A realistic ambition for the potential impact of the CCGs' longer term place based plans in which many or most community services would be integrated, co-located and work closely with primary care and social care to deliver care in the community from hubs serving localities of 30-50,000 people.
3. An operating model describing how care could be provided to deliver the longer term plans, utilising Population Health management to identify the potential capacity required – in terms of both staff and estate – to operate a community hub within each of the CCGs' identified localities.
4. The factors to consider as part of any implementation.

3.1 THE BASELINE POSITION

Calderdale and Greater Huddersfield CCGs serve a population of 469,000 people. This will grow to 478,000 by 2023 (0.4% per year). As this increase is concentrated in the over 50's where most of care takes place, actual demographic activity growth will be ~1% per year resulting in an expected 5% increase in activity from demographic growth over 5 years. If nothing changes, in 5 years our system will require 43 more acute beds
The current model is very fragmented in its service provision. Many different teams offer different packages to the same patients, and multiple teams will offer similar forms of care intervention but exclusively to patients with different conditions. As an example, there are over eight entry routes into community services across the two CCGs that are denoted "single points of access."
The CCGs' current plans are focussed on the populations placing greatest strain on the system (including the frail elderly, respiratory patients, and those awaiting transfers of care), and are designed to implement national best-practice in the delivery of care and design of pathways.
Successful implementation of the CCGs' currently planned pathway-based changes, could reduce non-elective bed days by 10% over 5 years.

3.2. THE OPERATING MODEL

As recognised in the CCGs' place based plans, improving the health of the population and achieving the potential 30% reduction in non-elective bed days is not about running

more, or a different set of initiatives. The most successful systems redesigned their out-of-hospital care with a broad integration of services and teams, including social care. This section summarises

- the model of care provided by this integrated approach;
- the method for delivering care from co-located teams operating out of community hubs and the capacity this might require in each locality

3.2.1 WHAT THE PROPOSED INTEGRATED CARE SYSTEM WOULD INVOLVE

Integrated community and social care systems provide 13 best-practice interventions or types of service to their patients[2]. These range from individual case management and co-ordination of care services, through the rapid availability of specialist and primary care services close to patients' homes, to intermediate care facilities. As a whole, the 13 interventions target the three main approaches to reducing hospital usage: they aim to proactively care for population health and prevent admissions; they provide care in alternative locations as appropriate; and they support quick and effective transitions of care between settings, including out of the hospital.

These 13 types of service are then tailored to the specific needs of the local population. High-need patients would receive more frequent intensive support. Patients with lower needs would receive timely access to appropriate care when needed alongside self-empowerment of care and education. To make this work, a needs-based stratification of the population is required to say both how many patients are in which need group and to identify exactly which patient needs which level of support. In this way, the right care is designed and provided for each patient. The report describes what this model might look like in terms of the care provided to a high-need, medium-need and low-need patient. This includes a description of their initial assessment by a multi-disciplinary team, the care package constructed using the 13 types of service, and what this means in terms of their average contact time with nurses, doctors and other health and care professionals.

3.2.2 HOW CARE WOULD BE DELIVERED, AND THE CAPACITY REQUIRED TO DO IT Central to the success of the best systems is the co-location and integration of all out of-hospital services based within and around community hubs. The community hubs would serve localities with populations of 30,000-50,000 people. Care provided by the hubs would be designed and organised by a central multi-disciplinary team, with a clear point of accountability for delivery of all out of hospital care in the locality. In Calderdale and Greater Huddersfield, this would mean that the existing programmes and level of care would still be provided, but teams with similar functions (for example, the various home visiting services provided by nurses or healthcare assistants) would be unified.

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[2] Source: King's fund, Case management: what it is and how it can be best implemented, 2011;
MDT development. Working toward an effective multidisciplinary/multi-agency team. NHSE, 2015;
Personalised care and support planning handbook: the journey to person-centred care. NHSE 2016.

Remodelling care in this fashion often means that a different mix of skills is required in the workforce, but this does not necessarily imply the levels of growth in the number of doctors or specialist nurses that would be required if we simply grew our current model of care to meet future demand. The report sets out, for each locality, the average contact time for patients with different needs per year, and the estimated workforce requirements by role, as well as our likely requirements for community beds and estate. To deliver an integrated model of care across both CCGs by 2023 would require a total of: 2000 FTEs, of which 157 would be a new role of Care Navigator; 169 community beds; and about 13,000m^2 of estate. The assumptions that drive this forecast can be adjusted within each locality, to reflect the packages of care designed for each population group by the local care providers and networks of GPs. The size of each locality will affect to some extent the services that can be provided economically within each hub. For example, all elements of pro-active and preventative care (MDT assessment, case management and care co-ordination) can be provided in hubs that serve 30,000 people, but the minimum efficient scale for an urgent care centre to operate is for populations of around 50,000.

The capacity and resource requirements described in the report focus on an efficient end-state, with services provided at scale. It may be that the CCGs decide to provide sub-scale services, for example to increase provision to populations in very rural areas: this would require additional resources for care delivery.

3.3. THE FACTORS THAT WILL ENABLE THE TRANSFORMATION

The CCGs have a good track record of piloting new services, then successfully rolling them out across the area. However, to run a complete transformation of their community services, additional focus and further work would be required on seven principal enabling factors.

a) *Change management for patients and staff*. Re-organising community and social care will not be possible unless clinical staff and patients understand and believe in the benefits of change. Some GP networks are already engaging with the programme, but clear role modelling from committed clinicians will drive later engagement and success. Likewise, we would need to engage patients to understand how to get the most from our new model of care, empowering them to shape its development and ultimately take greater control of their own health.

b) *Organisational design*. Locality based hubs will lie at the centre of an integrated primary, community, mental health and social care offer in each locality. While this will inevitably involve collaborative working across different professional groups, both the development and operation of these integrated services will need to proceed under a single accountable manager who is able to manage and coordinate the activity of contributing staff. Even if care is delivered through a partnership between different providers, having a single accountable person with

the authority to decide how care will be provided is a common feature of successful systems.

c) *System-wide ownership and accountability*. While a single manager should run the services in each locality, oversight is likely to be provided by a partnership board. This group should be able to hold the manager to account for progress and performance. Additionally, it should be a means for the manager to quickly access executive-level support when challenges arise.

d) *Funding*. It will be important to identify funding to ensure there is sufficient capacity within the new model of care.

e) *Ensuring contractual incentives are aligned*. We will need to work closely with our providers to ensure that the balance of incentives between acute provider, primary care networks, and community care providers are aligned with us around improved and more cost-effective patient care.

f) *Information sharing.* Timely flow of clinical information between all relevant health professionals is a crucial enabler for our new model of care. In addition, we will need to track the performance of our new model in order to ensure that it is delivering intended benefits.

g) *Digital and analytics*. The completion of the Yorkshire and Humber Local Health and Care Record Exemplar programme will provide a fantastic foundation. This will give all care providers appropriate access to care records, greatly facilitating the co-ordination of patients' care. However, this is only the tip of the iceberg in terms of the potential benefits it could help us to deliver. We will need to develop our capability to provide detailed analytics and reporting as part of future improvements to care – focused on those cases that can have the biggest impact.

The diagram below illustrates the new or expanding schemes across Calderdale and Greater Huddersfield that will address non-elective hospital usage.

The Greater Huddersfield and Calderdale health system has outlined new or expanding schemes that will address NEL hospital usage

Legend: Both CCGs; Calderdale; Greater Huddersfield

Area	Innovation	Number of proposed new initiatives	Example programmes
1 Prevention and pro-active care	a Case management	2	AF stroke prevention programmes
	b Multidisciplinary teams	2	Multidisciplinary interventions in care homes
	c Care co-ordination	5	First / single point of contact
	d Individualised care plan		
	e Frequent touch points		
	f Scheduled service user follow-ups		
	g Self-empowerment and education	3	Active Calderdale
2 Swift and appropriate access to care	h Rapid response	1	
	i Rapid access to primary care	2	GP extended access schemes
	j Access to specialist care	4	OPAT
	k Appropriate referral and medication practices	1	Medicines management programmes
3 Support with care transition	l Discharge support	2	8 High-impact changes to reduce DToCs
	m Intermediate care	4	Rehab beds and services
Total		26	Locality models for primary care

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