Right Care, Right Time, Right Place - Stakeholder Event
12th August
Questions and Answers

This document highlights some of the questions that were presented during the table top discussions at the Stakeholder Event. As discussed at the event, there are some questions that we cannot answer at the moment however this document will be continuously updated as we progress with our 'closer to home' models. Please feel free to contact us if you have any further questions.
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Engagement

Q: The results seem to be 'health' focussed rather than social care – isn't Right Care, Right Time, Right Place supposed to be both?
A: The focus for both Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCGs) is to continue the shift of services and resources from unplanned hospital care to integrated health and social care - delivered in community and primary care settings.

The engagement work certainly covered social care, in which feedback is as follows:

- More district nurses were favoured and more home help and social care services to keep people well in their own home
- There were concerns that staffing levels in the community were low and that in particular social care staff need more time to spend with the person they care for
- Social Care staff stated that a 7-day provision of Social Services is implicit in the new Care Bill and Urgent Care Agenda

You can find the full engagement analysis report here
http://www.rightcaretimeplace.co.uk/about/how-we-are-talking-to-you/

Q: We cannot understand why only 3% of Huddersfield showed their opinion on record. Was this due to questionnaires filled in unsupported?
A: The 3% relates to people who have completed the equality monitoring form with an identifiable Huddersfield postcode.

Q: How will you build on the positive comments / ideas as they help shape commissioning?
A: We have used the engagement work to continuously inform and develop our Care Closer to Home models and will continue to do so until the models have been finalised. In addition we will check to see if there are any gaps in our engagement that we need to address.

Q: Despite engagement will commissioners make decisions if there is public disagreement!
A: It is the commissioner's responsibility to make the decisions on health services within their area. This is why listening to what people tell us about the local NHS services gives us the best opportunity to know exactly what patients need and want. We do not believe that relying on existing knowledge and assumptions helps us to provide services that meet people's needs better.

Care Closer to Home Models and In Hospital Standards

Q: Is there a real understanding of the financial pressures on the system? The transition from old to new model will need services to run together for a time. Do we have the money to do this?

A: We are currently developing a Financial and Economic model that will produce a financial case for change to demonstrate the economic and financial sustainability of any proposed changes both during transition and post transition.

Q: How does the Single Point of Access work?

A: The detail on how the Single Point of Access (SPA) will work will be developed further through the specification. The specification is being developed through a multi-agency steering group and will involve representation from the public identified through our local Voluntary Sector and community networks.

Q: Are the models deliverable and achievable?

A: It is intended that the commissioning of community services will be done in a phased manner. As well as influencing our proposals for the models of Health and Social Care that we need to commission, our engagement has also: confirmed the fundamental need for more integrated care delivered in community and primary care settings; and provided feedback that the people in our communities will only gain confidence in our new model through experiencing the improvements for themselves.

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

Q: How can you deliver expectations locally to patients with chronic conditions?

A: One of our deliverables is to improve the quality of life of patients with a long term condition or illness. The delivery of supported self-managed care and integrated care delivered in community and primary care settings is paramount. Detailed work will continue on the expectations around quality and outcomes and how this will look in practice, however an example of this would be;

'A patient living in Sowerby Bridge with a long term condition would receive access to the dedicated multi-disciplinary team (MDT). This team will consist of a range of skilled and trained professional and clinical staff e.g. therapists, psychiatric nurses, social workers, voluntary workers, community matrons etc. The MDT will offer integrated physical health, mental health and social care support dependent on the patient's needs. Support and care would be available from the appropriately skilled members of the MDT, this could involve one or more members of the team at any one time. The MDT will support patients to manage their health and care needs where appropriate, either, at home, in their local community or within their locality e.g. Upper Valley.

Specialist support (such as specialist nurses) will be 'wrapped around' the multi-disciplinary teams providing expert advice, guidance and interventions at a practice, community and/or locality level. All services will be aligned to a GP practice; ensuring records are easily accessed and that the relevant information is shared between the GP and the MDT.'

Q: Why are we separating the Greater Huddersfield & Calderdale models? Can they be developed to be understandable?

A: The two Clinical Commissioning Groups, whilst very similar in terms of models, are at different stages with regards to development plus whilst the models are similar on paper this may look very different in practice in terms of the needs of the community, procurement and implementation. Both CCGs are developing 'a story' which will explain what the models are about, real life examples of how it works and how this in turn will lead to changes in hospital services and a public consultation.

Q: Who monitors the In – Hospital Standards?
A: Our requirements for In-Hospital Services are being developed jointly by Calderdale and Greater Huddersfield CCGs and will, in the first instance, be a set of joint standards. These joint standards set out the High level Outcomes we, as CCGs want to achieve, the scope of In Hospital Services and the standards that we want to apply to these services.

Q: What are the common standards now and how do the new ones compare?
A: The standards are based on established best practice and are additional to and do not replace existing CQC, NICE, CQUIN and standard contract targets. We are currently assuring these standards through a quality assurance group comprising representation from both Calderdale and Greater Huddersfield CCG. The Quality Committee signed off the standards subject to minor amends and further development; therefore an update will be submitted in due course.

Evaluation Criteria

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

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

We intend to commission these services on a locality basis. More work is needed to determine the number and geography for the locality teams, including integrated working with the Local authority. The areas covered by a locality team will be aligned with primary care/general practice (providing proactive co-ordination of care, particularly for people with long-term conditions and more complex health.

Q: How can does the Evaluation Process work?
A: Regardless of whether we decide to use a competitive process, we will still set out our requirements (for both Community Services and In-Hospital Services) in a formal Invitation to Tender (ITT) / Invitation to Commence Dialogue (ITCD) process.

There are three elements to our approach to evaluation:

- The first element identifies the accountabilities and responsibilities of the roles and groups involved in the evaluation
- The second element defines the process we will use to identify, evaluate and notify potential providers;
- The third element is the criteria we will use to undertake the evaluation. We have drafted our high level evaluation criteria and have grouped our criteria into seven high level categories and 20 sub-categories.