Strategic Outline Case
Transforming Services in Greater Huddersfield and Calderdale
A Strategic Outline Case proposal from Calderdale and Huddersfield
NHS Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership NHS Foundation Trust

February 2014
The Patient and Service User Perspectives

People locally and nationally have been telling us what they want from the NHS. Here are some of the key messages we are trying to respond to through this Strategic Outline Case.

‘The high standard of medical care I have received, coupled with the compassion, has shown me the very best our health service can offer. However, there have also been times when I have felt like a parcel.’ Suzi Hughes – Chair, Patient and Carer Network

‘Since 2011 National Voices has been saying that joining up care around the needs of the individual is the biggest step forward in quality that people who use services want to see.’ Don Redding, Director of Policy at National Voices

‘The wide range of urgent care services available and lack of standardisation and labelling results in patient confusion over how to access the right healthcare quickly; this leads to duplication, delay, increased clinical risk and poor patient experience.’ Keogh Urgent and Emergency Care Review

‘I didn’t know how to deal with my COPD. If I had known I could have done something about it, like self-management, which I do now.’ – a local person talking about supported self-care for COPD

‘I was told by my GP that I should go to A&E but I informed him I did not need to, I just needed some tablets … When I was seen [in A&E] I was told off by the doctor for wasting time in A&E.’ - A local person telling her story about getting hold of pain relief in a crisis

‘You need to treat the whole person. [At the moment] person has to go to different specialists and places. It would be much easier to centralise and put the person in the middle.’ A local person talking about planned care

‘It is far less stressful having services provided closer to home - Todmorden Health Centre is a great new resource for the town.’ - A local person talking about Todmorden Health Centre

‘Excellent course giving skills to deal with pain.’ ‘I would like to see GPs issuing a prescription for everyone with long term condition to attend Expert Patient Programme.’ A local person advocating the expert patient programme for people with pain

‘The NHS Confederation, National Voices and the Academy of Medical Royal Colleges are calling for ‘more meaningful’ engagement in how health services are arranged and changed with all those groups who are impacted by them. Past experience of NHS changes, which can be driven by financial or clinical crisis, has polarised the debate to the extent that the service risks being paralysed, even though major change is essential for its successful future.’ National Voices website

‘It’s important to get access to services no matter where you live, services can be patchy in places.’ – a local person describing the need for local services.

‘Only people in the know can navigate through the system. Dealing with so many people and each will only tell you their bit. If you don’t fit the speciality, you are not treated. Who coordinates?’ A local person describes their experience
Foreword by clinicians in the health and social care economy

This proposal has been jointly developed by Calderdale and Huddersfield NHS Foundation Trust, Locala Community Partnerships, and South West Yorkshire Partnership NHS Foundation Trust. Senior nurses, therapists and doctors in all three organisations have been involved in the development of the service model, both through the Health and Social Care Strategic Review and through work done in the individual organisations. Things doctors, nurses and therapists have said about the proposed changes include:

“This makes services more sustainable, it will allow very senior care to be on site for longer, 7 days a week.’
Dr John Naylor, Consultant in Geriatric Medicine. Calderdale and Huddersfield NHS Foundation Trust

“This shared model with community and hospital services allows better understanding and more person centred care planning.’
Barbara Schofield, Nurse Consultant, Older People Calderdale and Huddersfield NHS Foundation Trust

“A care system needs to be like a well-trained relay team, passing the baton with practised ease and confidence in each other.’
Arasu Kuppuswamy, Consultant Psychiatrist, SWYPFT

“There is no if. We need to do this. If not our local population will see services move to Leeds and other Trusts like Pinderfields and Manchester.’
Dr Maya Naravi, Consultant in Emergency Medicine Calderdale and Huddersfield NHS Foundation Trust

“Supporting people to support themselves to be independent and fulfil their lives is at the heart of a therapists work. The way of working described in the model including self-care is entirely consistent with this. Combined with truly integrated teams makes me feel very positive about the future.’
Tina Quinn, Locala Therapist

“The emphasis on the model of care and integrated teams with GPs in the centre is excellent. The opportunity to work with consultant colleagues in the community can only be a good thing. I fully support this development.’
Dr Steven Warner – GP & Medical Advisor, Locala

“Care and compassion in community nursing is enhanced not only by being able to work closely with colleagues in health and social care, but by supporting the people we care for to care for themselves. This Strategic Outline case takes this forwards and I welcome it.’
Helen Frain, Locala Senior Nurse

“It will ensure high quality care by providing the right care in the right place 24/7. This is good for patients, for me and my family.’
Janette Cockroft, Matron Medical Admissions Unit Calderdale and Huddersfield NHS Foundation Trust

“This will allow consultants to be more active in the community as an educator and advisor on care management.’
Sal Uka Consultant in Paediatric Medicine Calderdale and Huddersfield NHS Foundation Trust

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1. Executive Summary

1.1 Introduction

This Strategic Outline Case presents the case for changing the way NHS community and hospital services in Calderdale and Greater Huddersfield are provided.

The Strategic Outline Case has been jointly developed by Calderdale and Huddersfield NHS Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership Foundation Trust. This has been informed by discussion with other partner providers in the health and social care economy and by feedback from members of the public.

We believe the changes proposed in this Strategic Outline Case will improve the safety and quality of services for people and also respond to the challenge of increased demand and reducing resources.

1.2 Background

This Strategic Outline Case has been developed in the context of:
- The Strategic Review of the local health and social care economy
- The National Clinical Advisory Team (NCAT) recommendation to develop a future health service plan centred around more care, both planned and unplanned, being provided in the community, and the two hospitals having a clearer focus, one being designated the planned site and one the unplanned site.
- Conversations with the public and service users, where they have made clear they want care as close to home as possible and for all the different parts of the system to work well together.
- All relevant national health and social care policy, particularly The Keogh Urgent and Emergency Care Review, The Better Care Fund and associated policy direction and Future Hospital: Caring for Medical Patients.
- The health needs of our local population as set out in the Joint Strategic Needs Assessment

1.3 The Case for change and Opportunity for Improvement

The case for change is simple and based on the following:
- **We have challenges to ensure the safe provision of services for local people.** Shortages of professionals in key specialties and use of locums can lead to more hospital admissions, a longer stay in hospital than necessary, being cared for in the wrong place and being transferred between sites.
- **We have challenges to ensure that the care and support we provide is effective.** We cannot always provide senior (consultant) support as early as we would like, this means the care may not be as effective as possible. Our services could be better integrated, meaning there are risks of people experiencing gaps in care. There are not enough specialist services close to home, leading to more hospital admissions.
- **We have challenges to ensure we are efficient in how we deliver services.** There is growing demand on health and social care as the population ages, but no extra resource to support people. We need to use the established evidence base to work with public and staff to make services more efficient.
- **We need whole system leadership and quality improvement.** We need to equip staff from across our health and social care economy to do two jobs – the job they do and the job of improving quality.
- **We need to better use technology available** to share information, to use the technology we use in our daily lives in our health and social care.
The case for change is summarised in the diagram below.

<table>
<thead>
<tr>
<th>Increasing Demand for Services</th>
<th>Reducing Resources to Meet Increased Demand for Services</th>
<th>Providers not able to Guarantee Safety, Effectiveness and Efficiency</th>
</tr>
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<tbody>
<tr>
<td><strong>Opportunity to Improve Quality</strong></td>
<td><strong>Self-Care</strong> Help more people to self-care and maintain control and independence of their health and well-being.</td>
<td><strong>Integrated Support</strong> Help more people to access integrated support and specialist advice seven days a week as close to home as possible</td>
</tr>
<tr>
<td><strong>Opportunity to Improve Value for Money</strong></td>
<td>Increased self-care will reduce the number of people needing to seek help from a health or social care professional. It can also deliver wider benefits such as improved quality of life, reduced social isolation, and reduced time off work.</td>
<td>Provision of 7 day fully integrated support will reduce duplication of work, enable proactive care planning to minimise crisis, prevent escalation of needs (such as hospital admission or long term care) and optimise reablement and recovery.</td>
</tr>
<tr>
<td><strong>Key Enablers</strong></td>
<td>Putting people in control of their own health and wellbeing needs: People are engaged and supported to make decisions that will improve their health</td>
<td><strong>Leadership:</strong> Whole system strategy for quality improvement and workforce development that invests in staff and General Practice capabilities and skills</td>
</tr>
</tbody>
</table>
1.4 The Service Proposal

The service proposal is to offer integrated care and support for the whole population and provide specialist care where it is needed. The support will cross the boundaries between primary, community, hospital and social care. The service proposal builds on changes we have already made in the system such as integrating the work of the health rehabilitation teams and the local authority reablement service in Calderdale and similarly the community nursing teams and local authority teams in Kirklees; and also creating specialist sites for some specialties such as acute and complex surgery and trauma, improving health outcomes for the whole population.

The illustration below has been developed through the Greater Huddersfield and Calderdale Health and Social Care Strategic Review and is supported by all seven partner organisations. The integrated service proposal described in this Strategic Outline Case is consistent with this.

Our Future Care System

We propose that in the future across Greater Huddersfield and Calderdale people will be supported by community locality teams and two specialist hospitals (one delivering services for people that have an emergency or are acutely unwell and the other specialising in provision of planned hospital treatments).

The majority of people's support and care will be provided in the community. Hospital inpatient care will be one step in a pathway of continuous and relevant support to meet people's needs that extends from, and back to, the person's usual place of residence. The proposal is summarised in the model below:
There will be two specialist hospitals in Greater Huddersfield and Calderdale. One hospital will specialise in acute and emergency services, caring for those people who are most seriously or suddenly ill. One hospital will specialise in care for people undergoing planned treatments or surgery, such as hip operations, and attending outpatient clinics. Both hospitals will serve vital roles in the years ahead. Services will be reorganised, including A/E on one site and a Minor Injuries Unit on both sites.

These changes in the way hospital services are provided will improve safety by providing:
- Better care from specialist doctors, nurses and therapists
- Better bedside contact from doctors and nurses
- More supported self-care in the community and clarity on services available at each hospital

Both specialist hospitals will provide high quality care 24 hours a day 7 days a week.

1.5 Impact assessment
The Strategic Outline Case describes the impact of the proposal on: service users; on whole system economic viability; on social capital, and; on partner organisations strategies for Greater Huddersfield and Calderdale.

Impact on service users
The proposed model will ensure the highest standards of quality and safety can be delivered to service users, that services are more effective and are delivered in an integrated manner and that people are supported to self-care, just as the public have requested. It will enable people to receive the right care, at the right time in the right place.

Impact on whole system economic viability
This section:
- Makes the link between this Strategic Outline Case and the economic model and financial case as described in the Outline Business Case for the Greater Huddersfield and Calderdale Strategic Review Programme (May 2013).
- Outlines the key financial assumptions which underpin the proposed service model in the Strategic Outline Case and the opportunity for system savings based on a review of the current evidence.
- Identifies the key enablers.
- Provides a summary analysis of financial risk.

The Greater Huddersfield and Calderdale Strategic Review identified a total savings requirement for both commissioners and providers of £163m over 5 years.

The potential reconfiguration of services presents opportunities to increase efficiency and reduce costs in particular via:
- Reduce the number of secondary care beds, in an acute and mental health setting, by improving internal efficiency and providing alternative provision in the community.
- Improve the efficiency and productivity of community services by having an integrated provider service based on community localities.
- Reduce the overall reliance on statutory services through the promotion of alternative capacity and models of self-care.

An evidence base is provided to support each of these objectives.

This service model would contribute to the identified savings requirement of £163m over 5 years.
**Impact on social capital**

The NHS Confederation describes social value as ‘the social benefits achieved from public services, and considers more than just the financial transaction and includes wellbeing, health, inclusion and employment’.

By working differently as provider organisations and changing the way community services are currently provided the assumption would be that more people can be treated in the community, enabling them to continue with their normal lives, roles and responsibilities, which in turn would offer greater value to the economy as a whole.

**Impact on partner organisations strategies for Greater Huddersfield and Calderdale**

Throughout the development of the Strategic Outline Case we have remained cognisant of the strategic direction of the Clinical Commissioning Groups described through their commissioning intentions, and also the priorities of the local Health and Wellbeing Boards described through their joint Health and Wellbeing Strategies (JHWS). The proposal is aligned with the priorities of each of these four very important strategic contexts and therefore the impact on the delivery of these agreed priorities.

**1.6 Engagement and support for proposals**

In developing this proposal we have referenced engagement work:
- With the public and with service users
- With staff
- With partner providers including GPs, the Local Authorities and Yorkshire Ambulance Service

The proposals reflect key themes coming out of all this engagement, particularly to provide more services in the community, to work in partnership with the public and to make services as safe as possible. The proposals are fully supported by senior clinical leaders.

We of course will undertake significant staff and public engagement if the proposal is supported by commissioners.
2. Introduction

This is a Strategic Outline Case that proposes changes in the way NHS community and hospital services in Calderdale and Greater Huddersfield are provided.

The Strategic Outline Case has been jointly developed by Calderdale and Huddersfield NHS Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership Foundation Trust. Our aim is to work together, and with local communities, to provide exceptional standards of care and support that will enable optimal health at lowered system cost.

Calderdale Council, Kirklees Council, Calderdale Clinical Commissioning Group, Greater Huddersfield Clinical Commissioning Group, general practitioners and the doctors, nurses and therapists that work in all three organisations have been engaged and influenced the development of this Strategic Outline Case.

The Strategic Outline Case has also been informed by feedback from members of the public given at a number of public engagement events held over the past year when people have been asked what matters to them and what needs to change in the way we provide care and support.

We believe the changes proposed in this Strategic Outline Case will improve the safety and quality of services for people and also respond to the challenge of increased demand and reducing resources.

3. Purpose

The purpose of the Strategic Outline Case is to explain the challenges facing the current system, the risks if these issues are not addressed, and a proposed way forward.

The Strategic Outline Case will be submitted for consideration by Calderdale and Greater Huddersfield Clinical Commissioning Groups. It is intended that subject to their support, the Clinical Commissioning Groups will then present the Strategic Outline Case to Calderdale and Kirklees Adult Health and Social Care Scrutiny Panels and to the Health and Wellbeing Boards.

This strategic outline document will then provide the basis for wider stakeholder engagement and the development of a full business case. The changes that are proposed will require formal public consultation.
4. Background & Context

4.1 Strategic Review Context

Over the past two years the seven health and social care organisations in Greater Huddersfield and Calderdale have been working together through the Strategic Review. The purpose of this is to encourage innovation and transformation to address the shared challenge of meeting the increasing needs of an ageing population with limited and reducing resources.

The seven partner organisations are: Calderdale and Huddersfield NHS Foundation Trust (CHFT); Calderdale Clinical Commissioning Group (CCCG); Calderdale Metropolitan Borough Council; Greater Huddersfield Clinical Commissioning Group (GHCCG); Kirklees Metropolitan Borough Council; Locala Community Partnerships and the South West Yorkshire Partnership Foundation Trust (SWYPT).

At the start of the Review, four care streams were set up looking at: children's care, long-term care, planned care, and unplanned care. The care streams engaged local patients, carers, the third sector, public representatives and staff. The findings from this engagement, informed the development of a number of plans for improvements to the health and social care system. This work also highlighted a number of themes that impact on all areas of health and social care and which, between them, have the potential to really transform the way services are delivered, improving people’s outcomes and reducing costs further. The themes identified were: making the most of existing capacity and capability, digitising the health and social care economy, integrated services delivered in the community, integrated commissioning and personalisation, and taking forward the work of the children's care stream.

A Department of Health Gateway Review of the programme recommended that expert external opinion of the future model for emergency care for the health and social care economy should be sought. Acting on this recommendation Calderdale and Huddersfield NHS Foundation Trust invited the National Clinical Advisory Team (NCAT) to review the current emergency configuration and offer a view on the way forward. NCAT visited the Trust in June 2013 and met with many internal doctors and nurses and some Trust management, also GPs and commissioners, partner providers and Yorkshire Ambulance Service. NCAT recommended the Trust develop a future service plan centred around more care, both planned and unplanned, being provided in the community, and the two hospitals having a clearer focus, one being designated the planned site and one the unplanned site. The NCAT review confirmed that which site has which focus is a matter for local management to decide.

This Strategic Outline Case is informed by, consistent with, and builds on the significant work already undertaken through the Strategic Review. It also responds to the recommendations of the NCAT review. The aim of the Strategic Outline Case is to support the progress of the Strategic Review offering a clear recommendation for change that is fully supported by the three main providers of NHS health care in Calderdale and Greater Huddersfield.
4.2 What people have told us about services

Both the Calderdale and Huddersfield Strategic Review and South West Yorkshire Partnership Foundation Trust (SWYPFT) have recently undertaken public engagement events to better understand and consider the views of service users, the public and voluntary sectors. Engagement and feedback is essential when considering future service models and how they are delivered. The engagement events have enabled the partnership to highlight key priorities for the future and what really matters to the people who use our services.

SWYPFT have undertaken a series of engagement events to better inform their transformation programme. Over the summer 2013, 7 engagements events were held across all localities including Calderdale and Huddersfield. Over 500 people attended these events with a further 7 follow up events currently taking place to ensure that the feedback from the summer had been used to inform future services. Overall there were 5 key themes:

- I want services which keep me in the centre and which focus on my potential
- If I choose to make use of technology I want it to be available
- I want all organisations, both big and small, to work together so I don’t see the joins
- I want you to offer me as much choice as possible and help me understand those choices
- I want you to support my family and carers

Calderdale and Huddersfield Strategic Review undertook varied stages of engagement covering 4 main areas which included planned care, unplanned care, long term care and children’s services. The first stage included searching local and national files for any existing feedback from public, patients and carers. In order to engage further an engagement event was hosted in a community setting and invitations were sent to partner organisations that were best placed to identify public representatives. Although not all organisations took up the opportunity to attend the event, 50 people were in attendance. A questionnaire was also used to engage further with public, patients and carers. Survey participants included local people across Calderdale and Huddersfield, which included GP practices and Accident and Emergency Departments.

The main 6 themes captured were:

- We want to improve the health, well-being and safety of all our communities by supporting people to be independent and to deliver the right care, in the right place at the right time. To do this we need to change the way we provide health and social care service so that:
  - You can easily access the right information and guidance so that you can make informed choices for you and your family
  - You are able to tell your story once and are then supported to make positive choices to manage you and your families health
  - Wherever possible quality personalised care will be delivered close to your home to help you stay as safe, well and as healthy as possible, for as long as possible
  - Every child will have a healthy start and continue to lead a safe, happy life with every opportunity to achieve their potential within their families and communities

In addition during the period October to November 2013 Greater Huddersfield and Calderdale CCG’s undertook significant engagement activity to support the ‘National Call to Action’. This asked the public to give their views on four broad questions: How can we improve the quality of NHS care? How can we meet everyone’s healthcare needs? How can we maintain financial sustainability? What must we do to build an excellent NHS now and for future generations? A detailed report of the findings from this has been published. The general themes identified included for example: self-management; all agencies working together; improving access and bringing more hospital services into the community; investing in technology; investing in community and primary care services, and; improving education and information for the public about health.

Overall there appears to be a great deal of coherence and consistency of what people have told us about services and what is important to them. This Strategic Outline Case and the proposals for change build on this feedback.
4.3 National Policy Context

Whilst not exhaustive at the time of preparing this Strategic Outline Case there are seven key areas of important national policy or best practice that have particularly informed the development of proposals. These are shown in the table below.

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<tr>
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<tr>
<td><strong>The Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry</strong></td>
<td>The report of the failings at Mid Staffordshire Trust and the associated reports by Sir Bruce Keogh (<em>Review into the Care and Quality of Treatment provided by 14 Hospital Trusts in England</em>) and Don Berwick (<em>Improving the Safety of Patients in England</em>) describe the actions needed to ensure there is a clear focus on providing safe and compassionate care. These reviews and reports have informed the development of this Strategic Outline Case. Importantly the Strategic Outline Case describes proposals of how we can improve the safety of hospital care and reduce mortality.</td>
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<tr>
<td><strong>The Keogh Urgent and Emergency Care Review</strong></td>
<td>The report sets the strategic direction for the provision of urgent and emergency services in England over the next five years. The proposals in this Strategic Outline Case will enable and prepare us to respond to this national strategic direction.</td>
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<tr>
<td><strong>The NHS Services, Seven Days a Week Forum chaired by the National Medical Director</strong></td>
<td>The Forum's review identifies there is unacceptable variation in outcomes across the NHS in England for patients admitted to hospitals at the weekend. For patients admitted at weekends there is an increased mortality rate, poor patient experience and increased length of hospital stay and re-admission rates. The Forum proposes that clinical standards are adopted and fully implemented by 2016/17 to support the NHS to drive up clinical outcomes and improve patient experience at weekends. Under the present configuration of services, delivering the clinical standards for urgent and emergency in-patients at weekends is likely to add to overall hospital costs. The Forum recommends that reconfiguration of services and integrated working of hospital, community and primary care services may substantially reduce these costs. The proposals in this Strategic Outline Case describe how we can respond to enable seven day working across the health and social care system.</td>
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<td><strong>The Better Care Fund</strong></td>
<td>Nationally it has been agreed that £3.8bn of NHS funding will transfer to Local Authorities to create a single pooled budget for health and social care. The aim of this is that the fund should be an important catalyst for change, and enable the move towards more preventative, community-based care to help to keep people out of hospital and in community settings for longer. This Strategic Outline Case describes service proposals that could deliver this ambition.</td>
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<tr>
<td><strong>Future Hospital: Caring for Medical Patients</strong></td>
<td>This publication by the Royal College of Physicians provides an evidence base and case studies of the benefits associated with changing the way we care for people with medical needs by integrating care across hospital, community and social care services. The Strategic Outline Case describes proposals for doing this.</td>
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<tr>
<td><strong>The draft Health and Social Care Bill and ‘Dilnot’ Report</strong></td>
<td>The government’s proposals for social care funding reform (due to come into effect in 2016) will place a cap on the social care costs paid by an individual. The impact of this will further increase funding pressure for Local Authorities. This Strategic Outline Case describes proposals for integrating health and social care that could mitigate the impact of this funding pressure.</td>
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<tr>
<td><strong>Information and Management and Technology</strong></td>
<td>There are a number of national policy directives that set a clear direction and evidence base for increased use of technology in health and social care delivery to improve, patient safety, experience and efficiency of services. This Strategic Outline Case includes proposals for optimising the use of technology to enhance the effectiveness and efficiency of service provision.</td>
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<tr>
<td><strong>National economic context</strong></td>
<td>Nationally the country continues to recover from the economic crisis, public spending continues to be reduced in key areas. The national spending review in 2013 identified further reductions for local government and no growth for health. The financial context for delivery of health and social care will continue to be challenging.</td>
</tr>
</tbody>
</table>

These policies are set within the context of the Health and Social Care Act 2012. This Act has led to the creation of local Health and Wellbeing Boards and emphasises joint planning of services across health and social care economies.
4.4 Health Needs Context

This Strategic Outline Case sets out proposals of how we can respond to better meet the needs of people that live in Calderdale and Greater Huddersfield. The summaries below provide an overview of the needs of the resident population we serve. More detailed information is available in Calderdale and Kirklees Joint Strategic Needs Assessment reports.

**Calderdale**

Calderdale is facing some key challenges including an increase in population – which is greatest in the over 65s and the 0 to 15 year-old age group. More people are living longer with multiple health problems. In Calderdale it is estimated there are 2,300 people living with dementia and this is forecast to increase by about 75% over the next 15 years. More people in Calderdale are admitted to long-term residential care than in other parts of the country. Fuel poverty is estimated to affect a quarter of all households in Calderdale. There are constraints on local economic growth due to a lack of viable land for development and a highway network close to capacity. An estimated one in five children are living in poverty and there is rising childhood obesity. There is a growing health gap, with those living in Calderdale’s most disadvantaged communities experiencing greater ill-health than elsewhere in the district (there is a life expectancy gap between wards within Calderdale of up to 7 years). There is a similar gap in educational attainment between the most and least deprived areas. Behavioural factors which relate to health are not improving. Smoking prevalence and the harm caused by alcohol and obesity is increasing.

**Kirklees**

The population is increasing and will continue to grow, especially in the over 65 and the 0-15 year-old age group. More people are living longer with multiple health problems. In Kirklees it is estimated there are 4,000 people living with dementia and this is forecast to increase by about 75% over the next 15 years. There are high poverty and deprivation levels in Huddersfield along with higher rates of unhealthy behaviours and higher disease burden. Long term pain, depression and anxiety have the largest impact on local health. 1 in 5 adults reported suffering from depression, anxiety or other mental health condition. More than half of adults and 1 in 5 children are overweight or obese. Life expectancy at age 65 is also lower in Kirklees than nationally. Gaps in life expectancy between the least and most deprived neighbourhoods in Kirklees is 4.1 years for men and 3.4 years for women. Rates of tuberculosis and sexually transmitted infections are rising. Lifestyle choices have a significant impact on the major causes of ill health and premature death in Greater Huddersfield.
4.5 Current Service Provision

A summary of the health and social care services in Calderdale and Huddersfield is shown below.

**Calderdale and Huddersfield Foundation Trust (CHFT)**

CHFT employs 6000 staff and delivers community services in Calderdale and hospital secondary care services at Calderdale Royal Hospital (which has 450 beds) and Huddersfield Royal Infirmary (which has 420 beds).

Each year CHFT delivers 119,000 in-patient and day-case admissions, 414,000 out-patient appointments, 182,000 adult community service contacts, 110,000 children’s community service contacts and 141,000 attendances at its Accident and Emergency departments in Halifax and Huddersfield. The annual financial turn-over is £351m.

The range of community service provided in Calderdale includes: District Nursing, Health Visiting, School Nursing, Intermediate Care, Wheelchair Services, Equipment Loan Store, Physiotherapy, Occupational Therapy, Speech and Language Therapy, Podiatry and Specialist Nursing services.

Both hospitals provide: outpatient and day case services, Accident and Emergency services, acute medical services, level 3 intensive therapy unit for adults; rehabilitation for older people; a complete range of diagnostic services; endoscopy; therapy services, and; early supported discharge in respiratory and stroke and virtual ward to support discharge for vulnerable patients.

Calderdale Royal Hospital also provides: consultant led maternity unit; inpatient paediatric services; Level 2 Neo-natal intensive care unit (NICU); elective surgery; stroke services, and; interventional cardiology services.

Huddersfield Royal Infirmary also provides: trauma unit; complex and unplanned surgery; midwifery led maternity unit.

**Locala Community Partnerships**

Locala Community Partnerships employs 1,200 staff and is an independent Community Interest Company providing NHS community services to over 400,000 people in Kirklees and beyond. Most of the care and support is provided at home and in clinics, schools and health centres by teams of health visitors, district nurses, therapists and health promotion experts.

Each year, in Huddersfield, Locala delivers 800 intermediate care in-patient admissions, 3,500 day-case admissions, 3,500 out-patient appointments, 285,000 adult community service contacts, 75,000 children’s community service contacts, and 20,000 Health & Well-being contacts. The annual financial turnover for all Locala services is £47m.

Services provided include: District Nursing, Health Visiting, School Nursing, Musculoskeletal Services, Community Dermatology services, Speech and Language Therapy, Occupational Therapy, Continence Services, Contraceptive and Sexual Health Services, Intermediate Care Services, Walk-in Centre, Health Promotion and Improvement.

**South West Yorkshire Partnership Foundation Trust (SWYPFT)**

SWYPFT has a total workforce of 4,092 staff and provides integrated health and social care mental health services in Barnsley, Wakefield, Calderdale and Kirklees. The Trust provides 45,194 bed days of inpatient care and 161,821 patient contacts across Calderdale and Greater Huddersfield per year. The following range of services are provided in Calderdale and Greater Huddersfield: Mental health services for adults of working age (aged 18 to 65); Child and Adolescent Mental Health Services; Services for Older people (over 65) with a mental health problem; Services for people (mainly adults) with a learning disability whose behaviour challenges services, with intensive support needs and/or a mental health problem; Medium secure forensic services for people with a mental health problem and/or learning disability (also provide this service to the whole of Yorkshire and the Humber). In Calderdale additional services provided includes substance misuse/alcohol services and health improvement services.
Primary Care Provision in Calderdale and Huddersfield

There are 26 GP practices in Calderdale serving the population of 213,000 people. In Greater Huddersfield there are 40 GP practices serving the population of 245,000 people.

Social Care Provision

Kirklees Council provides a range of services to support vulnerable adults. With a focus on reducing dependence and where possible offering a range of, often integrated, support. This includes re-ablement, intermediate care and homecare. Kirklees Council has set its eligibility criteria at substantial and following an assessment to determine this, has a duty to provide services to people who meet this criteria. Adult social care also provides interventions to those with a lower level of need for example assistive technology, support to avoid hospital admission and care navigation. The council directly provides some services but most are now commissioned and delivered by the voluntary and independent sector. There is a need to stimulate the supply market for home care provision.

The adult social care market in Calderdale is changing in response to what people who use services say and the changing commissioning priorities of the Council and health partner agencies. Five significant trends are:

- **Good Quality Information:** 37,000 people contacted Gateway to Care during 2013, 21% more people than contacted in the previous year. 97% of requests were resolved without the need for formal assessment.

- **Greater choice and control:** 93% of people with assessed, eligible social care needs have a Personal Budget. A third now arranges their support through a direct cash payment so they can purchase their own care. 72% of all support is purchased from independent care providers. Over a third of people who receive managed home care told us that they want better options developed to enable them to take control of their personal budget and support arrangements.

- **Rapid decline in traditional ‘centre based’ care:** 32% fewer people are now choosing to spend their personal budget on a day centre type service compared with 4 years ago.

- **Consistency of care:** Although the number of people needing care in their own home has remained stable in the last 3 years, there is greater value on issues such as consistency of carer and care workers arriving on time1.

- **Quality of 24 hour care homes remains a concern:** There was a 25% increase in safeguarding alerts in, over half of which related to the care home sector. The number of permanent placements reduced by 9% during 2013. The new growth area has been a significant (62%) increase in demand for short stay transitional placements with a reablement and rehabilitation focus that helped people recover their confidence to continue living at home. There are 200 people on a waiting list who would chose an extra-care housing solution as an alternative if sufficient capacity was developed in the local market.

![Changing Demand of Services](image)

**Figure 1: Change in number of people receiving support from social care by type**

1 Personalisation and Engagement Consultation 2013
The Council has increased the level of choice and control that people have over the support and care they receive by introducing personal budgets and self-directed support. However, the balance of power in relation to decision making and the control of resources has largely remained with the Council.

This traditional model of care and support is no longer sustainable and it encourages dependence. People are encouraged from their first point of contact with health and social care services to become reliant on solutions being found for them and to simply be passive recipients of ‘care’. This leads to loss of confidence and evidence indicates that people in Calderdale spiral into a cycle of dependency and escalating support needs.

If we are to improve this situation there needs to be greater involvement and control given to individuals and communities in decision making, and the Council needs to become less bureaucratic, enabling creativity to flourish, and providing an opportunity for positive outcomes to be realised from the investment of public money.

This change will be seen in the changing role of staff who assess for and commission services from a buyer to a facilitator, with a new offer of support being made to local people where:

- **Information and advice**: The Council will co-ordinate the provision of information and advice to people and suggest options available that might produce the best outcomes for them which recognising that many people are self-reliant, often making use of their own resources to self-fund care and support.

- **Stimulating development**: The Council will be responsible for creating a responsive local market for care and support services. The change in emphasis from a buyer to a facilitator will require a new form of relationship with partners if we are to ensure that choice and affordability are maximised for people.

- **Reducing risk**: The Council will ensure that adults most of at risk of abuse or neglect have better life opportunities through seeking to inspire and oversee care providers to deliver better outcomes through rewarding quality and addressing failures.
5. The Case for Change and Opportunity for Improvement

5.1 Overview

The way community, hospital and social care services are organised and provided in Calderdale and Greater Huddersfield is not offering the most safe, effective and efficient support and care to meet people’s needs. Our aim is to work together, and with individuals and local communities, and partner organisations to provide exceptional standards of care to achieve optimal health and lowered system cost. We do not believe that the current system enables this. The case for change is simple and based on the following:

**We have challenges to ensure the safety we want to provide for people**

- At the moment there are not enough specialist services provided in people’s homes or close to where they live. This means that for many people their only option is to be admitted to hospital and often this occurs due to a crisis when their health has deteriorated and their safety is compromised. This could be prevented if more integrated and specialist services were available in the community offering proactive care planning and support.
- For people with acute mental illness that experience a crisis this could mean that they have to spend time in temporary places of safety (which may include police cells) or that on occasion they are admitted to hospitals a significant distance outside the local area.
- For people with multiple medical problems we know that when they are admitted to hospital too many people experience: a number of moves between wards; a longer length of stay in hospital, and; increased risk of a poor experience and outcomes.
- For people that have a serious life-threatening illness or accident and need Accident and Emergency services we know we cannot guarantee the consistent presence of senior doctors over-night and seven days a week. We also have shortages in the number of middle-grade doctors and a high use of locum staff in the A&E departments. This impacts on the safety of care. We cannot ensure the best clinical decisions are taken and offer the quality of support for patients and families we aspire to.
- The provision of A&E services in both Halifax and Huddersfield means that we cannot provide all the ‘essential’ on-site hospital facilities and acute medical and surgical expertise at both sites. As a result patients may need to transfer between hospitals.

**We have challenges to ensure the effectiveness of care and support**

- The care and support we provide is not as effective as we would wish as we are not offering enough support and early intervention to enable people to stay in control and make choices to self manage or self care. This earlier support could help individuals, families and communities to undertake activities that will enhance their health, prevent disease, limit illness and restore health. Increased self-care could reduce the number of people needing to seek help from a health or social care professionals. It can also deliver wider benefits such as improved quality of life, reduced social isolation, and reduced time off work. Self care is not about leaving people to cope on their own – it is an approach that will enhance and optimise their health and wellbeing.
- The services we provide are not sufficiently integrated to meet people’s needs. For people that have multiple needs the current organisation of services means there is significant risk of people experiencing gaps in care. One example of this is people that have a serious mental illness. They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease. Another example is that people who live in nursing homes may experience repeated admissions to hospital as the specialist support they need is not provided in the nursing home. This is often experienced by people at end of life. This is not the care we want for people and we can change this in the future.
More specialist care for long term conditions could be provided in the community. These types of services are referred to as ambulatory care and include conditions such as diabetes and asthma. Pro-active support and care planning could help people to stay as well as possible at home and avoid the need for their admission to hospital. This would improve their experience and health.

Sometimes we have to cancel people’s planned operations as the surgeons need to respond to meet the needs of emergency patients. We know this is a poor experience for people that may have arranged time off work and child care to enable them to have a scheduled operation. We can reduce the likelihood of this happening changing the way hospital services are organised.

**We have challenges to deliver the efficiency of services**

The health and care needs of people that live in Greater Huddersfield and Calderdale are increasing. People are living longer, many older people are likely to develop one or more long term condition and modern lifestyles are also creating more ill health. The impact of this is generating additional demand for health and social care services.

This growth in demand coupled with inflationary pressures results in an estimated £162.5m productivity and efficiency requirement over the next 5 year period. In totality this represents circa 5% efficiency requirement per annum. This is not achievable without system transformation.

The way we provide services currently is not as efficient as we need. There is an evidence base that if more people were supported to self manage and self care, and we integrated services, optimising the use of technology this would improve both quality and efficiency.

**We need to put people in control of their own health and wellbeing needs**

We need to ensure greater engagement and communication with local people so that they can have greater control over what happens to them and their family’s health. This is likely to be the best way to support people to make decisions that will improve their health and wellbeing status such as: adopting healthier lifestyles; making the best use of wider community support, and; the appropriate use of health and social care services.

**We need whole system leadership and quality improvement**

A deliberate and sustained leadership strategy that focuses on quality improvement and invests in staff capabilities and skills is needed. Currently there are seven health and social care organisations across Greater Huddersfield and Calderdale. A quality improvement strategy that unifies their collective intent and ambition is needed. Most importantly this needs to equip front-line staff in all seven organisations and in GP practices to have a shared aim and develop their skills and capability for quality improvement and efficiency. There are examples of health and social care organisations that have achieved large scale system change and sustained high levels of performance that we can learn from (e.g. Jönköping County Council). The shift we need to make is that all staff are equipped for two jobs – the job they do and the job of improving quality. This change will only be effective if the whole system changes together.

**We need to Optimise the Use of Technology**

The large scale use of information technology by members of the public, patients and health and social care professionals is essential to make possible these changes.
These are changes we should be making to improve the quality of services irrespective of pressures related to increased demand and reduced resources. In the absence of taking action Calderdale and Greater Huddersfield faces significant risks related to safety, unmet needs, financial instability, and; deterioration in the health of residents.

The case for change is summarised in the diagram below:

<table>
<thead>
<tr>
<th>Increasing Demand for Services</th>
<th>Reducing Resources to Meet Increased Demand for Services</th>
<th>Providers not able to Guarantee Safety, Effectiveness and Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opportunity to Improve Quality</strong></td>
<td><strong>Self-Care</strong> Help more people to self-care and maintain control and independence of their health and well-being.</td>
<td><strong>Integrated Support</strong> Help more people to access integrated support and specialist advice seven days a week as close to home as possible.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospital Services</strong> Improve emergency care and services for people that need inpatient hospital care.</td>
<td></td>
</tr>
<tr>
<td><strong>Opportunity to Improve Value for Money</strong></td>
<td>Increased self-care will reduce the number of people needing to seek help from a health or social care professional. It can also deliver wider benefits such as improved quality of life, reduced social isolation, and reduced time off work.</td>
<td>Provision of 7 day fully integrated support will reduce duplication of work, enable proactive care planning to minimise crisis, prevent escalation of needs (such as hospital admission or long term care) and optimise reablement and recovery.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Changes to hospital services will support a reduction in admissions and the length of time people need to stay in hospital; it will improve clinical safety; reduce mortality, and; decrease the cancellation of planned hospital care.</td>
</tr>
<tr>
<td><strong>Putting people in control of their own health and wellbeing needs:</strong> People are engaged and supported to make decisions that will improve their health.</td>
<td><strong>Leadership:</strong> Whole system strategy for quality improvement and workforce development that invests in staff and General Practice capabilities and skills.</td>
<td></td>
</tr>
<tr>
<td><strong>Key Enablers:</strong></td>
<td></td>
<td><strong>Large Scale Use of Information Technology:</strong> To provide services, enable self-care and support new ways of working.</td>
</tr>
</tbody>
</table>
The following paragraphs provide a description of the rationale, evidence and opportunity for improvement associated with the case for change shown in the above diagram.

5.2 The Evidence Base for the Case for Change

There is Increased Demand for Services

The population across Greater Huddersfield and Calderdale is growing. People are living longer and many older people are likely to develop one or more long term condition such as dementia, heart disease, diabetes and respiratory problems. The challenge for health and social care in providing high quality and effective services is increasing as there are more vulnerable, frail, elderly people many of whom may have dementia and multiple medical conditions. Modern lifestyles are also creating more ill health. Unhealthy eating and lack of exercise are contributing to increased prevalence of obesity, diabetes and cardiovascular disease in the population. (source: Calderdale and Kirklees Joint Strategic Needs Assessment).

The proposed changes in the way services are provided by Mid Yorkshire Hospitals will also increase the demand for health services in Greater Huddersfield.

Together these changes place a significant increased demand on health and social care services in Greater Huddersfield and Calderdale, both in terms of the number, and the complexity of people's needs that will require support in the future.

There is Insufficient Resource to Meet Future Demand

The NHS is set to receive just under 1% increased funding per annum at a time when it is estimated that we will have to generate a 5% efficiency saving per annum. In addition, Local Authority spending is reducing and this will impact on social care provision. There is concern this will lead to increased unmet needs of service users and carers. This impact may be exacerbated by changes associated with the welfare reforms. Reduction in access to social care is likely to increase pressure on health services as people seek alternate support. The Greater Huddersfield and Calderdale Health and Social Care Review has undertaken work to quantify the resource gap and identified system savings across the Calderdale and Huddersfield area in excess of circa £160m are required over the next five years. (source: Greater Huddersfield and Calderdale Health and Social Care Strategic Review 2013)

Providers not able to Guarantee Safety, Effectiveness and Efficiency

As described at the start of this section we are not able to guarantee the service is as safe, effective and efficient as possible due to the way services are designed. This reduces our ability to have more senior doctors and nurses in the community, and in hospitals in the evenings and at weekends.

We Can Support More People to Self-Manage and Self-Care

Reducing people's dependence on health and social care and increasing their sense of control and wellbeing is a more effective way of working. There is evidence that self-management support can improve people's knowledge about their condition and care, how they feel about their condition, and their ability to cope day to day. This results in both improved confidence to self-manage and quality of life.

We have high rates of emergency admissions to hospital for people with diabetes and asthma. Better management of these conditions and better support for self care and family carers could avoid such distressing experiences, leading to care that is more effective, a better experience and more productive.
There is evidence from the UK and elsewhere that self-management support can also alter the pattern of healthcare service use and subsequent healthcare costs. It has been suggested that self-management support programmes may reduce visits to health services by up to 80%. The potential economic benefits that may be expected from the introduction of an integrated and targeted self care service show cost savings of around £1,800 per person per year may be possible. There is good evidence that the effectiveness of self-management is enhanced when this is associated with community and voluntary sector involvement, peer support, use of technology and coaching models. (source: Helping people help themselves, A review of the evidence considering whether it is worthwhile to support self-management. The Health Foundation May 2011; Self Care Reduces Costs and Improves Health – The Evidence, Expert Patients Programme Community Interest Company, 2013.)

**We Can Integrate Services to Reduce Demand and Improve Quality**

Ensuring that people receive integrated and coordinated care close to home has been widely reported as achieving benefits associated with the experience of care, a reduction in hospital admissions, shorter lengths of stay in hospital and a reduction in out-patient attendances. Examples of this are Torbay Care Trust and Kaiser Permanente and the Veterans Health Administration in the US. The Veterans Health Administration reduced bed day use by over 50 per cent when it was transformed from a hospital-centred system to a series of regional integrated service networks. Kaiser Permanente uses one-third of the bed days the NHS does for comparable conditions for people aged 65 and over. Nationally it is estimated that one in five patients could be treated equally well or better out of hospital. (source: The evidence base for integrated care, Kings Fund 2011; Avoiding Hospital Admissions, Lessons from Evidence and Experience. The Kings Fund, 2010; Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme BMJ 2003, The Keogh Urgent and Emergency Care Review, NHS England 2013.)

In September 2013 the Royal College of Physicians published the report Future Hospital: Caring for Medical Patients. This provides an evidence base and case studies of the benefits associated with changing the way we care for people with medical needs by integrating care across hospital, community and social care services.

In the future, specialist medical care should not be confined to inside the hospital walls. We can reduce the number of people that need to be admitted to hospital by specialist medical teams spending part of their time working in integrated community teams providing proactive care planning and coordinated support for people.

Through integration we can also improve the services provided in hospital. We know that there are increasing numbers of people aged over 65 with multiple conditions that require holistic care in hospital. The way inpatient medical services are currently provided on a speciality ward basis means that too many inpatients may experience poor continuity of care. People with multiple medical problems may experience a number of moves between wards, a longer length of stay in hospital, and; the risk of poor experience and poor outcomes is increased. We can reduce the length of time people need to stay in hospital and improve their experience and recovery by ensuring better integration and coordination of hospital services. This will require that specialist medical care comes to the patient and the need to move between wards is minimised. In reach to hospital of support from community teams to proactively plan for discharge of patients is also known to be effective in reducing length of stay in hospital.

There is a clear link between mental and physical health. Sixty per cent of people over the age of 65 who are admitted to hospital have, or will develop, a mental disorder during their admission. On average, people with mental illness die five to ten years younger than the general population. There is strong evidence that provision of integrated physical and mental health services, offering liaison psychiatry interventions both in hospital and the community can improve patient outcomes and reduce healthcare costs. (source: No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, 2011.)
We Can Improve the Safety and Quality of Emergency and Planned Hospital Care

The NHS Services, Seven Days a Week Forum chaired by the National Medical Director identifies that reduced service provision, including fewer consultants working at weekends (in emergency medicine and acute in-patient specialties), is associated with England’s higher weekend mortality rate. Consistent services across all seven days of the week are required to provide high quality and safe care. The presence of senior clinicians is important for ensuring the best decisions are taken, reassuring patients and families and making best use of NHS resources. To improve the chances of survival and better recovery outcomes it is also important that the right hospital facilities and acute medical and surgical expertise is co-located with emergency services.

Accident and Emergency services are currently provided in both Halifax and Huddersfield, the distance between the two sites is 5.13 miles and approximately a 12 minute journey. Acute medical specialities are provided on both sites; stroke services, paediatrics, maternity and obstetric services are based in Halifax, and; trauma and acute surgery services are based in Huddersfield.

The current configuration of services on two sites means that:

- There are challenges in being able to provide senior doctor presence for extended (16) hours seven days a week on both sites. In addition there is a national workforce shortage in emergency middle grade doctors. As a result the two A&E departments have a high use of locum doctors (for example the two A&Es require a middle grade rota of 12 doctors and in the last 5 years there has only been a maximum of 7 doctors with gaps in the rota filled by locums).
- There is often a need for inter hospital transfers as there is not a co-location of all the expertise needed on both sites (i.e. trauma is at Huddersfield and paediatrics and obstetrics are at Halifax).

In June 2013 the National Clinical Advisory Team visited Calderdale and Huddersfield Foundation Trust and recommended that a one acute care site option is the best for the future safety, value and sustainability of healthcare. This change will enable an increased senior doctor (consultant) presence for extended hours over 7 days, minimise the use of locum middle-grade doctors and will reduce the need for inter-hospital transfer of patients.

In November 2013 NHS England published Sir Bruce Keogh’s Urgent and Emergency Care Report. This report provides evidence that the co-location of emergency and acute medical and surgical expertise can enable significant improvements in survival and recovery outcomes despite an initial increased travel time to the A&E department. The report also sets a direction that over the next five years there will be changes in the way that A&E services are provided. Of the 140 A&Es currently across England 40 – 70 major emergency centres will be established. The development of a single emergency and acute site for Greater Huddersfield and Calderdale would strengthen the current provision model and enable us to prepare and respond to this wider strategic direction.

The provision of planned hospital services and surgery on a single hospital site will reduce the likelihood of scheduled operations and care (such as hip replacements, cataract surgery) being disrupted by changes in demand for acute care. This will reduce the number of cancelled operations and enable the doctors and nurses working on the planned hospital site to spend more time with patients.

We Can Put People in Control of their Own Health and Wellbeing Needs

There is evidence that greater engagement and communication with local people to improve understanding and ownership of their health is a stronger predictor of health status than age, income, employment status, education level, race or ethnic group. Research has reported that people with low levels of engagement and health knowledge: are at greater risk of hospitalisation and have longer hospital visits; have higher rates of admission to emergency services; are less likely to adhere to prescribed treatments and self-care plans; have more medication and treatment errors; have less knowledge of disease management and health-promoting behaviours; have decreased ability to communicate with healthcare professionals and share in decision-making; are less able to make appropriate health decisions; make less use of preventive services, and; incur substantially higher healthcare costs. We need to develop whole system approaches to strengthen engagement with local people. (source: Patient Focused Interventions: A Review of the Evidence, The Health Foundation 2006.)
We Can Invest in Staff Capabilities and Skills to Enable Quality Improvement

Responding to the challenges described in this case for change will require leadership and collaboration across the system, from ward and hospital department to the GP, community services and social care, involving the whole spectrum of care professionals. There is evidence from organisations, such as Intermountain Healthcare in the United States or Jönköping County Council in Sweden that leadership for this scale of improvement involves reforming the system through a sustained effort designed to create the ways of working, people development, culture, systems and environment that are the conditions for promoting improvement. A deliberate and sustained leadership strategy that focuses on quality improvement and invests in staff capabilities and skills will be needed. (source: Leadership and Engagement for Improvement in the NHS, Kings Fund 2012; The Role of Leaders in High Performing Health Care Systems, Kings Fund 2011.)

In the context of increasing demand for services and reducing resources there are significant potential shortages in the health and social care workforce. In 2013 the Kings Fund published a briefing paper (NHS and Social Care Workforce: Meeting Our Needs Now and in the Future). This report summarises the workforce challenge and possible options to respond. The key principles are:

- An increased emphasis and expansion in the role of ‘generalists’ that are able to provide and coordinate integrated holistic support for people that have multiple needs and conditions.
- An expansion and increasing role for an informal workforce of peer support workers and volunteers.
- Developing staff skills so they have confidence in supporting more people to self care.
- Equipping staff with the confidence and skills to improve quality.
- Enabling staff to make greater use of technology to enable different ways of working and efficiency in the delivery of care and support.
- Offering flexible working patterns that will enable delivery of 7 day and extended hours working.

We Can Use Information Technology to Support New Ways of Working

Integrated digital care records are essential to ensure that patient related information and clinical decision and support tools can be viewed by authorised health and social care professionals to enable care delivery at the hospital bedside, in people's homes, in hospices and in ambulances. (source: Safer Hospitals, Safer Wards, NHS England 2013.)

The National Demonstrator Sites provide a clear evidence base that the use of telehealth and telecare can deliver a reduction in A&E attendances, hospital admissions, and mortality rates and also improve service user experience. (source: the Impact of Telehealth on Use of Hospital Care and Mortality, Nuffield Trust, 2012.)

There is also evidence that use of communication technology in the delivery of care can reduce costs and offer more convenient and accessible support for people. Digital first aims to reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions. Unnecessary means for example, attending a hospital or GP appointment to receive a test result that says everything is OK; or a visit to an outpatient clinic or GP surgery for something that could be discussed on the phone or via email or SKYPE. The aim is to use technology in healthcare where it can deliver the same high standards in a way that is more flexible and convenient for patients, and at a lower cost. (source: Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS, Department of Health 2011.)

Technological developments are also opening up new possibilities for community diagnostic services. A study at University College London Hospitals Foundation Trust in 2011 reviewed the potential benefits of community based diagnostic services. The research looked at community based diagnostics for imaging, cardiology, respiratory and pathology, covering a mix of ultrasound, spirometry, ambulatory ECG and blood pressure, resting ECG and plain film X-ray. The conclusion of the research was that a community model could add clinical value through improved access and support to patients and GPs and also reduce costs.
6. The Service Proposal

6.1 Principles and Goals

The aim of the service proposal described in this strategic outline case is to offer integrated care and support for people in Greater Huddersfield and Calderdale that crosses the boundaries between primary, community, hospital and social care.

Integrated care means improving the quality for individual patients, service users and carers to ensure that services are well coordinated around their needs and that their views and choices are the organising principle for the delivery of support; i.e. putting the patient at the centre of everything we do.

This will require the whole system working together from primary to community to hospital to social care, and; whether working as public employees, independent practitioners, or private and not-for-profit contractors; recognising that there is one integrated system that will support people to achieve the best possible outcomes within the resources available.

To do this will require us to equip and support staff to work in new ways and establish new behaviours. This proposal section of the Strategic Outline Case therefore also describes how staff will be supported to embed the cultural change needed and the important role of new technologies to enable this.

The illustration below has been developed through the Greater Huddersfield and Calderdale Health and Social Care Strategic Review and is supported by all seven partner organisations. The integrated service proposal described in this Strategic Outline Case is consistent with this.

Figure 1

Our Future Care System

The goals of the integrated service proposed in this Strategic Outline Case are that:

- People will be enabled to take more responsibility for their own health and well-being and to stay in control of the support and care they need e.g. through the use of personal budgets.
- As far as possible people will be supported to self-manage and self-care to stay well in their own homes and communities. The use of technology will be optimised to enable this.
- The support provided will be not just medical or nursing but will focus on rehabilitation and assisting people to live well in their community e.g. being able to shop again, reconnect with friends and rebuild social networks.
- When people need complex care it will be timely and appropriate and available 7 days a week and over extended working hours. There will be clear care plans co-created and agreed with service users and carers. Every effort will be made to meet people's needs in their own home or community setting so that an admission to hospital is not necessary. This will include provision of a range of specialised services, currently largely hospital based, being delivered in or close to people's home.
When people do need hospital care this will be coordinated and patient centred so that people do not experience delays in care or need to move beds or wards and specialist care is coordinated around their needs. Senior medical, nursing and diagnostic decision making support will be available 7 days a week. The focus will be on enabling people to leave hospital as soon as their clinical needs means they no longer require a hospital bed. Carers will be involved and informed.

- When people have more serious or life threatening emergency care needs they will receive treatment in a specialist hospital with the right facilities and expertise to maximise their chances of survival and make a good recovery.
- Planned treatments and operations (e.g. cataract surgery, hip replacement) will be provided in a specialist hospital. People will be offered a choice of dates for this and will be confident that their treatment date will not be cancelled or rescheduled.

6.2 The Proposed Delivery Model

To achieve these goals requires a new delivery model that changes the way of working across health and social care to offer holistic and seamless support to meet people's needs.

The proposal is that in the future across Greater Huddersfield and Calderdale people will be supported by: community locality teams; two specialist community centres, and; two specialist hospitals (one delivering services for people that have an emergency or are acutely unwell and the other specialising in provision of planned hospital treatments). The majority of people's support and care will be provided in the community. Hospital inpatient care will be regarded as one step in a pathway of continuous and relevant support to meet people’s needs that extends from, and back to, the person's usual place of residence.

The Locality Teams

Work is needed to determine the optimal number and geography for the locality teams. It will be important to ensure these are of sufficient workforce size to ensure resilience. The areas covered by a locality team will be aligned with GP practice populations so that there is clarity for every GP practice of which locality team they will be working with. GPs will have a central role in the multidisciplinary teams.

The locality teams will work closely with private and voluntary sector home care providers commissioned by the Local Authorities. It is known that in Kirklees and Calderdale there is currently insufficient market supply of these services to meet the demand to support the provision of more care closer to home. To enable the new model for locality teams to succeed will require effort to stimulate the supply market for home care provision in both districts.

The table below provides an overview of the key features of the locality teams and the strategic intent of how they will function. This is also illustrated at figure 2.
Scope  
The teams will be multidisciplinary offering fully integrated physical health, mental health and social care support. The teams will deliver all the community care for a locality and there will no longer be separate functional teams (such as District Nursing, Community Mental Health Teams). The teams will include general nurses, therapists, community psychiatric nurses, community matrons, social workers, volunteers and GPs. The locality teams will be aligned with and support intermediate tier and reablement services and hospital discharge coordinators. The locality teams will be strongly aligned with and work seamlessly with independent contractors such as community pharmacists and opticians, voluntary organisations and private sector partners that deliver care and support to people in the locality (e.g. home care providers, self-help groups etc.). The teams will be supported by specialist nurses, pharmacists, psychologists, therapists and doctors that will provide advice and consultancy to several teams. In some cases these specialists will be based in the team and in-reach to hospital and for others this will be a hospital outreach model. Physicians and specialist medical teams will spend part of their time working in the locality teams focusing on proactive planning with GPs and other members of the team to optimise people's care and avoid crises.

Access  
The teams will operate for extended hours over 7 days. 24 hour rapid crises response will be provided. There will be a single point of access so that via one phone call people can receive the support and advice they need.

Choice and Control  
The teams will work to ensure that people are able to stay in control of their care and support and are offered choices, where possible, of how their needs might be met. This will include use of personal budgets.

Self-Management and Care  
All members of the team will be skilled and trained in enabling people to self-manage and self-care. This will be the first option considered. The approach will be to support individuals, families and communities to undertake activities that will enhance their health, prevent disease, limit illness and restore health. These activities will be derived from the knowledge and skills of the members of the locality team, voluntary sector organisations and patient experience. People will be supported to undertake activities individually or in participative collaboration.

Shared Information  
The multi-disciplinary team will have a single integrated shared record and undertake agreed single joint assessment processes. There will be the ability for this record to be viewed and used in all care settings including people's homes, in hospital and in GP practices.

Care Planning  
Pro-active care planning for people with multiple needs will be undertaken. People will be supported to self-author plans if appropriate or to co-produce plans with professional members of the team. Specialist doctors and nurses will support care planning to enable optimal care and avoidance of crises. Risk stratification tools will be used so that the teams can ensure that the appropriate intensity of support and care is targeted and available for the most vulnerable people living in localities.

Coaching Care Navigation & Care Coordination  
Based on people's needs a range of approaches will be used. This will include coaching and care navigation to enable self-care and management. It is expected that much of this can be delivered by volunteer health trainers, peer support workers and expert patients. A Recovery College approach to equip people with the skills and information they need to enable self-management and care will be implemented. The Recovery College model is a central facility that people can access which offers a range of self-care, coaching and partnership approaches, set out in a college type prospectus. For people with multiple or complex needs health and social care professional care coordination will be provided.

Interventions  
The team will be able to access specialist doctors and nurses to provide advice and interventions in the community (e.g. intra-venous therapies) that will enable people to stay at home and avoid admission to hospital or to be discharged earlier from hospital.

Technology  
The team will support people to make full use of technology to optimise care delivery and efficient working. This will include assistive technology, telehealth, and mobile working.

Volunteers and 3rd Sector  
The teams will work in partnership with the voluntary sector to enhance the support options available for people. Clear alignment with initiatives such as Community Health Champions will be made.
The Specialist Community Centres

In addition to the integrated community teams centred on GP practices there will be two specialist community centres that will provide a hub for the provision of integrated and specialist services across local communities. One of the centres will be Todmorden Health Centre in Calderdale and the other one will be Holme Valley Memorial Hospital in Kirklees.

More work is needed to fully define the range of support and integrated services at these two centres. The aim is to build on and enhance the existing services.

The centres in the future could offer, for example: some minor injury capability (e.g., sprains and strains, minor burns and scalds); most outpatient appointments (including antenatal and postnatal care); health information services (including healthy living classes); pharmacy; teaching and training; social care; cognitive behaviour therapy (CBT) and other mental health services; patient and social groups; contraceptive and sexual health services; community nursing and therapy services; diagnostics (point-of-care pathology and radiology); proactive management of long-term conditions, and; other health professionals such as opticians or dentists. In addition the hubs can be a focus for social activities that truly bring health and social care into the community. The Cafe at Holme Valley is an example whereby communities can use this facility for a variety of physical, social and mental health activities.

Whilst these two sites will offer a hub it is not intended that they will be the only community sites in Calderdale and Huddersfield from which an extended range of integrated services is available. Where it is possible and effective the preferred option will be to offer support and care in people’s homes and in GP practices.
The Specialist Hospitals

There will be two specialist hospitals in Greater Huddersfield and Calderdale. One hospital will specialise in acute and emergency services, caring for those people who are most seriously or suddenly ill. One hospital will specialise in care for people undergoing planned treatments or surgery, such as hip operations, and attending outpatient clinics. Both hospitals will serve vital roles in the years ahead.

These changes will go hand in hand with the development of the community locality services (described above) to enable more people to be supported and receive care closer to where they live and reduce the need for unnecessary hospital admissions.

Senior nurses, doctors and therapists that work in the hospital, the mental health trust and community services support these changes. In addition the National Clinical Advisory Team (NCAT) which is a team of medical experts have visited Calderdale and Huddersfield Foundation Trust and recommended this is the right step. This change in the way hospital services are provided will enable:

**Better care from specialist doctors, nurses and therapists.** Each hospital will do different things and have NHS staff who specialise in those services. If a patient has a road accident or heart attack, they will go to a hospital geared up for that urgent care. If they need a planned operation such as a hip replacement they will be cared for in a hospital designed to meet their needs.

**Improved safety.** In the years ahead there will be more demand on hospitals and fewer doctors available in the system. This change will enable services to continue to protect patient safety and ensure the right clinical staff are in the right place. This includes being able to provide senior doctor presence in A&E at night and at weekends and to reduce the use of locum doctors. Stroke services in London have been reorganised in this way redirecting patients with suspected strokes from 32 admitting hospitals to only 8. The result of this is that London now has the best stroke services of any capital city in the world, saving more lives and returning more patients to independent living.

**Better bedside contact from doctors and nurses.** The separation of urgent and non-urgent hospital care will reduce the likelihood of a doctor being called away from delivering planned care because, for example, a serious road accident has happened.
Figure 3 below provides an illustration of the proposed change in hospital services and the increased provision of specialist services in the community. The direction of the arrows on this diagram illustrate where we propose services will be hospital based and out-reach to community locality teams or where services will be community based and in-reach to hospital.

Figure 3
The Acute and Emergency Specialist Hospital

The acute and emergency hospital will specialise in providing treatment for people who have a serious or life threatening emergency care need. The hospital will bring together on one site the necessary facilities and expertise, 24/7, to maximise people’s chances of survival and a good recovery. The following services will be provided:

- Adult Accident and Emergency Department
- Paediatric Accident and Emergency Department
- Level 2 and Level 3 Intensive Therapy Unit (ITU)
- General Medicine
- Acute Elderly Medicine and Elderly Assessment service
- Stroke
- Cardiology
- Respiratory
- Oncology
- Haematology
- Neurology
- Gastroenterology
- Acute and complex surgery
- Day surgery
- Trauma
- Endoscopy
- Paediatrics
- Complex Maternity
- Midwifery led maternity
- Gynaecology
- Neonatal Intensive Care
- Outpatient services
- Therapy services
- Diagnostic services

For example, if you or a member of your family are experiencing a loss of consciousness; acute confused state and fits that are not stopping; persistent, severe chest pain; breathing difficulties; severe bleeding that cannot be stopped, the Acute and Emergency Specialist Hospital is where you would be taken or directed to.

The Planned Specialist Hospital

The planned specialist hospital will provide scheduled support and treatments. It will also provide nurse led minor injury services that will offer walk-in access. The following services will be provided:

- Minor injury unit
- Outpatient services
- Therapies
- Diagnostics
- Medical day case
- Rheumatology
- Rehabilitation
- Dermatology
- Endoscopy
- Planned Inpatient Surgery
- Day Case Surgery
- Mid-Wifery led Maternity services

Work will be undertaken with primary care and local GPs to develop minor illness services on this site. For example, if you or a member of your family are requiring treatment for sprains and strains; broken bones; wound infections; minor burns and scalds; minor head injuries; insect and animal bites; minor eye injuries; injuries to the back; shoulder and chest, you will be able to get care at the Planned Specialist Hospital.
**Principles for Both Specialist Hospitals**

Both specialist hospitals will provide high quality care 24 hours a day seven days a week. Care will be integrated and coordinated to optimise continuity of care and ensure that people's holistic needs are met. The core principles of hospital inpatient care will be that:

- Fundamental standards of care will always be met.
- Patient experience will be valued as much as clinical effectiveness.
- Responsibility for each patient's care will be clear and communicated.
- Patients will have effective and timely access to care, including appointments, tests, treatment and moves out of hospital.
- Patients will not move wards unless this is necessary for their clinical care.
- Robust arrangements for transferring of care will be in place.
- Good communication with and about patients will be the norm.
- Care will be designed to facilitate self-care and health promotion.
- Services will be tailored to meet the needs of individual patients, including vulnerable patients.
- All patients will have a care plan that reflects their individual clinical and support needs.
- Staff will be supported to deliver safe, compassionate care, and committed to improving quality.

At both specialist hospitals there will be provision of 24 hour, 7 day, psychiatric liaison services that will support all adults admitted to hospital who have mental health problems. The changes in the shape of hospital services described above will also offer opportunity to consider the optimal alignment of acute inpatient psychiatric services for Calderdale and Kirklees in the context that the current arrangement of psychiatric beds for Kirklees has been acknowledged as interim.

### 6.3 Key Enablers of the Service Proposal

**Putting people in control of their own health and wellbeing needs**

As described in the case for change there is need to ensure engagement and communication with local people so that they can have greater control over what happens to them and their family's health. When developing the proposals, continuing to involving the public and front line staff will be a priority.

**Leadership: Quality Improvement and Staff Development**

Transformation of the system to deliver the service proposals that have been described will require clear and sustained leadership over time. This needs to be underpinned by a shared set of explicit values which are manifest at all levels in the system. These values should include:

- Placing the quality of people's support and care, especially safety, above all other aims.
- Engaging, empowering, and hearing service users, patients and carers throughout the entire system and at all times.
- Fostering whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.
- Embracing transparency to enable accountability, trust, and the growth of knowledge.

All staff will be encouraged to recognise that they have two jobs: to do their job and improve it. This philosophy is based on the idea that the combination of their professional knowledge (specialist knowledge, values, skills, ethics) and improvement knowledge (system, variation, psychology, methodology) will result in increased value for the people and patients that we support. The focus for delivery of this will be on what people want and need, rather than what professionals feel they should have.

To do this we will implement a specific whole system quality improvement approach for Greater Huddersfield and Calderdale that is based on learning from the success of Jonkoping County Council in Sweden. This will include establishing a dedicated quality improvement unit and all staff being provided with specific quality improvement training and development support. This will have a strong focus on clinical leadership, systems thinking, variation, learning based knowledge and change psychology.
**Technology**

Information technology underpins the model and future ways of working. It supports people in self-management as well as self-care, and it allows all staff to be more effective and efficient in the ways that they will work. Information technology is all about information; access at the right time for the right people, and the information being useful.

The way people and staff will access information is through a variety of means; lap tops, tablets, televisions etc. The way the information ‘flows’ will vary but will all be underpinned by some key features; data stored centrally and accessed via the intranet, remote and mobile working with the ability to connect into the data source, applications that are intuitive and allow best use of data.

The model will be underpinned by four technology areas of development; integrated record, Telehealth, Communications and Diagnostics, as well an overall technology infrastructure. To progress these areas it is important to understand what we have now, why it is important to change and what the change will be and how it will be achieved. (note: a list of abbreviations used in the following tables is included in the appendices)

**What we have now**

<table>
<thead>
<tr>
<th></th>
<th>Infrastructure</th>
<th>Integrated Record</th>
<th>Telehealth</th>
<th>Communications</th>
<th>Diagnostics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHFT</strong></td>
<td>Single network provided by the HIS. Some remote working. Limited integration of clinical IT systems across the hospitals.</td>
<td>EPR, S1 in the community. Limited integration with primary care e.g. prescribing</td>
<td>Examples of remote/virtual consultations. Integrated working with other providers and nursing homes.</td>
<td>Cisco Limited real time clinical pathways data and early warning systems.</td>
<td>Full range of diagnostic, not all directly connected to EPR or S1.</td>
</tr>
<tr>
<td><strong>SWYPFT</strong></td>
<td>Single network provided by the HIS. Some remote working</td>
<td>RIO</td>
<td>Telehealth monitoring, health coaching, care navigation, &amp; post hospital discharge Telehealth.</td>
<td>Microsoft Lync</td>
<td>Mental health related diagnostic only</td>
</tr>
<tr>
<td><strong>Locala</strong></td>
<td>Cloud data storage. Fully mobile</td>
<td>Use S1</td>
<td>Limited, relates to LA systems.</td>
<td>Microsoft Lync</td>
<td>Limited access. Some community ultrasound</td>
</tr>
<tr>
<td><strong>Kirklees LA</strong></td>
<td>Single network provided by the KLA. Some remote working &amp; virtual desk top.</td>
<td>Care first Access to S1 &amp; RIO as required</td>
<td>Remote vital signs monitoring. Assistive technology.</td>
<td>Microsoft Lync</td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Calderdale LA</strong></td>
<td>Single network provided by the CLA. Limited remote working.</td>
<td>Bespoke Client Information System. limited sharing of information</td>
<td>Focus on assistive technology</td>
<td>Cisco</td>
<td>Nil</td>
</tr>
</tbody>
</table>

There are some common themes across the providers, all having some sort of system or development in place for the technology areas under consideration. For technology to be a fundamental enabler of the clinical model their on-going development needs to be set on a course that brings together their collective impact; the sum will be greater than the parts.
The following table describes the areas of technology that are being developed as part of the Calderdale & Huddersfield Strategic Review, but that can be accelerated by this strategic outline case and are specific to enabling the care model.

<table>
<thead>
<tr>
<th>Area</th>
<th>Why is the development important?</th>
<th>What will we do?</th>
<th>How will we do it?</th>
<th>How will we know it has been done?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infrastructure</strong></td>
<td>So that there is a single technical infrastructure to support self-care. Access to the same record is essential.</td>
<td>Develop cloud-based technical infrastructure with access via the intranet.</td>
<td>Work with teams and technical colleagues to develop and implement the infrastructure.</td>
<td>Patients can easily access a single record.</td>
</tr>
<tr>
<td><strong>Integrated record</strong></td>
<td>So that patient and all members of the team have access to the same record.</td>
<td>Sharing the existing record and creating a single version for both patient and the team.</td>
<td>Use the current functionality to share the records and implement a solution that integrates the record.</td>
<td>The patient and all members of the team can access the same record.</td>
</tr>
<tr>
<td><strong>Telehealth</strong></td>
<td>To support self-care for patients with a condition that requires ongoing monitoring.</td>
<td>Implement a single communication tool that integrates with any external communication tools.</td>
<td>Integrate solution with the record and assistive technology.</td>
<td>Communication is not a barrier, and information is shared and the patient is fully informed.</td>
</tr>
<tr>
<td><strong>Diagnostics close to home</strong></td>
<td>To support patients by reducing unnecessary visits to acute services.</td>
<td>Have a planned approach to implementing diagnostics that can be close to home.</td>
<td>Develop a plan to implement diagnostics that can be close to home.</td>
<td>A proportion of diagnostics are removed from an acute setting into the community and access is better for patients.</td>
</tr>
</tbody>
</table>
**Risks of Using New Technology**

Risks to using new technology are mitigated by having the correct resource, expertise and structured project approach to implementation and change. Based on the wealth of experience that sits with providers the key risk areas and mitigations would be;

<table>
<thead>
<tr>
<th>Risk area</th>
<th>What the risk is</th>
<th>How it will be mitigated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>• That the quality of care is compromised.</td>
<td>• At each stage there will be a full Quality Impact Assessment. Improving quality will be a core requisite of this development.</td>
</tr>
</tbody>
</table>
| Infrastructure  | • That a single cloud based infrastructure cannot be implemented due to existing IT infrastructures.  
• That a new infrastructure is not safe.  
• That the new infrastructure will not function as planned.  
• Business continuity and resilience | • Full technical assessment of existing infrastructures. Clear transition plan to new solution.  
• Ensure all IG requirements are assessed and met.  
• Full assessment and testing prior to implementation.  
• Business continuity plan will be developed. |
| Training        | • That clinicians and non-clinicians in the teams are not able to use new technology or the full functionality.  
• That patients are not able to use technology. | • Have a comprehensive training plan in place prior to implementation and change.  
• Training for patients is bespoke to their abilities. Work with the 3rd sector to support patients. |
| Communication   | • That implementation and changes are not fully communicated.                    | • Have a comprehensive communication plan in place that includes all stakeholders.      |
| Transformation  | • That change in working practices do not happen.                                | • Invest in the process required that allow change to happen.  
• Hold sessions with clinicians to generate ideas.  
• Implement what we know works.  
• Work with patients and clinicians specifically around how technology supports self-care. |

**Summary**

The use of technology will allow people to self-care in a way that they previously have not been able to. By giving access to all the information that they require as well as the ability to be proactive in their care, self-care becomes easier and the first choice.

By having single methods of communicating as well as a single record of care, clinicians and members of the health and social care system are more able to deliver efficiencies. More importantly the system will be enabled to transform.

There are local, national and international example of technology in health and social care that are tried and tested. These need to be adopted and spread. How technology is used in our everyday lives as well as in industry needs to be assessed and understood and adapted in health and social care where possible.
Persons perspective

- My hospital doctor has one version of my health record. My GP has another & social care have their own version.
- None of them know everything about me.
- I try to look after myself in the best way I can but it’s difficult because I don’t know what others have planned for me.
  - There are times when I would like to speak to my health or social care worker and I can’t, unless it fits with what they are doing.
- I use lots of technology in my everyday life, why not in health?
  - I have access to my own health & social care record.
  - I work with my clinician and carer to co-create my care plan.
  - I understand and have set my goals.
  - I update my health & social care record and know what makes me well and what doesn’t.

Professionals perspective

- I have to send people to hospital for a simple diagnostic test, which are often repeated as the results are not available to other clinicians.
  - I can’t speak to my fellow clinicians or social care colleagues when I need to.
- I only know the care I am involved in not that of my colleagues in the rest of the system.
- There is a shared record, I understand at any time what the care plan is and how the care is coordinated.
- I can coach people to manage their condition, they manage their condition and I intervene when I need to.

- I can get a quick diagnostic test often in the community. The results are accurate and the results are accessible.
7. Examples of What We Are Doing Now

The proposals described in this Strategic Outline Case set a high level of ambition of the changes we can make to improve people's lives and ensure the quality of experience, safety and efficiency of services.

New ways of working such as the use of technology, more support for self-management and self care, better links with voluntary organisations and integrated team working are key to the success of our proposal.

We believe this can be achieved as there are already a number of examples of where we are delivering this new way of working already. We have included real examples of patient stories in this section to illustrate that the proposals are achievable. This Strategic Outline Case will enable these approaches to be spread and systemised across Greater Huddersfield and Calderdale.

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Creative Minds – A service user story
South West Yorkshire Partnership Foundation Trust

I have been in and out of mental health services for 20+ years all that time living with a bipolar and depressive disorder that feels like living in a fog. Recently I found myself involved with them again due to many external factors. I was referred for Psychology support and was informed I’d been placed on a waiting list. I wasn’t able to access other services as I was on the waiting list. By chance, whilst waiting for an initial psychological assessment, I noticed a note about art for wellbeing. Having never drawn and never had the ability to draw what drew me to the note I will never know. I rang the number and spoke to a very nice reassuring voice telling me that I could attend the next session starting beginning of December.

I arrived and did the taster sessions and loved it. I continued to go and each week I felt more confident and was actually excited at going to ‘art’. I had nothing but the support of the Creative Minds and the wonderful tutors and the other students in the group to keep me going through a very tough time in my life.

I was hooked, Instead of taking sleeping tablets, I got my art pad out and sketched when things were on my mind. I was sleeping like I had never slept before. I began to feel ‘reasonable’ and ‘well’ I still attend the group and have sold a couple of my works of art. I attend any meetings I can regarding creative minds to improve the service I am medication free (after 20+years) and doing really well.

I finally feel free of the fog that has blighted my life for so many years. My daughters can all see the difference in me and are so pleased they finally have a mum that isn’t so depressed that I cannot get out of bed or cope with everyday life let alone all the issues that arise within it.
**Telehealth / Care Navigation – A Service User Story**

*South West Yorkshire Partnership Foundation Trust*

I’d never really thought much about my health until last winter. I started feeling really out of breath and it got worse very quickly. I ended up in hospital with heart failure and pneumonia. I thought I was going to die. Because breathing was so difficult, I could hardly do anything for myself and I couldn’t see how I would ever get back to any kind of normal life. I was really scared all of the time. While I was still in hospital, they introduced me to Janet, the heart failure nurse. She set me up with a monitoring machine to use at home.

I use it every morning – it has sensors that can take my temperature and blood pressure, and record my weight. Then it sends the results through to the Care Navigators. They can see if everything is on track. The monitor also asks you lots of questions about your health and depending on what your answers are, it might give you some advice on things like diet, or how much water you should be drinking. I understand a lot more about heart failure now and it’s made me feel more confident about coping with it myself.

I sometimes have a bit of a blip – my weight might go up or my blood pressure might be a bit high. When that happens, the local Care Navigators give me a call straight away. They are nurses too. They tell me what I need to do. That might be getting my diet back on track or drinking a bit more water. But then a few months after I’d been discharged, they spotted one morning that my temperature had gone up a bit. I have to admit, I did feel a bit chesty. They told me to go and see my GP. He gave me some antibiotics to nip the chest infection in the bud. If we hadn’t done that, I would probably have ended up back in hospital.

The Care Navigators can be quite clever about how they give the advice – they talk to you and ask questions that make you want to change things for the better. I don’t think I would have managed to lose weight without them motivating me. I certainly would have been too scared to go out and start walking. I make sure I get out for a walk most days now.

It’s a funny thing – Janet doesn’t actually need to come and see me that often, but I feel really well looked after. My wife, Barbara feels much more at ease as well as there is always someone at the end of a phone to give her some advice. I don’t need to see my GP that often either – only when I really need to. So even though I’m getting support every day, I’m actually using the health service a lot less.

Every so often, they ask me to answer some questions about how well I understand my heart problems and how well I feel I’m coping. They don’t seem to take things for granted. I don’t know what I would have done if I hadn’t had the kind of support they are giving me.

**Recovery College – A student story**

*South West Yorkshire Partnership Foundation Trust*

Allison had a series of things which happened in her life which included childhood issues followed by several bereavements. This culminated in her admission in 2008 to a Psychiatric ward which she describes as the lowest point in her life. Through taking control of her future and the support of a mental health nurse she has gradually rebuilt her life including attending college and gaining additional qualifications.

The Exchange is the newly developed Recovery College in Barnsley which first began running courses in September 2013. Allison volunteers at the college and in the first term she co-produced, facilitated and delivered a full course on depression. Allison was able to explain depression from the perspective of knowing what it really feels like which means that she has been able to offer insights to the students who enrolled for the course that they found invaluable. She describes herself as “not having recovered from depression and anxiety but now knowing how to live with it.”
Following this course Allison has taken overall responsibility for running the Depression Support Group. She is also working with others to develop a course on food and mood that will be delivered to students at the college. It will be added to a revised version of the prospectus for The Exchange in a future term.

When asked about what she thinks the Recovery College gives to people Allison said “I think it shows people that they can still achieve great things and therefore gives them hope for the future, it helps people to take individual responsibility for and therefore move on with their lives.”

Allison says that her experience at The Exchange means that she now feels more of a person and has a goal to work towards. She is now clear that she wants to get a job which uses her experience, knowledge and skills.

Microsoft Lync – A service user’s story

Locala Community Partnerships

A Healthcare Assistant (HCA) visited Mr G to discuss his wound care. During the visit to get advice from a senior nurse, the HCA was able to use her laptop computer to start a Lync conversation with a Community Matron. This enabled a three way video conversation between the HCA, Mr G and the Community Matron to discuss care of Mr G’s wound. Everyone could see Mr G’s care plan on the laptop screen and the HCA was able to point the camera at Mr G’s wound so the Community Matron could see it and offer advice on the appropriate wound care needed. Following the video conversation new wound care medication was ordered using electronic prescribing. Mr G was able to obtain expert and timely advice in his own home and was supported so he understands how to manage his wound. With the support of the Community Matron, through the video conversation, the HCA was able to answer his questions.

Microsoft Lync – A Service User’s Story

Locala Community Partnerships

Mrs F had been discharged from hospital and to support her recovery she needed some adaptations to her home. An Occupational Therapist (OT) visited Mrs F to assess what was needed and would be best suited for her home. The OT saw that some adaptations were required and she was able to use Microsoft Lync to send an instant message to one of her colleagues to see what equipment was available. Her colleague responded and a video conference commenced. The OT could use the camera on the laptop so her colleague could see the layout of Mrs F’s home and then select the appropriate equipment from the online equipment store catalogue and arrange for installation. The use of Lync allowed a quick and efficient communication and prevented a referral for another home visit. This was much quicker and convenient for Mrs F, who was very pleased.
Community Care Teams – a service user’s story
Locala Community Partnerships

Mrs G is a frail and elderly patient and lives alone. She was visited by her Community Matron on a Friday afternoon. Unfortunately Mrs G was unwell with a raised blood pressure and she was dehydrated. The Community Matron thought she was on verge of having no option but to request an admission to hospital. However, because the Community Matron is part of the Community Care Team she was able to communicate with the GP immediately and between them they decided to adjust Mrs G’s medication. She then briefed district nursing, part of the community care team, who were working over the weekend and the (social) homecare provider, who agreed to provide additional support over the weekend with the support of the district nurses if they were worried. By supporting the homecare provider carers with the health back up of the district nursing team a hospital admission was prevented. Communication through the team was quick and efficient through using technology.

Community Care Teams – A Service User’s Story
Locala Community Partnerships

Mrs N had a complex medical history, which was putting a strain on her and her husband’s relationship. Following her discharge from hospital this strain was causing Mr N to behave aggressively to the district nursing team who were visiting Mrs N daily. This meant the district nurses were visiting in pairs. The Local Authority Health Trainer, who was working closely with the district nurses as part of the Community Care Team agreed to provide some psychological support to Mr and Mrs N along with teaching some coping mechanisms. This significantly improved stress levels within the home and as a result district nurses no longer needed to visit in pairs.

Telemonitoring – Service user experience
Calderdale and Huddersfield Foundation Trust

Gerald, 71 has been using telemonitoring to help him manage his Chronic Obstructive Pulmonary Disease (COPD). Gerald says ‘with a condition like mine you do worry, and telemonitoring gives you the confidence. Some mornings I wake up feeling rough and I do my readings and it tells me whether I need to contact my nurse or if I am ok. Before I would have rung the doctors anyway, so it saves time for them and it puts my mind at rest. If I am ill I don’t panic now, because I know it will be nipped in the bud and it keeps me out of hospital. It’s really reassuring for me and my wife, like a pair of arms round you’.

Jayne the specialist nurse says ‘I’ve found it good for anxiety. They can see for themselves how their oxygen levels are so that gives them reassurance and it’s helping to teach self-management’.

Bev, the specialist nurse says ‘Telemonitoring is working well for some patients, for example for people coming out of hospital. It’s enabling me to keep a close eye on their oxygen levels and see things improving. Also for some patients who had frequent visits to hospital largely due to anxiety, telemonitoring has meant they can see their symptoms for themselves and if these look stable they have confidence to stay at home whereas before they would have dialled 999’.
Intermediate Care – Mrs Brown’s experience

Calderdale and Huddersfield Foundation Trust

Mrs Brown was experiencing discomfort, had a temperature and had hip pain. Her GP came out, diagnosed a urine infection and prescribed antibiotics and pain killers for Mrs Brown’s hip pain. The GP felt that Mrs Brown did not require emergency hospital admission but would benefit from a period of rehabilitation. The GP rang Gateway to Care requesting an assessment for Mrs Brown. They arranged for an assessment by a nurse with our Crisis Intervention Team. Within two hours of the GP telephone referral, a Crisis Intervention Team Nurse-Susan, assessed Mrs Brown at her home with her family present. Following this assessment Mrs Brown was admitted to an intermediate care bed.

Once there, with Mrs Brown and her family, the Occupational Therapist agreed a plan for the staff to support Mrs Brown’s personal care and kitchen activities; the Physiotherapist completed exercise plans for Mrs Brown to follow, supported by a rehab assistant on a daily basis and Mrs Brown had a home visit with the Occupational Therapist. This identified that some equipment would be needed to support discharge, help assist function, independence and to help prevent future falls. This included the use of telecare equipment e.g. falls detectors.

Mrs Brown responded well to rehabilitation and went home with a package of care. She gained confidence in her abilities and was delighted to be able to go back to her own home, rather than needing to move to 24 hour care. Mrs Brown’s sons were pleased that she was home and happy, they too were confident that the right level of support was available to her to enable her to stay there. Admission into Intermediate Care has avoided unnecessary admission to hospital for Mrs Brown.

Myra’s story – The Kirklees Gateway Workers

Kirklees MC

Myra is a 48 year old woman with learning disabilities. Myra was recently made redundant from full time employment and after struggling with the benefits system became depressed. A Gateway Worker was introduced to Myra by the Kirklees Neighbourhood Housing community wardens. They were concerned about her behaviour and mental health after losing her main and only carer a few months ago.

Myra agreed to a Gateway Worker visit and explained how she felt the benefit system had let her down – she felt frustrated, confused and alone. She was anxious around money issues. She lost her tenancy and wasn’t receiving any income. Myra’s Gateway Worker supported her by phoning Job Centre Plus and referred her to the Kirklees Community Benefits Team. Myra was on antidepressants and the worker encouraged her to review the medication with her doctor. This was reviewed and changed for her. Myra continued to get regular support from the church. The Gateway Worker also referred Myra to a Volunteer Co-ordinator to put the wheels in motion for a volunteering role.

Myra called to explain how much she had enjoyed her time volunteering at a luncheon club and was looking forward to having more opportunities. She confirmed that she was now receiving the benefits she was entitled to and thanked the worker for the support she had received. Myra has now got experience in her chosen field of employment and is available for work.
Susan’s story – The Kirklees Gateway Workers

Susan, 56 years is recovering from major brain surgery after having a large tumour removed, nearly a ¼ of her brain removed. She is now living with her daughter Helen who works full time but they both feel that she has not recovered enough to live independently as she had, prior to the operation. Susan had coped well with the operation and battled hard to recover to this stage, making slow but steady progress. She was feeling isolated, alone, she was being treated for depression and had a long path to go down to achieve all she wanted to achieve but could see the light at the end of the tunnel.

Debbie the Gateway Worker assigned visited Helen at home and began to look at other support she could access and things of interest that Susan could choose from to help her to feel less isolated and support her healing. Although very low in confidence she looked at her options and decided to try a number of services. Firstly she asked Debbie to put her in touch with a Health Trainer as she felt some gentle exercises would be a good start. The Health Trainer also suggests CBT and Helen felt this was useful and enabled her to move forward with Debbie to access a whole host of other services. These included The Barton Unit, Support 2 Recovery, PAL's & Accessbus.

Susan is grateful for the help and support provided by the Gateway Worker Service and now says “I feel there is hope”.

Christine’s story – The Shopmobility Service

Christine is a regular user of the Shopmobility service, and has been since August 2006. She has used the service at Gateway to Care close to 200 times.

Christine has always found it to be a “pleasant experience to collect her scooter” because everyone at Shopmobility is so “friendly - with no task being too much trouble”. Christine has always felt that the Shopmobility staff members “really care about any problem you have”.

Christine comes into Huddersfield every Thursday to meet her sister, niece and cousin for lunch. She is then able to enjoy travelling around town with her family to look at all the different shops and says that her pleasant experiences in town would be impossible without our service.

“I have fibrosis in both lungs and cannot walk very far before becoming breathless”

Christine says that she is able to spend a much longer time in town whilst using a Shopmobility scooter, and that there are quite a lot of shops that she simply would not be able to access without it.

Christine absolutely loves being able to have a scooter every week. She finds everyone “so pleasant” and every second she spends in town you can’t help but notice the huge smile on her face!
Case Study 3 – Neighbourhood Support
Calderdale MC

Audrey is aged 75. Audrey was a full-time carer for her husband Brian. Brian had cancer, and was fed through a tube on a daily basis, making it difficult to go out.

Audrey and Brian spotted a poster for a local Neighbourhood Scheme meeting and thought they’d give it a go. They tried things they had never done before such as Tai Chi, Brian tried painting whilst Audrey enjoyed the crafty club. Audrey remembered “it gave us something different to talk about and things to do separately which was what we needed”.

After Brian died in January this year, Audrey continued to attend crafty club and other social activities, and by the summer had joined the Neighbourhood Scheme committee meetings. Audrey has been very glad to have the local group in her life at such a difficult time and says it gives her things to look forward to. Audrey feels that her voice is heard within the group and she knows she can get involved on any level, but she is taking things one step at a time. Without Brian there to drive, other people in the group are starting to offer her which Audrey finds invaluable, keeping her connected to friends and giving her vital social contact.

Case Study 4 – Stroke Recovery
Calderdale MC

John had a stroke which has affected his memory and his mobility.

John is an ‘outdoors’ person. He did not want to attend a traditional day service or to be helped in his home, but to be able to continue with his long-time activity of enjoying country walking. John needs support to do this, as due to short-term memory problems he is at risk of becoming disoriented to his surroundings. John has previously fallen while out walking with his dog.

John chose to take control over support needs through taking his personal budget as a Direct Payment. With his DP John arranged for a support worker from Scope Aspire Services to accompany him on his walks. The benefits of this are providing respite for his partner, but also provide valuable reminiscence for John as he visits places from his past. Scope matched John with a support worker with a similar background and interests to John and who is familiar with stroke recovery. John values the support and friendship he gets from his support worker. John has also found that his memory is improving as a direct result of this support.

Case Study 5 – Assistive Technology
Calderdale MC

Kenneth had become confused as the result of an infection. He kept getting out of bed through the night and was falling regularly as his mobility had become poor. He lived with his wife Margaret, who was constantly tired, not sleeping, constantly listening for him moving around.

Their daughter Jean contacted Gateway to Care who directed her to telecare. A worker went to the house to meet Margaret and Jean to establish the issues. A bed sensor was installed, linked to care assist, so that if Kenneth got up through the night Margaret was alerted so she could get up too, check that he was all right, and help him back to bed without him falling.

Once the infection was under control, his mobility improved and he got up less through the night. At this point the family asked for the equipment to be removed but they know what help could be available if they need it in the future.
8. Impact Assessment of the proposal

This section of the Strategic Outline Case describes the impact of the proposals on: service users; on whole system economic viability; on social capital, and; on partner organisations strategies for Greater Huddersfield and Calderdale. Dependent on local and national approval it is intended that significant elements of the proposals described in this strategic outline case will be implemented within 2 years from approval, with full implementation in 5 years, and whole system benefits optimisation within 10 years.

8.1 Impact on Quality for Service Users

The proposals in this Strategic Outline Case will deliver significant benefit for service users. There will be the need to undertake a full Equality Impact Assessment. Subject to support for this Strategic Outline Case the Equality Impact Assessment will be undertaken as part of the next steps to develop an Outline Business Case, this will be informed by wider public and stakeholder engagement and consultation. A summary of the key impacts on quality for service users that the proposals will deliver are summarised below:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>• There will be specialist services available to support you in your own home or close to home so that you do not need to be admitted to hospital.</td>
</tr>
<tr>
<td></td>
<td>• If you or your family have a life threatening illness or accident you will be sure that all the support and expertise you need is available on the same site as the A&amp;E and you will not need to be transferred between hospitals. This will improve your chances of survival and a good recovery.</td>
</tr>
<tr>
<td></td>
<td>• If you are admitted to hospital the services will be organised around you and you will not need to move wards. Senior doctors will be available 7 days a week and specialist care will come to you.</td>
</tr>
<tr>
<td></td>
<td>• You will be able to go home from hospital as soon as possible with the support you need in the community available 7 days a week.</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>• We will help you and your family to take control of your health and where possible support you to make decisions to manage your own care. This will help you to stay as well as possible and improve your quality of life.</td>
</tr>
<tr>
<td></td>
<td>• We will ensure support and care is integrated around you and that there are no gaps in care. For example people living in a nursing home will not need to be admitted to hospital at end of life; people with mental health problems will have better support for their physical health needs; people with asthma or diabetes are less likely to need to be admitted to hospital to receive the care they need.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>• We will use technology to make your experience of care more efficient and convenient. For example you may not need to take time off work or make a difficult journey to hospital to get advice and support. We can use technology such as telehealth and skype to communicate.</td>
</tr>
<tr>
<td></td>
<td>• You will only need to tell your story once and we will have integrated records – so the professionals providing you with support will always have the most up to date information wherever they see you.</td>
</tr>
<tr>
<td></td>
<td>• Your operations and appointment are less likely to be cancelled as we will be able to more effectively manage emergency and planned care demands.</td>
</tr>
<tr>
<td>More Timely</td>
<td>• You will be able to access and benefit from specialist support and care 7 days a week both in the community and in hospital.</td>
</tr>
<tr>
<td></td>
<td>• You will be able to use technology to make accessing care more convenient.</td>
</tr>
<tr>
<td>More Choice &amp; Control</td>
<td>• You will have the information and support you need so you can choose the care that will meet your needs.</td>
</tr>
<tr>
<td></td>
<td>• You will be offered a personal budget that you can use on the things that will most help you.</td>
</tr>
<tr>
<td></td>
<td>• Care will be available close to home helping you to stay in control and do the things important in your life like supporting your family and going to work.</td>
</tr>
<tr>
<td></td>
<td>• The support provided will be not just medical or nursing but will focus on assisting you to live well in your community for example being able to shop again, reconnect with friends and rebuild social networks.</td>
</tr>
</tbody>
</table>
8.2 Outline Economic Modelling of the Case

The purpose of this section is to:
- Make the link between this Strategic Outline Case and the economic model and financial case as described in the Outline Business Case for the Greater Huddersfield and Calderdale Strategic Review Programme (May 2013).
- Outline the key financial assumptions which underpin the proposed service model in the Strategic Outline Case and the opportunity for system savings based on a review of the current evidence.
- Identify the key enablers.
- Provide a summary analysis of financial risk.

The aim of the economic model in this Strategic Outline Case is to support the achievement of better health value for patients by:
- Providing integrated health and social care services in the community which support a model of care which can maintain people at home and ensure secondary care admission is a last resort.
- Putting people in control of their own health and well-being by promoting self-care.
- Ensuring all parts of the service model can demonstrate improved productivity and maximise efficiencies.
- Reducing the demand and investment in specialist secondary care.

**Summary of the financial case in the Strategic Review Business Case**

The Greater Huddersfield and Calderdale Strategic Review identified a total savings requirement for both commissioners and providers of £163m over 5 years. This was based on the following analysis:

- The total resources across the Health and Social Care economy based on 2013-14 plan is £647m; of which £353m (55%) is currently commissioned with CHFT, Locala and mental health services the largest of which is SWYPFT The remainder is split £113m spend with Local Authorities and £181m with other providers.
- The level of financial challenge over the next 5 years is described in two ways: firstly the level of internal efficiency requirement within providers of £120m; and secondly a financial estimate of the impact of demographics of £43m for the whole of the health and social care spend of £647m.
- The total financial challenge was therefore described as £163m, £120m generated by the efficiency programmes of providers; and £43m which commissioners would need to identify either a productivity gain or a real saving from existing provision to be reinvested in services to meet demographic pressures.
- The impact of demographics was mapped by a report commissioned by Greater Huddersfield CCG, Calderdale CCG and Calderdale & Huddersfield NHS Foundation Trust. The modelling undertaken has shown that over the next 5 years growth will be seen as follows: 5% 0-19 year olds, 1% 20-64 year olds and 13% 65+ (taken from Office of National Statistics 2010 sub-national population projections for both localities). The greatest demographic pressure is within the elderly population (as seen below), this fits with the national trend of a disproportionate increase in over 65 age group when compared to others age groups; and a higher resource utilisation per head due to complexity and need.

**Table 2**

<table>
<thead>
<tr>
<th></th>
<th>Opening £m</th>
<th>Growth 5 Years</th>
<th>Closing £m</th>
<th>Change £m</th>
<th>Local NHS Providers £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>65</td>
<td>5%</td>
<td>68</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>20-64</td>
<td>296</td>
<td>1%</td>
<td>299</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>65+</td>
<td>286</td>
<td>13%</td>
<td>323</td>
<td>37</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>647</td>
<td></td>
<td>690</td>
<td>43</td>
<td>23.2</td>
</tr>
</tbody>
</table>
Key Financial assumptions to support the proposed service model

The objectives of the proposed service model are to:
- Reduce the number of secondary care beds, in an acute and mental health setting, by improving internal efficiency and providing alternative provision in the community.
- Improve the efficiency and productivity of community services by having an integrated provider service based on community localities.
- Reduce the overall reliance on statutory services through the promotion of alternative capacity and models of self-care.

The key sources of evidence and analysis that have been used to develop this economic model are:
- Health and Social Care Strategic Review: Data Analysis and Modelling, 2012.
- Closing the NHS Funding Gap: How to Get Better Value Health Care for Patients, Monitor, 2013.

Clinical evidence and analysis shows that by supporting people to self-care and providing care closer to home in fully integrated health and social care locality teams can create a reduction in attendances at A&E, outpatient attendances, emergency admissions and readmissions, and length of stay; as well as provide significant quality benefits.

For the savings to be achieved, an upfront investment in out of hospital resources will be required to support this. No assumption has been made in the current modelling where any re-investment of resources will be required on the basis that an increasing focus on self care may require alternative types of provision and workforce. The focus and timing of re-investment will be considered in more detail in the next stage of development of the business case.

The financial model was produced to assess the benefits and costs of delivering better coordinated care and a focus on more out of hospital care, as follows:
- Baseline data was produced for the impacted target areas, including activity, bed days and resultant bed requirement.
- Demographic growth was overlaid based upon the Office of National Statistics 2010 sub-national population projections for the local area.
- An assessment was made using national research and analysis, and better care better value indicators to highlight efficiency opportunities; with savings identified using current acute tariff and assuming they are releasable.
- An assessment was made about the level of out of hospital service provision required in order to deliver the potential efficiencies.

Summary of Cost Benefit Evaluation of proposed Service Model

A summary of the productivity and efficiency savings from outline economic model is shown below:

Table 3

<table>
<thead>
<tr>
<th>Service Change</th>
<th>Net Saving Opportunity £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Reduce hospitalisation and improve acute service efficiency</td>
<td>33</td>
</tr>
<tr>
<td>2) Improve efficiency of community services</td>
<td>24</td>
</tr>
<tr>
<td>3) Enable more people to self-care</td>
<td>17</td>
</tr>
<tr>
<td>Sub Total Savings</td>
<td>74</td>
</tr>
<tr>
<td>4) Invest to enable changes</td>
<td>(24)</td>
</tr>
<tr>
<td>Total Saving</td>
<td>50</td>
</tr>
</tbody>
</table>
The rationale is based upon:

- There is opportunity to reduce hospitalisation and improve efficiency in the use of hospital services by delivering community-based integrated support for people with long term conditions and by applying efficient working in the hospital. Analysis of this has identified the opportunity to reduce the value of hospital services required by £31m. This is achieved through reduction in length of stay, admission avoidance and reduction in outpatient activity by delivering the upper quartile performance against Better Care, Better Value Indicators and using current acute tariff assumptions. This represents approximately 10% saving on acute secondary care; if we apply the same assumption to Mental Health inpatient provision this would equate to approximately £2m.

- There is scope to improve the efficiency of community based services e.g. through service improvement approaches and optimising the use of technology. The assumption is that a 30% gain in productivity on a community health based budget of circa £79m could deliver £24m savings. (Monitor, Digital First)

- More people can be supported to self-care and manage their condition reducing demand for services. It is reported that savings of £1,800 per person with a Long Term Condition is achievable. If approximately 30% of Calderdale and Huddersfield population have a Long Term Condition this is 137,400 people (Population for Greater Huddersfield is 245,000 and Calderdale 213,000 giving a combined population of 458,000). If 7% of these people successfully self-care this equates to 9,600 people and a saving of £17m (Monitor, Expert Patients Programme).

- To achieve the above changes will require an investment in the capacity and capability of integrated community and self-care support. We have estimated that the equivalent of 70% of the cost saving from hospital utilisation (£33m) will be cash releasing and be reinvested in alternative community provision i.e. £24m. This assumption is based upon evidence gathered from other Trusts (e.g. Sandwell & West Birmingham, Bristol).

- The total net recurrent saving (after investment) is £50m.

- The gross saving opportunity through productivity and redesign is £74m (table 3) compared to an £85m theoretical target derived from applying Monitor planning assumptions of 5% efficiency.

- The gross efficiency saving does not identify the relative contribution of cash releasing and non-cash releasing.

Key Enablers

The savings opportunity outlined above is based on a high level analysis of the current resources for the three providers and applying the impact of redesign using the published evidence available. There are a number of key enablers for change, some of which will require additional investment which are outlined below:

- Workforce - realignment of the current workforce to the revised model will impact on the number of people employed. Given 70% of costs currently relate to pay in order to achieve the level of savings required the overall paybill will need to reduce which will potentially generate non-recurrent additional costs of restructuring.

- Use of technology - the overall efficiency of the model is reliant on the use of technology to improve sharing of information and provide alternative access to information and services by innovative use of technology. This requirement is consistent with the work being undertaken by the digitisation programme within the Calderdale and Greater Huddersfield Transformation programme.

- Estate - The model represents a significant shift of clinical work to community settings and to self care which will have a major impact on the design of estate for hospital services and the utilisation of community assets across the strategic partnership.

- Finance - The modelling has not made any assumptions about the impact of changes to CCG allocation or local authority savings targets set centrally. The implementation of this level of service change will require a plan for managing transition, including short term double running costs. This will require a risk and benefits framework to manage financial and service risk.
Estate Implications for the Hospital Sites

The proposed transformed service will have an impact upon the estate requirement moving forward, as more people are supported to self-care and care is moved closer to home. The modelling carried out in order to arrive at the productivity and efficiency savings demonstrated the below revised bed base if the efficiency savings were to be achieved.

<table>
<thead>
<tr>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base line</td>
</tr>
<tr>
<td>Demography 1-5</td>
</tr>
<tr>
<td>Demography 6-10</td>
</tr>
<tr>
<td>Reduce hospitalisation and improve acute service efficiency</td>
</tr>
<tr>
<td>Community Reprovision</td>
</tr>
<tr>
<td>Mid Yorkshire</td>
</tr>
<tr>
<td>Closing Position</td>
</tr>
</tbody>
</table>

The bed requirement is flexed up and down during the course of the year to cover pressures in the system at different times of the year. The baseline bed base used is derived from beds that are opened to cover both core capacity and flexible capacity. It includes; general and acute, rehab and maternity beds, as well as additional capacity required to cover service pressures and winter pressures (taken as the 12/13 average additional winter capacity). It excludes cots.

The revised bed base includes anticipated activity shift due to proposals within Mid Yorkshire NHS Foundation Trust. Whilst this is not part of the Calderdale and Huddersfield footprint it needs to be recognised in order to calculate the size of the acute estate moving forward.

Modelling undertaken has demonstrated that the above 736 bed base would be split as 649 beds on an unplanned site and 87 beds on a planned site.

There would need to be significant capital investment to transform the estate footprint across Calderdale and Huddersfield so that it can meet the proposed service provision. Preliminary work has shown this could be in the region of £150m required for the acute estate.

Affordability

The Strategic Outline case has identified a set of key assumptions using the current evidence base, could deliver a radical system re-design of care and treatment which is transformational; maintains safe and effective services; and is financially sustainable. The model proposed will require additional analysis in order to progress beyond a strategic outline case to the next stage. This will include more detailed work on profile of savings over a 5 year period; the profile and quantum of re investment including costs of digitisation, workforce reprofiling and estate management. In summary this means that the outline case has presented the potential “opportunity” of system re-design but has not tested the financial affordability. This work would be undertaken in the next stage subject to approval by commissioners; recognising that it not in the interest of any parties to the joint work to pursue options which are not affordable.
Key Risks and Issues

As the service model is being developed, there are a number of key risks that have been identified and will need to be proactively managed:

Key financial risks
- Service proposal does not achieve the projected savings which are forecast using the evidence base
- Strategic outline case proposal is rejected by partners and commissioners
- Pace of change required to maintain overall viability of the health and social care system is faster than changes can be delivered in practice.
- Savings identified are using current acute tariff income assumptions; however releasing income at tariff does not mean providers can remove a corresponding level of cost.
- There will be an element of double running costs during the implementation of changes where there will be a requirement to fund both "old" and "new" services whilst the services are being configured and set up. This may raise affordability issues in the short term.
- The costs of implementation will be significant with issues around affordability; such as capital costs for IT and estate modernisation, and workforce restructuring costs.
- There may be risk of double counting of costs and benefits.
- Providers must ensure that they have sufficient working capital to meet their financial obligations. This means that they need to maintain a certain cash balance and level of operational performance to remain financially viable. Therefore the timing of any reconfiguration will need to be carefully monitored.
- Central changes to CCG allocation and Local Authority targets may impact on the affordability of change proposals.

Mitigation
- Agree a risk sharing framework between providers and commissioners.
- Agree work programme and prioritisation of detailed analysis to support production of more detailed implementation plan to test the validity and feasibility of delivering the financial assumptions outlined above.

Conclusion

In summary the section above has demonstrated the following:
- The financial impact of the service model proposed is consistent with the financial assumptions with the Monitor Planning guidance;
- Calculation of economic benefit is based on detailed modelling or published evidence base;
- The service model savings meet the level of challenge set out in the economic and financial case within the Greater Huddersfield and Calderdale Strategic review outline business case;
- The service model provides for a level of reinvestment in alternative community provision and has the potential to generate sufficient savings which can be utilised as a productivity gain to absorb the increase in demand predicted due to demographics.
8.3 Impact of the Strategic Outline Case on Social Capital

The Marmot Review ‘Fair Society Healthy Lives’ 2010 clarified the importance of all local services working together to address the social determinants of health, as part of an effective and efficient response to the complex inter-related needs of our communities. This is entirely consistent with the person centred approach which underpins this Strategic Outline Case.

The NHS Confederation describes social value as ‘the social benefits achieved from public services, and considers more than just the financial transaction and includes wellbeing, health, inclusion and employment’.

The services described in this Strategic Outline Case will act on the wider determinants of health through the partnerships they forge and the approaches adopted to enable self care. This co-produced and bottom up approach lends itself to adding social value. A key enabler for this will be workforce change. By increasing the use of coaching, peer support, and navigation by third sector partners we will have the opportunity to capitalise on the social value that exists in communities. Locality teams will also forge links with the social housing, learning and leisure sectors to support them in contributing to an integrated approach to wellbeing.

By working differently to provide more care locally, we will enable more people to continue with their normal lives, roles and responsibilities, which in turn will offer greater value to the economy as a whole.

A key aspect of the approach will be to enable more person-led initiatives that help people to participate meaningfully in their communities. Examples of this are already in action and provide useful pathfinders for the future.

For example one of the Creative Minds initiatives which has been developed by third sector organisation Support 2 Recovery with the help of SWYPFT and funding from local CCGs is an art group and gallery within the Packhorse Centre in Huddersfield. This has provided therapeutic social activity for people owning their own recovery from mental ill health and also has wider social benefit in terms of participation and economic activity in the town centre. Direct sales of art works have contributed to the local economy but perhaps more crucially this initiative builds social capital and parity of esteem.  http://www.southwestyorkshire.nhs.uk/quality-innovation/creative-minds/project-directory/the-art-shop/

In addition we will ‘think local’ in areas such as procurement to play an important role in the economic regeneration of our communities. This could include supporting the burgeoning local new-media industries in developing ways of communicating and involving people in taking ownership of their health and wellbeing.

To achieve these broader impacts on social value the economic case of this Strategic Outline Case describes the level of reinvestment required in the capacity and capability of integrated community and self-care support. We have estimated that 70% of the cost saving from hospital utilisation (£33m) will need to be reinvested which is £24m. This reinvestment will cover a range of alternative provision, not just statutory services.

We have engaged with Huddersfield University Business School to help evaluate the implementation of the Innovation Compass which provides a balanced scorecard to promote the conditions necessary within our services for the development of person centred approaches. The local University is a key driver of economic regeneration, and as such this partnership offers a unique opportunity to learn together and add local social value. This partnership could for example include the evaluation of the social return on investment achieved through the proposed model.

8.4 Impact of the Strategic Outline Case on Partners and Stakeholders

Throughout the development of the Strategic Outline Case we have remained cognisant of the strategic direction of the Clinical Commissioning Groups described through their commissioning intentions, and also the priorities of the local Health and Wellbeing Boards described through their joint Health and Wellbeing Strategies (JHWS). Here we described how the proposal is aligned with the priorities of each of these four very important strategic contexts and therefore the impact on the delivery of these agreed priorities.
Alignment with Calderdale JHWS

Calderdale Health and Wellbeing Board strategy has identified 6 priority outcomes. These are that Calderdale is a place:
- Where people have good health
- With a balanced and dynamic local economy
- Where children and young people are ready for learning and ready for life
- Where fewer children under the age of 5 live in, and are born into, poverty
- Where older people live fulfilling and independent lives
- Where everyone has a sense of pride and belonging based on mutual respect

Good health - There are success measures linked to each priority. Calderdale JHWS calls for a major integrated programme to improve healthy lifestyles and make Calderdale a place where more people enjoy being active, based on the format of “Active Calderdale”, developing a brand and profile, which encourages people of all ages to develop a more active lifestyle. The emphasis on self care in this model will support this priority. Developing a service model that promotes good health is a key feature of the Strategic Outline Case.

Balanced and dynamic local economy - The JHWS also call for investment in local businesses and a buy locally campaign. Whilst not directly linked, organisations are aware that a change in service model has the potential to affect employment in the district. As a conscientious local employer all partners will work to ensure that no district is disadvantaged through the changes.

Children and young people - One of the four workstreams of the Strategic Review has focused on children’s services. We will maintain this focus ensuring services are integrated around the child and transition to adult services are appropriate through the adolescent years.

Older people - Much of this strategic outline case is prepared to respond to the aging population identified in the JHWS. Through the changes outlined we will be in a better place to ensure older people are supported to remain in control of their lives and stay comfortable in their own homes for as long as they want. Also there will be support for all people living with chronic long-term conditions to manage their condition from home.

Pride and belonging based on mutual respect - Through engagement with the public and other stakeholders on the content of this Strategic Outline Case we will work to ensure that all stakeholders feel proud of the health and social care economy we develop for the future, and that the services offered demonstrate our respect for the local population, irrespective of age, gender, sexual orientation, religion or race.

Alignment with Kirklees JHWS

The Kirklees Health and Wellbeing (HWB) Board have developed a Joint Health and Wellbeing Strategy (JHWS). This is used to support planning and decision making at the HWB Board and the CCGs. The JHWS vision is that by 2020:

No matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality.

The 2010 JSNA informed the development of the current Kirklees JHWS in drawing out 4 key areas for development and action. They are:
- Emotional health and wellbeing
- Food and nutrition
- Alcohol
- Learning and skill across the life course
Emotional health and wellbeing - Emotional wellbeing helps us all cope with life’s challenges. The JSNA emphasises this as the recurring theme behind many local issues as well as varying widely between groups of people. With the increased focus on supported self-care emotional wellbeing becomes even more important. In the Strategic Outline Case we propose that provision of physical and mental health and social care is integrated through the locality team. This multi-disciplinary team will support people in all aspects of their health care in a unified manner.

Food and nutrition – An integrated care approach will enable us to support people in all aspects of their care, including food and nutrition. It will also allow us to identify early any problem areas as agencies work together in a more integrated way.

Alcohol - Partnership working to reduce alcohol related consequences across Kirklees needs to expand further in using a whole population approach of increasing self-perception of levels of alcohol really drunk, strengthening earlier intervention and prevention, tackling alcohol related anti-social behaviour and domestic abuse. This integrated, locality model of service delivery, with good access to supported self care, will support this priority.

Learning and skills across the life course – The JHWS describes the importance of enabling everyone, especially carers and those with health issues, to develop the motivation and skills to manage their own health and wellbeing. This is a key strand of the Strategic Outline Case. Also we aim to develop our own workforce to change their approach to care provision, where the professional’s role becomes a partnership role, empowering the patient and their family, as well as providing health care.

Alignment with Calderdale CCG commissioning intentions and Greater Huddersfield CCG commissioning intentions

The CCGs identified the importance of effective partnership working and the opportunities to work in collaboration to improve local health outcomes. This Strategic Outline Case is continuing the work of the Health and Social Care Strategic Review in its commitment to this objective.

The Better Care Fund is identified as one such area where partnership working across the health and social care system will be required. Proposals in this Strategic Outline Case are developed in line with the objectives of the Better Care Fund.

Integrated community services is identified as a key enabler to reducing preventable death and inequalities in health. In the short term, the development of specialist community nursing and local frailty services are key contributors to moving towards a truly integrated system.

A high quality, urgent care system is described as a priority and schemes such as RAID, Quest for Quality and End of Life are positive contributors to this vision. This Strategic Outline Case builds significantly on this priority.

The growth in demand for elective secondary care services is identified. The Strategic Outline Case Identifies creating a more efficient service for patients and more outreach to primary care.

Improvements in technology can support and enhance the quality of care provided. Amongst a broad range of priorities, there is value to patients in working towards a shared electronic patient record locally. We also see technology playing an important role in supporting redesign of the clinical workforce against an expected backdrop of future shortages in key clinical roles. This is a key transformational area where we can drive improvements across the local health economy in understanding and delivering significant benefits to patients.
Alignment with Health and Social Care Strategic Review (HSCSR)

The seven organisations who commission and deliver the majority of health and social care services in Calderdale and Halifax have been working together to undertake a Strategic Review of Health and Social Care.

Delivery of a ‘best in class’ health and social care system requires us to build capacity in our communities, integrate services and industrialise the use of technology to transform the way we care for, and support people. This transformational change will only be achieved with the active support of our stakeholders and the public.

The HSCSR has an agreed vision for the health and social care economy of Calderdale and Greater Huddersfield. This is ‘Better Lives, Improving Health. Working Together for Effective Support’.

The shared vision is to improve the health, well-being and safety of all our communities by supporting people to be independent and to deliver the right care, in the right place at the right time. The HSCSR states ‘To do this we need to change the way we provide health and social care service so that:

- You can easily access the right information and guidance so that you can make informed choices for you and your family
- You are able to tell your story once and are then supported to make positive choices to manage you and your families health
- Wherever possible quality personalised care will be delivered close to your home to help you stay as safe, well and as healthy as possible, for as long as possible
- Every child will have a healthy start and continue to lead a safe, happy life with every opportunity to achieve their potential within their families and communities
- High quality, safe, specialist care will be available when you and your family need them.
- Make the best possible uses of our shared resources

This Strategic Outline Case has been developed to deliver the vision identified in the HSCSR.

Impact on Social Care Provision

The intention of this Strategic Outline Case is to reduce the number of people admitted to hospital, reduce the number of people who need to visit the hospital and reduce the length of stay for people in hospital by delivering more care in people’s own homes, through secondary care integrating better with GPs, community nursing teams and social care teams and by supporting people to self care in their own homes. Inevitably this will lead to nervousness about increasing pressure on social care provision at a time when it is most under pressure. To mitigate this risk we have spoken to social care providers about our plans and included their views in the service model. We have also identified ways in which the Better Care Fund can be used to address these issues in the community. The economic case for the Strategic Outline Case includes investment of resources in community services.

Impact on Yorkshire Ambulance Service (YAS)

YAS were part of the NCAT review in the summer and are aware of this Strategic Outline Case proposal to differentiate the role of the two hospitals and provide more care in the community. Inevitably this change will impact significantly on the YAS blue light service and also patient transport services. YAS have confirmed their commitment to work with us at the detailed planning stage once the Strategic Outline Case is agreed by commissioners. YAS have been working in detail with Mid-Yorkshire Hospitals on a proposed reconfiguration of hospital and community services in Wakefield and Dewsbury.
9. Engagement and Support for Proposals

This section describes the engagement that has been undertaken in developing the Strategic Outline Case and the support for the proposals.

9.1 Engagement and support from the public, patients and service users

As described in section 4.5 both Calderdale and Huddersfield Strategic Review and SWYPFT have recently undertaken public engagement events to better understand and consider the views of service users, the public and voluntary sectors.

The key themes that have come out of these dialogues were:

- Patients want to be at the centre of seamless services. People want to receive services without seeing the join between services. They also want to make sure we share information
- Use technology wherever we can
- People want a choice of services
- Support families and carers, and support people to be independent, ensuring services are designed for them, not for the professionals
- Provide care as close to home as possible
- Every child will have a healthy start and continue to lead a safe, happy life with every opportunity to achieve their potential within their families and communities

The proposal reflects these priorities. However the proposal has not yet been tested with the public, patients and service users. Following agreement of the proposal with commissioners, engagement will commence with the public.

9.2 Alignment with commissioning intentions and Health and Wellbeing Board priorities

The focus of this Strategic Outline Case on planned care, emergency care and integration of care in the community with hospital services is directly aligned with the Calderdale CCG priorities.

The proposal outlined in this Strategic Outline Case describes the integration of physical and mental health, putting people at the centre of integrated care and focusing on supported self care to support people to live their lives as independently as possible. This is in line with the priorities identified by Greater Huddersfield CCG and Kirklees Health and Wellbeing Board.

9.3 Alignment with other stakeholders

The proposals outlined in this Strategic Outline Case are directly aligned with the vision of the Health and Social Care Strategic Review to improve the health, well-being and safety of all our communities by supporting people to be independent and to deliver the right care, in the right place at the right time.

The HSCSR vision states ‘to do this we need to change the way we provide health and social care service so that:
- You can easily access the right information and guidance so that you can make informed choices for you and your family
- You are able to tell your story once and are then supported to make positive choices to manage you and your families health
- Wherever possible quality personalised care will be delivered close to your home to help you stay as safe, well and as healthy as possible, for as long as possible
Every child will have a healthy start and continue to lead a safe, happy life with every opportunity to achieve their potential within their families and communities.

High quality, safe, specialist care will be available when you and your family need them.

Make the best possible uses of our shared resources’

The Strategic Outline Case is consistent with this vision. Both local authorities have been aware of the development of the Strategic Outline Case and the alignment with the community model.

Yorkshire Ambulance Service (YAS) are an important provider partner in the delivery of this service model. They were part of the team interviewed in June when all partners agreed with NCAT’s proposal to create a planned and unplanned site. YAS are aware of and supportive of the direction of travel outlined in this document and will become involved in the detailed analysis that will be undertaken in the Outline Business Case (OBC).

9.4 Engagement with Calderdale and Huddersfield Foundation Trust Doctors and Nurses

Over a two week period in November 2013 the Trust directors and senior managers conducted 1:1 interviews with a wide range of consultant doctors and nurses. Interviews were offered to all nurse consultants and lead clinicians and clinical directors in the Trust plus all consultants in specialties of A/E, MAU, Cardiology, Respiratory and Geriatrics. These specialties were identified as the ones most likely to change significantly in response to the NCAT recommendations and the Future Hospital Commission recommendations on the delivery of acute care in hospitals.

There was overwhelming support for the direction of travel proposed. Respondents identified that this proposal would improve patient experience, they provided examples of how this would happen such as reducing length of stay and improving early access to senior decision makers through 7 day working. Respondents also described this proposal as providing higher quality, safer care than the current model through greater standardisation, opportunities to improve recruitment and opportunities to integrate secondary care further into the community.

Whilst in support of the direction of travel there were issues raised by doctors and nurses. This included the level of estate development required on one site to facilitate the model, they wanted to see an analysis of bed numbers, and flagged the requirement to invest in community services, including consultant workforce in the community to facilitate the model. Finally they flagged the potential impact on patients’ travel and transport and the need to address this in the outline business case.

Examples of the comments some of our senior staff provided are shown below.

Right care, first time, every time is what we want but from both a medical and patient point of view.  
**Sally Anne Wilson A&E Consultant**

It will improve flexibility and ability to provide extended hours and 7 day working.  
**Andrew Hardy, Acute Care Physician**

More local home based care for people with a long term condition and some acute conditions requiring antibiotic therapy at home via Out Patient Antibiotic Therapy service (OPAT) should be expanded.  
**Alan Hart Thomas, Respiratory Physician**
### 10. Topics for Discussion

The preceding sections of this document have set out the case for change (section 5) and a proposed future service model (section 6).

The following topics have been identified for discussion with staff, key stakeholders, public, patients and their representatives.

<table>
<thead>
<tr>
<th>Topics</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Continue with the existing hospital and community service model and configuration.</td>
</tr>
<tr>
<td>2.</td>
<td>Implement the community and hospital service model proposed in section 6 with Huddersfield Royal Infirmary as the site for acute and emergency care and Calderdale Royal Hospital as the site for planned hospital care.</td>
</tr>
<tr>
<td>3.</td>
<td>Implement the community and hospital service model proposed in section 6 with Calderdale Royal Hospital as the site for acute and emergency care and Huddersfield Royal Infirmary as the site for planned hospital care.</td>
</tr>
<tr>
<td>4.</td>
<td>Continue with the existing community service model and change emergency hospital care provided locally so that those people needing specialist treatments are transferred to a major emergency centre outside the local area. Huddersfield Royal Infirmary and Calderdale Royal Hospital would offer ‘see and initiate treatment’ services with people needing specialist treatments transferred to specialist centres. This would reduce demand at the local emergency centres in Halifax and Huddersfield.</td>
</tr>
<tr>
<td>5.</td>
<td>Any other ideas resulting from extensive engagement with a wide range of stakeholders, including patients and the public.</td>
</tr>
</tbody>
</table>

Subject to confirmation of support for the proposals and strategic direction described in this Strategic Outline Case the next step is to undertake further discussion through a process of wider stakeholder engagement to develop an Outline Business Case. The Outline Business Case will test the qualitative benefits, affordability and value for money related to each topic. This will then be subject to formal public consultation.

As well as considering the impact that these proposed changes would have on Calderdale & Huddersfield residents, we have also had to consider the impact on our residents as a result of proposed service changes from other areas. For example, Clinical Commissioners in both Wakefield and North Kirklees, together with the Mid Yorkshire NHS Trust, are proposing significant changes across their main acute service sites at Dewsbury, Pinderfields and Pontefract. As a result there is a possibility that demand for emergency care will increase particularly at the HRI site and we will be working closely with Yorkshire Ambulance Services and other partners to establish what this means for care not just in our area but what this means across West Yorkshire, East Lancashire and Greater Manchester.

At the time of preparing this Strategic Outline Case the potential merits of topic 2 to secure longer term benefits, sustainability and value for money has been recognised by the Board of Calderdale and Huddersfield Foundation Trust. This preliminary view will be transparently and robustly tested through stakeholder engagement and public consultation.
11. Conclusion

The case for change and proposals described in this Strategic Outline Case offer the opportunity to improve the safety and quality of services in Greater Huddersfield and Calderdale in a context of increasing demand and reducing resources. The proposals are ambitious and will require formal public consultation and must demonstrate that the four Department of Health tests for major service reconfiguration have been met.

This Strategic Outline Case starts to address the four tests (as shown below). Subject to Greater Huddersfield and Calderdale CCGs confirmation of support further stakeholder engagement and public consultation will inform the development of a full business case and demonstrate that the four tests have been met.

<table>
<thead>
<tr>
<th>Reconfiguration Tests</th>
<th>Relevant Information Provided in this Strategic Outline Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Commissioner Support</td>
<td>The proposals are consistent with the direction identified by the Greater Huddersfield and Calderdale Strategic Review. The proposals are also aligned with the commissioning intentions of Greater Huddersfield and Calderdale CCGs. During preparation of the Strategic Outline Case there have been several discussions with the Chairs and Chief Officers of both CCGs and this has informed the proposals that are presented. During the past two months an engagement meeting and a workshop with GPs has taken place and the feedback and discussion at these confirm support for the general direction of the proposals described in the Strategic Outline Case.</td>
</tr>
<tr>
<td>Public and Patient Engagement</td>
<td>The proposals have taken account of views expressed by members of the public about current services and what matters to them that were provided as part of the Greater Huddersfield and Calderdale Strategic Review and through engagement events held by SWYPFT. The proposals strongly align with the priorities identified in Calderdale and Kirklees Joint Health and Wellbeing Strategies (and with the Joint Strategic Needs Assessment for each Council) which are based on extensive public consultation and engagement.</td>
</tr>
<tr>
<td>Clinical Evidence Base</td>
<td>The Case for Change section of the Strategic Outline Case details the clinical evidence related to the changes proposed. The proposals are consistent with the national strategic direction for emergency services described by NHS England Medical Director and draws on the substantial evidence base associated with Sir Bruce Keogh’s report. The changes proposed for the way community services are provided draws on a range of evidence sources such as the King’s Fund, the Royal College of Physicians and the Institute for Healthcare Improvement. Senior doctors and nurses that currently deliver the services on which these proposed changes will impact over-whelming support the strategic direction of the Strategic Outline Case recognising the need for change to improve safety and quality.</td>
</tr>
<tr>
<td>Patient Choice</td>
<td>The proposed changes in the way community services will be provided will significantly improve choice and control for people. At the heart of these proposals is that services will be truly personalised and tailored to help support and meet people's needs. The proposed changes in the configuration of emergency and hospital services has taken careful account of the need to balance access and the significant clinical evidence that patient safety and improved outcomes can be achieved through the concentration of planned and unplanned services on two separate sites. According to the evidence this should result in better treatment and reduced mortality from serious illnesses and injuries.</td>
</tr>
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</table>
12. Recommendation

It is recommended that the governing bodies of Calderdale CCG and Greater Huddersfield CCG:

i. Confirm their support for the proposals and strategic direction described in this Strategic Outline Case.

ii. Present this Strategic Outline Case to the Adult Health and Social Care Scrutiny Panels and Health Wellbeing Boards in Calderdale and Kirklees to request their support that further work should be undertaken to publicly consult on the proposals and to develop a full business case.
### Glossary of Abbreviations & Terms

<table>
<thead>
<tr>
<th><strong>Assistive Technology</strong></th>
<th>A range of devices or tools that help a person’s independence.</th>
<th><strong>Integrated record</strong></th>
<th>A single record of all health and social care.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care First</strong></td>
<td>The Kirklees Local Authority electronic client record.</td>
<td><strong>Remote working</strong></td>
<td>The ability to connect to the information you require wherever you are.</td>
</tr>
<tr>
<td><strong>Client Information System</strong></td>
<td>The Calderdale Local Authority electronic client record.</td>
<td><strong>RIO</strong></td>
<td>The Mental Health electronic clinical record.</td>
</tr>
<tr>
<td><strong>Communications</strong></td>
<td>The electronic systems that allow us to communicate through voice over internet phone calls, instant messaging, video conferencing. There are too systems; Microsoft Lync &amp; Cisco Jabber.</td>
<td><strong>S1</strong></td>
<td>SystmOne. The electronic clinical record used by most GPs and is the community.</td>
</tr>
<tr>
<td><strong>Cloud</strong></td>
<td>A remote server store where all electronic information is stored. Access and connection to this store is via the intranet.</td>
<td><strong>Telehealth</strong></td>
<td>The process of supporting health &amp; care related activities remotely.</td>
</tr>
<tr>
<td><strong>EPR</strong></td>
<td>Electron Patient Record used in CHFT.</td>
<td><strong>Virtual Desk top</strong></td>
<td>Being able to have a duplicate version of your computers desk top even when you are not connected to your network.</td>
</tr>
<tr>
<td><strong>IG</strong></td>
<td>Information Governance; the measure put in place to ensure safe, secure &amp; appropriate use of information.</td>
<td><strong>Vital signs</strong></td>
<td>Clinical signs for example, pulse, blood pressure, oxygen saturations.</td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td>The Cloud, wires, network and hardware that allows the technology systems to function.</td>
<td><strong>Risk Stratification</strong></td>
<td>A method of understanding patients’ needs and using a risk prediction approach to identify those people who are the most regular users of hospital services (and are at risk of re-admissions).</td>
</tr>
<tr>
<td><strong>In-reach</strong></td>
<td>A term used to describe services that are community based but also some aspects of care are provided in hospital setting (i.e. inreach to hospital).</td>
<td><strong>Out-reach</strong></td>
<td>A term used to describe services that are hospital based but also some aspects of care are provided in the community (i.e. outreach from the hospital to community).</td>
</tr>
<tr>
<td><strong>HIS</strong></td>
<td>Health Informatics Service</td>
<td></td>
<td></td>
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</tbody>
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