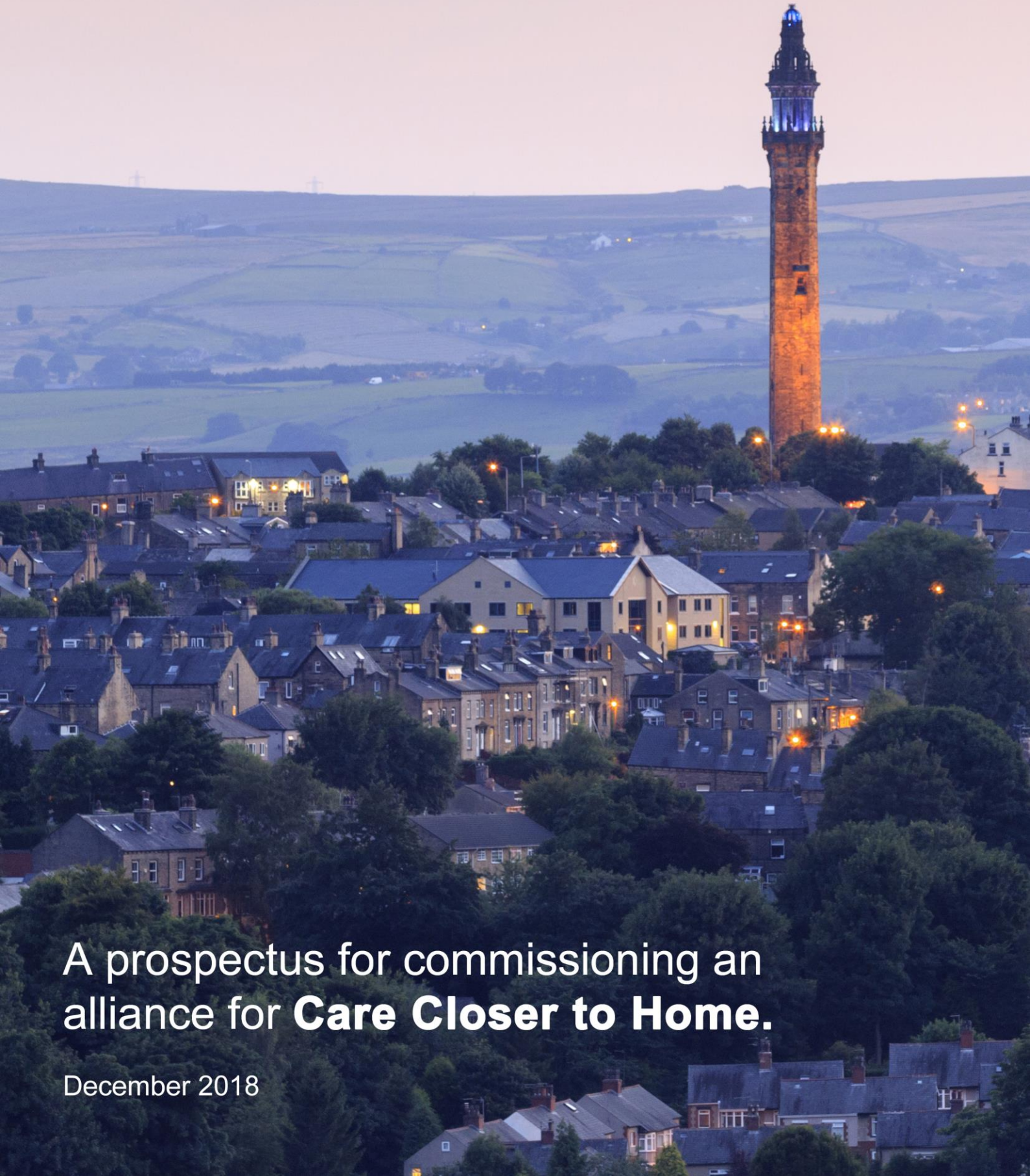
NHS
Calderdale
Clinical Commissioning Group



A prospectus for commissioning an alliance for **Care Closer to Home.**

December 2018

Contents

1. Context – Case for Change

1.1 Strategic Vision

Calderdale's Health & Wellbeing Board (HWB) – representing a broad system partnership agreed its strategic vision in 2017. Its aspiration is to be the best Borough in the North and a place where:

- People are empowered to take greater control over their lives and outcomes
- Resources and assets are used to address the wider determinants of health and support well-being
- The system shifts towards prevention – changing the ways in which organisations and their staff work.

The plan on a page captures the model which brings together the things that are important to health and well-being in Calderdale

The Calderdale HWB has agreed a set of outcomes by which it will test success delivery of its vision;

- Improving health and reducing inequalities (ensuring: children have the best start in life, health inequalities are reduced and, people are enabled people to live independently at home for a long as possible)
- Improving the quality of services and the experiences of those who receive them.
- Improving efficiency (ensuring services and ways of working are effective, productive and avoid waste)

In delivering the vision, the HWB has also set an approach to improving health and care – the approach is described in 'Calderdale Cares' – its aims are:

- System collaboration, sharing common resources to deliver agreed population health outcomes

- Focusing on prevention, self-management and technology (Active Calderdale a priority in this)
- Integrating health and care commissioning
- Incentivising the development of integrated health and care models – creating seamless pathways for those who use them.
- Improving the interface between community and hospital care
- Promoting evidenced based practice and innovation.
- Locality working across Calderdale; aligning budgets and determining the spread of resources across localities.

1.2 The Case for Change

Across the Calderdale system the overarching case for change is clear and the CCG plays an important role in delivering Calderdale Cares. The current CCG/health position against the Calderdale Care triple aim can be summarised as follows:

Improving Health and Inequalities:

We face significant social and health inequalities across Calderdale and huge variation in life expectancy. Our current care models have proved unsuccessful in significantly reducing inequalities and mortality rates – particularly in our most deprived communities.

Quality and Experience:

Our current care models have not enabled us to sufficiently shift the balance from unplanned episodic to planned and self-care. This means that our population are more likely to; attend A&E, be admitted to hospital for potentially avoidable conditions and stay longer than is necessary, resulting in harm and poorer patient experience and outcomes. These avoidable emergency admissions are predominantly across a number of long term conditions including: cellulitis, congestive heart failure, asthma, diabetes, hypertension, UTIs, Angina and Sepsis

Efficiency:

Demand for, and cost of, local health services is increasing at a time when the economic situation means resources will be limited for some time. If the local system is unable to redesign and transform services in a way that drives up quality within that available resource then our patients will experience poorer outcomes as a result.

1.3 The Opportunities

“The majority of unplanned care is the result of a failure in planned care”.

We know our system is over-reliant on emergency unplanned hospital activity compared to the rest of the country, with high levels of ‘avoidable’ admissions.

We are looking at transformational change with a focus on reducing the reliance on unplanned and episodic admissions to hospital. Our current spend on planned community services dependent on scope is between £14m - £18m per annum. Our current spend per annum on emergency admissions is £32.8m. The potential opportunity to reduce our unplanned spend is identified by Right Care benchmarking data as £5.5m per annum, and through the national data on avoidable admissions (Conditions not Requiring Hospital Admission and Ambulatory Care Sensitive Conditions) as £6.4m per annum. This provides an important opportunity to shift the spread of resources from acute hospital, to community offers.

1.4 How the Views of our Population have Shaped our Thinking

The CCG has undertaken extensive engagement and formal consultation to shape its plans for community services, particularly through the Right Care Right Time Right Place consultation. The top 4 themes are identified below, however a full composite report detailing the findings can be found on CCG website www.calderdaleccg.nhs.uk, giving clear information to the patient about their health conditions and the plan for their care:

- Delivering more services closer to home
- Delivering flexible services that offer the right care at the right time in the right place
- Key message about 'understandability' – compelling public narrative

2. What We Would Like To Change

2.1 Since the launch of Care Closer to Home (CC2H) in 2014-15, we have seen a shift in the thinking and improvements in the way partners are working together to strengthen existing services and explore new opportunities for the Calderdale population.

2.2 The CCG's CC2H animation (which can be found on YouTube) describes how collaboration could work better for; our population, our communities, and our partners. We have already taken steps, and made changes; such as investing in teams who work across care settings to provide continuity and integrated care; providing tools that help people take control of their health and wellbeing; and more recently in the development of locality working.

CC2H also seeks to optimise the use of evidenced-based technologies and new treatments and encourage clinicians and professionals to innovate and test new ways of working. Our plan recognises the scale and pace of the transformation programme in Calderdale. The premise includes focusing on targeted preventative, proactive services, self-care and early intervention in the community.

The Department of Health's vision is 'to help you live well for longer' and is aimed at putting prevention at the heart of our nation's health. Their mission is to improve health life expectancy so that, by 2035, we are enjoying at least five extra years of healthy, independent life, whilst closing the gap between

the richest and poorest.

Prevention Vision for Calderdale

We want Calderdale to be a place where people, families and whole communities work together to lead longer, healthier and happier lives. We'll do this by:

- Moving the focus from treating sickness and disease to one of prevention and maintaining wellbeing throughout peoples' lives
- Everyone working together towards the same goals
- Addressing the issues that affect peoples' health and wellbeing to reduce health inequalities
- Being driven by local need; not based on existing service provision

References:
National Prevention Strategy, 2011
Health & Wellbeing Board/Calderdale Cares/Single

References:
National Prevention Strategy, 2011
Health & Wellbeing Board/Calderdale Cares/Single Plan for Calderdale
Population Health Management NHSE Sept 2018

2.3 We have identified principles which underpin our CC2H approach:

- People are empowered to take greater control over their lives and outcomes
- Resources and assets are used to address the wider determinants of health and support well-being
- The health and care system shifts towards prevention – changing the ways in which organisations and their staff work.
- Community services should work seamlessly alongside and with primary care, particularly with general practice.
- Community services should be truly 'community' and have a strong sense of local place
- Care should be based on what matters to each patient
- The type and route of care delivery should suit the type and preferences of patients. This can mean different modalities for different types of patients.
- Professionals providing community-based care are delivering at the top end of their licence, enabling general practice to focus on population health management and acute teams to focus on people requiring specialist provision. The role of general practice is described in **Appendix A**
- Services are delivered in a way that constantly improves health outcomes of the population, by providing high quality care, efficiently and within the financial resources available

2.4 NHS England's Five Year Forward View (FYFV), which was published in October 2014, sets out recommendations for sustaining and improving the NHS: improving quality of services, reducing fragmentation, and accelerating integration. It describes new models of care to improve integration of services, with a particular focus on the delivery of out of hospital care. This

includes:

- A drive towards outcomes-based commissioning: *"personalised care will only happen when statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be key outcomes of care; and that patients, families and carers are often "experts by experience"*
- Decisive steps are needed to break down the barriers in how care is provided between services, including health and social care, and to develop radical new care delivery options.
- Creating an integrated community and GP led model, focusing on population based commissioning across the system. We have been building on the CCG's Primary Care Strategy to transform our local system and deliver both CC2H and our hospital change programme.

Delivering the vision for integrated commissioning involves our providers working more collaboratively in localities in 2018/19, building on the infrastructure adopted from the New Care Model of 5 localities with populations of 30,000 – 50,000 as set out in **Appendix B**

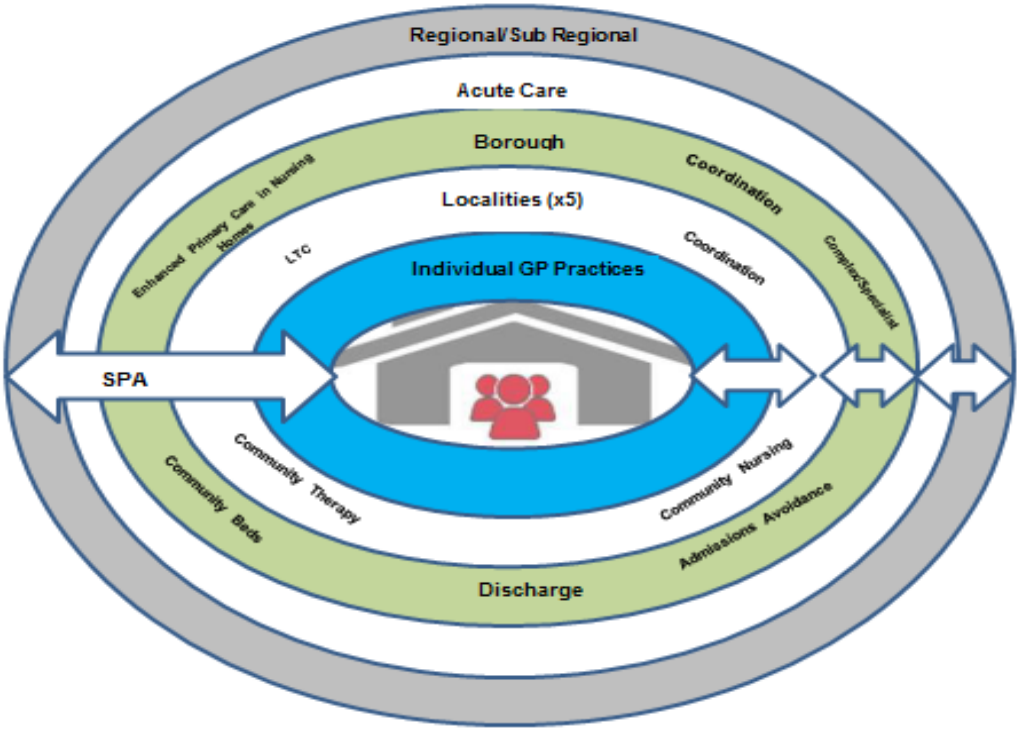
To maximise the impact of working differently, each locality will require population segmentation and risk stratification tools to support development of service offers. This will require our providers (GPs, practice staff, community services, acute physicians, mental health teams, social care and the third sector) working more closely together, sharing patient data, drawing on their insight into different care usage patterns within both the localities and across the population of Calderdale. Use of such tools to target interventions on a locality basis is proven to assist in reducing the reliance on emergency hospital admissions and aid development of proactive and preventative community service.

A defining feature of top-performing integrated care systems is that they understand the populations they serve. A needs-based stratification of the population is the basis for the design of a model of care.

Packages of care are then constructed to serve high-need, medium-need and low-need populations. See example provided in **Appendix C**

2.5 We are confident we can face the challenges ahead, working together with individuals, communities across Calderdale. The following graphics illustrate the individual service levels on which a model could be based, starting in the person's own home, moving outwards towards specialist services provided on a regional and sub-regional basis.

Levels of Service Delivery by Functional Group



Levels of Service Delivery

Patients Homes

Many out of hospital service are delivered within patients own homes to either support them to stay as well as possible, or recover as quickly and as well as possible

Localities

5 networks providing care to 30,000-50,000 registered patients
Specific community services 'wrap round' GP services/network to provide holistic health and social care. Examples include community nursing and care coordination

Primary Care 'Hub'

Hubs that offer the primary care home service/functions but will include additional services which require greater scale in order to support delivery

Borough

Service/function that need to be delivered at Borough wide level rather than through primary care 'hub' models

3. How we would like to do this

3.1 The CCG wishes to work with organisations who share its vision and who demonstrate innovation and willingness to work in partnership to deliver a truly seamless service for our patients and population, in line with the principles set out in section 2.0. The CCG is not pursuing the traditional procurement and tender model as this is felt to be more disruptive and not representative of the system working with Calderdale Cares, previous CC2H and vanguard work.

As such, the CCG is proposing that an alliance approach be adopted to provide CC2H in Calderdale. Integration and collaboration are essential to this approach, and as such members entering into an 'Alliance Approach' will be equal partners - a single overarching agreement to deliver contracted services, sharing risk and responsibility to achieve better outcomes for our population.

The alliance will be governed through a collective leadership board, comprising representation from all contracted, and/or commissioned providers, and with agreed terms of reference. The board will be directly accountable to the lead commissioner for contractual purposes, supported by the contract management team and associated functions within the CCG. It is through this board that relationships and the provision of services within the Alliance will be managed.

An Alliance model is considered the most suitable approach here because:

- It will allow for a collaborative approach, strengthening relationships between commissioner and all providers;
- It recognises the contribution of the range of providers for CC2H in Calderdale; and
- It will ensure that the system works together towards achieving shared agreed outcomes.

3.2 <u>Outcome based commissioning</u>

The vision for Calderdale frames an approach on improving outcomes. Using the triple aim, the CCG proposes to underpin delivery of its community services with three key outcomes; better health, better care and better value.

The CCG requires providers to collaborate and deliver an integrated approach that will address the current gaps in care and challenges around care co-ordination - leading to positive impacts on patient experience and outcomes.

In particular, a more holistic and more patient-centred approach will help with the co-ordination of care for groups of patients including; frail older people, those living with long-term chronic illnesses and mental health disorders, and people with medically complex needs, for which effective and integrated

community services are a vital support.

Focused on people, and working together; providers will maximise outcomes for the patients as well as the system. This is especially true where the collaborations expand beyond the traditional statutory sector agencies and incorporates the important contribution made by the voluntary sector, technology and as well as independent sector organisations.

Considered in this way, the underlying principles of delivering value-based integrated care can be summarised as:

- Know your local population analytically in terms of need and what outcomes matter to them
- Think differently; don't be constrained by how it's "always been"
- Getting started is a prerequisite to being successful
- The patient/customer/person is the innovator in the system. Work with them, study, see how they seek care and the information they use to do so
- Don't focus on the organisational forms or contractual structures; consider instead how together you will together deliver for the population.

The outcome indicators are set out below.

Domain	Vision (Outcome)	Short Term Indicators
Population Health	Keep the population healthy and help them stay well	Avoidable Admissions – composite of: Admissions for ambulatory care sensitive conditions per 100,000 (IAF) Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHSOF) Admissions for conditions that do not require hospital admission per 100,000 (IAF) Emergency admissions for children with lower respiratory tract infections (LRTIs) (NHSOF) Mental Health indicators to be determined
Proactive Prevention & Patient Centred Approach	Through self-care, proactive management and a patient centred approach, problems will be detected early and stop them getting worse A coordinated	Rate of emergency admissions per 100,000 (BCF) Rate of delayed transfers of care per 100,000 population (BCF) Emergency readmissions within 30 days of discharge from hospital (NHSOF) Out of area placements (local trajectory)

	model of care will help people to stay out of hospital and long term care	Patient experience of care/ quality of life (national surveys v local survey)
System, Staff & Sustainability	Calderdale will be an attractive place to work due to its model of care that maximises the value of every pound invested in health and care	Total bed days associated with emergency admissions (Vanguard/ New Care Models) Staff turnover Staff experience (local survey) Carer reported quality of life (ASCOF)

The Outcomes Framework is captured in **Appendix D**

3.3 Approach to commissioning

Our approach to commissioning a more integrated provision is to advise the market of our intentions through the publication of this prospectus.

NHS Calderdale CCG is acting in its capacity as commissioner for healthcare services on behalf of the registered population of Calderdale.

This prospectus is to advise that the commissioner has determined to seek to develop an alliance in respect of the currently contracted providers of services identified within the scope of 'Care Closer to Home'. Over the next two years, this will entail the providers of services developing and entering into an overarching agreement with the commissioner and other providers to deliver services under existing service contracts in a more collaborative and integrated way to the population served by the CCG.

This provides notice for the services currently in the scope for Phase 1 of CC2H. We intend to continue to commission a range of community based health and care services for the registered patient population covered by the CCG and the resident population of Calderdale MBC.

The services to be provided in Phase 1 are open for discussion between the Alliance, however, these could include:

- Traditional Community Services, such as; District Nursing, Community Matrons (including Quest) rapid response and falls team and specialist nursing for example, Parkinson's and Heart Failure Nurses.
- Place based Older People's Mental Health Services, for example IAPT, dementia teams etc
- Maternal Health
- Assistive Technology – Telehealth in the community, provided by Baywater Healthcare

The scope of services offered through this integrated approach is anticipated to increase over time. The CCG sees this process as a significant stepping

stone for more integrated care and the delivery of Calderdale Cares.

It is anticipated that further development of this approach over time may result in; the commissioning of a 'contract' for up to 10 years, to manage a single population budget for the services that will innovate and transform access to, and delivery of, community health and care services - meeting a defined set of outcomes and performance measures.

Future phases will be identified following discussions with Calderdale MBC as part of our approach in representing a broad system partnership under Calderdale Cares, with a view to identify if any areas of Public Health and Adult Social Care services will be included in the scope.

The purpose of this document is to inform the market of our approach and is not a call for competition.

4. Conclusion

We require providers to be innovative and offer solutions that provide the right skills, in the right numbers and the ability to flex service offers to meet the needs of the patients across Calderdale and in localities. Therefore we wish to commission a new community model for the people of Calderdale that will:

- Keep them healthy and help them stay well
- Detect problems early and stop them getting worse
- Help people to stay out of hospital and long term care
- Manage admissions to hospital and long term care and make sure that when people are well enough to leave that they are supported to be discharged as soon as possible

6. Next Steps

The CCG have communicated our proposed approach to the majority of existing community providers in Calderdale, with further dialogue to follow.

It is expected that a CC2H Alliance Board will be established to undertake the business required in creating and delivering an Alliance approach.

APPENDIX A

THE ROLE OF GENERAL PRACTICE IN THE CARE CLOSER TO HOME MODEL

Our model for Care Closer to Home recognises the unique position of General Practice. GP's as expert generalists build longstanding relationships with their patients and local communities. They are key to developing services that support the growing number of patients with multiple, complex, long term health problems and helping them manage their conditions at home and in the community with support from the right specialist at the right time. It is expected that through the integrated model, there are four areas where benefits will be realised:

1. **Collaborative working** – providing an opportunity to develop a wider range of community services avoiding duplication through more joined up ways of working with the multi- disciplinary teams, whilst at the same time making more effective use of resources
2. **Capacity** – enabling better access for people requiring services. This could be in the form of more available appointments, specialist nurses working from the practice and expanding on good practice currently working in the community, such as the Quest Matrons
3. **Better access** – to consultations provided in different sites or remotely. Specialists will be available to provide urgent advice to primary care professionals providing support in decision making and care planning for patients with complex and/or deteriorating conditions.
4. **Closer to home** – services provided closer to home and in reassuring settings providing a wider range of tailored services and continuity of care. This will provide an opportunity to build more extensive community teams involving community nursing, secondary care specialists and social care.

The network of services within the localities will wrap around general practice to enable general practice to take a much stronger role in ensuring the delivery of integrated care closer to home, particularly;

- Proactive co-ordination of care, particularly for people with long-term conditions, and those people with more complex health and care problems – supported by risk profiling
- Introduction of a single care plan for children and young people
- Involving patients and carers more fully in managing their own health and care
- Holistic care: addressing people's physical, psychological and social needs, health needs and social care needs
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances
- Preventing ill-health, ensuring more timely diagnosis of ill-health, and supporting wider action to improve community health and well-being
- Ensuring consistently high quality of care: effectiveness, safety and patient experience
- Promoting Self-Care

The provider(s) of Community Services will have to demonstrate how its operating model will be designed to ensure that the foundation of NHS care will remain the registered population in General Practice. This includes both ensuring that service delivery is centred around the practice as well as ensuring that the patient medical records held by the practice form the basis of the medical records for the wider system . The role of General Practice is therefore fundamental.

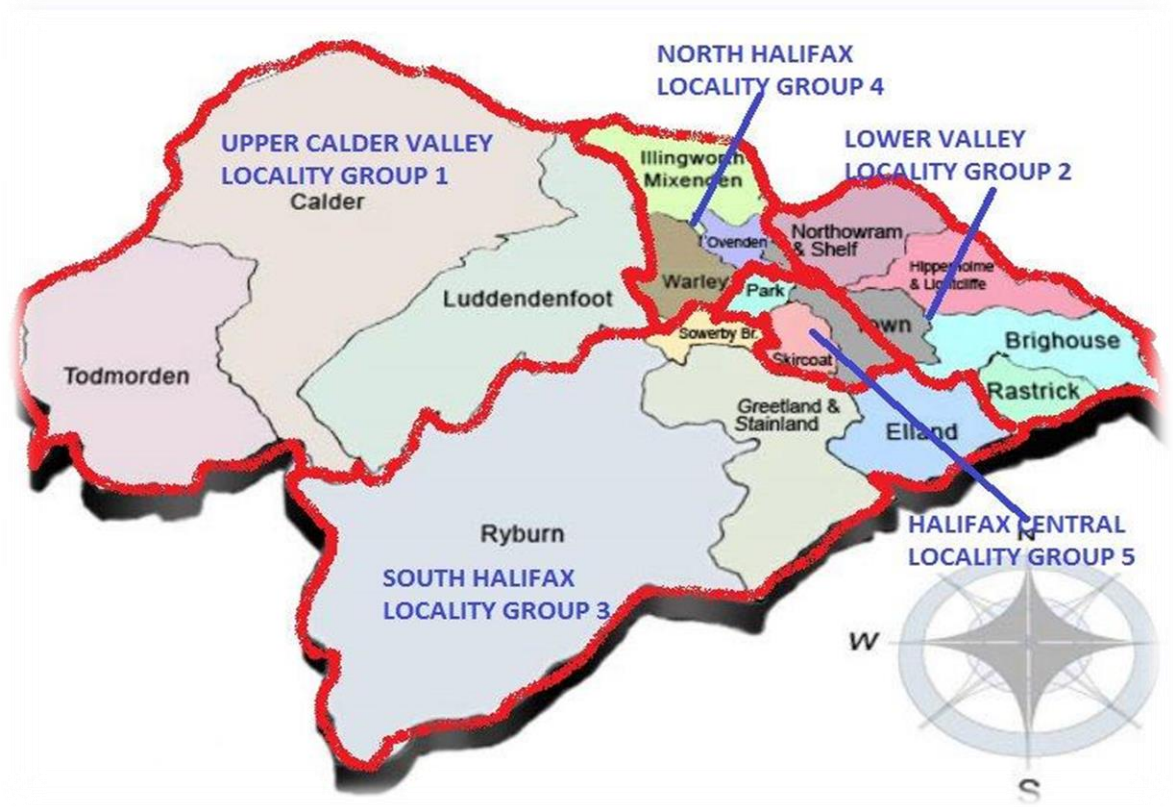
Currently, clinical responsibility for all patients within their own homes (including residential and nursing) sits with the registered general practice. Moving to integrated closer to home care will necessitate the development of a new model for clinical responsibility for patients within their own homes and responsibility will no longer sit by default with General practice.

Appendix B

Locality Working

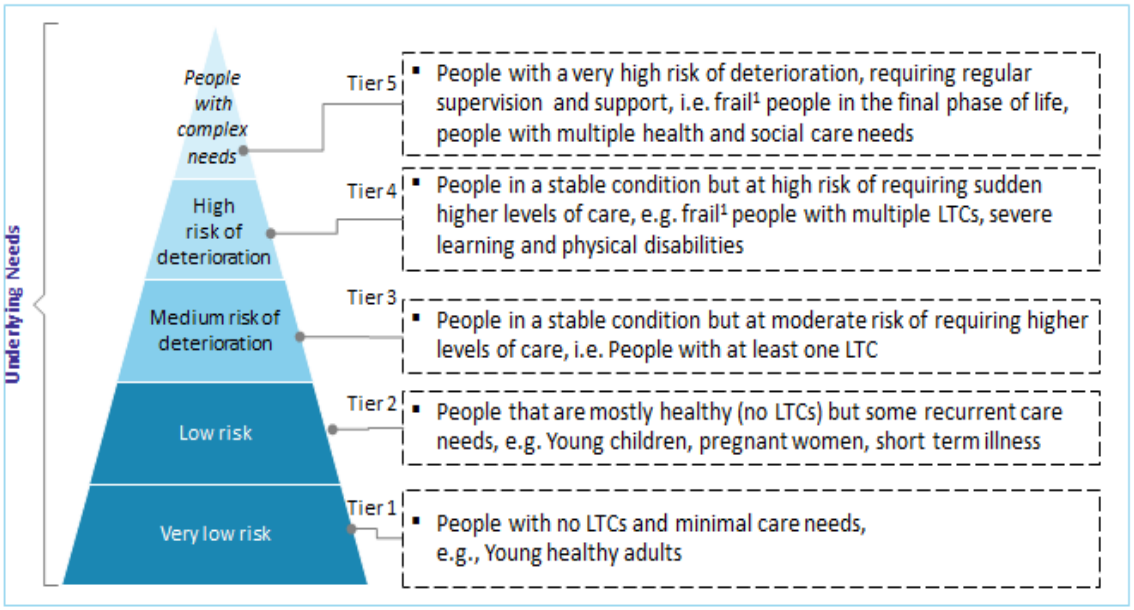
The CCG's vision for integrated commissioning is to transform CC2H and move towards an integrated community and primary care led model, focusing on population based commissioning across the system. We have been building on the CCG's Primary Care Strategy to transform our local system and deliver both CC2H and our hospital change programme.

The vision for integrated commissioning involves working more collaboratively in localities in 2018/19, building on the infrastructure adopted from the New Care Model of 5 localities with populations of 30,000 – 50,000. The map below provides a view of the 5 localities.



APPENDIX C

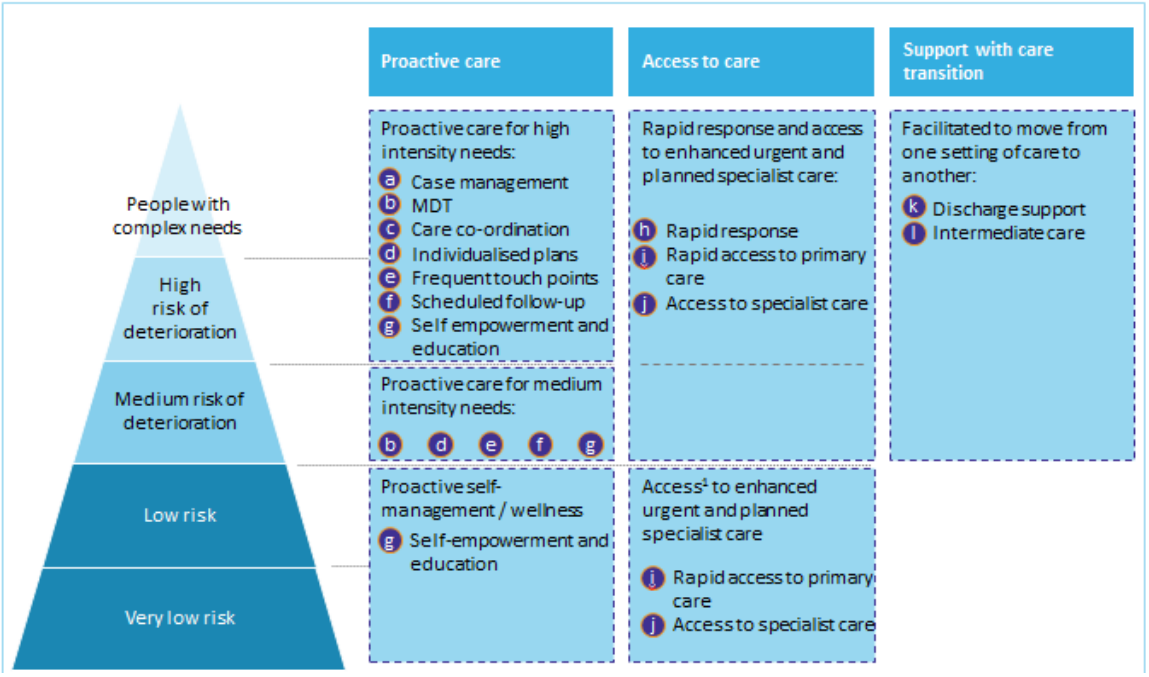
Top systems specifically design care packages around segments of the population with differing needs



Top performing integrated systems have the following programmes

	Innovation	Activity
1 Prevention and pro-active care	a Case management	Pro-active case finding, assessment, care planning and care co-ordination for patients with long term conditions, putting them, their families and carers at the centre of decision making
	b Multidisciplinary teams	A regular whiteboard session with a core group of professionals to pro-actively discuss patients or users who are at risk of requiring increased input. Additional professionals may participate ad hoc
	c Care co-ordination	Provides a single point of contact and helps the patient and their supporters to navigate complex services. Often provided by a care navigator, or care co-ordinator, but this can also be the patient
	d Individualised care plan	Develop a patient-centric care plan based on their current and future needs, focusing on what is important to the patient, beyond clinical treatment. It takes a 'whole life' approach
	e Frequent touch points	Pro-active, regular and frequent contact with health professionals for at-risk patients to reduce the risk of crisis events
	f Scheduled service user follow-ups	Use of regular scheduled follow-ups to reduce the requirement for urgent care services
	g Self-empowerment and education	Patient education programs and use of technology to support self-care, with the aim of empowering the patient to become independent and resilient, taking responsibility for their own health
2 Swift and appropriate access to care	h Rapid response	A multidisciplinary team that can be deployed to assess patients and prevents hospital admissions by providing health or social care support for those experiencing an episode of illness or injury
	i Rapid access to primary care	Facilitating access to primary care in the acute setting, after appropriate triage. Also includes improved access from extended opening hours or other channels, eg eConsult
	j Access to specialist care	Access to consultant support and specialist care in the community, including diagnostics
	k Appropriate referral and medication practices	Avoid unnecessary interventions by only referring patients as appropriate
3 Support with care transition	l Discharge support	Community, primary and social care in-reach to support early assessment and discharge of patients from acute care. Dovetails with intermediate care and overseen by a care navigator
	m Intermediate care	Provision of step-up or step-down care in a patient's home or a community hospital inpatient facility to prevent unnecessary admissions to, and to facilitate early discharge from, acute care

Bundles of these integrated care interventions can then be designed for each population need group



Appendix D

Outcomes Framework – approach to identify the indicators that underpin the outcomes for Care Closer to Home

Characteristics of Indicators

Indicators can be more or less robust and meaningful depending on their characteristics and whether they meet certain criteria.

Some generic criteria that indicators should meet if they are to be useful include (see also Association of Public Health Observatories 2008):

• Importance and relevance
• Validity
• Accuracy
• Reliability
• Feasibility
• Meaningfulness
• Implications for action
• Avoidance of perverse incentives

Criteria for Selection

In the context of this project, some wider considerations also informed the selection of indicators, such as:

- Size of the population covered
- Representation of important aspects of the care system
- (Wholly or partly) within the control of care services i.e. attributability
- Change detectable within suitable time frames
- Unambiguous interpretation
- Likelihood of being meaningful to users, carers and the public
- Likelihood of being meaningful to care professionals, managers and commissioners
- Reflecting the user perspective and/or value for money perspective
- Timeliness
- Ability to assess the impact on inequalities between user groups and areas in terms of access and outcomes of care
- Measurable from routinely collected data.

Principles (taken from Institute for Healthcare Improvement)

Balance – an indicator set must balance the current need of a system and the future direction of the system

Parsimony – to maintain a system perspective, a small set of indicators is required. If there are too few, significant dimensions are overlooked; if there are too many, the indicators cease to have targeted value in providing guidance to the system

Alignment – with purpose of the system

Usefulness – indicators must signal stability, improvement or decline

Adaptability – indicators must work in the present. However as conditions change we will need to periodically ensure indicators serve their intended purpose

Phasing

The selection and monitoring of indicators will need to be reviewed and updated. New and additional indicators will need to be phased in the Outcomes Framework as the model or Care Closer to Home progresses in Calderdale:

- Short-term: maximisation of currently available data sources. The proposed list of indicators can be derived from routinely available health and social care data.

- Medium to long term: The potential for measuring integrated care more comprehensively than is feasible currently will be greatly enhanced by information developments, for example, record linkage across health primary/secondary/community) and social care services. There will be the potential to introduce additional indicators from new analyses of existing data as well as from new data sources as they develop. Progressive and innovative providers will be seeking to explore these data developments to open new paradigms in the assessment of outcomes.

This will include:

1. Clinical data – assessment and monitoring of an individual's health status
2. Mortality data – births and deaths
3. Administrative data – admissions, discharges, prescriptions, outpatients that reflect the whole patient journey
4. Patient reported data – information provided by patients about symptoms, quality of life and wellbeing

References

http://piru.lshtm.ac.uk/assets/files/IC_and_support_Pioneers-Indicators.pdf

https://www.nuffieldtrust.org.uk/resource/trusted-measures-analytical-resources-for-integrated-care