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Right Care, Right Time, Right Place Programme

The out-of-hospital opportunity | Final report | 16th November 2018

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Executive summary (1/2)

- Calderdale and Greater Huddersfield intend to **reconfigure their acute hospitals**. This redesign will ultimately lead to a reduced bed base, but the current bed capacity will be maintained until the CCGs' out-of-hospital plans can sufficiently reduce acute hospital usage.

- If no additional out-of-hospital demand management plans are delivered, the **demographic growth alone would create a need for 43 more NEL beds by 2023.**

  — *See section, "The baseline position."*

- The top-performing health systems worldwide and in the UK are adopting an integrated model for out-of-hospital care. By focussing on better management of population health and wellbeing, and by better co-ordinating services, they are able to reduce acute hospital usage. If Calderdale and Greater Huddersfield were to implement a similar integrated care system, the **CCGs believe they could reduce NEL bed days by 30%** (77,000) over 5 years.

  — *See section, "An opportunity to do things differently: assessment of the total potential within Greater Huddersfield and Calderdale," and annexe 7.*

- To do this, CCGs need to understand:

  1. what interventions are involved in these systems,

  2. what is the delivery model and capacity required to do this in their areas, and

  3. what they will need to put in place to make the transition to a similar integrated system.

Executive summary (2/2)

1 Top-performing systems **design their packages of care around the specific needs of populations** in areas covering 10,000-100,000 people. They then provide 13 types of programme for these populations, that broadly aim to (i) proactively manage population health and prevent admission, (ii) provide rapid access to primary care and specialist advice in out-of-hospital settings, and (iii) facilitate discharge and transfers between care settings.

— *See section, "An opportunity to do things differently: what would a top-performing system look like in Calderdale and Greater Huddersfield?" and Annexe 1.*

▪ The system's **existing plans have been matched against these best-practice initiatives. Their impact on acute care should at least cover demographic growth**, with the potential to reduce NEL bed days by 28,000 (c. 10%).

— *See section, "How do existing plans measure against this vision, and what is their expected impact?" and annexes 2, 3 and 4.*

2 Calderdale and Greater Huddersfield are moving towards a locality or primary care network model, in which many or most community services will be integrated, co-located and work closely with primary care. Top-performing systems have taken this approach, but have completely integrated all services, including social care, delivering care in the community from hubs serving each locality.

— *The capacity implications for providing integrated care in Calderdale's and Greater Huddersfield's localities are given in section, "What is the capacity required to deliver the proposed model of care, and how should it be organised?" and annexes 5 and 6.*

3 CCGs need to understand the principal enablers they should put in place to move towards a fully-integrated care system. CCGs should then follow a concrete implementation plan to successfully trial the model at their pilot localities, before rolling out the change across their areas.

— *This process is outlined in section, "How should this be done in practice?" and in annexe 7.*

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The baseline position

An opportunity to do things differently

How do existing plans measure against this vision, and what is their expected impact?

What is the capacity required to deliver the proposed model of care, and how should it be organised?
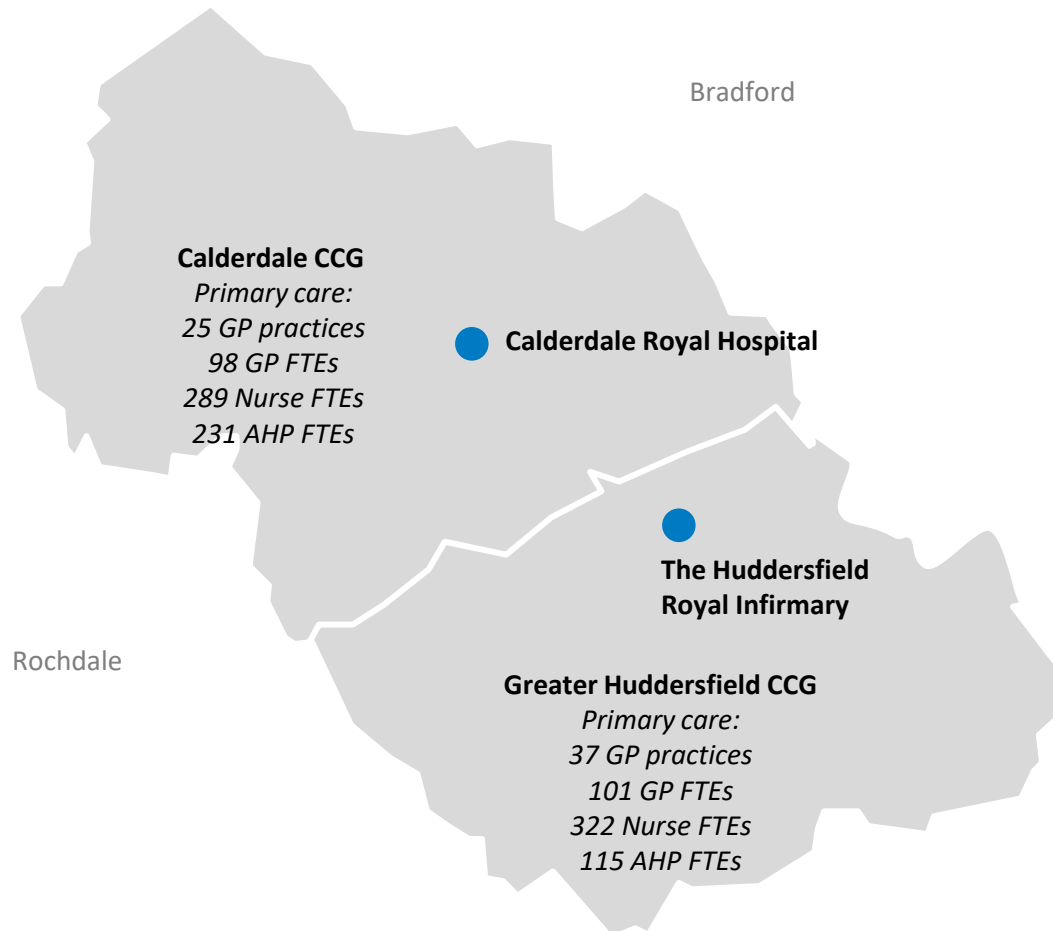
How should this be done in practice?

Section summary: The baseline position

- Calderdale and Greater Huddersfield CCGs serve a population of 469,000 people. This will grow to 478,000 by 2023, with all of this growth happening in the over 50s.

- If nothing changes, in 5 years the system will require 43 more acute beds.

- To address this challenge and improve the quality of care within the region, CCGs have been developing with their partners a series of strategies for out of hospital care, covering:

  1. Reconfigurations of hospital services,

  2. Movement of many services closer to home, with increased community care provision,

  3. Reformation of the community care model around networks or localities of GP practices, and

  4. Remodelling of the intermediate and rehabilitation pathways

The Greater Huddersfield and Calderdale health and care systems serve a combine population of 469,000 people

- **Calderdale CCG** serves about 216,000 people in West Yorkshire, with an allocation of more than £275m.
- Its main **acute provider** is Calderdale and Huddersfield Foundation Trust, but it also has significant patients flows to Bradford Teaching Hospitals FT
- **Community services** are also provided by CHFT, and **mental health services** by SWYPFT.

- **Huddersfield Royal Infirmary** provides A&E, day cases, outpatient services and specialist emergency surgery
- 420 beds
- **Acre Mill**, opposite, provides outpatient services

Bradford

Calderdale CCG
Primary care:
25 GP practices
98 GP FTEs
289 Nurse FTEs
231 AHP FTEs

● **Calderdale Royal Hospital**

Rochdale

● **The Huddersfield Royal Infirmary**

Greater Huddersfield CCG
Primary care:
37 GP practices
101 GP FTEs
322 Nurse FTEs
115 AHP FTEs

- **Calderdale Royal Hospital** provides A&E, day case and outpatient services, planned surgery as well as consultant-led maternity care, neonatal care and paediatrics
- 450 beds
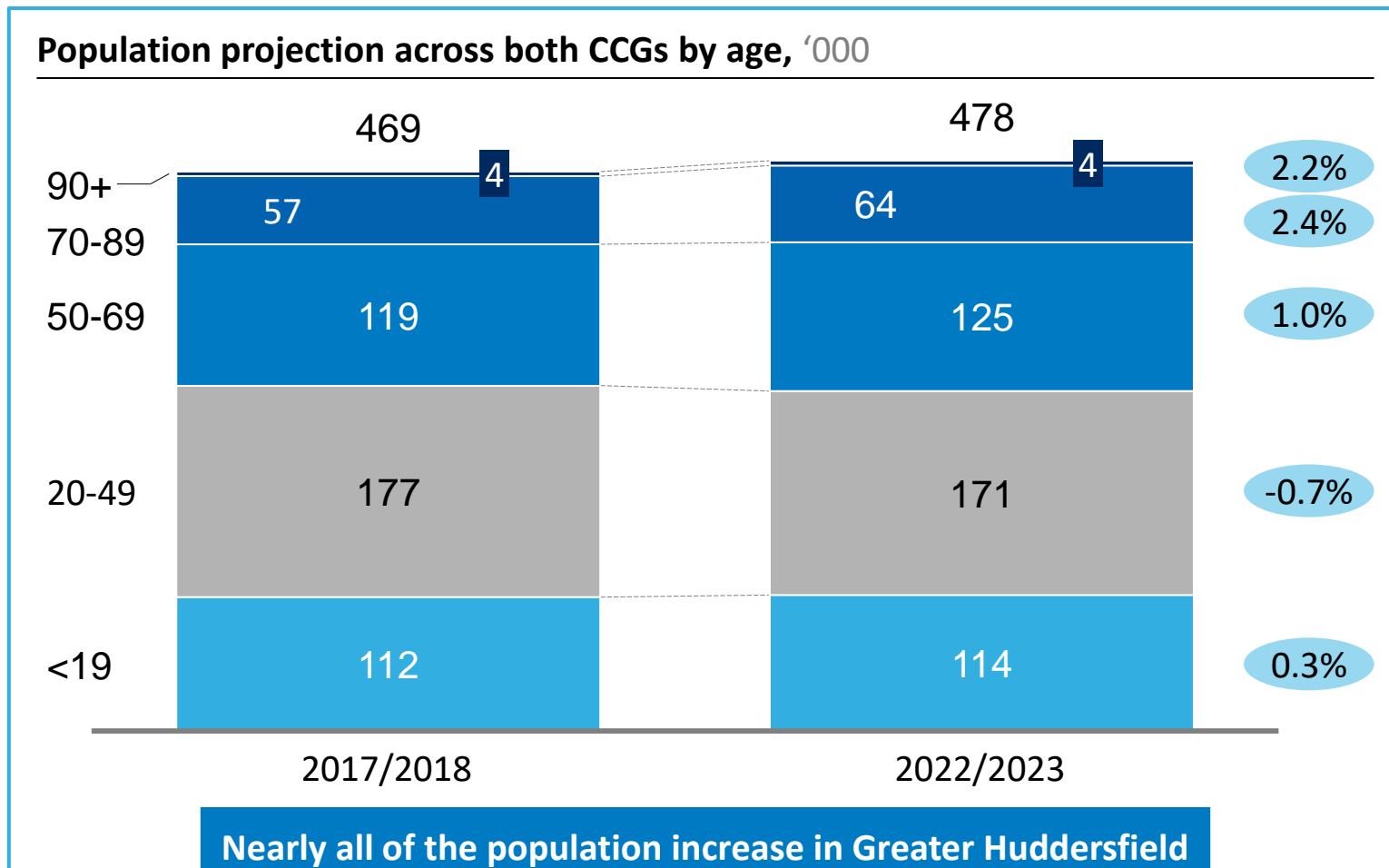- SWYPFT 54 acute psychiatric beds

- **Greater Huddersfield CCG** serves a population of about 253,000 in Huddersfield and surrounding areas, with an allocation of more than £290m.
- Its main **acute provider** is Calderdale and Huddersfield Foundation Trust.
- **Community services** are provided by Locala; **mental health services** by SWYPFT.

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The population is expected to grow by 0.4% p.a. to 2023 with over 70s growing 6x faster than the ov1erall population

( ) 2017/18-2022/23 compound annual growth rate

Population projection across both CCGs by age, '000

	2017/2018	2022/2023	CAGR
Total	469	478	
90+	4	4	2.2%
70-89	57	64	2.4%
50-69	119	125	1.0%
20-49	177	171	-0.7%
<19	112	114	0.3%

Nearly all of the population increase in Greater Huddersfield and Calderdale is set to happen in the over 50 population

NOTE: the distribution of population by age group is taken from ONS - Table 3: 2016-based subnational population projections for NHS regions and clinical commissioning groups in England and applied to actual population from QOF 2017/18 ; then adjusted for 5 growth rate for each age group from ONS
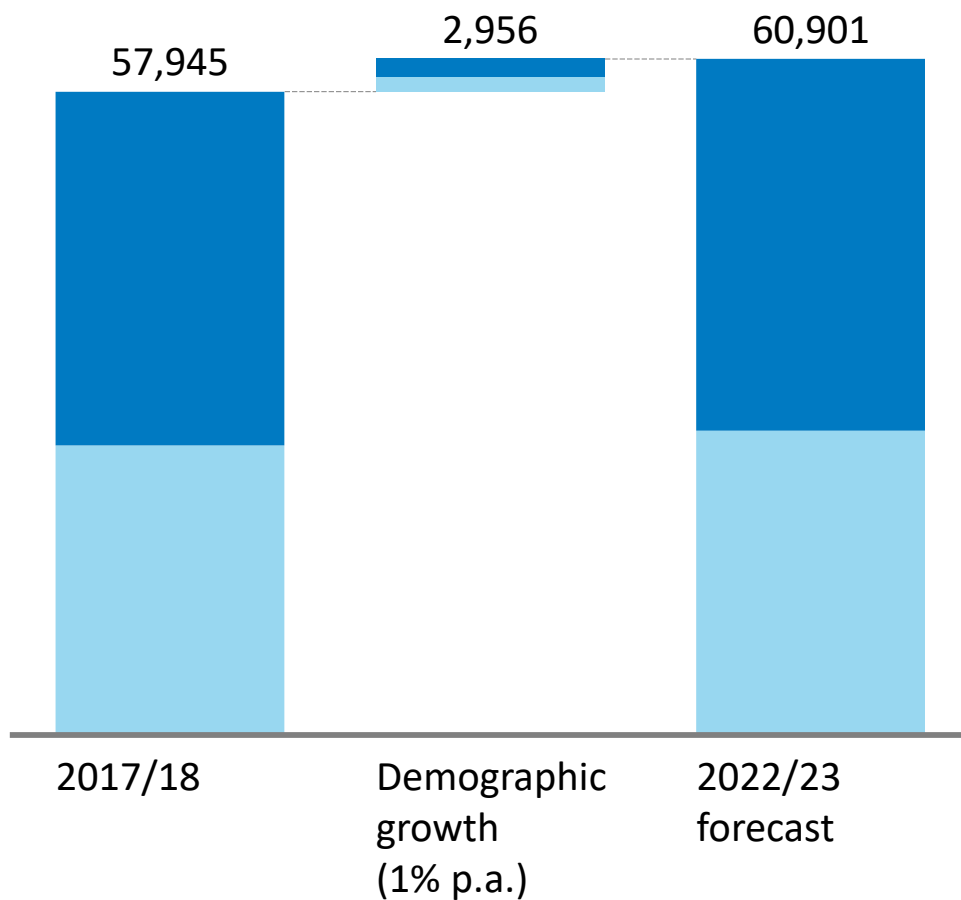
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If CCGs do nothing, by 2023 CHFT will require 43 more beds to cope with activity increases

NEL admissions per year, current and forecast by 2023
Patients, excl. oncology and maternity admissions

57,945

2,956

60,901

2017/18

Demographic growth (1% p.a.)

2022/23 forecast

Hospital bed requirements
Beds (all sites)[1]

843

43

886

2017 bed base

Demo-graphic growth (1% p.a.)

Forecast 2023 requirements
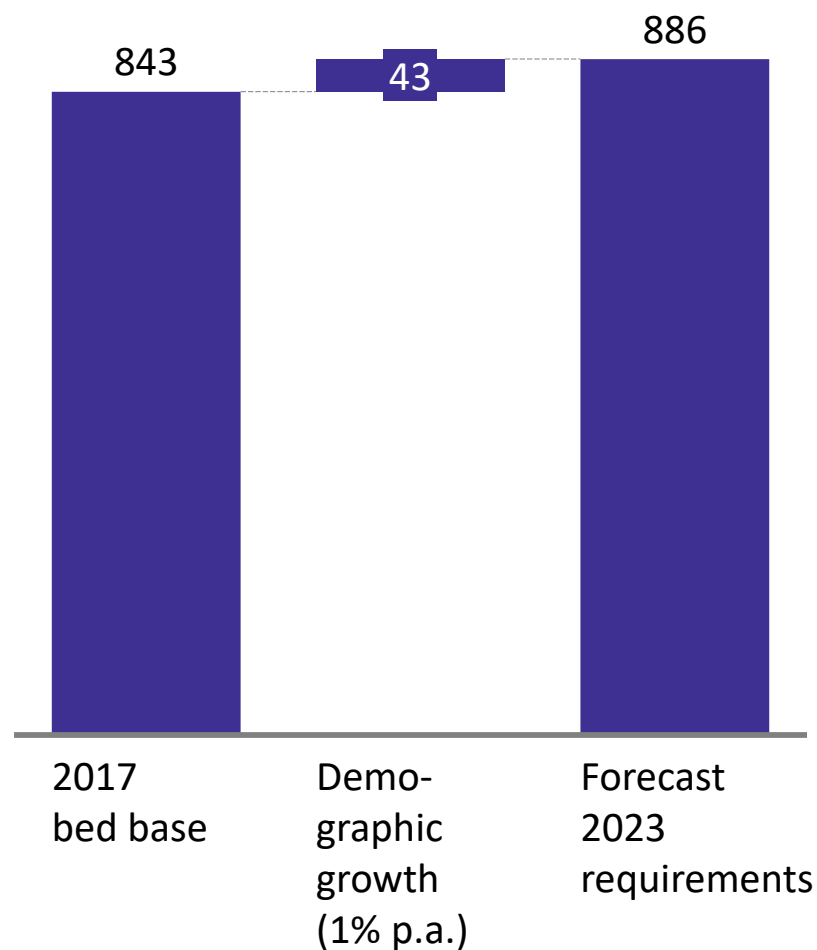
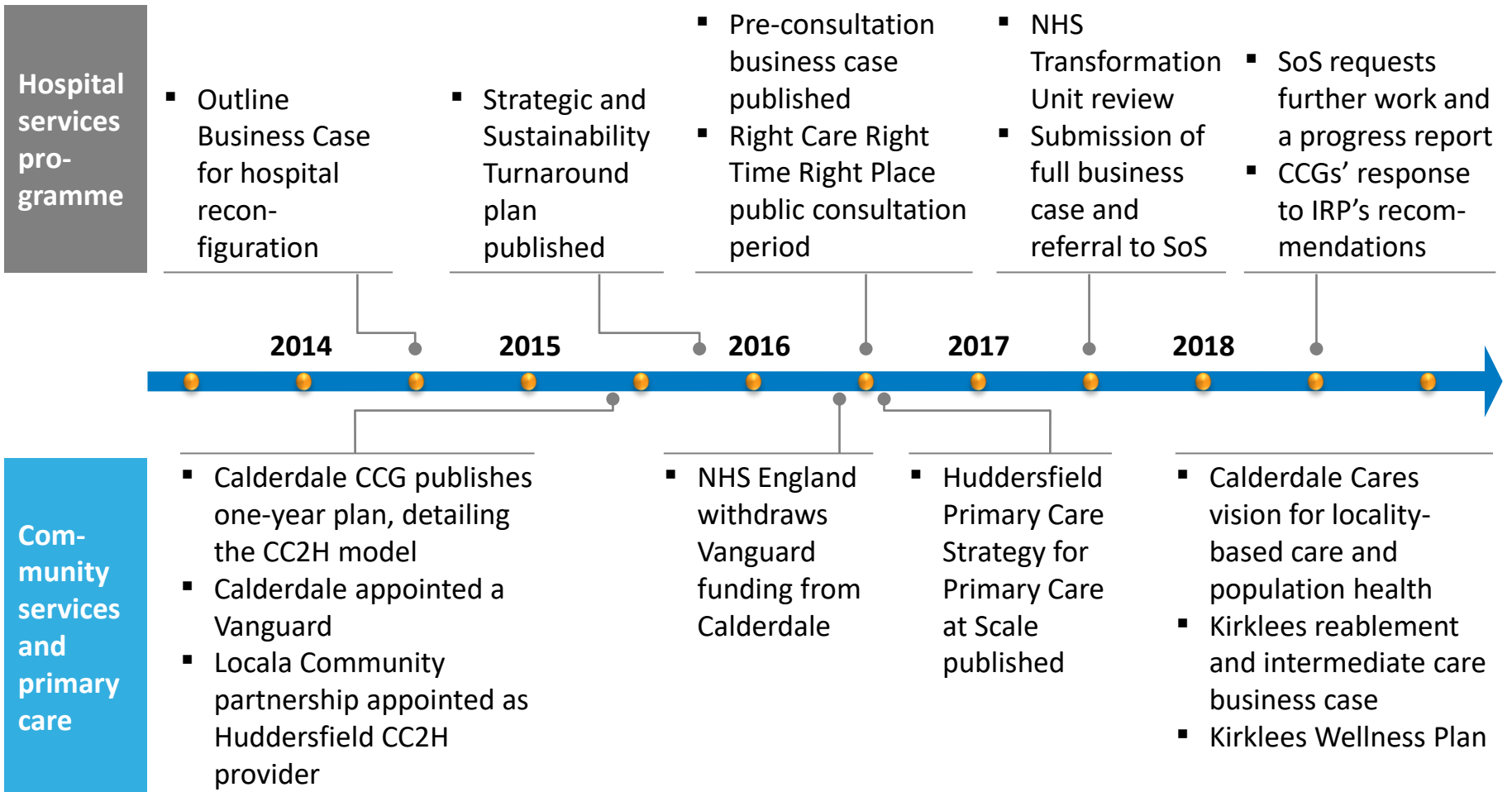1 Bed numbers in CHFT's model reflects usage and availability (e.g. day-cases can take 0.5 beds,), correct at time of CHFT's modelling in 2017, not the current physical bed base on the two sites (around 870)

SOURCE: Activity data and growth forecasts: 2017/18 SUS data with 1% per annum demographic growth assumption;   Bed base growth: CHFT modelling

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The Calderdale and Greater Huddersfield health systems have a series of major plans for the reconfiguration of patient care out of acute hospitals

	Main elements	**Current status**
Right Care, Right Time, Right Place: Hospital services programme	- Proposed **reconfiguration of existing hospital services** - Shift to a model with one hospital focussed on planned care, and one hospital focussed on non-elective and urgent care - Both hospitals would retain A&E, urgent care centres, day case and outpatient services - Calderdale Royal Hospital would provide emergency and acute care	- Reconfiguration plans are awaiting capital funding and approval from the Secretary of State - Acute hospital bed capacity will be maintained at its current level until the out-of-hospital plans and services can sufficiently reduce acute service usage
Care closer to home	- Both CCGs have developed **expanded community-based care models**, involving the provision of services closer to patients' homes rather than in hospital - Both CCGs are **developing plans to model their community service provision around the locality-based models of primary care**	- Community service provision has expanded over the last 5 years - GH CCG has appointed Locala as the sole provider of community care (subject to recommissioning in 2019). - CHFT provides community care in Calderdale, but the CCG is looking to redesign its community offering around localities
Locality models for primary care networks	- Both CCGs are designing **place-based networks of primary care** to cover localities of 30,000-50,000 patients - GP practices will meet on a regular basis to design and refine pathways specific to their local populations - This locality structure will be used as the foundation for further development of all other out-of-hospital care provision, and management of broader population health	- All networks will have held their first meetings by end of 2018 (initial meetings in Calderdale have already taken place). - Two pilot sites have been identified in Calderdale. - Both CCGs intend to integrate a range of community services (exact services to be included in the pilots are not yet decided). - Localities and their community hubs will also be the focus for wider community integration and third sector collaborations.
Redesign of intermediate care and reablement	Greater Huddersfield and Kirklees have developed plans that involve: - One, single access point into intermediate and reablement care, through MDT assessment - Integrates with the community hubs, primary care networks and domiciliary care provision - Promotes flexible assignment of intermediate care beds (as step-up or step-down, for example)	- Greater Huddersfield and Kirklees presented their joint business case to the SMT in October 2018 - Calderdale is considering a similar redesign process, but has not yet completed its service design. The CCG and authority may choose to redesign intermediate care as part of its wider changes to out-of-hospital care and the move to a locality model.

Timeline of major plans completed to date

Hospital services pro-gramme

- Outline Business Case for hospital recon-figuration

- Strategic and Sustainability Turnaround plan published

- Pre-consultation business case published
- Right Care Right Time Right Place public consultation period

- NHS Transformation Unit review
- Submission of full business case and referral to SoS

- SoS requests further work and a progress report
- CCGs' response to IRP's recom-mendations

2014   2015   2016   2017   2018

Com-munity services and primary care

- Calderdale CCG publishes one-year plan, detailing the CC2H model
- Calderdale appointed a Vanguard
- Locala Community partnership appointed as Huddersfield CC2H provider

- NHS England withdraws Vanguard funding from Calderdale

- Huddersfield Primary Care Strategy for Primary Care at Scale published

- Calderdale Cares vision for locality-based care and population health
- Kirklees reablement and intermediate care business case
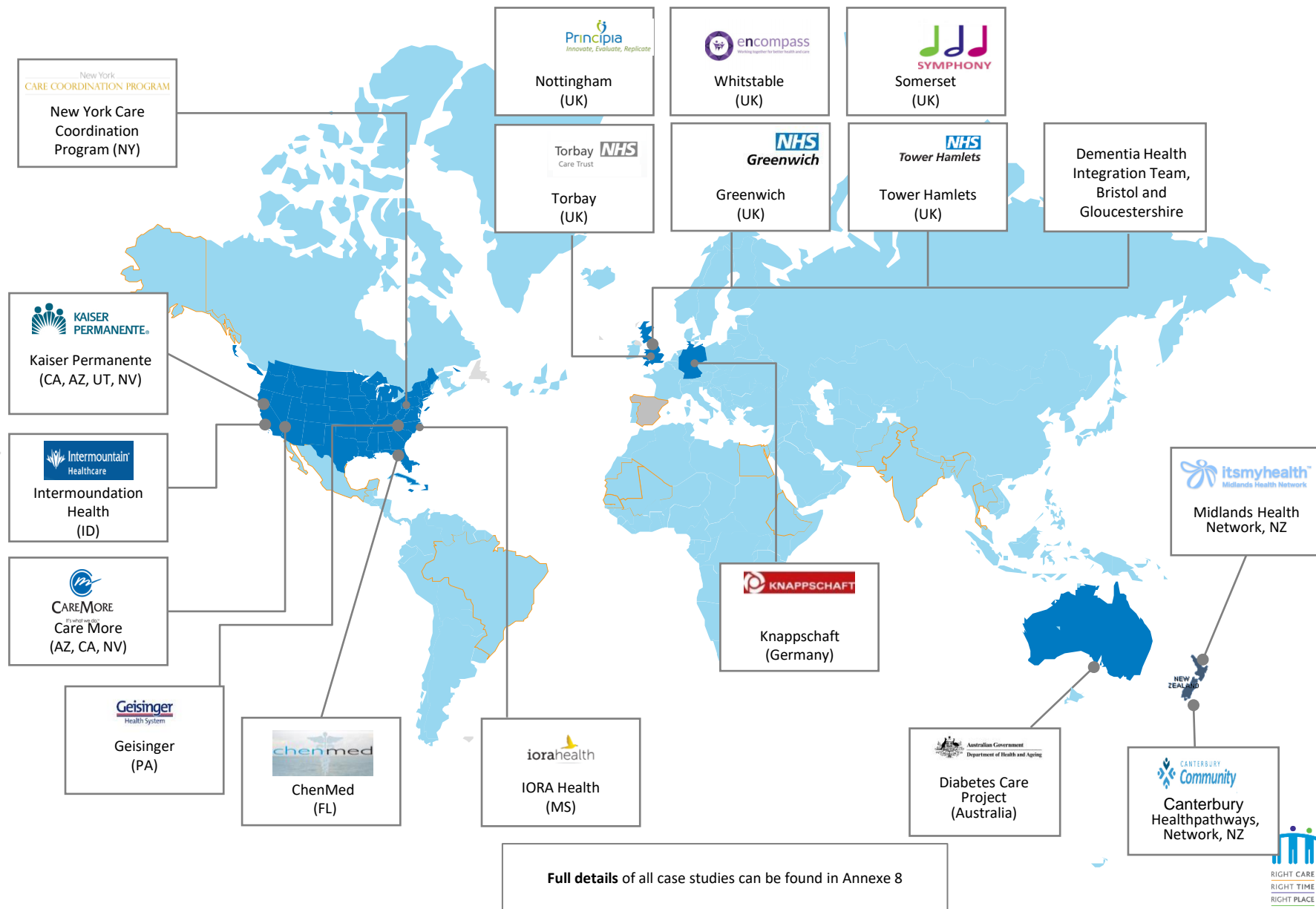- Kirklees Wellness Plan

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- The baseline position

- **An opportunity to do things differently**

  — **Assessment of the total potential within Greater Huddersfield and Calderdale**

  — What would a top-performing system look like within Calderdale and Greater Huddersfield?

- How do existing plans measure against this vision, and what is their expected impact?

- What is the capacity required to deliver the proposed model of care, and how should it be organised?

- How should this be done in practice?

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Section summary: Assessment of the total potential within Greater Huddersfield and Calderdale

- Systems around the world have made significant changes to their acute hospital usage, and improved the quality of their out-of-hospital care, by transforming to fully-integrated care systems

  – *See annexe 8 for detailed case studies from the UK and around the world*

- These **top-performing systems have 20-40% fewer NEL bed days** per weighted population than Calderdale and Greater Huddersfield

- They have got to this point by achieving reductions in NEL bed days of 15-40% over 4-6 years

- Calderdale and Greater Huddersfield CCGs have set an **ambition to reduce NEL bed days by 30% in 5 years**, to make them one of the best-performing CCGs in the UK
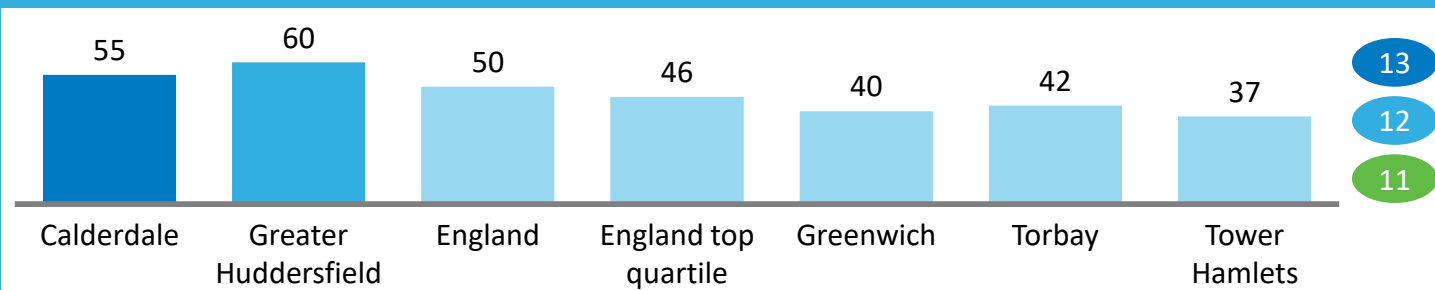
International health systems have transformed their reliance on acute services by moving to an integrated out-of-hospital care model
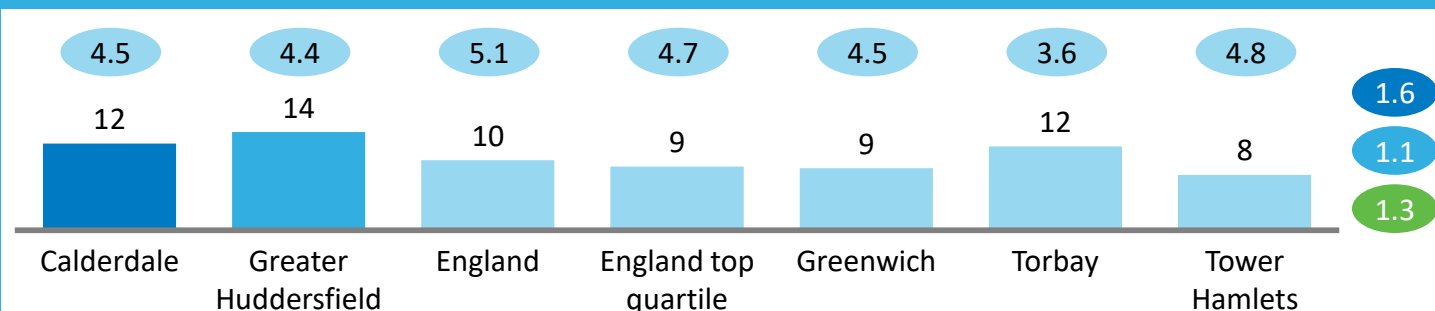

New York Care Coordination Program (NY)

Nottingham (UK) — Principia
Innovate, Evaluate, Replicate

Whitstable (UK) — encompass
Working together for better health and care

Somerset (UK) — SYMPHONY

Torbay (UK) — Torbay NHS Care Trust

Greenwich (UK) — NHS Greenwich

Tower Hamlets (UK) — NHS Tower Hamlets

Dementia Health Integration Team, Bristol and Gloucestershire

Kaiser Permanente (CA, AZ, UT, NV) — KAISER PERMANENTE

Intermoundation Health (ID) — Intermountain Healthcare

Care More (AZ, CA, NV) — CAREMORE It's what we do

Geisinger (PA) — Geisinger Health System

ChenMed (FL) — chenmed

IORA Health (MS) — iorahealth

Knappschaft (Germany) — KNAPPSCHAFT

Midlands Health Network, NZ — itsmyhealth Midlands Health Network

Diabetes Care Project (Australia) — Australian Government Department of Health and Ageing

Canterbury Healthpathways, Network, NZ — CANTERBURY Community

Full details of all case studies can be found in Annexe 8

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Top performing UK systems have 10% fewer NEL admissions and 20-30% lower length of stay

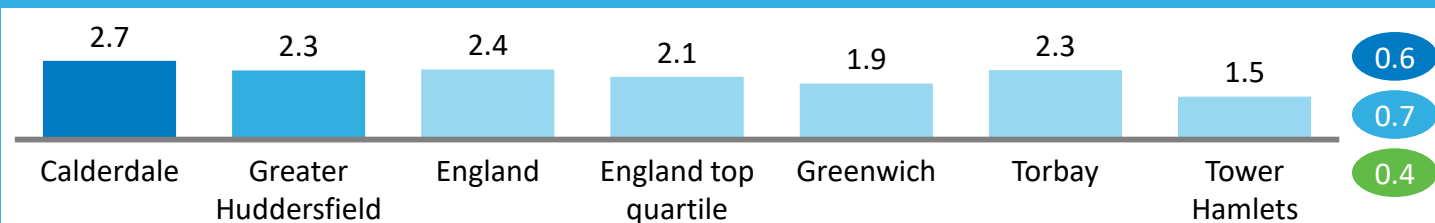(X) ALOS, days   (X) Calderdale variation[1]   (X) Greater Huddersfield variation[1]   (X) Top quartile variation[1]

NEL bed days per 100,000 weighted population, 000s bed days[2]

Calderdale	Greater Huddersfield	England	England top quartile	Greenwich	Torbay	Tower Hamlets
55	60	50	46	40	42	37

13
12
11

NEL admissions per 100,000 weighted population, 000s admissions[2]

Calderdale	Greater Huddersfield	England	England top quartile	Greenwich	Torbay	Tower Hamlets
4.5	4.4	5.1	4.7	4.5	3.6	4.8
12	14	10	9	9	12	8

1.6
1.1
1.3

EL admissions per 100,000 weighted population, 000s admissions (2016/17)[3]

Calderdale	Greater Huddersfield	England	England top quartile	Greenwich	Torbay	Tower Hamlets
2.7	2.3	2.4	2.1	1.9	2.3	1.5

0.6
0.7
0.4

- Calderdale and Greater Huddersfield have ~ 25% more NEL admissions than England's top quartile.

- Torbay has one of the best lengths of stay in the country, particularly for over 65s – 20-30% lower than Calderdale and Greater Huddersfield.

- Variation for NEL bed days for both CCGs is significantly larger than for the UK top quartile.
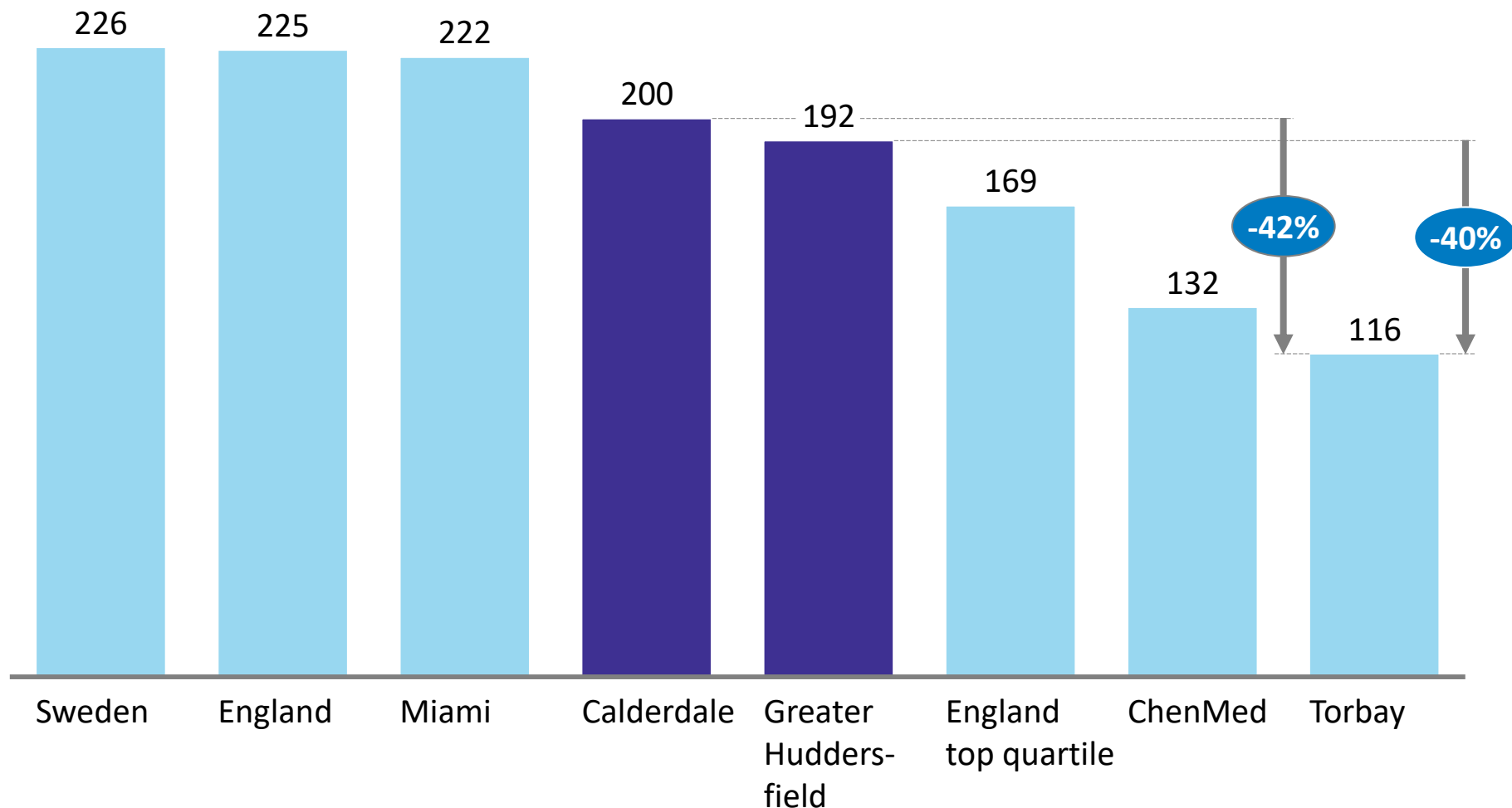
1 System variation defined as interquartile range of 000s of admissions per 100,000 weighted population between GP practices of 16 hours, 7 days a week
2 All data are for 2016/17, save for Calderdale and Greater Huddersfield, which represent the most recent 2017/18 data.
3 Significant differences between the system's 2017/18 SUS EL admission data and 2016/17 HES benchmark data make sensible comparison impossible. Data for EL admissions is all 2016/17 HES data. (More recent benchmark data are not yet available from NHS Digital.)

SOURCE: HES, 2016/17 data, Calderdale and Greater Huddersfield SUS data 2017/18, and ONS population estimates.

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Focusing on the older population, the opportunity is even greater, with leading systems achieving 20-40% fewer bed days for over 65s

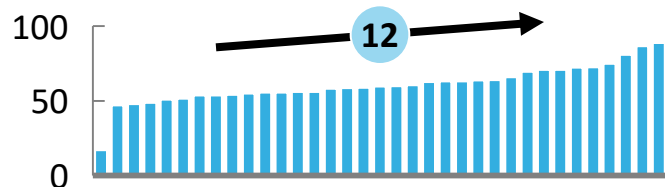**NEL bed days per 100,000 aged over 65s supported by the system,** 000s bed days[1]

Sweden	England	Miami	Calderdale	Greater Huddersfield	England top quartile	ChenMed	Torbay
226	225	222	200	192	169	132	116

-42%   -40%

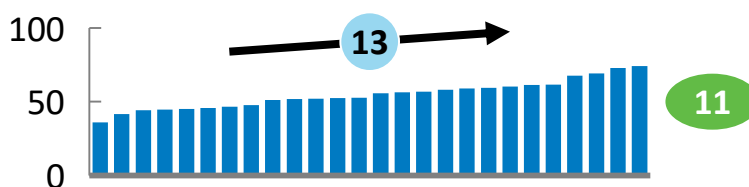RIGHT CARE
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Calderdale has greater variation in NEL metrics than top-quartile CCGs, indicating potential for improvement of performance by standardizing existing best practice

NEL bed days per 100,000 weighted population by GP practice, 000s bed days[2]
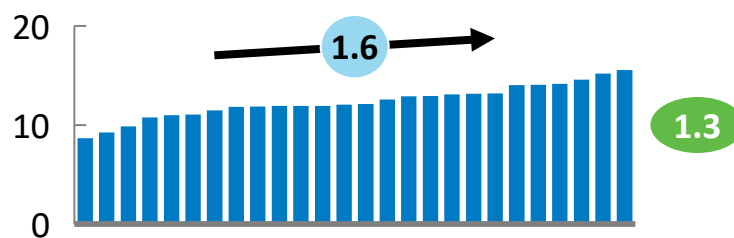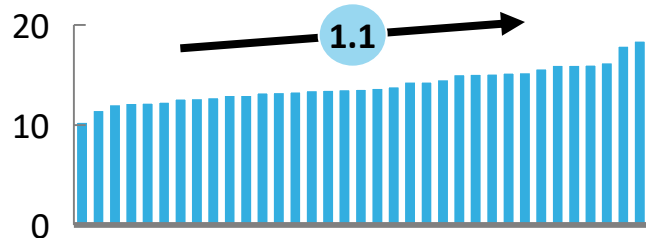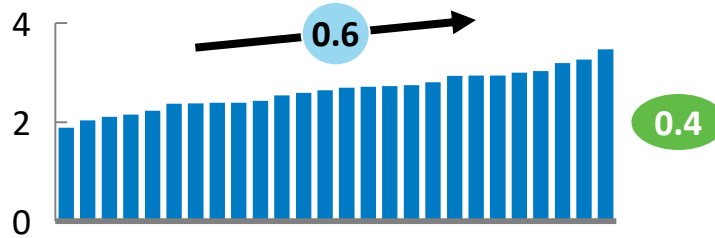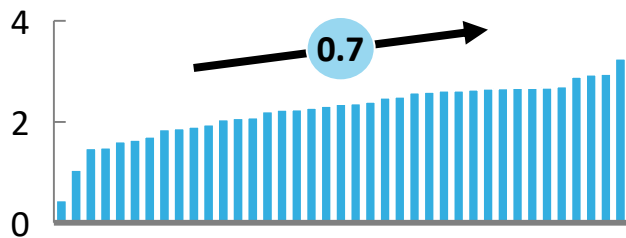
Greater Huddersfield

Calderdale

NEL admissions per 100,000 weighted population by GP practice, 000s admissions

Calderdale exhibits much larger variation in NEL admissions than top-quartile CCGS

EL admissions per 100,000 weighted population by GP practice, 000s admissions (2016/17)[3]

Both CCGs have higher variance in EL admissions than top-quartile CCGs

Legend:
- X — CCG variation[1]
- X — Top quartile variation[1]
- Greater Huddersfield
- Calderdale

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NEL admissions by GP practice population

Non elective admissions
Comparison on activity per 1000 weighted population
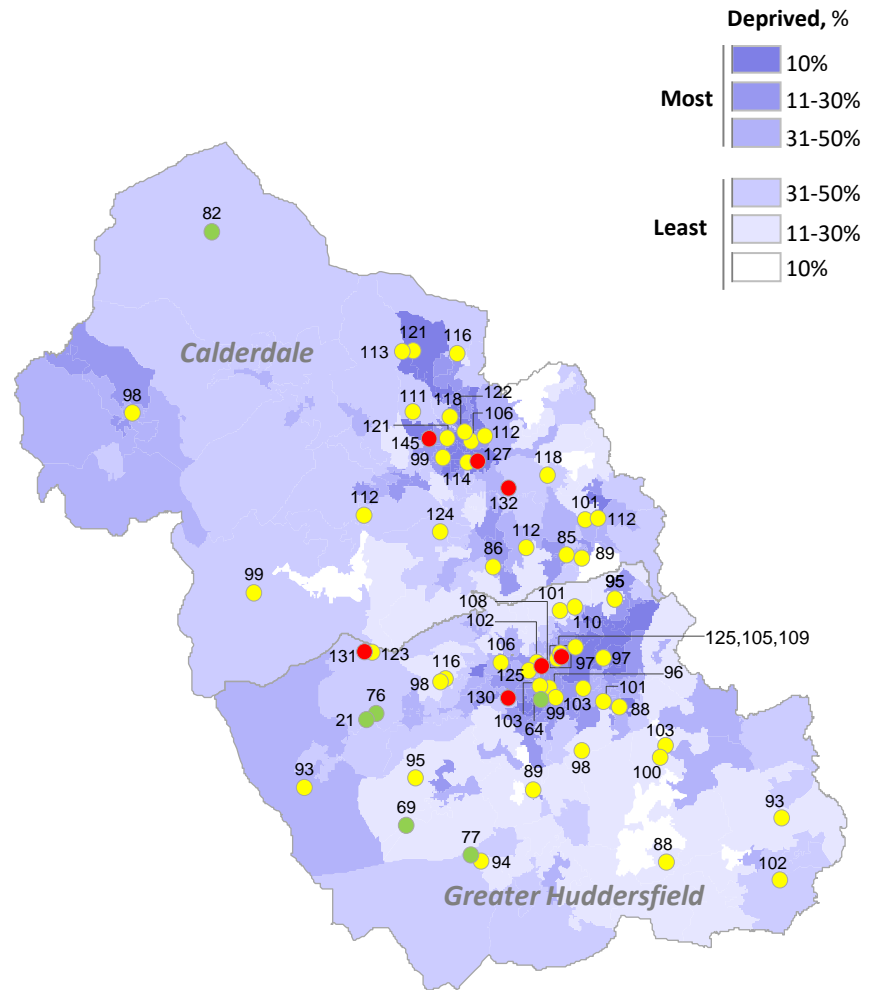
Non elective bed days
Comparison on time in hospital per 1000 weighted population

1 Quartiles and averages are for GP practices over the whole country.

SOURCE: HES 2016/17 and ONS 2015 IMD records.

Patients with one of three ACS conditions alone account for 11% (29,000) of NEL bed days

ACS conditions (000s admissions, 2017/18)[1,3]

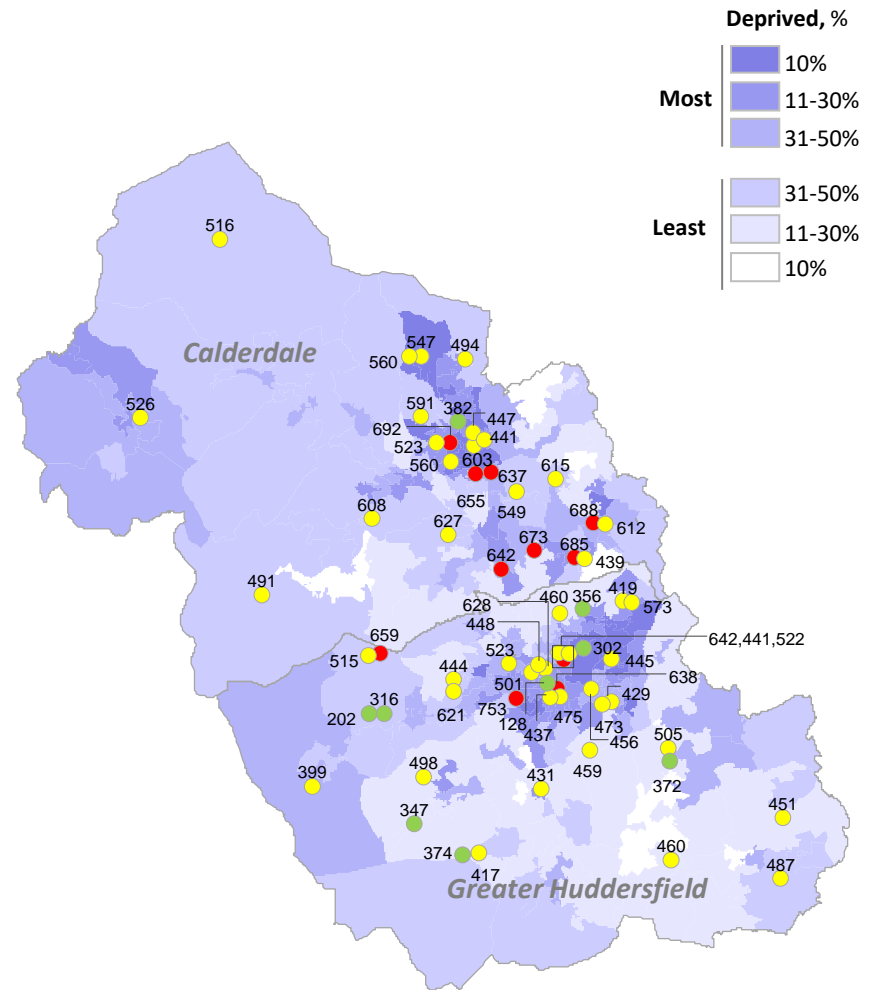|	
Calderdale and Huddersfield	4.3
National average	4.0
National top quartile	3.2

CNRA (000s admissions, 2017/18)[1,3]

Calderdale and Huddersfield	7.1
National average	6.3
National top quartile	5.3
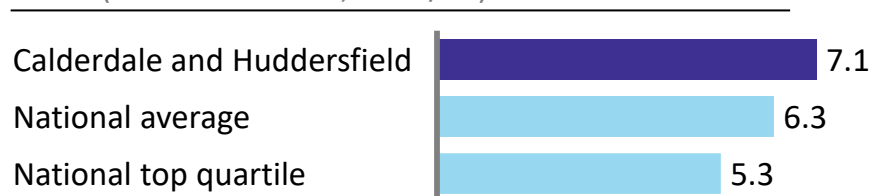
NEL from over 65s (000s bed days)[1,2]

Calderdale and Huddersfield	164
National average	169
National top quartile	137

NEL (000s bed days)[1,2]

Calderdale and Huddersfield	257
National average	221
National top quartile	203
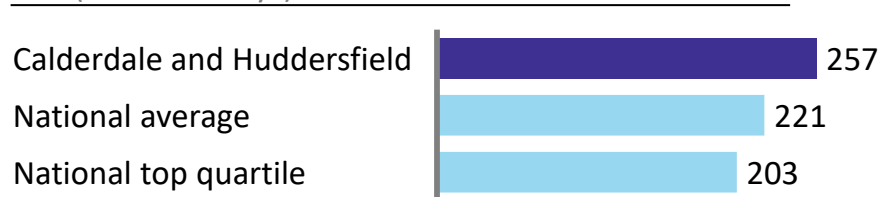
Top causes of ACS bed days
000s bed days in 2017/18
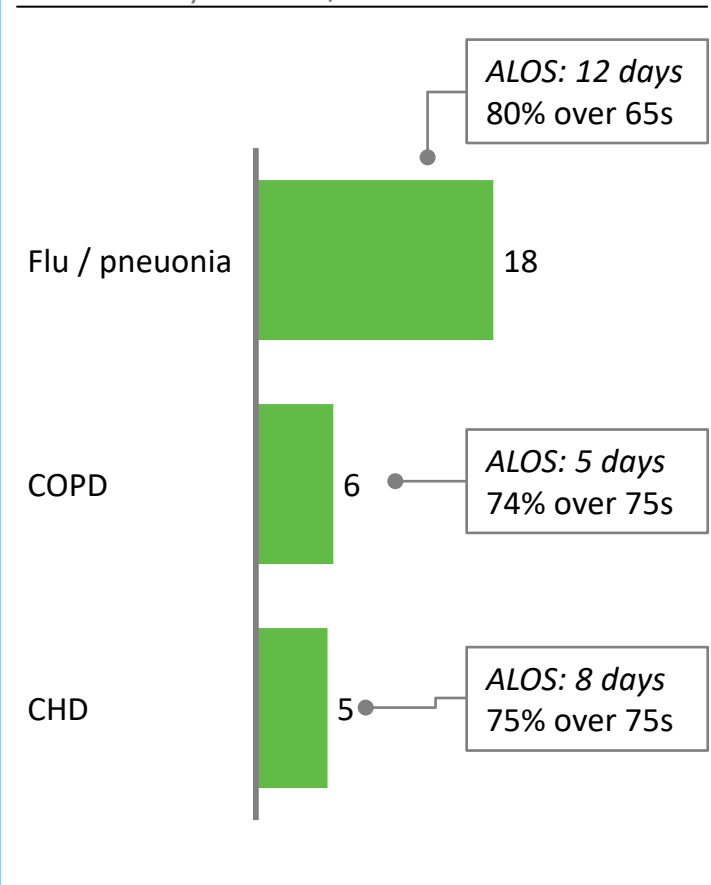
Flu / pneuonia	18
COPD	6
CHD	5

ALOS: 12 days 80% over 65s

ALOS: 5 days 74% over 75s

ALOS: 8 days 75% over 75s

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Top performing health systems have achieved 15-40% reductions in bed days through the introduction of integrated health systems

Changes in health system bed days reported over 4-6 year periods, for programmes implemented in the last 10 years, %
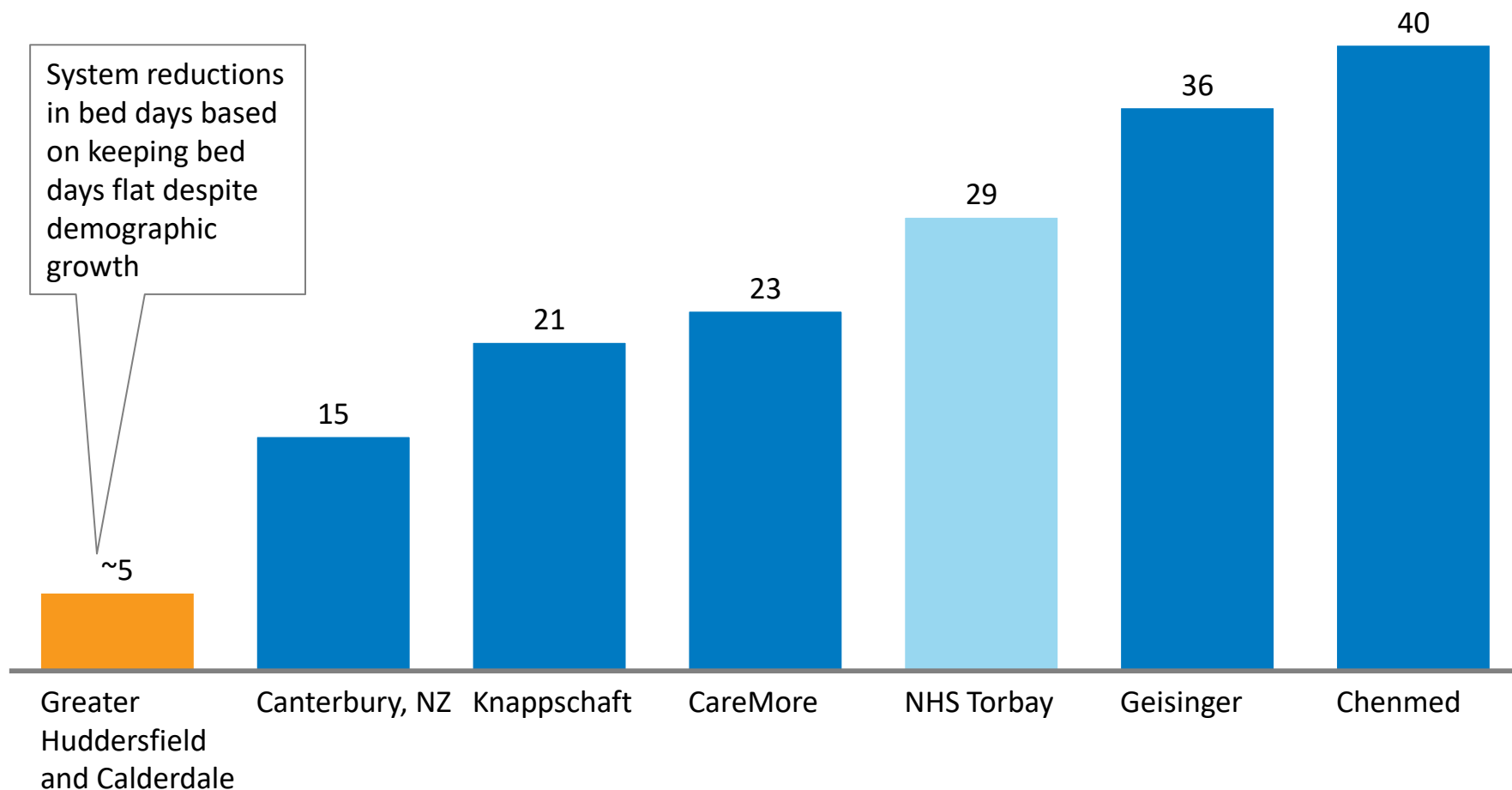
System reductions in bed days based on keeping bed days flat despite demographic growth

Category	Value
Greater Huddersfield and Calderdale	~5
Canterbury, NZ	15
Knappschaft	21
CareMore	23
NHS Torbay	29
Geisinger	36
Chenmed	40

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Both CCGs agree that they should seek to reduce NEL bed days by 30% over 5 years

Summary of evidence base

- Top-performing systems have 20-40% fewer NEL bed days per weighted population than Calderdale and Greater Huddersfield.
- These systems have got to this point by achieving reductions in NEL bed days of 15-40% over 4-6 years.
- There is potential within Calderdale and Greater Huddersfield to make similar changes, because:
  1. System improvements so far have only held off demographic growth;
  2. A significant portion of NEL admissions are avoidable, principally from flu, pneumonia, UTIs, COPD and CHD;
  3. There is larger variation in NEL admissions across the patch (especially in Calderdale) than in top-quartile CCGs; and
  4. Calderdale and Greater Huddersfield have not yet implemented a full out-of-hospital transformation that matches the best existing models.

Declared ambition

- CCGs must develop plans that **at least** offset demographic growth in patient demand, and better care for population health.

- CCGs believe that the potential in their system, and the gap to top-performing systems, indicates they can make a similar NEL reduction as the best UK comparators.

- This would involve better caring for population health, through an integrated out-of-hospital care model.

- **They have set an ambition of achieving a 30% reduction in NEL bed days over 5 years** by implementing this type of model.

- This ambition is a total bed-day opportunity. This includes both admission avoidance and length of stay reductions.[1]

1 As of November 2018, there are no plans to reduce bed capacity until plans for sufficient acute bed usage reductions can be demonstrated.

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- How do existing plans measure against this vision, and what is their expected impact?

- What is the capacity required to deliver the proposed model of care, and how should it be organised?

- How should this be done in practice?

Section summary: What would a top-performing system look like within Calderdale and Greater Huddersfield?

- 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 constructed separately to serve high-need, medium-need and low-need populations

- **Top integrated care systems provide 13 types of programme for these populations**, that broadly aim to (i) proactively manage population health and prevent admission, (ii) provide rapid access to primary care and specialist advice in out-of-hospital settings, and (iii) facilitate discharge and transfers between care settings.

  - *See Annexe 1 for a detailed description of what these packages of care could comprise for each of the high-, medium- and low-needs population groups in Calderdale and Greater Huddersfield*

Top performing systems provide highly-targeted care packages to patients based on their needs

Underlying Needs

Pyramid (top to bottom):
- *People with complex needs*
- High risk of deterioration
- Medium risk of deterioration
- Low risk
- Very low risk

Tier 5 — People with a very high risk of deterioration, requiring regular supervision and support, i.e. frail[1] people in the final phase of life, people with multiple health and social care needs

Tier 4 — People in a stable condition but at high risk of requiring sudden higher levels of care, e.g. frail[1] people with multiple LTCs, severe learning and physical disabilities

Tier 3 — People in a stable condition but at moderate risk of requiring higher levels of care, i.e. People with at least one LTC

Tier 2 — People that are mostly healthy (no LTCs) but some recurrent care needs, e.g. Young children, pregnant women, short term illness

Tier 1 — People with no LTCs and minimal care needs, e.g., Young healthy adults

1 LTC (Long term condition) defined as any of: AF, CHD, HF (all causes), Hypertension, PAD (including Stroke, TIA), Asthma, COPD, Cancer, CKD, DM, Pall care, RA, Osteoporosis, Dementia, Depression, Epilepsy, Learning Disabilities, Mental Health; excludes CVD primary prevention

For each population segment, bundles of care are provided to address three areas: (1) proactive care and admission prevention, (2) access to care outside of hospital, and (3) support with transition out of or away from hospital care

1 — Proactive care

Proactive care for high intensity needs:

- (a) Case management
- (b) MDT
- (c) Care co-ordination
- (d) Individualised plans
- (e) Frequent touch points
- (f) Scheduled follow-up
- (g) Self empowerment and education

Proactive care for medium intensity needs:

(b) (d) (e) (f) (g) (k)

Proactive self-management / wellness

- (g) Self-empowerment and education

2 — Access to care

Rapid response and access to enhanced urgent and planned specialist care:

- (h) Rapid response
- (i) Rapid access to primary care
- (j) Access to specialist care
- (k) Appropriate referral and medication practices

Access[1] to enhanced urgent and planned specialist care

- (i) Rapid access to primary care
- (j) Access to specialist care
- (k) Appropriate referral and medication practices

3 — Support with care transition

Facilitated to move from one setting of care to another:

- (l) Discharge support
- (m) Intermediate care

Population segments (pyramid)

- People with complex needs
- High risk of deterioration
- Medium risk of deterioration
- Low risk
- Very low risk

1 Includes face to face access to physical and mental health services, community and social services, and non-face to face access to all of the above when appropriate

Definition of the defining elements of integrated out-of-hospital care

		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

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- What is the capacity required to deliver the proposed model of care, and how should it be organised?

- How should this be done in practice?

Section summary: How do existing plans measure against this vision, and what is their expected impact?

- Across Calderdale and Greater Huddersfield CCG and their providers, there are over 25 initiatives that:

  - Are new or expanding from 2018/19, or planned for the future;

  - Will have an impact on acute hospital care in terms of NEL bed days; and

  - Will therefore reduce the system's usage of acute services over and above the baseline.

  - *See Annexe 2 for full details of these plans, and the dates each initiative will be fully rolled out*

- These initiatives will go some way towards realising the full potential of the system to remove 30% of NEL bed days over 5 years, and **could save at least 28,000 bed days** (c. 10% of baseline).

  - *See Annexe 3 and accompanying excel model for detailed impact estimates, timelines and risks of not fully achieving these estimated effects.*

- Overall, all partners in Greater Huddersfield and Calderdale are working to implement best practice and there has been a substantial amount of progress in both defining system strategies and rolling out targeted initiatives in the last 2 years. Nevertheless, many care pathways are highly fragmented, with many points of access, and many teams face significant capacity shortfalls.

  - *See Annexe 4 for a more detailed qualitative assessment of current plans, what it takes to move to best practice, and risks to achieving this transformation.*

- The **change of delivery model** in both CCGs to a locality or primary care network model **provides an opportunity to transform the way care is provided**, and to comprehensively deliver an integrated out-of-hospital service in the area.

  - *The next sections will describe what a fully-integrated model of care would look like, and what it would take to put in place.*

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

Legend:
- Both CCGs
- Calderdale
- Greater Huddersfield

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

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1 Overview of new or expanding schemes: Prevention and pro-active care

Both CCGs

(c) **End of life care model reconfiguration:** CHFT and Kirkwood Hospice are leading an integrated remodelling of end of life care in Calderdale and Greater Huddersfield. Its focus is on care co-ordination, as well as out of hours care, ensuring that patients have care plans in place and are appropriately cared for in their preferred settings.

(c) **Single points of access:** Several "single points of access" exist at the moment, e.g. for adult mental health across both CCGs, the acute frailty services run by CHFT, Locala services, the Gateway to Care for intermediate and adult social care in Calderdale, the respiratory services in Calderdale, MSK clinics (separately) in both CCGs, and for adult social care in Greater Huddersfield. Both CCGs have plans to simplify some of these access routes.

(c) **Red bag scheme**: Provision of red bags to care homes, to improve care co-ordination between the hospital and care home.

(c) **End of Life Training** programmes for care home staff.

Calderdale

(b) **Remote monitoring of LTC patients at home** particularly for COPD and respiratory patients, with support provided by an MDT.

(g) **Active Calderdale** plans for the Borough to be the most active in the North, as part of the national Local Delivery Pilots to improve population activity.

(g) **National Diabetes Prevention Programme** relaunch in 2018/19.

Greater Huddersfield

(a) **Atrial Fibrillation Stroke Prevention:** case identification and management for patients with AF. GPs are supported to better identify AF patients, with access to mobile ECG kits. Patients are given access to appropriate anticoagulant medication to reduce stroke risk.

(a) Expansion of **Locala's Local Incentive Schemes** that provide access to case management and care co-ordination to prevent admissions from specific risk groups

(b) **Care home support and interim service**: an expanded re-procurement of care home support services, providing MDT support to care homes in the area, 24/7 telemedicine support and a single nominated GP for each care home.

(c) Expansion of the **EPACC** programme, to increase the proportion of people with electronic palliative care co-ordination records at death, and reduce the proportion of those with EPACCs dying in hospital.

(g) **Kirklees Wellness Model** as part of Community Plus aims for improved population wellness and physical activity

2 Overview of new or expanding schemes: Swift and appropriate access to care

Both CCGs

(j) **Community respiratory services**. Existing primary care and support services for COPD and asthma patients are being re-funded in Calderdale, but the system hopes to improve this area of focus as part of its shift to an integrated care alliance. Respiratory services are also one area of focus for admission avoidance by Locala in Greater Huddersfield.[1]

(j) **Frailty and falls programme.** A comprehensive set of initiatives to target frailty and falls is operational, and expanding, in both CCGs.

(k) **Medicines management programmes** in both CCGs, that target both cost of drugs, and polypharmacy / medicine effectiveness.

(i) **Substantive primary care changes** include:
- **Access incentive schemes** to increase capacity in GP appointments;
- **Improved or Extended Access Schemes** to widen the hours in which appointments are available;
- **Implementation of the ten high-impact changes in the GP Forward View** to release GP time and make primary care more effective;
- **Remodelling of primary care into place-based locality models**, in line with the Five Year Forward View; and
- **Digital primary care development** to improve patients' access to appropriate primary care, and to improve primary care efficiency, freeing up capacity.

(h) **Improvements to both Hear and Treat and See and Treat pathways,** led across CCGs by YAS.

Calderdale

(j) **Outpatient antimicrobial therapy (OPAT)** provided in the community, preventing admission: this programme is mature and successful in GHCCG, the hospital still provides services in **Calderdale**, where the CCG aims to develop a similar community model.

Greater Huddersfield

(j) Expansion of the **DVT pathway** for diagnosis and treatment in primary care.

(i) **Expansion of primary care workforce**, including nursing and clinical pharmacists.

3 **Overview of new or expanding schemes: Support with care transition**

Both CCGs

l **Delayed Transfers Of Care**: coordinated efforts to further reduce DTOCs include:

— Hospital-bed implementation of the **8 high-impact changes** to reduce DTOCs, and the **SAFER** patient flow programme; and

— **Discharge to assess** programme, providing flexible step-up and step-down intermediate care (or "choice and recovery") beds in nursing homes across and community hospitals both CCGs.

m **Enhanced Reablement / Recovery at Home**: ongoing expansion of home care and reablement services in both CCGS to support the removal of rehab beds from ward 8C at CHFT.

Calderdale

l **Hospital avoidance team** capacity and service growth, to provide 9am-9pm services 7 days per week.

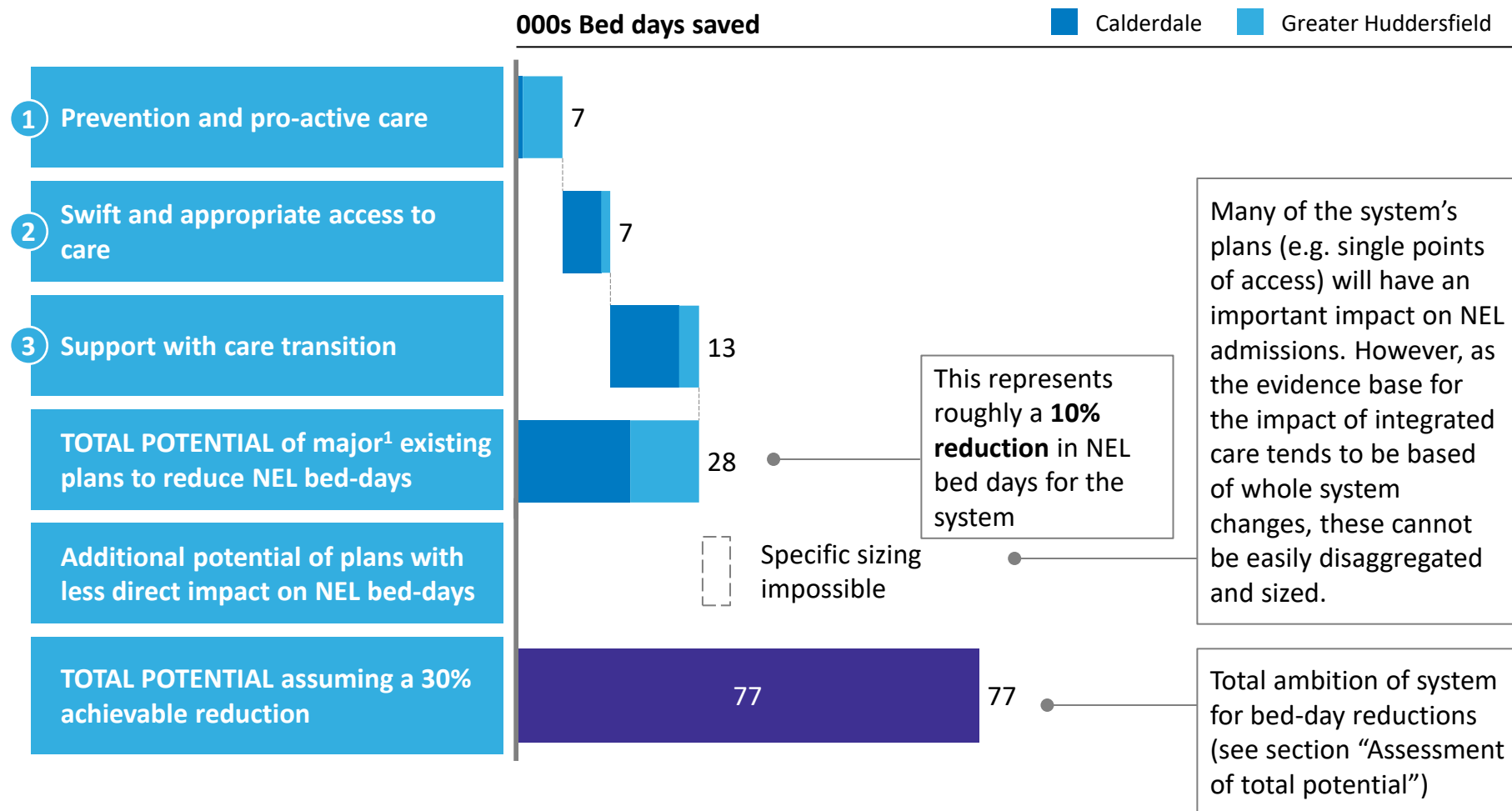**m** **Reorganisation of home care** provision by the local authority.

Greater Huddersfield

m **Redevelopment of the intermediate care and rehabilitation programme** in Greater Huddersfield and Kirklees over the next 2-5 years, designed around a centralised independent living team.

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Calderdale and Greater Huddersfield's most impactful current plans could achieve a c. 10% reduction in NEL bed days over 5 years

000s Bed days saved

■ Calderdale   ■ Greater Huddersfield

(1) Prevention and pro-active care — 7

(2) Swift and appropriate access to care — 7

(3) Support with care transition — 13

TOTAL POTENTIAL of major[1] existing plans to reduce NEL bed-days — 28

This represents roughly a **10% reduction** in NEL bed days for the system

☐ Specific sizing impossible

Additional potential of plans with less direct impact on NEL bed-days

Many of the system's plans (e.g. single points of access) will have an important impact on NEL admissions. However, as the evidence base for the impact of integrated care tends to be based of whole system changes, these cannot be easily disaggregated and sized.

TOTAL POTENTIAL assuming a 30% achievable reduction — 77   77

Total ambition of system for bed-day reductions (see section "Assessment of total potential")

For full details, refer to annexe 3 and accompanying excel model

1 Plans judged likely to have an impact on NEL admissions within 5 years, and for which a specific evidence base exists

CCGs and LAs have several important plans for more integrated out-of-hospital care which are supported by a disaggregated evidence base

◔ Limited impact or maturity   ● Significant impact or maturity

		Likely impact on NEL admissions	**Ambition of plans vs best practice**	**Strategy and implementation plan in place**	**Plans assessed**	**Comment**
1 Prevention and pro-active care	**c** Care co-ordination	◕	◑	◔	▪ Single points of access	▪ Multiple SPAs ▪ Plans to consolidate some, not all ▪ Implementation plan not in place
	g Self-empower-ment and education	◑	◕	◑	▪ Active Calderdale ▪ Kirklees Wellness Programme ▪ National Diabetes Prevention Programme	▪ Kirklees' plans are clear in requirements, and looking to procure single provider ▪ Calderdale is just starting its strategy & implementation
2 Swift and appropriate access to care	**h** **i** Rapid response, and rapid access to primary care	◕	◕	●	▪ Access Incentive Schemes ▪ Extended Access Schemes ▪ Digital Primary Care Development ▪ 10 High Impact Changes ▪ Wider Workforce Roles in Primary Care	▪ CCGs are responding to national initiatives to put expand patients' access to primary care ▪ This involves both increased capacity, a broader range of hours of operation, and a wider range of accessible specialties (including nursing or pharmacists) ▪ The move to locality-based primary care will assist in the rapid provision of access to primary care

Development of these plans will go some way towards realising the full 30% NEL bed-day reduction potential of the system
- The evidence base that covers these types of intervention consists of systems that have implemented multiple initiatives as part of a larger transformation
- It is not possible from these cases to identify specific support for each plan, or group of plans
- We have provided a qualitative assessment of these schemes' maturity and ambition against best practice

The risks of not delivering on out-of-hospital plans go beyond financial impact, also affecting future operations and the quality of care

	Risks of not delivering the 10% savings from current plans	**Risks of not delivering the 30% savings from a transformation in care**
Quality of care and patient experience	▪ Without improvements to care, diseases will develop further; when patients become ill they will deteriorate further; and when treated, patients will be in hospital for longer ▪ Without the increases to community-based care closer to home, patients will have more limited remote access to care and have to travel further to access care	▪ Additionally, without a reformed operating model, **services will remain fragmented**, difficult to access and navigate for patients
Operational and financial implications	▪ Without successfully mitigating demographic growth, CHFT will need to invest in more beds to increase the capacity of their hospitals	▪ Without demonstrating a reduction in acute service usage, the **reconfiguration of hospital sites** - and the associated bed reduction and financial savings **will not be possible** ▪ The **longer-term sustainability of the model of care is jeopardised**: a hospital system is being used to provide care to those who shouldn't be in hospital

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Summary assessment of system plans: the overall level of ambition and progress to-date is encouraging

Learning from best-practice	In their design of individual pathways, both CCGs are frequently adopting best practice. MDT assessment underpins many areas of community care. National best-practice guidelines underpin the transformations planned for end of life care and for increasing access to GPs and primary care. CCGs are also ensuring to design their various initiatives around the populations with the highest needs, and that place most demand on the system (for example, care home residents and the frail elderly).
Focus on population health and wellness	Additionally, both CCGs are investing in programmes to improve the broader health and wellbeing of their populations. Active Calderdale and the Kirklees Wellness plan have set strong ambitions for the future health and mobility of their populations, but both schemes are yet to develop much beyond the articulation of a strategy and requirements for service provision.
Ability to pilot and scale successfully	Both CCGs have demonstrated their ability to run pilot programmes, and turn them into mature schemes that have measurable impact on hospital care. Good examples include the OPAT programme in Huddersfield, the QUEST programme in Calderdale, and changes to the provision of intermediate care beds in nursing homes.
Working together with multiple partners	Many schemes demonstrate an ability for all system partners to work together, under nominated executive leadership. Good examples include the delayed transfer of care programme, led by CHFT, and the reforms to end of life care which involve close working between the Kirkwood Hospice, CCGs, Las and CHFT. CCGs are also borrowing ideas for well-performing new initiatives from each other, for example the development of care home support in Greater Huddersfield that is learning from the success of QUEST, or plans to improve OPAT in Calderdale in light of its success in Greater Huddersfield. As the system moves to integrate services within community hubs, it is crucial that all partners, from social services and primary care through to community providers, are able to contribute to the design of the system, as well as to its running and oversight.

Summary assessment of system plans: there remain significant challenges around the multiplicity of services, and difficulties creating capacity in the right places

Fragmenta-tion and duplication of services	Both Calderdale and Greater Huddersfield have been expanding and improving service provision in the community. However, there is now a large amount of fragmentation and duplication of services, and a very large number of entry points into out-of-hospital care. For example, there are eight separate "single points of access" for various community and social services across the CCGs; and a very large number of teams that provide some form of home care or at-home reablement service. These teams may have differing scopes in terms of the intensity or duration of support that they provide, but they are run relatively independently, and are not able to efficiently share resources among themselves. The integration between community care teams and social work teams is even more limited.
Capacity within the intermediate and home care services	Both CCGs frequently find that their intermediate bed provision, and short-term reablement teams, are operating at capacity. Intermediate beds in both CCGs have very long stay patients (in months, rather than weeks), and most capacity is currently used only as a step-down resource. Greater Huddersfield has also identified that their reablement teams are keeping many patients on their caseload for longer than expected, transitioning into the provision of longer-term domiciliary care.
Workforce	Both CCGs face recruitment challenges that compound the capacity problems they face. In particular, recruiting for rural areas, or for rarer skillsets (such as therapists) can be challenging.

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Summary assessment of system plans: there is an opportunity to transform care through new delivery models

The planned re-organisation of care around primary care localities

The system has ambitions to provide integrated care systems, designed around small population groups, that support patients in or as close to their homes as much as possible. Both CCGs have identified and brought together networks of GP practices to support populations of 30,000-50,000 people. These networks will meet regularly to shape local community care pathways. Both CCGs intend to integrate existing services within these localities, although to varying extents in their first pilot locations. Detailed models for what the delivery of this care will look like, and how CCGs will transition from their current system, are still in development, but this strategic direction reflects that taken by the most successful community care systems in the UK and elsewhere.

Opportunity to transform out of hospital care provision

The launch of the locality model for primary care provides an ideal opportunity to do things differently. Top performing out-of-hospital systems use exactly this type of structure, designing care requirements and packages around smaller population groups of 30k-50k. However, they have mostly taken a completely integrated model: social, primary and community care teams are co-located, with shared management and shared teams. Complete integration was often the underpinning enabler for delivery of all the aspects of out-of-hospital care identified earlier in this report. In the process, problems of pathway fragmentation and capacity were tackled. Torbay, for example, found that co-location and integration of these services led to more efficient sharing of caseload between teams, more effective assessment of who needed longer-term care, reductions in LoS in intermediate care beds, and a reduced duplication of care provision between services. The launch of a locality model in late 2018 in both CCGs provides an ideal opportunity to fully pilot this type of approach in a locality.

Need to develop concrete implementation approach

Both CCGs have expressed a desire to design their community care around their primary care networks. However, they need to quickly be more specific about how they will achieve this. Ensuring strong engagement from all partners in their pilot sites, getting exceptional managers for these localities, and then deciding exactly how they will provide integrated care in these localities, are important first moves: the process of getting the service running in one area will inform the expansion of the model to the rest of the system. The CCGs' experience in running and scaling pilot programmes previously provides reassurance that they can be successful in this approach.

Analyses of the capacity required to make these changes, and of the enablers that need to be in place for success, are the subject of the next two sections
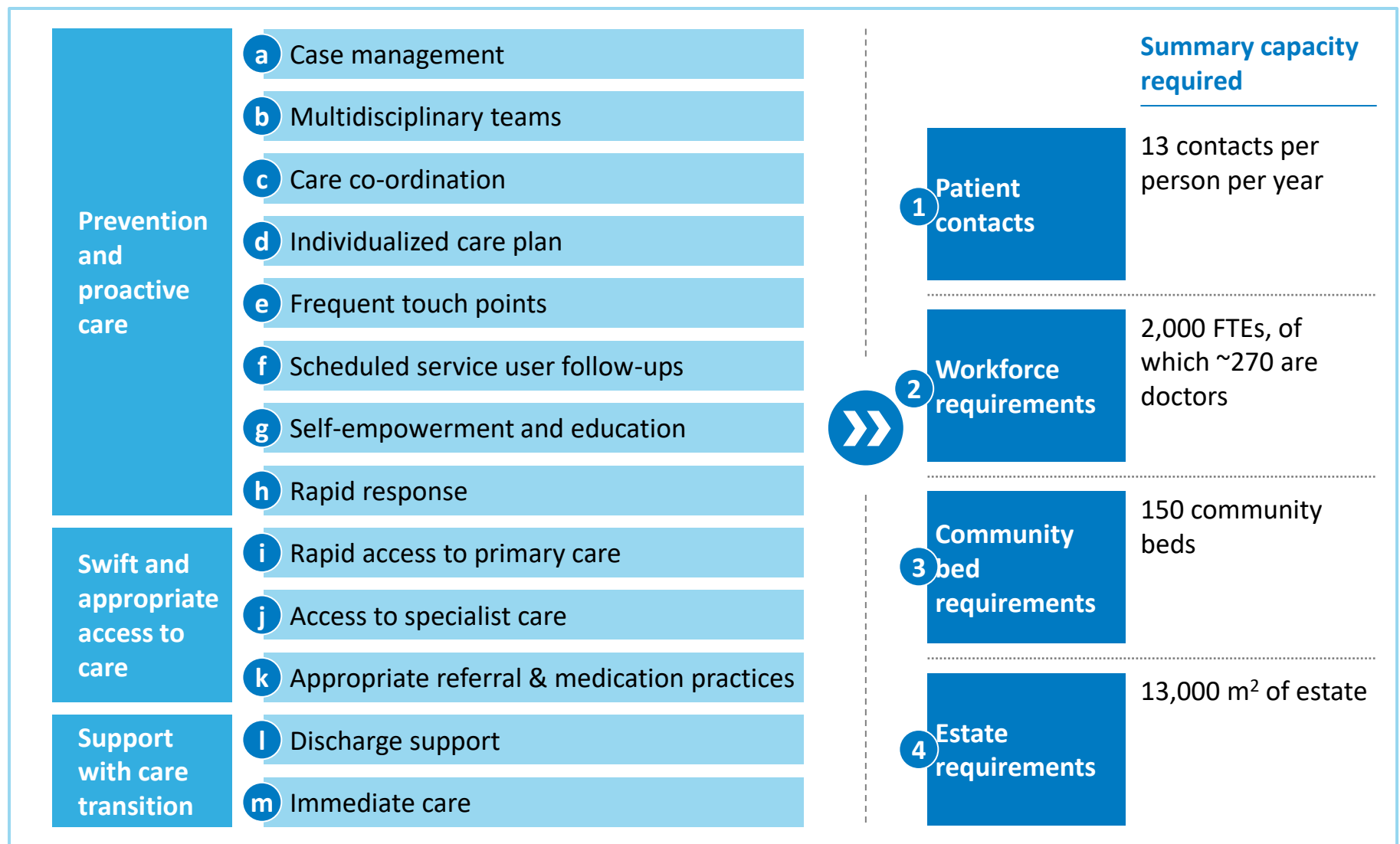
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Section summary: What is the capacity required to deliver the proposed model of care, and how should it be organised?

- The capacity model shown in the following pages describes a **theoretical model of care fitted to the Calderdale's and Greater Huddersfield's populations**. The assumptions it relies on for health system activity and population segmentation will need to be further tested and developed to ensure they adequately meet the specific health system needs of each locality.

- Packages of care for high, medium and low-needs patients has been mapped against Greater Huddersfield's and Calderdale's population, to evaluate the capacity required for a fully-integrated care programme. This provides an **'end-state' vision of a fully-transformed care model**. It would involve:

  - Patient contacts averaging 13 per person per year;

  - 2,000 FTEs, including ~270 doctors (this includes ~16 more GP FTEs); and

  - 150 community beds and 13,000m^2 of estate.

- This capacity and workforce plan represents the efficient end-state after a complete transformation to an at-scale integrated service model. Calderdale and Greater Huddersfield may want to operate some sub-scale services (for example in rural areas), which would entail greater resource provision. Additional resources and capacity would also be required during the transition, to plan, direct and lead the changes to services.

- The high risk population covers ~7% of the health system population, with a contact frequency 5-10 times higher than the medium and low risk populations

  - *Annexe 5 describes, for each locality in Calderdale and Greater Huddersfield, the capacity required to deliver a fully-integrated model of care.*

- Calderdale and Greater Huddersfield should consider **how best to design community hubs to serve the localities they have setup**. The capacity model currently assumes the most operationally efficient lay-out of services. However, there may be a need to accept some sub-scale services to ensure adequate access for the whole population, particularly in remote areas.

  - *See annexe 6 for an assessment of the range of services that can be supported in a hub that provides for different sizes of population, between 1,000 and 100,000 people.*
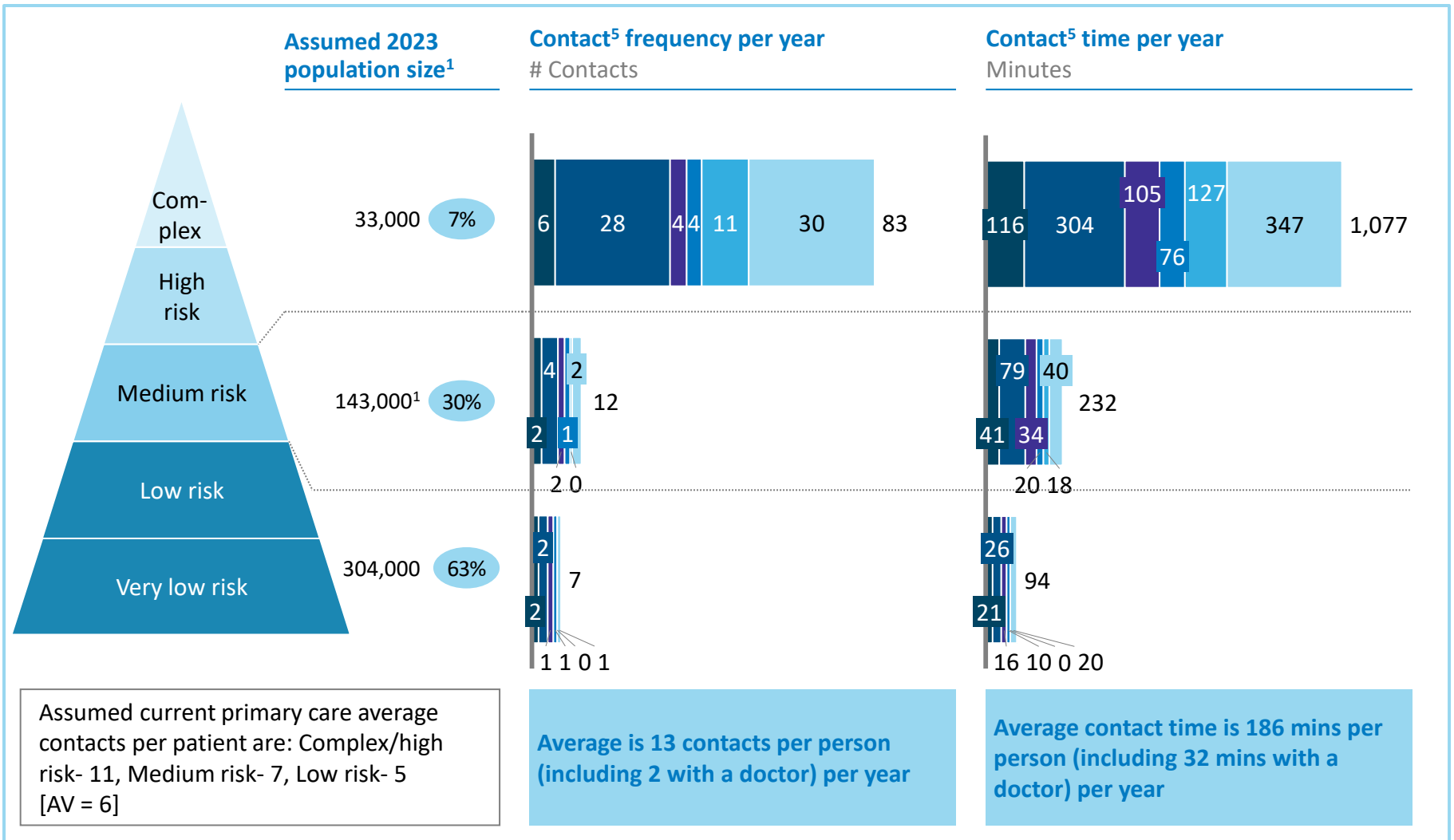
The package of care required for each need group has been mapped against Greater Huddersfield's and Calderdale's population, to evaluate the capacity required to implement the programme

Prevention and proactive care

- **a** Case management
- **b** Multidisciplinary teams
- **c** Care co-ordination
- **d** Individualized care plan
- **e** Frequent touch points
- **f** Scheduled service user follow-ups
- **g** Self-empowerment and education
- **h** Rapid response

Swift and appropriate access to care

- **i** Rapid access to primary care
- **j** Access to specialist care
- **k** Appropriate referral & medication practices

Support with care transition

- **l** Discharge support
- **m** Immediate care

Summary capacity required

1 Patient contacts
13 contacts per person per year

2 Workforce requirements
2,000 FTEs, of which ~270 are doctors

3 Community bed requirements
150 community beds

4 Estate requirements
13,000 m^2 of estate

For full details, refer to annexe 5 and accompanying excel model

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1 Contact frequency and contact time per patient, by population group

Legend: Doctor[2] · Nurse[3] · Allied Health Professional · Mental health practitioner · Formal Carer · Other[4]

Assumed 2023 population size[1]

Population group	Population size	%
Complex / High risk	33,000	7%
Medium risk	143,000[1]	30%
Low risk / Very low risk	304,000	63%

Contact[5] frequency per year
 # Contacts

- Complex/High risk: 6, 28, 4, 4, 11, 30 — total 83
- Medium risk: 4, 2 — total 12; 2, 1; 2 0
- Low risk / Very low risk: 2 — total 7; 2; 1 1 0 1

Contact[5] time per year
Minutes

- Complex/High risk: 116, 304, 105, 76, 127, 347 — total 1,077
- Medium risk: 79, 40 — total 232; 41, 34; 20 18
- Low risk / Very low risk: 26 — total 94; 21; 16 10 0 20

Assumed current primary care average contacts per patient are: Complex/high risk- 11, Medium risk- 7, Low risk- 5 [AV = 6]

Average is 13 contacts per person (including 2 with a doctor) per year

Average contact time is 186 mins per person (including 32 mins with a doctor) per year

---

1 30% of population assumed to have at least 1 LTC, based on comparable CCG data. Approximately 10% of population considered frail or high risk, with the top 4% of the population flagged as highly complex. Assumed all complex elderly and LTC – high risk have at least one LTC. Primary care contacts are based on national benchmarks applied to the population
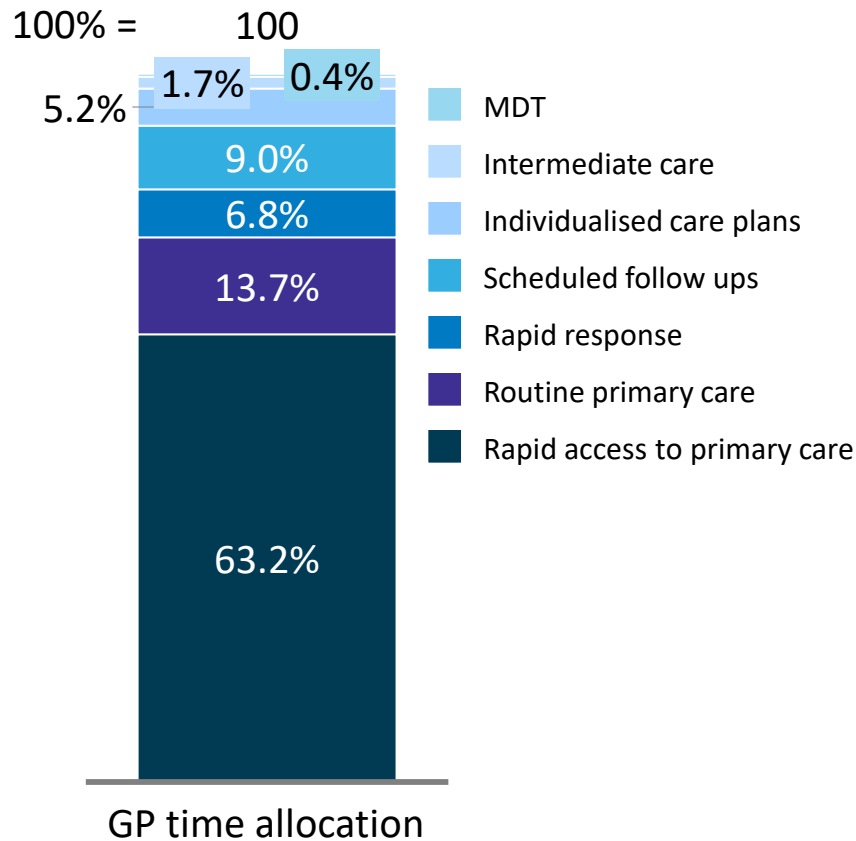2 Includes GPwSI's, specialist doctors and generalist doctors   3 Includes generalist nurses, specialist nurses, and healthcare assistants
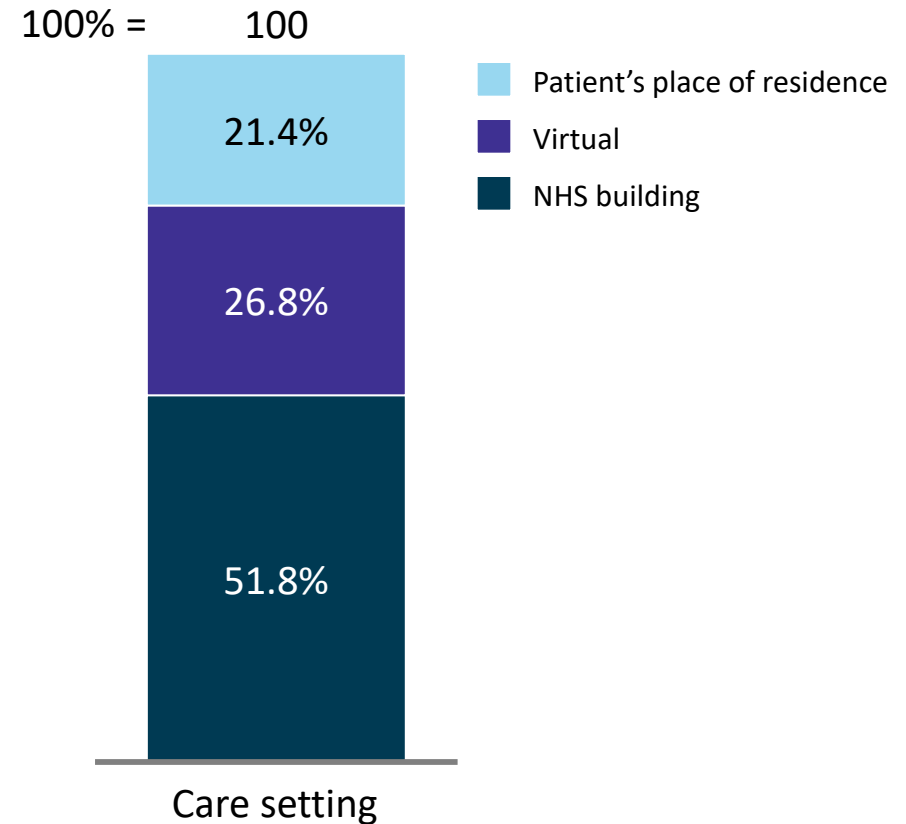4 Includes social care worker, pharmacist, paramedic, wellness coach
5 Contact includes all activities related to patient care. All contacts involve interaction with the patient except for the MDT which accounts for ~10% of all contacts

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Percentage of generalist doctor time spent on different activities

100% = 100

5.2%
1.7%
0.4%
9.0%
6.8%
13.7%
63.2%

- MDT
- Intermediate care
- Individualised care plans
- Scheduled follow ups
- Rapid response
- Routine primary care
- Rapid access to primary care

GP time allocation

Location where care will be delivered by generalist doctor

100% = 100

21.4%
26.8%
51.8%

- Patient's place of residence
- Virtual
- NHS building

Care setting

Generalist doctors will focus on providing **rapid access to primary care**, **routine primary care** and **rapid response** within different settings of care

2 Key skills for the integrated model of care

Role[1]	Skills	Description
Patient	Understands own health	Provided physically and mentally able, should be empowered to lead their interaction with the health system
Relative or supporter	Patient's advocate	Where the patient is unable to take the lead, acts in the patient's best interests and acts as a conduit for information whilst empowering the patient
Specialist doctor	Specialist clinical	Doctor with specialised medical or surgical knowledge e.g., consultant, psychiatrist, GPwSI
Generalist doctor	General clinical	Doctor with generalist medical training with a holistic view of the patient e.g., GP
Specialist nurse	Specialist clinical	Nurse with specialist knowledge, e.g., nurse practitioner specialised in heart failure
Paramedic	Specialist Clinical	Expert in dealing with acute illness and injury
Generalist nurse	General clinical	General nursing skill set, e.g., community nurse or practise nurse with a holistic view
Mental health practitioner/CPN	General mental health	Knowledge and skills relating to managing patients with mental health problems, and interactions with the physical health care system
Allied health professional	Specialist clinical	Therapeutic experts, including occupational therapists, physiotherapists, dietitians etc.
Pharmacist	General clinical	Detailed knowledge of drugs, interactions and side effects and simple illnesses
Social care worker	Professional support	Social care skillset that could range from expert social work to a broader skill set that includes knowledge of how to access social support, e.g. lunch clubs or befrienders
Formal carer	General	Domiciliary or re-ablement carer to support people in their homes
Care navigator or care co-ordinator	Predominantly administrative	Acts as a single point of contact for a patient's interactions with health and social care, with an excellent knowledge of local services and acts as the patient's advocate
'Wellness' coach	General health knowledge	A person with skills at offering health and wellbeing advice as part of the 'make every contact count' philosophy. Could be teachers, nurses, community representatives etc

1 This is not a complete list, but represents the staff groups delivering the majority of services that would benefit from integration

2 Future workforce requirements under new models of care

High risk ■ **Medium risk** ■ **Low risk**

(xx) Change 2018-23

Role[1]	Estimate of current workforce 2018, FTE	New model estimated workforce 2023, FTE[2]	Net difference
Doctor Specialist		21 / 38, 59	59
Doctor Generalist	199	69 / 83 / 63, 215	16
Nurse Specialist	43	48, 60	17
Nurse Generalist	458	65 / 92 / 75, 233	-225
Healthcare support workers	108	120 / 134 / 39, 292	184
Allied Health Professional	448	94 / 121 / 75, 289	-159
Social Care Worker[3]	100	107 / 47, 154	54
Mental health practitioner	180	56 / 55 / 53, 165	-15
Formal Carer		100 / 84, 185	185
Pharmacist	12	60 / 25, 138	126
Care navigator		117 / 41 / 0, 157	157
Paramedic[4]		20 / 7, 27	27
Wellness Coach		48, 48	48
Total	**1,500**	**2,000**	**473**

- Total GPs required from 199 to 215
- Total registered nurses required from 458 to 233, but 184 healthcare support workers and 157 more care navigators are required
- In practice you would not have a sudden shift in nurse generalist numbers, instead they would take different roles across the health system
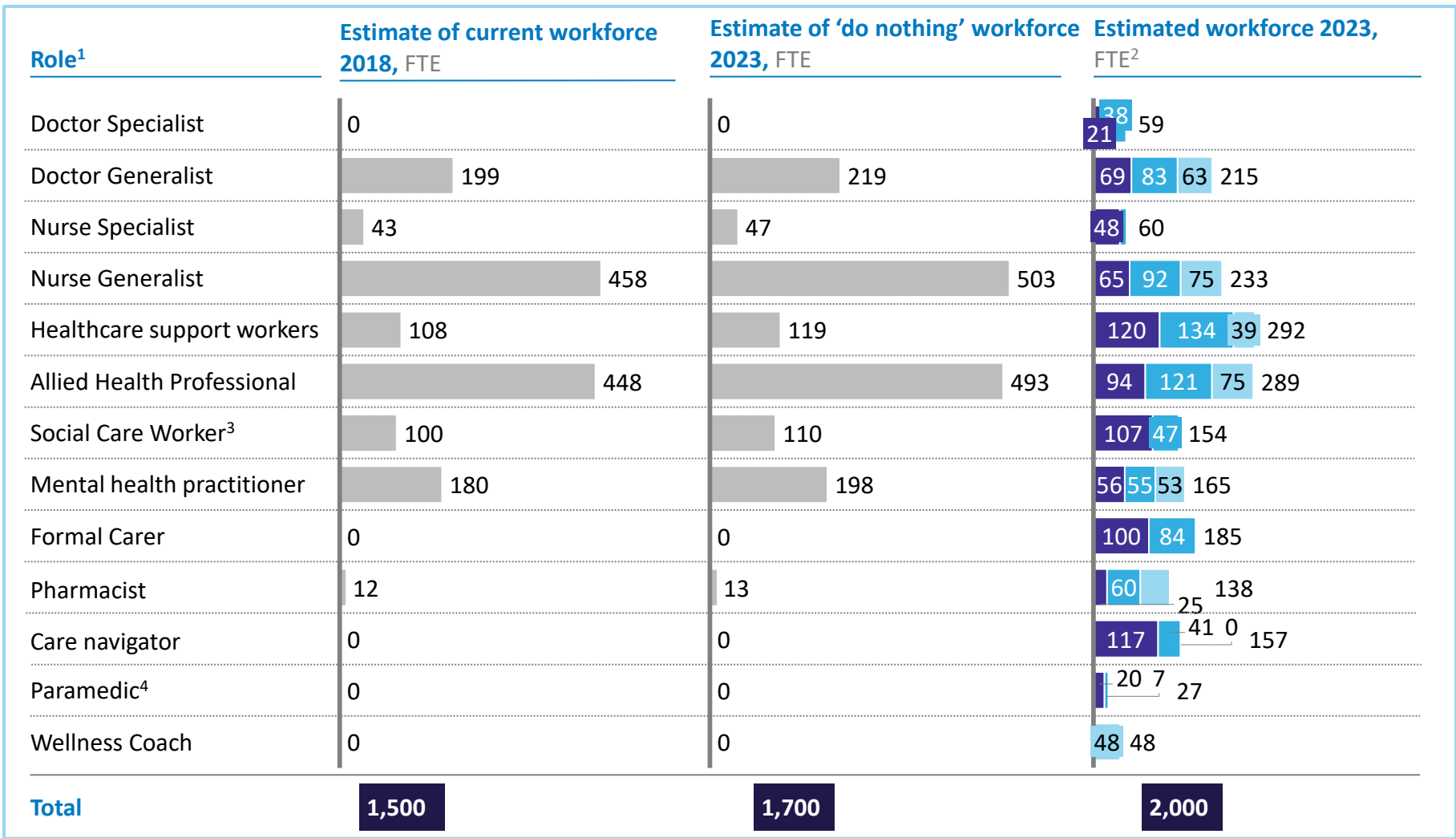
Note: current workforce 2018 is a best estimate based on available data. As more information becomes available this should be refined and updated.

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2 Future workforce requirements under new models of care in comparison to the do nothing estimates

■ High risk ■ Medium risk ■ Low risk

(xx) Change 2018-23

Role[1]	Estimate of current workforce 2018, FTE	Estimate of 'do nothing' workforce 2023, FTE	Estimated workforce 2023, FTE[2]			
Doctor Specialist	0	0	21	28		59
Doctor Generalist	199	219	69	83	63	215
Nurse Specialist	43	47	48			60
Nurse Generalist	458	503	65	92	75	233
Healthcare support workers	108	119	120	134	39	292
Allied Health Professional	448	493	94	121	75	289
Social Care Worker[3]	100	110	107	47		154
Mental health practitioner	180	198	56	55	53	165
Formal Carer	0	0	100	84		185
Pharmacist	12	13	60		25	138
Care navigator	0	0	117	41	0	157
Paramedic[4]	0	0	20	7		27
Wellness Coach	0	0	48			48
Total	**1,500**	**1,700**	**2,000**			

Note: current workforce 2018 is a best estimate based on available data. As more information becomes available this should be refined and updated.

1 Roles match those described in the NMOC. Where no figure entered, data is not currently available workers with similar roles to NMOC, e.g. adult social care outside of care homes
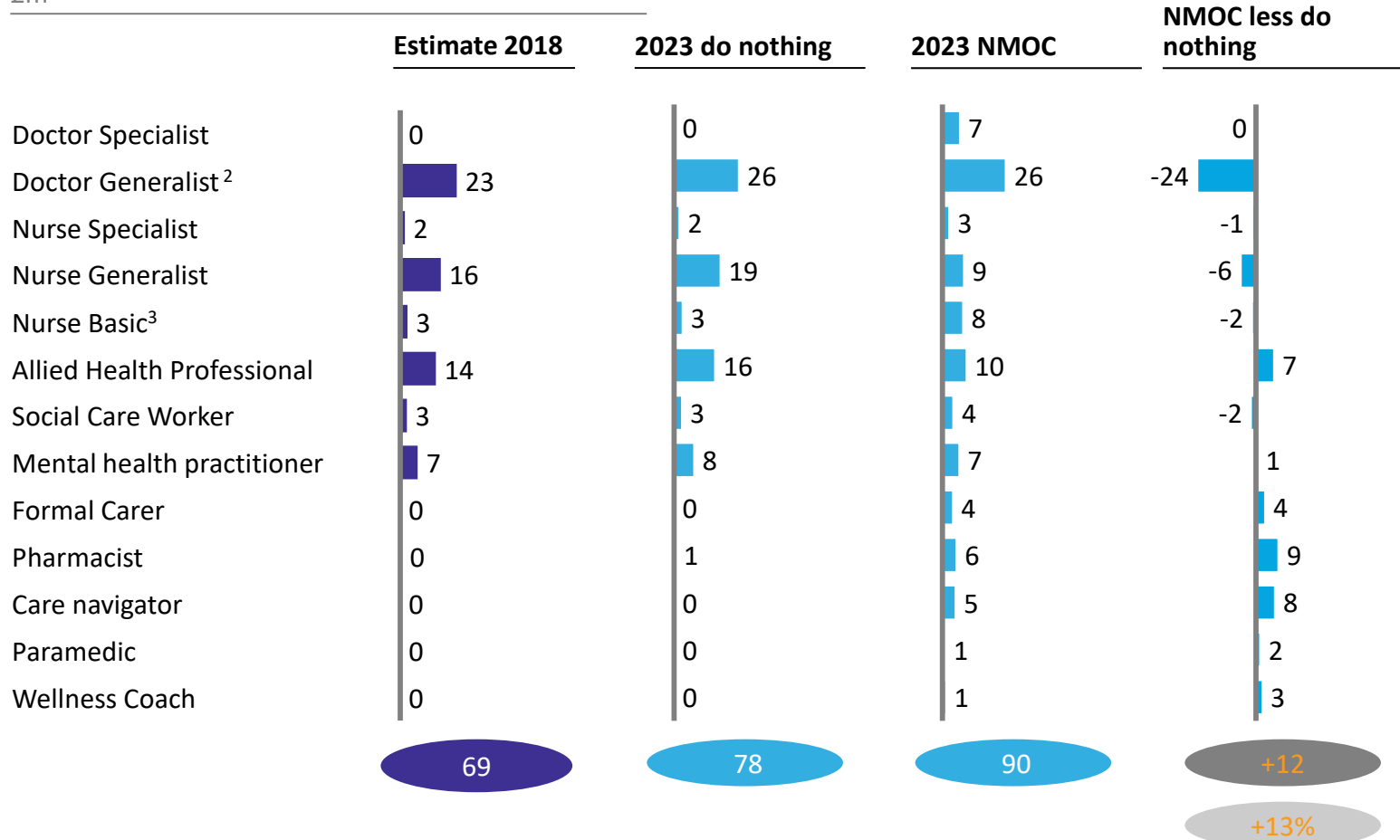2 Assumes 70% utilisation for all staff   3 Approximation of social care
4 As per roles in NMOC, does not include those currently working in ambulances

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The forecast workforce for the new model of care would require an investment of £12 million, vs the 'do-nothing' baseline

Change in cost of different workforce groups[1]

£m

	Estimate 2018	2023 do nothing	2023 NMOC	NMOC less do nothing
Doctor Specialist	0	0	7	0
Doctor Generalist [2]	23	26	26	-24
Nurse Specialist	2	2	3	-1
Nurse Generalist	16	19	9	-6
Nurse Basic[3]	3	3	8	-2
Allied Health Professional	14	16	10	7
Social Care Worker	3	3	4	-2
Mental health practitioner	7	8	7	1
Formal Carer	0	0	4	4
Pharmacist	0	1	6	9
Care navigator	0	0	5	8
Paramedic	0	0	1	2
Wellness Coach	0	0	1	3
	69	**78**	**90**	**+12**
				+13%

1 Based on midpoint of salary banding for each specialist. Workforce costs assumed to grow 1% pa. Doctor salary equivalent to band 9, Nurse Specialist – 50% band 7 50% band 6, Nurse Generalist – 50% band 6 50% band 5, Nurse Basic – band 4, AHP – band 5, Social Care Worker – band 4, MHP – band 5, Formal Carer - £16209 - £17955 based on HCC data, Pharmacist – band 6, Care navigator – band 5, Paramedic – band 6, Wellness coach – band 4
2 Excludes GPs working in MIU and GPwSIs providing specialist OP care
3 Includes health care assistants

3 In the new integrated care model, approximately 169 community beds will be required to provide intermediate care
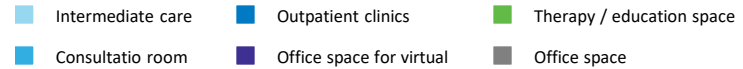
■ Calderdale CCG   ■ Greater Huddersfield CCG

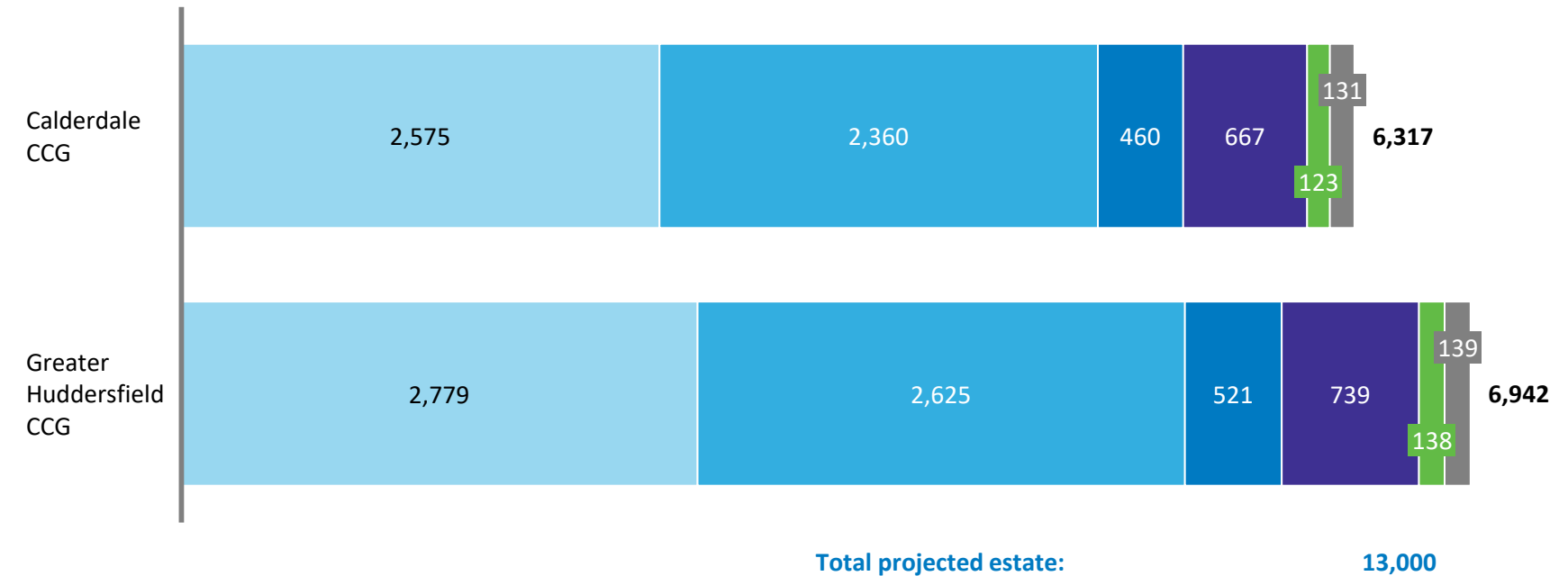## Intermediate care bed demand in new model of care, 2023

	Demand in spells (000s)	Bed days (000s)	Number of beds required
Step up beds	1.1 / 1.1 → 2.2	3.4 / 3.2 → 6.6	9 / 9 → 18
Step down beds	0.8 / 0.9 → 1.7	23.5 / 25.3 → 48.8	64 / 69 → 134
Total	1.9 / 2.0 → 3.9	26.7 / 28.8 → 55.4	73 / 79 → 152
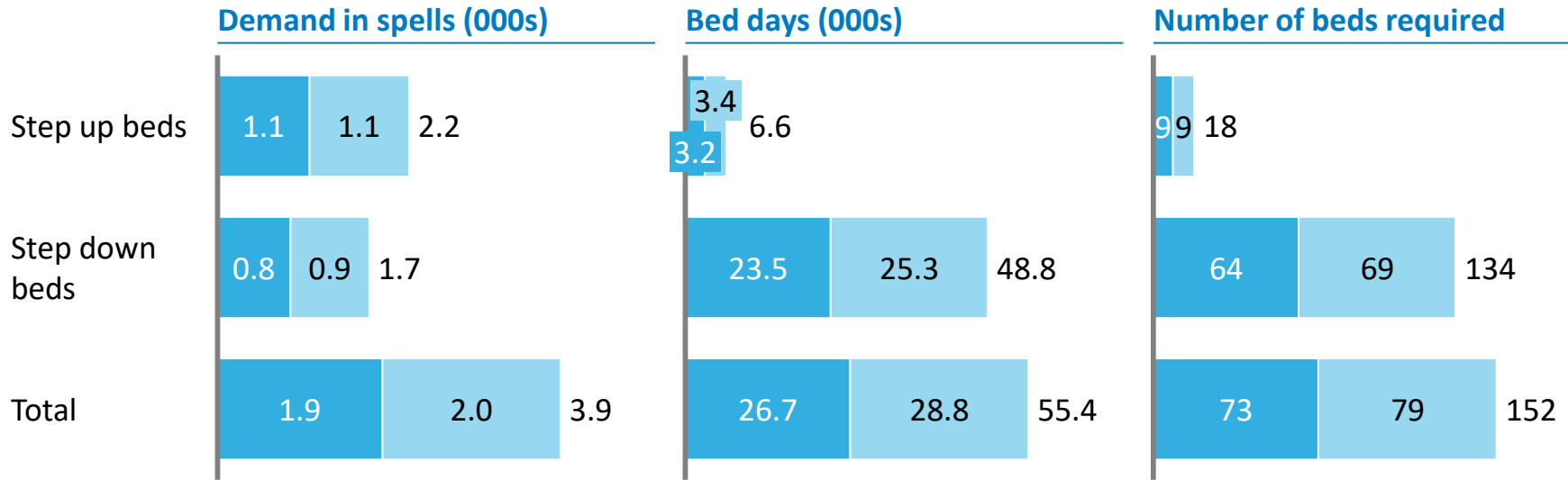
Current number of beds: 87

- In 2023, Greater Huddersfield and Calderdale is projected to have 60,000 acute non-elective admissions
- The **cost of a growth in intermediate care beds from 87 to 152 could be around £2.4 million**, assuming £100 per bed day
- Step up care demand assumed to be equivalent to 1 in 10 avoided non-elective admissions a year
- Step down care demand is assumed once yearly for 5% of the high risk population (60% of admitted); 50% delivered in an NHS building, and 1% of medium risk population; 65% delivered in NHS building
- Temporary step up care length of stay assumed to be 3 days. Step down care length of stay assumed to be 28 days
- Full occupancy assumed for step up and step down beds

4. In the new model of care, Calderdale and Greater Huddersfield CCGs require ~13,000m² of community estate

Legend:
- Intermediate care
- Consultation room
- Outpatient clinics
- Office space for virtual
- Therapy / education space
- Office space

Potential community estate required²
Projected 2023, m²

	Intermediate care	Consultation room	Outpatient clinics	Office space for virtual	Therapy / education	Office space	Total
Calderdale CCG	2,575	2,360	460	667	123	131	**6,317**
Greater Huddersfield CCG	2,779	2,625	521	739	138	139	**6,942**

Total projected estate: **13,000**

- In the new model of care, requires ~13,000m² of community estate in order to deliver community care (including primary care, intermediate care, preventative care and MIUs/ UCCs)
- This is XX than the current available estate
- However, this is the minimum viable estate as it does not take into account scale considerations for efficiency & does not include diagnostics estate

1 Only includes community hospitals shown, for which data was available. Some estate at Andover and LNFH is currently used for acute services

2 This excludes estate required for diagnostics, estate calculated based on 9 m2 for a consultation room/therapy room/MIU consultation room, 3 m2 for a unit of open plan office space, 20m2 for an MDT room. Circulation space e.g. for corridors, receptions and toilets, were included with a multiplying factor of x2.

Step up care demand assumed to be equivalent to 1 in 10 avoided non-elective admissions a year. Step down care demand is assumed once yearly for 5% of the high risk population (60% of admitted); 50% delivered in an NHS building, and 1% of medium risk population; 65% delivered in NHS building. Temporary step up care length of stay assumed to be 3 days. Step down care length of stay assumed to be 28 days. Full occupancy assumed for step up and step down beds

Calculations based on projected 2023 activity in MIU's/UCC's, given projected growth and shifts of activity into the community. Assumes opening hours of 16 hours, 7 days a week

SOURCE: Previous work in a similar healthcare system, projected activity based on population projections from ONS database and current activity data from Calderdale and Greater Huddersfield CCGs

Calderdale and Greater Huddersfield should consider how best to design community hubs to serve the localities they have designed

Localities of 30k-50k have been defined

		GP practice (8-10k)	Small hub (25k+)	Medium hub (50k+)	Large hub (75k+)
Proactive care	MDT		✓	✓	✓
	Case management		✓	✓	✓
	Care coordination		✓	✓	✓
Access to care	Access to OP		✓ (dashed)	✓	✓
	Access to UCC			✓	✓
	Access to urgent primary care	✓ (dashed)	✓ (dashed)	✓	✓
	Routine primary care	✓	✓	✓	✓
Care transition	Intermediate beds				✓

- Large hubs provide the largest range of services to the underlying population, with decreased access as a trade-off
- Small health hubs can be co-located with GP practices to increase efficiency
- A series of smaller hubs, with access to fewer UCCs, could serve the system's choice to cover populations of 30k-50k
- **For more details** on estate organisation and the services that can be provided at-scale for different population sizes, see Annexe 6

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Contents

- The baseline position

- An opportunity to do things differently

- How do existing plans measure against this vision, and what is their expected impact?

- What is the capacity required to deliver the proposed model of care, and how should it be organised?

- **How should this be done in practice?**

Section summary: How should this be done in practice?

- Both CCGs have defined their localities, and GP networks have started to meet. The CCGs now need to think about **how they will implement fully integrated services** within these localities.

- The CCGs need to **engage** GPs and wider stakeholders in this move, **design** and **pilot** the integrated care model in one locality in each CCG, before scaling over the whole patch.

- As part of this process, CCGs need to **develop seven important enabling factors**, in addition to redesigning their model of care.

  - *See annexe 7 for a suggested implementation plan that sets out how to change and develop the model of care, and these enabling factors, over timescales of 3, 12 and 36 months. Annexe 7 also suggests KPIs to track on all these factors as part of this process.*

The system has brought together GP networks that will form the locality structure for community care. CCGs now need to think about implementation.

Engage	Design and set up	Pilot	Scale
▪ Engage GPs early about the benefits for them of an integrated model ▪ Ensure committed executive support in all partner organisations from the outset ▪ Dedicate leadership time in the CCGs to this programme	▪ Work with the pilot site to agree which services will be integrated ▪ Use workshops at this site to agree assumptions driving the capacity model ▪ Put in place systems to track performance ▪ Release funds to 'pump-prime' the pilot site	▪ Recruit an outstanding site manager ▪ Develop approach for need-stratifying patients and existing caseload ▪ Operate integrated teams from the same room / building ▪ Measure and report performance	▪ Expand the model to new sites ▪ Use staff from the pilot as teachers and activists for the new model ▪ Develop organizational structure that sits across all localities

Current programmes should be maintained, then brought into the new model of care

As CCGs begin to design and pilot their integrated care programme, they should **agree and follow an implementation plan**. This plan should cover how changes to the model of care will be made, as well as how important enabling factors will be developed.

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The implementation plan should consider changes to the model of care, as well as important enabling factors

Changes to the model of care	Human factor enablers	Structural enablers
Remodelled patient pathway	Organizational design	Funding
Workforce and training	System-wide decision making, ownership, accountability	Design of contractual incentives and reimbursement models
Estate and beds	Change management for patients and staff	Information sharing
Transport		Digital system development

Please see Annexe 7 for a fuller outline implementation plan and suggested KPIs

Over the next 2-3 years the system will need to take the following steps to change its model of care

Element of plan	First 3 months	First year	Next 2-3 years
Remodelled patient pathway	▪ Pick a locality to pilot a full integrated model. ▪ Agree a population segmentation with locality workforce and select a segment to focus on ▪ Agree what fantastic care looks like for each population and the activity assumptions behind this with locality workforce	▪ Design and trial-run model of service provision. ▪ Begin reorganising how lists are run in general practice ▪ Develop and implement care coordination function ▪ Start proactive daily huddles with MDTs and GPs to discuss at risk patients	▪ Expand the pilot into other localities. ▪ Seek to include additional providers into model, e.g. mental health, voluntary sector ▪ Look to further pull out medical specialties into the community in broader outpatient redesign
Workforce and training	▪ Decide which services will be co-located and integrated. This will likely include social services, community rehab and home teams, and district nursing ▪ Launch org design team development training to get staff used to working in different teams	▪ Select system leadership for pilot ▪ Teams start working from same site ▪ Adjust team composition during the pilot to improve service provision ▪ Further training programs to include cross training e.g. district nurses trained in safe guarding	▪ Train and develop generalist health workers, who can be flexibly assigned to release capacity from the specialist nurses and doctors.
Estate and beds	▪ Identify a hub on which to collocate services (ideally in primary care)	▪ Build out the hub for the pilot locality from existing community estate ▪ Evaluate potential additional intermediate capacity, look for capacity in nursing homes	▪ Move towards the end-state bed and estate requirements to ensure that each locality is well-served, with local physical hubs.
Transport		▪ Understand any limitations and difficulties in existing transport infrastructure.	▪ Work with local authorities to implement creative solutions as necessary: for example, provision of specific community buses.

Seven enablers will support the cultural and structural changes required to make interventions successful

	Current situation	**Where the system needs to be**
Organizational design	▪ Localities designed around networks and meetings of GPs	▪ Local hubs integrate all of primary, social and community care with a single accountable manager in each locality
System-wide decision making, ownership, accountability	▪ Partnership boards used as decision making body across localities	▪ Partnership board used to hold locality managers to account, but not for day-to-day action ▪ Strong executive sponsorship in all partners
Change management for patients and staff	▪ Early engagement with GP partnerships started	▪ Bold clinical leadership and role modelling ▪ Engagement with population and patients so that they understand how to navigate the new system
Funding	▪ Plans for new model of care to be funded under existing budgets	▪ Early investment to ensure that pilots are successful ▪ Locality manager has a pooled budget ▪ Change management will require additional funding, in addition to the costs of the end-state workforce
Design of contractual incentives and reimbursement models	▪ Contractual arrangements for locality model still being decided, although an Alliance framework in Calderdale is proposed	▪ Incentives aligned across all players, in hospital and out, to maximise care quality and value for the CCG
Information sharing	▪ Limited current frameworks for sharing and agreeing performance metrics quickly and easily	▪ Operational and performance information quickly between all system partners ▪ Clinical information shared between all health professionals as appropriate in the integrated teams
Digital system and analytics capability development	▪ CCGs will be able to use integrated EHRs when LHCRE is complete, but progress is slow ▪ Digital and mobile tools are already used in places to make remote assistance to, and monitoring of, patients simple and cost effective	▪ LHCRE rolled out into routine use, with electronic records accessible to all relevant care staff ▪ Growing capability to turn available data into valuable digital operational tools and reports

Please see Annexe 7 for a fuller outline implementation plan and suggested KPIs

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Right Care, Right Time, Right Place Programme