RIGHT CARE
RIGHT TIME
RIGHT PLACE

Transforming Health and Social Care in Calderdale and Greater Huddersfield

Outline Business Case

Contents

1. Executive Summary

1.1 Introduction

Over the past two years the health and social care organisations across Calderdale and Greater Huddersfield have been listening to the views of local people and working together to review and develop proposals to improve services. As a result of this work Calderdale and Huddersfield Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership Foundation Trust developed a joint Strategic Outline Case describing proposals for service change.

This Outline Business Case (OBC) builds on the Strategic Outline Case and describes the Strategic, Economic, Commercial, Financial and Management cases for the development of NHS community and hospital services for the people living in the footprint of Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCGs). It is important to note that whilst the proposals contained in this document are aimed at serving the needs of Calderdale and Greater Huddesfield resident populations, the model of provision described in this OBC offers the potential to provide an acute and emergency hospital that could serve a population of 1.2m people who live within the M62 corridor and are within 30 minutes travel time of the accident and emergency services proposed.

The OBC has been jointly developed by doctors, nurses, therapists and managers of three healthcare providers in the area:
- Calderdale and Huddersfield NHS Foundation Trust (CHFT)
- Locala Community Partnerships (Locala)
- South West Yorkshire Partnership NHS Foundation Trust (SWYPT)

in partnership with other key stakeholders such as Yorkshire Ambulance NHS Trust, local GP providers, Kirklees social care providers, 111 services and Community Pharmacy representatives. Other local providers such as Calderdale social care providers have been invited to contribute to the OBC. The providers have discussed the proposals with the 3rd sector and members of the public.

The OBC has drawn on a wide range of external expertise and support so that it is informed by best practice and learning from successful service reconfigurations that have been undertaken in other areas. This includes: the Consultation Institute, DLA Piper, Interserve, Capita, Jacobs Engineering, PA Consulting, and highly respected National Clinicians as well as the expected stakeholders.

The objective of the Outline Business Case is to appraise the five scenarios that were identified in the Strategic Outline Case and to provide information that will assist all partners to demonstrate evidence that this Outline Business Case addresses the Department of Health 4 Tests for Major Service Reconfiguration.

Calderdale and Greater Huddersfield Clinical Commissioning Groups are responsible for any future decision regarding implementation of the proposals described in this Outline Business Case. No decision has been made at this stage.
The five scenarios the OBC has appraised are:

i. Continue with the existing hospital and community service model and configuration.

ii. Implement the community and hospital service model proposed with Huddersfield Royal Infirmary as the site for acute and emergency care and Calderdale Royal Hospital as the site for planned hospital care.

iii. Implement the community and hospital service model with Calderdale Royal Hospital as the site for acute and emergency care and Huddersfield Royal Infirmary as the site for planned hospital care.

iv. Continue with the existing community service model and change emergency hospital care provided locally so that those people needing specialist treatments are transferred to a major emergency centre outside the local area. Huddersfield Royal Infirmary and Calderdale Royal Hospital would offer 'see and initiate treatment' services with people needing specialist treatments transferred to specialist centres. This would reduce demand at the local emergency centres in Halifax and Huddersfield.

v. Any other ideas for changing services resulting from extensive engagement with a wide range of stakeholders, including patients and the public.

The 4 major reconfiguration tests that will need to be met through formal public consultation and final business case for the changes proposed in this document are:
- Clinical Evidence - Evidence of a robust tested clinical evidence base for the proposed service model.

- Public Engagement – Evidence that views of the local population have been received and considered in the development of this service model
- GP Commissioner Support – Evidence that the service model proposed is in line with the commissioning intentions of the local Clinical Commissioning Groups and supported by local GPs.
- Choice – Evidence that the service model supports the public's right to choose how they receive services.

Sections 4.4 to 4.7 of the OBC provide information and evidence in relation to each of these four tests.

1.2 The Strategic Case

1.2.1 The Strategic Case: Context & Current Service Profile

In this section the context to the proposal and an overview of the current health and social care position is provided. The diagram below summarises the current position:

1.2.2 The Strategic Case: The Case for Change

There is a compelling evidence base that the way community, hospital and social care services are currently organised and provided in Calderdale and Greater Huddersfield is not offering the most safe, effective and efficient support to meet people's needs. Local people and the doctors, nurses and therapists that currently provide services want things to change to achieve better health outcomes, a better experience of care and increased convenience and efficiency of service delivery. The current system is not able to provide the right care, in the right place, at the right time.

Our aim is to work with individuals, local communities, and partner organisations to provide exceptional standards of care to achieve optimal health outcomes, safety, and efficiency. The key elements of the case for change are that currently, too many people:

- are dying in our hospitals. The hospital Standardised Mortality Rate is higher than the England average.
- are admitted to residential or nursing home care
- stay longer in hospital than is clinically necessary
- are admitted to hospital with a long term condition
- are readmitted within 30 days
- wait over 5 weeks for diagnostic services.
- report they do not have a good experience when they attend A&E
- leave A&E without having been seen.

CHFT has higher than the national average number of complaints per 1000 inpatient episodes.
Too many nurses are taking time off sick.

High priority is currently being given to implement actions that will address these concerning issues and these actions are described in section 3. However the impact of these actions is constrained by the current configuration and service delivery models. This OBC explains why a transformation and reconfiguration of services is needed to enable consistent achievement of the high quality of care and outcomes that we want for local people.

What Happens now for comparison?

There is not enough Out of Hospital Care Close to Home:

- the majority of services are provided 5 days a week only.
- There is not enough self care support to help people to stay in control and make choices.
- There are not enough specialist services close to home and services are not coordinated. For many people who are unwell their only option is to be admitted to hospital.
- There are risk of gaps in care e.g. people with a serious mental illness are almost twice as likely to die from coronary heart disease and four times more likely to die from respiratory disease.

Hospital Services are not as effective and safe as they could be

- people with more than one medical need move between wards
- we are not able to provide consultant doctors in A&E seven days a week and there is a high use of locum speciality doctors
- there is often a need for inter hospital transfer of patients
- services are not compliant with standards for Children and Young People in Emergency Care
- children do not receive shared care from a consultant surgeon and a paediatrician
- planned operations are sometimes disrupted / cancelled by emergency pressure.

The proposed changes described in this OBC will allow us to deliver key national standards.

There is a substantial clinical evidence base and clinical support for this case for change, described in section 4.4. This covers the following:

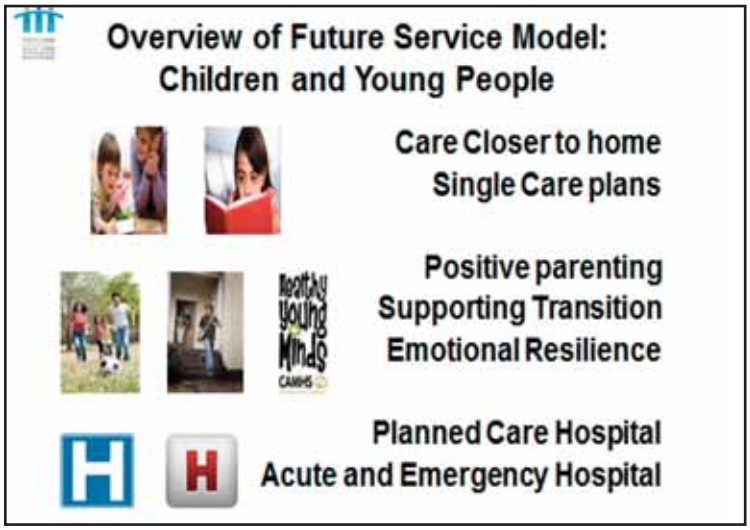
- The National Clinical Advisory Team Recommendations for change
- External Independent Clinical Review of the Outline Business Case
- Local Clinical Support for the Outline Business Case
- Evidence of the positive impact of the partial hospital reconfiguration implemented in 2005/06
- Literature Review - Sources of Evidence

1.2.3 The Strategic Case: New Service Models

In response to the challenges outlined in section 1.2.2 the three providers have developed a service model that will deliver the outputs listed in the table below:

Increasing Demand			
Reducing Resources			
Not able to Guarantee Safety, Effectiveness, Efficiency			
Quality	**Self-care** Support people to self-care and maintain control.	**Integration** Integrated community and specialist support, 7 days a week, close to home.	**Hospital Services** Reconfigure emergency and inpatient hospital care.
Value for money	Reduce the number of people needing help from a health or social care professional.	Reduce duplication, minimise crisis and prevent escalation.	Reduce admissions and length of stay. Improve clinical safety. Reduce mortality.
Enabler	Putting people in control of their own health		
	Whole System Leadership		
	Use of information technology		

The model can be described in terms of adults, and in terms of children and young people. This is detailed in section 5.



1.2.4 The Strategic Case: Capacity Plan and Implications

To understand the impact of the service model described in section 5 on hospital and community capacity, modelling has been undertaken over the next ten years to 2023/24. The activity and capacity outputs identified in this section have been used in the economic evaluation in section 9.

The Strategic Outline Case used a number of evidence based assumptions to forecast the likely impact of the service changes on capacity and efficiency. The work that has been undertaken in preparation of this Outline Business Case has involved the doctors, nurses, therapists and operational managers that currently provide the services to test the assumptions used in the Strategic Outline Case in terms of deliverability and quality impact.

Over the next ten years there will be growth in demand for hospital activity due to the increasing needs of the population. However the increased demand for hospital based services can be mitigated by new ways of working and implementation of the new service models that are described in this OBC.

The key capacity issues identified in the Outline Business Case are:
- 20% net reduction in hospital beds (from 802 to 636) is possible by working in new ways and providing more care and support out of hospital
- 85 beds will be required on the planned hospital site
- 551 beds will be required on the unplanned hospital site
- 5% growth in demand for community services due to more care and support provided out of hospital
- 7% demographic growth in demand for community services
- 12% community services efficiency opportunity that is possible from working in new ways
- a high-level assessment of the impact on GPs and Social Care capacity has also been undertaken.

1.2.5 The Strategic Case: Workforce Plan and Implications

The purpose of this section is to explain the workforce impact and requirements of implementing the proposed new service models. The information provided in this section includes:
- the workforce capacity required to deliver the new model.
- the impact of the proposed new service model on workforce clinical and quality standards.
- The approach to support workforce transition and new ways of working.

Overall the service model will be able to deliver:
- An increased range of services and support in the community
- 7 day working
- Improved staffing ratios
- Shared care and Multi-Disciplinary Team working

We will do this by:
- Ensuring the workforce is deployed in the most effective and efficient way to enable implementation of the new service models
- Supporting staff through transition to the new service models
- Ensuring staff are equipped with the necessary skills and training to work in new ways

There will be requirement for fewer staff working in the hospital and increased capacity in the community. Some of the additional community capacity can be delivered through improved and new ways of working (i.e. efficiency).

The overall net impact on workforce is a reduction of 409 WTE hospital based staff over the next ten years.
We are committed to supporting the health and wellbeing of all staff and where possible the continuing employment of the current permanent workforce now and into the foreseeable future. We will work with staff to support redeployment to new roles in the community and minimise the need for job losses.

1.2.6 The Strategic Case: Estates and Travel Plan and Implications

This section of the Outline Business Case describes:

- The estate requirements and implications in relation to the proposed reconfiguration of hospital services to establish a specialist acute and emergency hospital and a specialist planned care hospital utilising the current hospital sites at Calderdale Royal Hospital and Huddersfield Royal Infirmary.
- The estate requirements and implications in relation to the development of two community hubs at Todmorden Health Centre and Holme Valley Memorial Hospital.
- The travel implications for service users and carers related to the proposed reconfiguration of services.

In the new service model the key estate requirements are:

- 85 planned care hospital beds
- Additional 130 unplanned care hospital beds (551 total)
- Expanded A&E and Intensive Care Unit
- Relocation of acute services to concentrate on one site
- No estate development needed at Todmorden

Factors the OBC considers in relation to the suitability of CRH or HRI as the Unplanned Hospital site are:

- Site constraints / feasibility
- Estate alteration costs - PFI & non-PFI
- Speed to implementation
- Future site flexibility
- Population use and income drift
- Under-utilised estate
- Travel impact

Procurement options for the development of the estate include:

- Investment of Trust funds
- Prudential borrowing
- Private Finance Initiative (variation of existing PFI or new PF2)
- Joint Venture

A detailed travel impact assessment has been undertaken. This has assessed the travel implications for emergency ambulance, car and public transport journeys to hospital. Specific analysis in relation to the population impact relative to deprivation, age, and race has been included. The conclusions of this are that there are no disproportionate impacts of the change in travel time related to whether HRI or CRH is the planned or unplanned hospital care site. Currently 76% of patients and 60% of the whole population are within a 15 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary. With 96% of both patients and the population being within a 30 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary.

1.3 The Economic Case

The section describes the possible options (or scenarios) that respond to the case for change described in section 4 and the proposed service model detailed in section 5. This section includes an evaluation of the options using criteria that have been informed by the views of stakeholders.

It should be noted that this is a provider business case and recommendation – it is not the final decision on public consultation options. The approach used is consistent with HM Treasury – Public Sector Five Case Model – Delivering Value from Spending Proposals. The approach is consistent with major reconfiguration of services undertaken elsewhere. stakeholders have been involved in determining the evaluation criteria. The outcome of this engagement is described in the table below:

The Evaluation Criteria	Stakeholders Views
Quality of Care - Which options would provide better clinical quality and safety? Which options would provide a better experience for patients?	Reduce the need for people and staff to transfer between hospital sites; Ensure critical co-location of services; Use the clinical evidence base on safety and effectiveness; Must provide 7 day service; Must support self care; Take account of impact on wider multi-agency working e.g. police, safeguarding; Must enable integrated service provision; Environment of care is therapeutically important to achieve best outcomes.
Access to Care - Do any options significantly minimise the average and/or total time it takes people to get to hospital by ambulance, car (off-peak and peak) and public transport?	Distance of travel, transport links and frequency of visits is important; Must provide more services in community and use technology to reduce the need to visit hospital; Take account of health inequalities and ensure any changes do not make these worse or disadvantage vulnerable people.
Value for Money - Which options would have the lowest capital costs? Which options will give the largest Net Present Value (overall financial benefit) over the next 20 years?	Need to understand the cost of options; Lowest cost not always best solution.
Deliverability & Sustainability - Which options would have the lowest transitional cost (double-running costs) of transferring services between hospitals? How long will it take to deliver the proposed changes in each option? Which options will offer a solution for the next 20 years.	Estate and site flexibility for development is important; Must offer a sustainable solution for next 10 – 20 years; Must enable a resource shift and not transfer workload from hospital to other parts of system without investment.
Co-dependencies with other strategies - How much does each option fit with what is happening, or may happen, nationally or in West Yorkshire.	The future location of other A&E departments in West Yorkshire is important; Impact on local economies is important – local jobs and regeneration; Keep services local to Calderdale and Huddersfield.

The 5 scenarios were evaluated using these criteria. The evaluation outcome is shown in summary below and described in section 9.

The providers have evaluated scenarios 2 and 3 as scenarios to progress. Clinical Commissioning Groups will need to determine the final options for public consultation.

The Evaluation Criteria	Do Nothing	HRI Unplanned CRH Planned	CRH Unplanned HRI Planned	Out of Area Transfers	New Ideas
Quality of Care	No	Yes	Yes	Query	--
Access to Care	No	Yes	Yes	No	--
Value for Money	No	Yes	Yes	Query	--
Deliverability & Sustainability	No	Yes	Query	Query	--
Co-dependencies with other strategies	No	Yes	Query	Query	--
Evaluation Summary	**Discount**	**Take Forward**	**Take Forward**	**Discount**	**Discount**

1.4 The Commercial Case

This section of the Outline Business Case describes the options for procuring both a revised service offer, and the estates and facilities required to deliver this proposal. It sets out possible funding options for the required investment in estates and facilities and procurement options for the three current main providers.

The commercial case shows how the proposed procurement approach demonstrates a robust plan to source the estates and services requirements described in Section 6 – Strategic Case: Capacity Plan, and the extent to which that provides a commercially viable route for Calderdale and Greater Huddersfield. The model represents a significant shift of clinical work to community settings and to self-care which will have a major impact on the design of the estate for hospital services and the utilisation of community assets across the strategic partnership.

In general the procurement of enabling estate and facilities is led by the providers. Conversely the procurement of reconfigured services is a matter for commissioners. Therefore where this section addresses service procurement it is expressly limited to demonstrating that viable procurement options exist and does not seek to encroach on the commissioner's decision-making process.

This section demonstrates that there are a range of strategies available to procure and fund the proposed service re-configuration. Further work will be undertaken through the Full Business Case process to evaluate these options so that a preferred procurement strategy can be proposed.

1.5 The Financial Case

This section provides a detailed description of the financial case for change and how the options that have been considered address the financial challenges faced by commissioners and providers. Whereas the Economic Case answers the question what is the best option, the Finance Case considers the affordability of the option. This section also includes an outline of the funding sources and demonstrates the financial impact of the proposed changes upon the existing organisations.

The key messages you should take from this section are:

- There are significant long term affordability challenges for commissioners and providers of health and social care, which require system-wide changes to be made.
- The current projections suggest that the three providers have identified a £51m contribution to the efficiency challenge so far over the next 5 years and £74m over the next 10 years, based on the services identified as being in scope.
- This OBC can only consider the areas within scope of the three organisations and therefore seeks to demonstrate how the proposals compare against the assumptions that were made within the Calderdale and Greater Huddersfield Strategic review. This was previously identified as £163 million system wide efficiency savings requirement; however, this system wide requirement is currently under review to test its validity given a number of key planning assumption changes.
- A sensible approach from commissioners and providers needs to be adopted to look at alternative funding mechanisms and local tariff approaches moving forward, utilising the full flexibilities within the NHS contracts.
- There will be a need to enter into risk sharing agreements to support the sustainability of the health and social care system.
- Option 2 best contributes to the affordability challenge at a system-wide level, at the same time as improving patient care. However, further work needs to be done to fully work through the impact of the changes being proposed.
- There will need to be a collective effort to explore new options for developing financially sustainable delivery of health and social care for Calderdale and Greater Huddersfield.

In summary, given the need to invest in improving outcomes and quality for patients in addition to meeting growing patient demand, system-wide service reconfiguration is the only way to achieve financial sustainability in health and social care in Calderdale and Huddersfield.

1.6 The Management Case

This section of the Outline Business Case describes how the service changes could be delivered over the next four years.

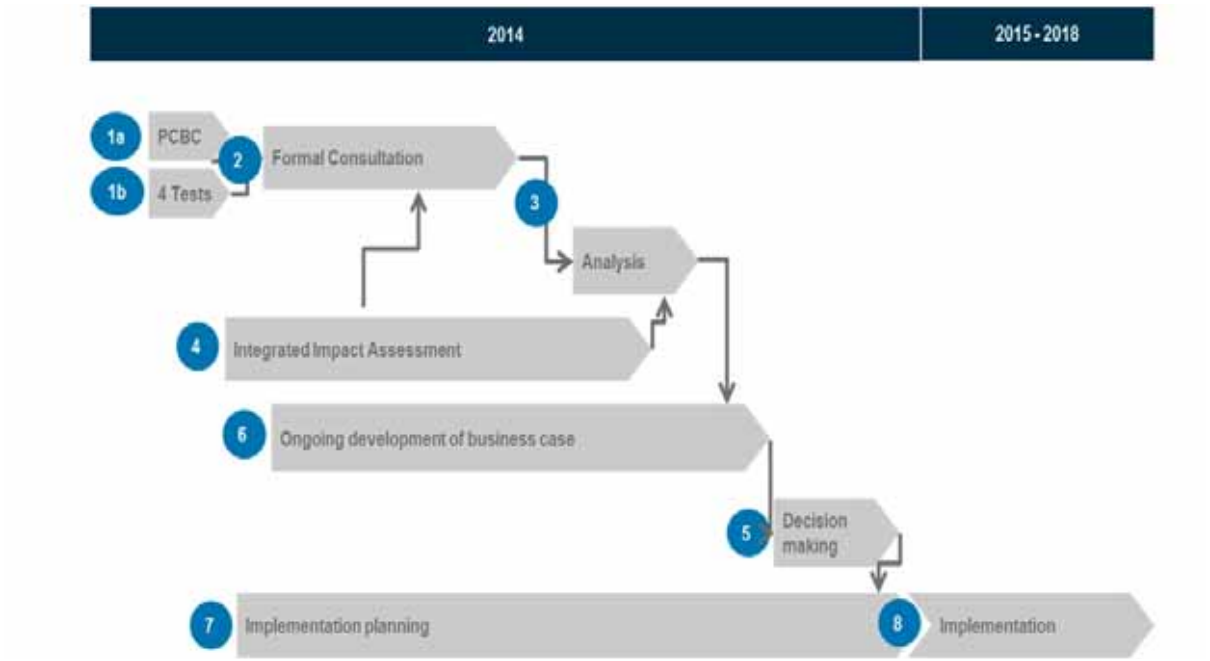
Calderdale and Greater Huddersfield Clinical Commissioning Groups are responsible for any future decision regarding implementation of the proposals described in this Outline Business Case. No decision has been made at this stage.

Both Clinical Commissioning Groups agreed following publication of the Strategic Outline Case in early 2014 that the following actions are progressed:

i. That Calderdale and Huddersfield Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership Foundation Trust undertake further work engaging over a five month period (between January and May 2014) with stakeholders to provide additional

clarity regarding the proposals for service change. This additional information is presented in this Outline Business Case.
ii. That during the five month period Clinical Commissioning Groups would engage and listen to the views of the public and stakeholders about the proposals described in the Strategic Outline Case.
iii. That both Clinical Commissioning Groups would then take account of the findings from the public engagement and consider the Outline Business Case to decide whether to undertake a 13 week period of formal public consultation on the proposed service changes over the Summer of 2014.

The decision making process following acceptance of the OBC is outlined in the diagram below:



PCBC – pre- consultation business case, 4 Tests – the Department of Health Four Tests that must be met for Major Reconfiguration (clinical evidence, GP Commissioner Support, Public Engagement, Choice)

1.7 Conclusion and Recommendation

The current service models in Calderdale and Greater Huddersfield are neither clinically or financially sustainable into the future. The service changes proposed in this OBC are derived from a strong clinical evidence base and are supported by the doctors, nurses and therapists that provide the services. The plans have also been informed by the views of local people and the changes they want to see to enable the provision of more support and care out of hospital. The proposed new service models will enable improved safety, quality and system efficiency.

The recommendation is that Calderdale and Greater Huddersfield Clinical Commissioning Groups consider this Outline Business Case and commence Public Consultation on the service changes proposed.

Subject to this agreed way forward further work will then be undertaken to develop the Full Business Case that will be informed and enhanced by the process of Public Consultation.

As provider partners we wish this Outline Business Case to signal a substantial development and change in the health and social care sector that will have fundamental implications on how we deliver services in the future.

These developments need to be based on the principles set out in this document – especially those of care closer to home, with more self care at its heart. These developments are how we will deliver services in an era of fast-moving technological improvements and with people getting more real-time information on their health and care. There are areas described in Section 13.3 which we believe will have major impacts and create further opportunity for system improvement.

The Full Business Case will develop further detail and the additional service and economic opportunities related to:
- The further scope for Out of Hospital Care – more care delivered close to home
- Optimising and maximising the service efficiencies possible in delivery of community services.
- Reducing the capital build costs (reduce the size of the hospital estate required)
- Exploring the options to reduce the cost of capital financing and procurement options
- Exploring options to reduce transitional / dual running costs

2. Introduction

This is an Outline Business Case that proposes changes in the way NHS community and hospital services in Calderdale and Greater Huddersfield are provided. The Outline Business Case has been jointly developed by Calderdale and Huddersfield NHS Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership Foundation Trust. Our aim is to work together, and with local communities, to provide exceptional standards of care and support that will enable optimal health at lowered system cost.

Calderdale Council, Kirklees Council, Calderdale Clinical Commissioning Group, Greater Huddersfield Clinical Commissioning Group, general practitioners and the doctors, nurses and therapists that work in all three organisations have been engaged and influenced the development of this Outline Business Case. The Outline Business Case has been informed by feedback from members of the public given at a number of specific public engagement events held over the past two months and during the past two years when people have been asked what matters to them and what needs to change in the way we provide care and support.

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

2.1 Background

Over the past two years the health and social care organisations across Calderdale and Huddersfield have been listening to the views of local people and working together to review and develop proposals to improve services.

As a result of this work Calderdale and Huddersfield Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership Foundation Trust developed a joint Strategic Outline Case describing proposals for service change that aim to offer: more support to help you to look after your own health; more integrated services and care in your home or local community, and; improved likelihood of survival and making a good recovery if you are seriously ill or injured. The Strategic Outline Case also responded to the recommendations that were made by the National Clinical Advisory Team that visited Calderdale and Huddersfield Foundation Trust in June 2013.

The Strategic Outline Case was submitted for consideration by Calderdale and Greater Huddersfield Clinical Commissioning Groups in January 2014. During February and March 2014 Calderdale and Greater Huddersfield Clinical Commissioning Groups presented the Strategic Outline Case at public meetings of the Health and Wellbeing Boards and the Adults Health and Social Care Scrutiny Panels in Calderdale and Kirklees. Briefing meetings were also held with local Members of Parliament. Copies of the Strategic Outline Case and the National Clinical Advisory Team Report were subsequently published.

The Strategic Outline Case identified five scenarios for discussion about how the proposed service changes might be addressed. The five scenarios are:

i. Continue with the existing hospital and community service model and configuration.

ii. Implement the community and hospital service model proposed with Huddersfield Royal Infirmary as the site for acute and emergency care and Calderdale Royal Hospital as the site for planned hospital care.

iii. Implement the community and hospital service model with Calderdale Royal Hospital as the site for acute and emergency care and Huddersfield Royal Infirmary as the site for planned hospital care.

iv. Continue with the existing community service model and change emergency hospital care provided locally so that those people needing specialist treatments are transferred to a major emergency centre outside the local area. Huddersfield Royal Infirmary and Calderdale Royal Hospital would offer 'see and initiate treatment' services with people needing specialist treatments transferred to specialist centres. This would reduce demand at the local emergency centres in Halifax and Huddersfield.

v. Any other ideas for changing services resulting from extensive engagement with a wide range of stakeholders, including patients and the public.

Calderdale and Greater Huddersfield Clinical Commissioning Groups are responsible for any future decision regarding implementation of the proposals described in the Strategic Outline Case. No decision has been made at this stage. Both Clinical Commissioning Groups have agreed that the following actions should be progressed:

- That Calderdale and Huddersfield Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership Foundation Trust should undertake further work engaging over a five month period (between January and May 2014) with stakeholders to provide additional clarity regarding the proposals for service change. This additional information will be presented in an Outline Business Case and submitted to the Clinical Commissioning Groups by the end of May.

- That during the five month period of engagement there will be public engagement led by the Clinical Commissioning Groups to engage and listen to the views of the public and stakeholders about the proposals described in the Strategic Outline Case.

- Both Clinical Commissioning Groups will then take account of the findings from the public engagement and consider the Outline Business Case to decide whether to undertake formal public consultation on the proposed service changes.

To be able to commence public consultation Commissioners will need to demonstrate evidence against the four Department of Health tests for major service reconfiguration. This evidence will then be further tested through the public consultation process and the development of a full business case. Information in relation to the four tests is provided in this OBC. The four tests are:

- *Clinical Evidence* – Evidence of a robust tested clinical evidence base for the proposed service model.
- *Public Engagement* – Evidence that views of the local population have been received and considered in the development of this service model
- *GP Commissioner Support* – Evidence that the service model proposed is in line with the commissioning intentions of the local Clinical Commissioning Groups and supported by local GPs.
- *Choice* – Evidence that the service model supports the public's right to choose how they receive services.

2.2 Approach to Developing the Outline Business Case

This Outline Business Case has been jointly developed by Calderdale and Huddersfield Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership Foundation Trust.

There has been significant engagement with stakeholders (such as GPs, social care, voluntary organisations, Yorkshire Ambulance Service) to inform the Outline Business Case. This has included: specific engagement workshops to support the development of the proposed service models (see section 5); stakeholder involvement to undertake appraisal of the five scenarios (see section 9) and the findings from the public engagement led by Clinical Commissioning Groups have been taken into account and informed the Business Case (see section 4.5).

2.3 Structure of the Outline Business Case

The structure of the Outline Business Case uses the HM Treasury - Public Sector Five Case Model – Delivering Value from Spending Proposals. The five sections are:

The strategic case	This section revisits and provides more detail of the service proposal that was described in the Strategic Outline Case. It explains how the proposal offers a good strategic fit and is derived from a robust and clinical evidence based case for change. This includes the rationale of why change is required, as well as a clear definition of the intended benefits, outcomes and the implications for patient activity, workforce estates and travel.
The economic case	This section appraises the five scenarios that have been identified as the possible response to the service proposal. The appraisal includes assessment of how well each scenario could achieve the intended benefits and outcomes and a cost benefit analysis. The economic appraisal generates a shortlist from the five scenarios to be progressed.

The commercial case	This section demonstrates that there are estate and service procurement options for the shortlisted scenarios.
The financial case	The section demonstrates that the shortlisted scenarios are affordable. It identifies the capital and revenue requirement for the shortlisted scenarios together with an assessment of the impact upon the balance sheet and income and expenditure accounts.
The management case	This section demonstrates that the shortlisted scenarios are capable of being delivered successfully, in accordance with recognised best practice. This includes demonstrating that the issues raised through public engagement have been taken into account and that there are robust arrangements for change management, the delivery of benefits and the management and mitigation of risk.

2.4 Scope of the Outline Business Case

The proposals for service change described in this Outline Business Case are far reaching and have been developed through partnership and engagement across the Calderdale and Greater Huddersfield health and social care economy. The changes described will have impact on the whole health and social care system enabling improved and new ways of integrated working for the benefit of local people.

The services provided by CHFT, SWYPFT and Locala that are directly within the scope of this OBC are: the hospital services provided at Calderdale Royal Hospital and Huddersfield Royal Infirmary; physical health community services provided by Locala and CHFT in Calderdale and Greater Huddersfield, and; mental health liaison services provided by SWYPFT across Calderdale and Greater Huddersfield.

Whist there has been close in involvement in developing the OBC, Social care provision, primary care contractor services (GPs, dentists, opticians and community pharmacy services), and specialist mental health services are outside the direct scope of this OBC.

2.5 Purpose of the Outline Business Case

The purpose of this Outline Business Case is:

- to revisit the proposals and assumptions described in the Strategic Outline Case (using the five case public sector model described above) and identify preferred scenarios that Clinical Commissioning Groups will be requested to approve are taken forward for formal public consultation.
- to provide information that will assist all partners to demonstrate evidence that this Outline Business Case addresses the Department of Health four tests for major service reconfiguration.

3. The Strategic Case: Context and Current Service Profile

The purpose of this section is to provide the context to this programme and an overview of the current health and social care position. This section will provide context for the case for change and the proposed new service models described later in this outline business case.

After reading this section, you should understand:
- The context of the programme and local and national drivers for this work,
- The main features of the current health and social care services for the area,
- The performance of current services including what patients, public, staff and wider stakeholders have told us about our current services

3.1 The context of this work as part of the Calderdale and Greater Huddersfield Strategic Review

Over the past two years the seven health and social care organisations in Greater Huddersfield and Calderdale have been working together through the Strategic Review.

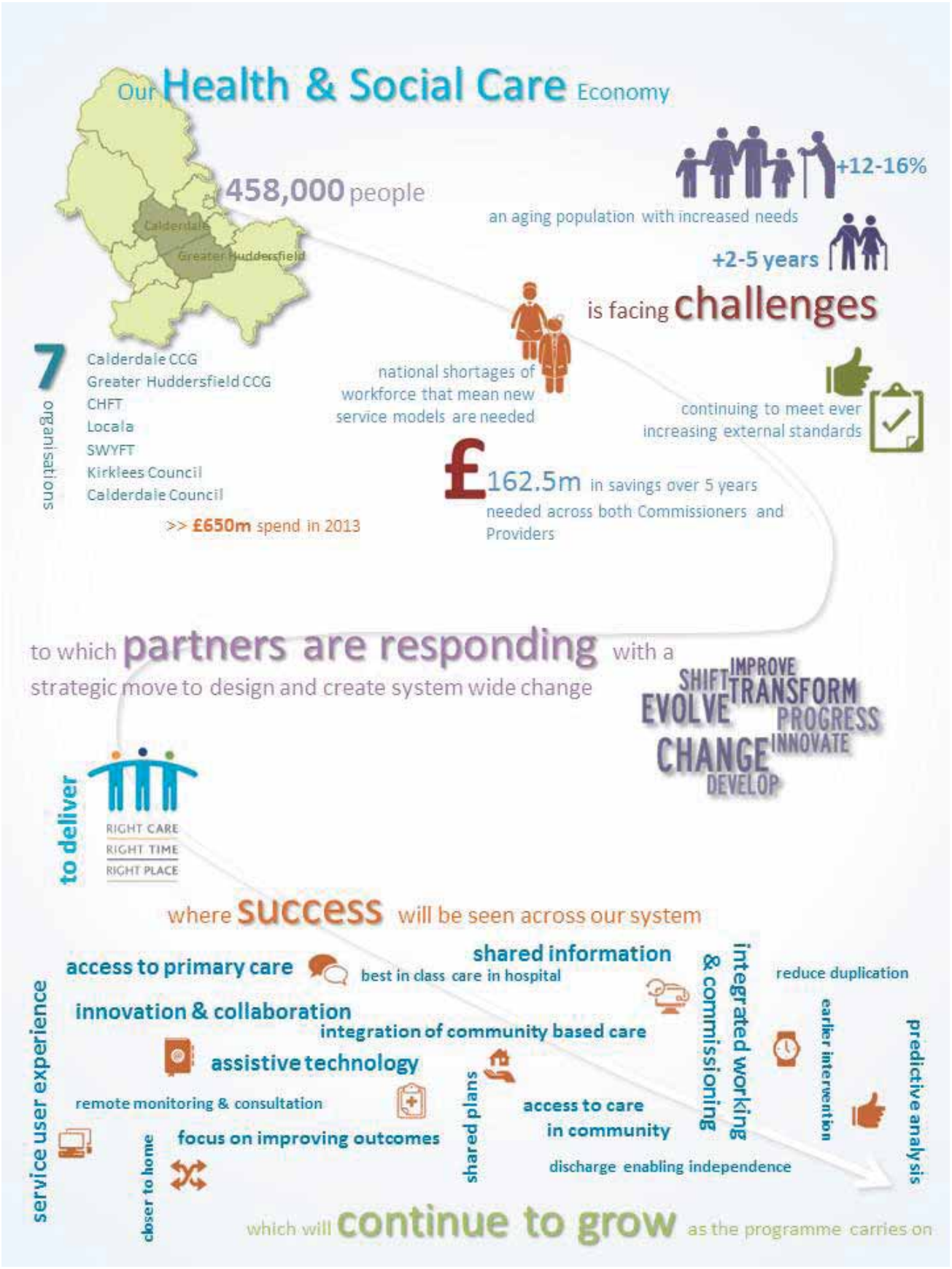
The seven partner organisations are:
- Calderdale and Huddersfield NHS Foundation Trust (CHFT)
- Calderdale Clinical Commissioning Group (CCCG)
- Calderdale Metropolitan Borough Council
- Greater Huddersfield Clinical Commissioning Group (GHCCG)
- Kirklees Metropolitan Borough Council
- Locala Community Partnerships
- Southwest Yorkshire Partnership Foundation Trust (SWYPFT)

The purpose of the strategic review is to encourage innovation and transformation that will address the shared challenges of:
- meeting the needs of an ageing population (further information in section 3.3)
- continuing to deliver care to increasing external standards (further information in section 3.5)
- significant financial pressures for commissioners and providers (further information in section 3.10)
- national shortages of key elements of the workforce (further information in section 3.9)

Without significant change to the way that services are provided, the future health and care needs of the residents of Calderdale and Huddersfield will not be met. The current model of service configuration is not sustainable in terms of maintaining quality standards and meeting demographic demands and action needs to be taken to address this.

The work of the strategic review and the response of providers (CHFT, SWYPFT and Locala), including the proposed model of care set out in this Outline Business Case seek to address this unsustainable position.

The figure on the next page illustrates the overall Strategic Review journey:


Our Health & Social Care Economy
458,000 people
Calderdale
Greater Huddersfield
+12-16%
an aging population with increased needs
+2-5 years
is facing challenges
7 organisations
Calderdale CCG
Greater Huddersfield CCG
CHFT
Locala
SWYFT
Kirklees Council
Calderdale Council
>> £650m spend in 2013
national shortages of workforce that mean new service models are needed
continuing to meet ever increasing external standards
£162.5m in savings over 5 years needed across both Commissioners and Providers
to which partners are responding with a strategic move to design and create system wide change
SHIFT
IMPROVE
TRANSFORM
EVOLVE
PROGRESS
INNOVATE
CHANGE
DEVELOP
to deliver
RIGHT CARE
RIGHT TIME
RIGHT PLACE
where success will be seen across our system
access to primary care
best in class care in hospital
shared information
reduce duplication
integrated working & commissioning
earlier intervention
predictive analysis
service user experience
innovation & collaboration
integration of community based care
assistive technology
remote monitoring & consultation
shared plans
access to care in community
focus on improving outcomes
closer to home
discharge enabling independence
which will continue to grow as the programme carries on

Through the strategic review, professionals from all seven partner organisations have worked together to develop proposals to address the challenges to meet the health and social care demands of the future. These proposals have been informed by the views of service users, staff, the public and voluntary sector organisations through a range of exercises that have had an engagement reach of approximately 25,000 people (more detailed information on these engagement exercises can be found in section 3.2).

The Strategic Review is focused around five care streams and as a result of the engagement exercise a number of cross-cutting themes that impact on all areas of health and social care have also been identified. These cross-cutting themes have the potential to really transform the way services are delivered, improving people's outcomes and reducing costs further. The five care streams and the cross-cutting themes are set out below:

Care streams

Making the most of existing capacity and capability	Digitising the Health and Social Care economy	Integrated services delivered in the community	Integrated commissioning and personalisation	Taking forward work of the Children's Care Stream

Themes that impact on all areas of health and social care

We want to improve the health, well-being and safety of all our communities by supporting people to be independent and to deliver the right care, in the right place at the right time.

To do this we need to change the way we provide health and social care services so that:

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

In accordance with best practice, in 2013 a Department of Health Gateway Review of the programme was undertaken. One of the recommendations from this Gateway Review was that expert external opinion of the future model for emergency care for the health and social care economy should be sought. Acting on this recommendation Calderdale and Huddersfield NHS Foundation Trust invited the National Clinical Advisory Team (NCAT) to review the current emergency configuration and offer a view on the way forward.

NCAT visited the Trust in June 2013 and met with many doctors and nurses and some Trust management, also GPs and commissioners, partner providers and Yorkshire Ambulance Service. NCAT recommended the Trust develop a future service plan centred around more care, both planned and unplanned, being provided in the community, and the two hospitals having a clearer focus, one being designated the planned site and one the unplanned site. The NCAT review confirmed that which site has which focus is a matter for local management to decide.

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

3.2 What People have told us About Services

Engagement and feedback is essential when considering future service models and how they are delivered. A series of events engaging patients, service users, public representatives, staff members and third sector organisations have enabled the Strategic Review partnership to highlight key priorities for the future and what really matters to people who use services. The table below summarises some of the key issues local people have identified during engagement exercises in response to the question "why do services need to change?".

- People understanding and truly taking control of their condition, not being passive recipients of care but actiely managing their condition
- More Services in the community- more staff working with and supporting local people in their own home and community e.g. better access to equipment to use in own home and more day care and respite care for carers
- Better management of risk and safeguarding - keeping people safe when they are unwell e.g. more health visits to vulnerable families, increased community staff and regular house calls
- Investment in community and primary care as well as local community and voluntary groups that provide support for local people with health conditions e.g. utilise youth clubs and community centres and put services in existing community buildings
- Improved discharge planning and better hospitals e.g. ensure robust discharge plans backed up with health and social care services 24/7, assign a professional to keep daily contact in first week following discharge
- Investment in technology use technology better and invest in future technology, especially for monitoring and sharing information between services and patients e.g. education by social media, consider apps to support people and train them in their use
- Working together all agencies, not just health, should work together to improve health and wellbeing e.g. joint teams managed together, ability for health and social care professionals to access a shared record
- Improved education and information for people- there needs to be more information about how to maintain health and wellbeing and avoid preventable conditions and how to access services e.g. condition specific education courses
- Improved access to health services e.g. have specialist staff in GP practices, one point of access for people with long term conditions
- Staff training e.g. train all staff to change the culture of the NHS, improve communication with patients
- Regular check-ups e.g. offer a wide variety of health and wellbeing checks 'an MOT or health review'.
- National solutions and campaigns are needed on a national scale e.g. changes made by government such as higher taxes on sugar, alcohol, smoking
- Stronger accountability e.g. clear ways of measuring quality of care in all settings, learn from mistakes

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

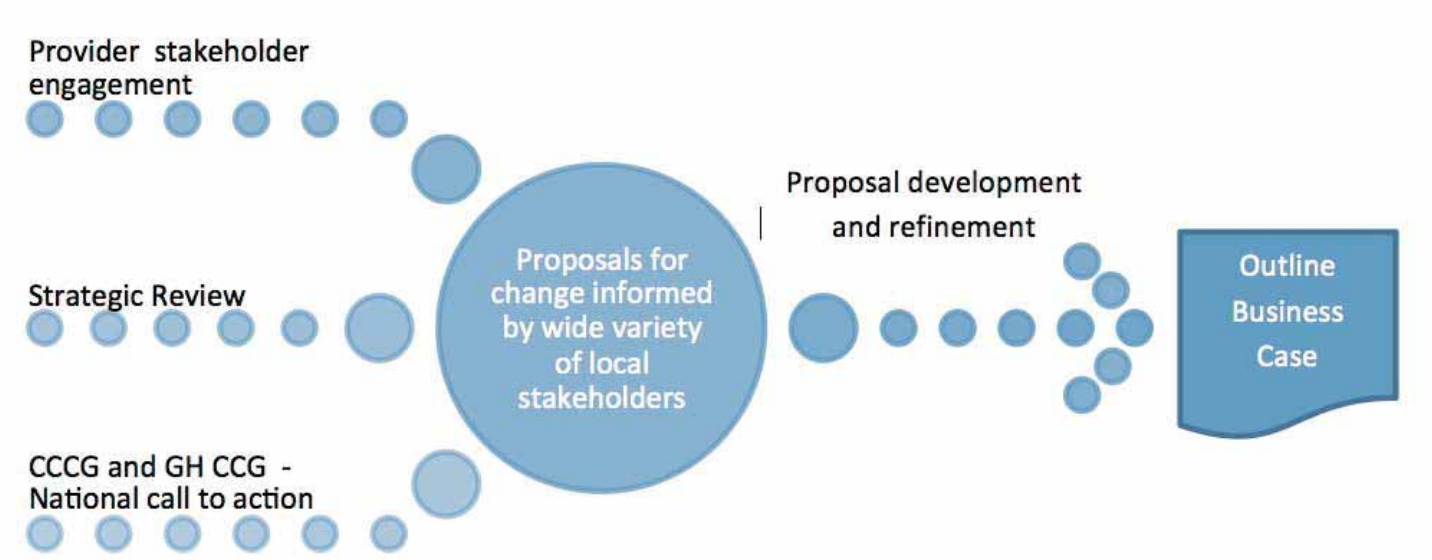
"I didn't know how to deal with my COPD. If I had known I could have done something about it, like self-management, which I do now."
A local person talking about supported self-care for COPD

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

Senior doctors, nurses and therapists that currently provide the services in hospital and in the community have also identified the need for service and system change to improve the safety and effectiveness of care for patients in the future. Staff engagement has confirmed support for the need to change services:

- To provide more proactive and responsive care for people in their own homes or close to home and as result reduce the number of people that have to be admitted to hospital.
- To provide more specialist care in people's homes and the community so that people do not need to come to hospital for outpatient appointments and tests or to be admitted for care.
- To provide all the support people need 7 days a week so that if people are admitted to hospital they can go home sooner.
- To increase the use of technology to enhance the safety, efficiency and timeliness of care provided in the community and in hospital.
- To organise staff and services so that all the necessary specialist services that need to be together to deliver the best standards of clinical care are available on the same hospital site
- To make sure people have early access to senior doctors, nurses and therapists who can make decisions about the care they need and offer the best information and advice for people.

This Outline Business Case has been informed by the engagement undertaken by different organisations over the last couple of years to better understand and consider the views of service users, the public, voluntary sector organisations and staff.



Engagement undertaken by South West Yorkshire Partnership Foundation Trust

SWYPFT has undertaken a series of engagement events to inform service transformation plans. Over the summer of 2013, 7 engagements events were held across all localities including Calderdale and Huddersfield. Over 500 people attended these events with a further 7 follow up events held more recently to ensure that the feedback has been used to inform future services. Overall there were 5 key themes identified:

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

Engagement undertaken by Calderdale and Huddersfield Foundation Trust
CHFT has an active and on-going programme of engagement activities to hear people's views on current services and potential future services. These activities include friends and family test, compliments and complaints and structured discussions around service changes. One example is the significant public engagement undertaken in September last year in relation to the potential relocation of services from Princess Royal Community Health Centre. In 2005/06 the Trust undertook significant public engagement in relation to the partial reconfiguration of some hospital services to provide acute surgery and trauma services at Huddersfield Royal Infirmary and consultant led obstetric services at Calderdale Royal Hospital. These changes were made for the same clinical reasons described in this Outline Business Case i.e. that the concentration and co-location of specialist expertise was necessary to improve the safety and clinical outcomes of these services. The clinical evidence base for this was recognised and supported by Commissioners at that time. The changes made in 2005/06 have been successful in delivering improved outcomes. These benefits could be even further enhanced by taking action to co-locate all acute and emergency services on a single hospital site.

Engagement activities have continued throughout the development of the Strategic Outline Case and the Outline Business Case, with CHFT engaging staff, the public, membership council, other providers of health and social care services, political representatives and staff side representatives in their work. These engagement activities are led by senior doctors, nurses and therapists from CHFT. Specific engagement activities in relation to the development of this Outline Business Case has ranged from 1:1 interviews with over 100 staff, to open drop in sessions, to workshops with other providers to review how we can redesign services.

Engagement undertaken by Locala Community Partnerships
As a social enterprise, Locala offers a membership programme which is actively involved in the development of services. Membership of Locala helps local people and staff shape services for the benefit of the Locala community on an on-going basis. Locala uses patient feedback (compliments, concerns and comments) to shape the services that they provide. This includes the Friends and Family test and the independent online feedback website, Patient Opinion.

In 2013 Locala was actively involved in the public engagement relating to the planned closure of Princess Royal Community Health Centre in Huddersfield.

Locala is actively involved in the various work streams of the Strategic Review and promotes public engagement via the 'Right Care, Right Time, Right Place' website and engaging in social media activity.

Engagement undertaken through the Calderdale and Huddersfield Strategic Review
The Strategic Review has undertaken extensive public and stakeholder engagement covering four themes: planned care, unplanned care, long term care and children's services. The first stage included collating and analysing local and national information available of existing feedback from the public, patients and carers. Specific engagement events were also held. A questionnaire was also used to engage further with public, patients and carers. Survey participants included local people across Calderdale and Huddersfield, which included GP practices and Accident and Emergency Departments. In addition during the period October to November 2013 Greater Huddersfield and Calderdale CCG's undertook significant engagement activity to support the 'National Call to Action'. This asked the public to give their views on four broad questions:

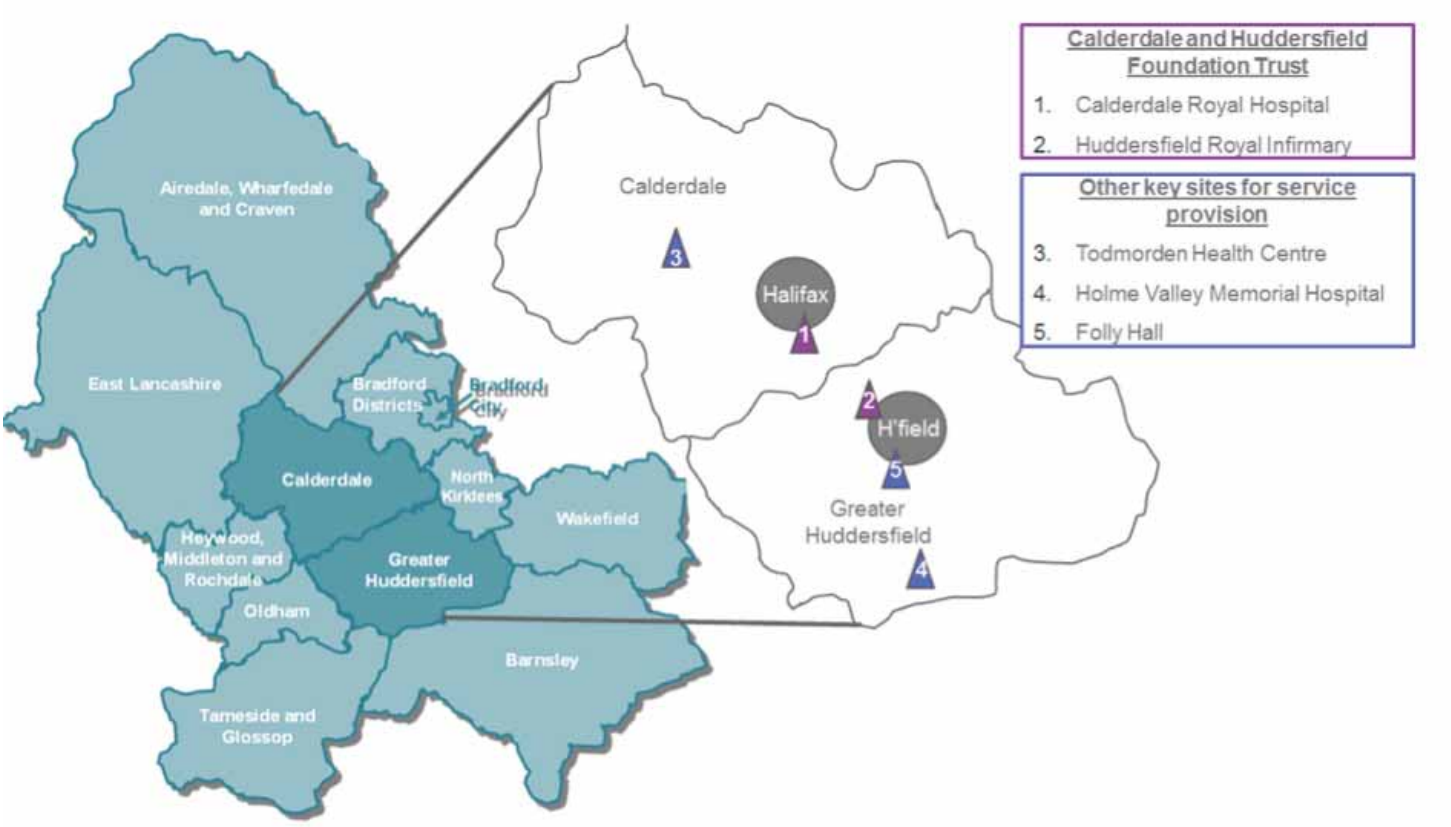
- How can we improve the quality of NHS care?
- How can we meet everyone's healthcare needs?
- How can we maintain financial sustainability?
- What must we do to build an excellent NHS now and for future generations?

A detailed report (Call to Action: Engagement Report for Calderdale and Huddersfield Strategic Review) of the findings has been published. The general themes identified included for example: self-management; all agencies working together; improving access and bringing more hospital services into the community; investing in technology; investing in community and primary care services, and; improving education and information for the public about health.

Overall there appears to be a great deal of coherence and consistency of what people have told us about services and what is important to them. This Outline Business Case and the proposals for change build on this feedback and stakeholder engagement will continue to be fundamental to the success of the programme. Significant and long-lasting change will only be achieved if the public, patients, health professionals and other local stakeholder groups inform and support the decisions taken. The programme recognises this and section 12 (the Management Case) of this Outline Business Case provides further detail regarding on-going stakeholder engagement.

3.3 Demography and Health Needs

This Outline Business Case relates to provision of services across Calderdale and Greater Huddersfield, however it is recognised that the health economy does not operate in isolation or with defined boundaries. Changes to service provision in neighbouring localities for example, as a result of the Mid Yorkshire NHS Trust strategic review, are expected to result in an increase of attendances at HRI A&E department. Similarly changes made as part of this programme of work may also impact neighbouring health economies. The focus of this programme of work is on the Calderdale and Greater Huddersfield health economy and the most significant changes will occur within this footprint.



Population growth

The population for Greater Huddersfield is 245,000 and for Calderdale is 213,000 giving a combined population of 458,000 people. However the environment is not static and changes will continue to be seen across Calderdale and Greater Huddersfield as shown in the figure below:

The growth in population means that more people will require access to health and social care services. Much of this demand will come from older people as this cohort of the population are likely to develop one or more long term condition such as dementia, heart disease, diabetes and respiratory problems.

The challenge for health and social care in providing high quality and effective services is exacerbated by the aging and expanding population, but also as modern lifestyles are also creating more ill health across all ages of the population. Unhealthy eating and lack of exercise are contributing to increased prevalence of obesity, diabetes and cardiovascular disease in the population. The impact of this is generating additional demand for health and social care services.

A summary of the health profile for each area is provided below.

	Calderdale	Greater Huddersfield
Population growth	The population is increasing and will continue to grow, especially in the over 65 and the 0-15 year-old age group. It is expected that population that Calderdale CCG commission services for will increase by 10% over the next 25 years.	The population is increasing and will continue to grow, especially in the over 65 and the 0-15 year-old age group. Estimates suggest that by 2030 the population will be 278,700 (an increase of >15.2% since 2010).
Mental health and dementia	In Calderdale it is estimated there are 2,300 people living with dementia and this is forecast to increase by about 75% over the next 15 years	In Kirklees it is estimated there are 4,000 people living with dementia and this is forecast to increase by about 75% over the next 15 years. 1 in 5 adults reported suffering from depression, anxiety or other mental health condition.
Deprivation	Fuel poverty is estimated to affect a quarter of all households in Calderdale. An estimated one in five children are living in poverty Higher rates of Infant Mortality are associated with higher levels of deprivation, and the Infant Mortality Rate (IMR) for Calderdale is significantly higher than England average (7.53 per 1,000 live births compared to 4.69 per 1,000 live births).	There are high poverty and deprivation levels in Huddersfield along with higher rates of unhealthy behaviours and higher disease burden. Long term pain, depression and anxiety have the largest impact on local health.
Lifestyle factors and obesity	Behavioural factors which relate to health are not improving. Smoking prevalence and the harm caused by alcohol and obesity is increasing. There is rising childhood obesity and it is estimated that 40% of all illness in Calderdale can be attributed to lifestyle factors	Lifestyle choices have a significant impact on the major causes of ill health and premature death in Greater Huddersfield. 52% of adults in the GHCCG area are overweight or obese, and 1 in 5 children are overweight or obese.
Life expectancy and inequalities	More people are living longer with multiple health problems. There is a growing health gap, with those living in Calderdale's most disadvantaged communities experiencing greater ill-health than elsewhere in the district (there is a life expectancy gap between wards within Calderdale of up to 9 years).	More people are living longer with multiple health problems. Life expectancy varies across GHCCG, with the gap in life expectancy at birth at 3.4 years for men and 3 years for women. Average life expectancy at birth is also lower than the national average: 78.1 year for men (78.5 national) and 81.8 for women (82.5 national).

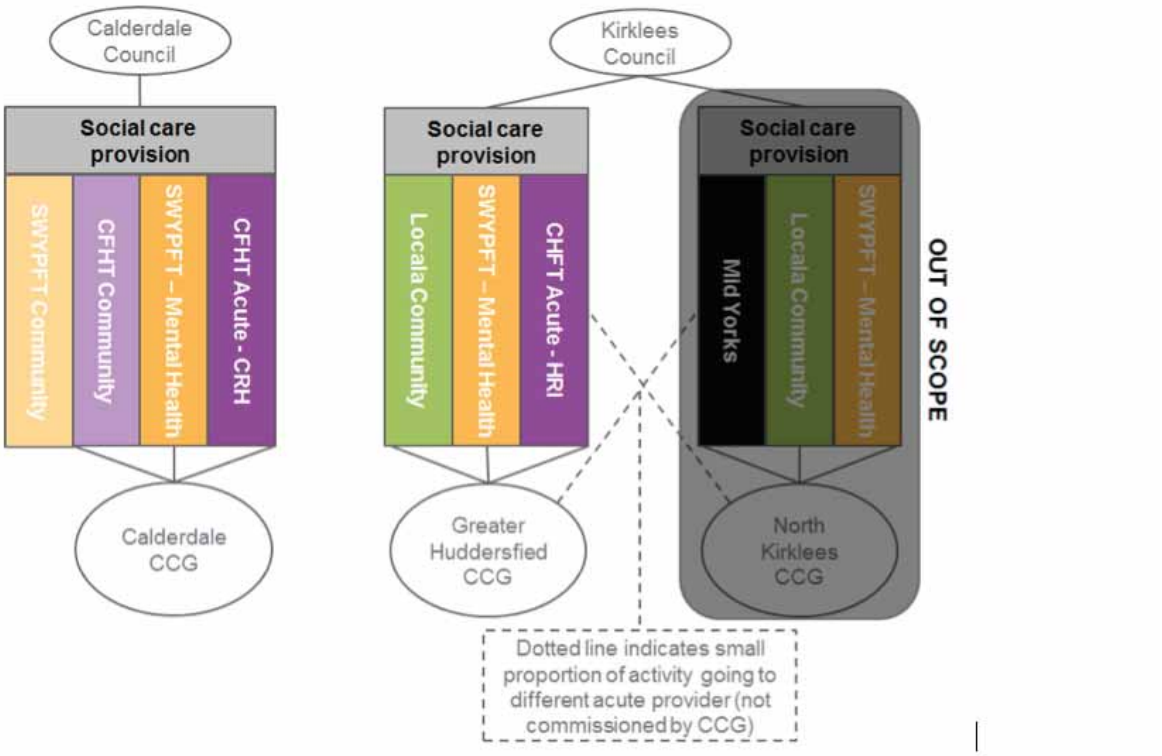
Commissioners and providers are already taking action to address the increasing and changing profile of needs, however without transformational change the current arrangements for health and social care service provision will not be able to meet the increasing and changing demands placed upon it in the future.

Doing nothing is not an option, this Outline Business Case sets out options for transformational change that will allow commissioners and providers to meet the demands of the future in a sustainable way.

3.4 Health and Wellbeing Strategies and Commissioning Intentions

The commissioning of health services is the responsibility of Clinical Commissioning Groups. CCGs commission services for all the people (whether they are registered with a GP or not) within their designated geographical area. As CCGs include all GP practices as members, to avoid any conflict of interest within clinical commissioning, CCGs are not responsible for GP or other primary care contracts. The commissioning and provision of social care is the responsibility of the relevant local authority.

CCGs can commission services from NHS and/or non-NHS organisations (third sector, social enterprise, private company), for example palliative care services provided by a third-sector hospice or musculoskeletal services from a private physiotherapy company.
The current commissioning arrangements for the majority of acute, mental health, and community care services for Calderdale and Huddersfield are illustrated below. The main providers of this care are CHFT, SWYPFT and Locala, however the CCGs also commission some services from other providers (not shown as not a main provider).



The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. It is intended that this approach will translate to patients and the public experiencing more joined-up services from the NHS and local councils.

The Health and Wellbeing Strategies and Commissioning Intentions referenced below have all been developed following extensive engagement with local residents and patients and through the work of professionals from health and local authority organisations. This Outline Business Case is aligned with and supports achievement of the priorities identified in these Health and Wellbeing strategies and the CCG commissioning intentions.

The Joint Health and Wellbeing Strategy for Calderdale

Calderdale's Joint Health and Wellbeing Strategy (JHWS) 2012 – 2022, published in March 2013 by Calderdale Health and Wellbeing Board sets out their vision for improving the wellbeing of local people and reducing inequalities in Calderdale and the priority outcomes that partners across Calderdale have agreed to focus on in to deliver this vision. The vision and priority outcomes are set out below, and full details of the strategy can be found here.

"Our vision is for Calderdale to be an attractive place where people are prosperous, healthy and safe, supported by excellent services and a place where we value everyone being different and through our actions demonstrate that everyone matters."

The outcomes identified as those that should be priorities within the Wellbeing Strategy see Calderdale as a place:

- Where people have good health
- With a balanced and dynamic local economy
- Where children and young people are ready for learning and ready for life
- Where few children under the age of 5 live in, and are born into, poverty
- Where older people live fulfilling and independent lives
- Where everyone has a sense of pride and belonging based on mutual respect

The Joint Health & Wellbeing Strategy for Kirklees

The Joint Health & Wellbeing Strategy for Kirklees, 2013 – 2020 can be found here. The Kirklees JHWS vision is that by 2020:

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

The outcomes include, across the whole population of Kirklees we want:

- Inequalities in health and wellbeing to be reducing, both locally and against national outcomes
- Increase skills and capacity in communities generating energy for change
- The level of support available to individuals, families and communities reflecting their level of need
- Threats to public health to be minimised and dealt with speedily.

To achieve these outcomes and achieve the JHWS vision, the following principles and actions have been agreed.

- Making mental health everyone's business
- Focussing the outcomes of the system/service on the cause of the issue
- Making systems/services person and community centred
- Making best use of resources (people, money, assets) to reduce duplication
- Focussing on all three levels of prevention; stopping issues starting, detecting and dealing with issues and minimising the consequences where they do.

Calderdale Clinical Commissioning Group – Commissioning prospectus

The commissioning prospectus captures Calderdale CCG vision, priorities, objectives and commissioning intentions.

Calderdale CCG aims to address the challenge of reducing the level of health inequalities affecting their communities. It recognises that many of these health issues can only be tackled by working together with other health and local authority bodies, and this has influenced the longer term commissioning strategy of the CCG. In the long term, Calderdale CCG aim to:

- Develop locally owned partnerships
- Build long term change through prevention and health improvement measures
- Empower patients to take responsibility for self-care and self-management of health conditions
- Make primary care the best it can be; accessible and local
- Improve planned care to get the service right for different groups of people
- Ensure people get access to Emergency Care in the right place at the right time
- Integrate Hospital Care so all doctors function as part of an extended care team
- Improve training and education facilities so we have joint primary and secondary care approaches
- Motivate a strong workforce so we get the health offer right for our patients.

Greater Huddersfield Clinical Commissioning Group – Commissioning prospectus

The GHCCG commissioning prospectus sets out Greater Huddersfield CCG vision and ambitions for commissioning, including the priority areas and desired outcomes and outputs. It has been informed by the Kirklees Joint Strategic Needs Assessment (JSNA) and developed with all member GP practices and in consultation with partner organisations and the public.

The GHCCG prospectus sets out priority areas against four themes and eight programmes. The themes are:

- Quality – Commission for quality and improve quality management information
- Engagement – Improve patient and public engagement and arrangements for assessing patient experience
- Information Technology (IT) – Improve and join up IT systems to support better patients care. Giving patients access to their medical records.
- Workforce – Planning, development and succession planning.

This Outline Business Case is aligned with and supports achievement of the priorities identified in the Health and Wellbeing strategies and the CCG commissioning intentions referenced in this section.

3.5 National Policy Context

In recent years a number of public inquiries and reviews have been undertaken and published that focus on quality and safety across all areas of the health and social care sector. These continue to influence national policy and best practice, and whilst not exhaustive at the time of preparing this Outline Business Case there are nine key areas that have particularly informed the development of proposals. These are shown in the table below.

Policy Area / Issue	Summary	Relevance to this Outline Business Case
The Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry *February 2013* and Transforming care: a national response to Winterbourne View hospital *December 2012*	The report of the failings at Mid Staffordshire Trust and separately at Winterbourne View, and the associated reports by Sir Bruce Keogh (Review into the Care and Quality of Treatment provided by 14 Hospital Trusts in England) and Don Berwick (Improving the Safety of Patients in England) describe the actions needed to ensure there is a clear focus on providing safe and compassionate care.	These reviews and reports have informed the development of this Outline Business Case. Importantly the Outline Business Case describes proposals of how we can improve the safety of hospital care and reduce mortality.
The Keogh Urgent and Emergency Care Review Urgent and Emergency Care report *November 2013*	The report sets the strategic direction for the provision of urgent and emergency services in England over the next five years.	The proposals in this Outline Business Case will enable and prepare us to respond to this national strategic direction.

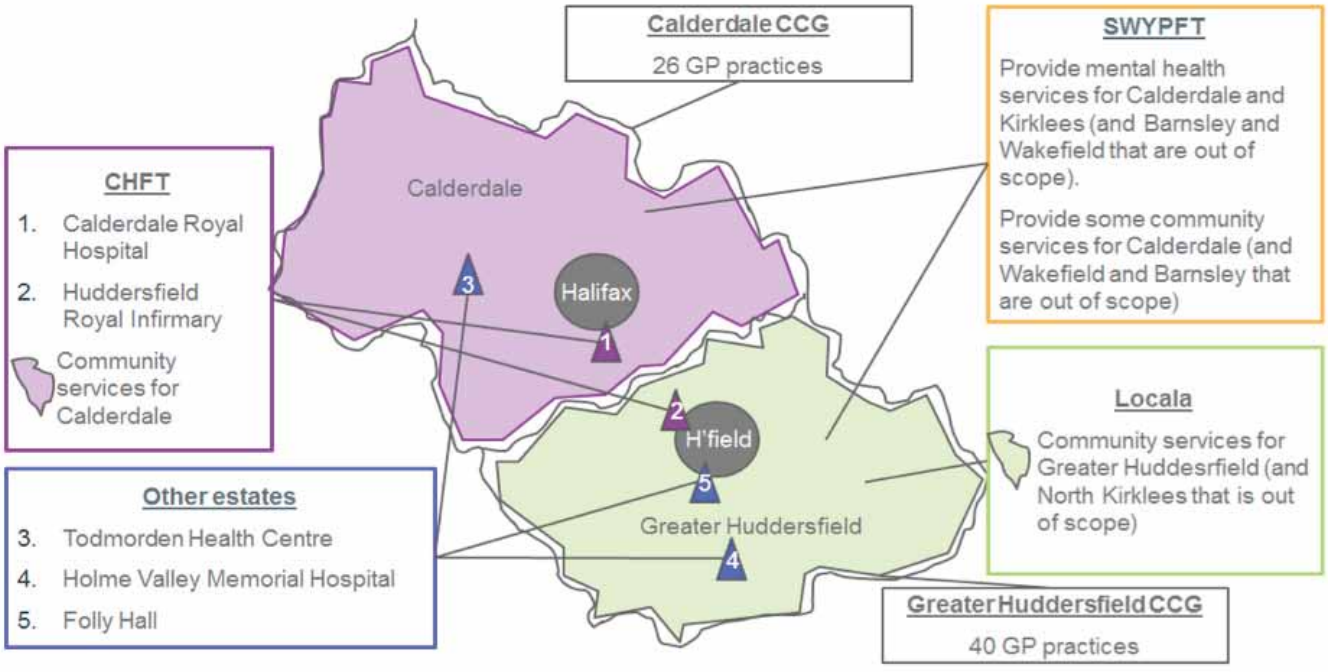
Policy Area / Issue	Summary	Relevance to this Outline Business Case
The NHS Services, Seven Days a Week Forum chaired by the National Medical Director *Forum established in February 2013*	The Forum's review identifies there is unacceptable variation in outcomes across the NHS in England for patients admitted to hospitals at the weekend. For patients admitted at weekends there is an increased mortality rate, poor patient experience and increased length of hospital stay and re-admission rates. The Forum proposes that clinical standards are adopted and fully implemented by 2016/17 to support the NHS to drive up clinical outcomes and improve patient experience at weekends. Under the present configuration of services, delivering the clinical standards for urgent and emergency in-patients at weekends is likely to add to overall hospital costs. The Forum recommends that reconfiguration of services and integrated working of hospital, community and primary care services may substantially reduce these costs.	The proposals in this Outline Business Case describe how we can respond to enable seven day working across the health and social care system.
The Better Care Fund *Announced by the Government in the June 2013 spending round*	Nationally it has been agreed that £3.8bn of NHS funding will transfer to Local Authorities to create a single pooled budget for health and social care. The aim of this is that the fund should be an important catalyst for change, and enable the move towards more preventative, community-based care to help to keep people out of hospital and in community settings for longer.	This Outline Business Case describes service proposals that could deliver this ambition.
Future Hospital: Caring for Medical Patients *September 2013*	This publication by the Royal College of Physicians provides an evidence base and case studies of the benefits associated with changing the way we care for people with medical needs by integrating care across hospital, community and social care services.	The Outline Business Case describes proposals for doing this.
The draft Health and Social Care Bill and 'Dilnot' Report Report July 2011 *The draft Care and Support Bill was published on 11 July 2012*	The government's proposals for social care funding reform (due to come into effect in 2016) will place a cap on the social care costs paid by an individual. The impact of this will further increase funding pressure for Local Authorities.	This Outline Business Case describes proposals for integrating health and social care that could mitigate the impact of this funding pressure.
No health without mental health strategy. Launched February 2011	This a cross-government mental health outcomes strategy for people of all ages sets a clear and compelling vision for improving mental health and wellbeing in England.	This Outline Business Case describes proposals for more joined up working across mental and physical health services with a focus on improving the wellbeing of the whole population which is in line with this strategy.
Information and Management and Technology – in line with the NHS policy '*Making the NHS more efficient and less bureaucratic*'	There are a number of national policy directives that set a clear direction and evidence base for increased use of technology in health and social care delivery to improve, patient safety, experience and efficiency of services. Two reports published in January 2013 demonstrated the potential benefits of making better use of technology and prompted the Health Secretary Jeremy Hunt to challenge NHS to go paperless by 2018.	This Outline Business Case includes proposals for optimising the use of technology to enhance the effectiveness and efficiency of service provision.
National economic context	Nationally the country continues to recover from the economic crisis, public spending continues to be reduced in key areas. The national spending review in 2013 identified further reductions for local government and no growth for health. The financial context for delivery of health and social care will continue to be challenging.	This Outline Business Case proposes service changes that will optimise the use of the available resources and improve effectiveness and efficiency.

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

3.6 Overview of the Services Currently Provided

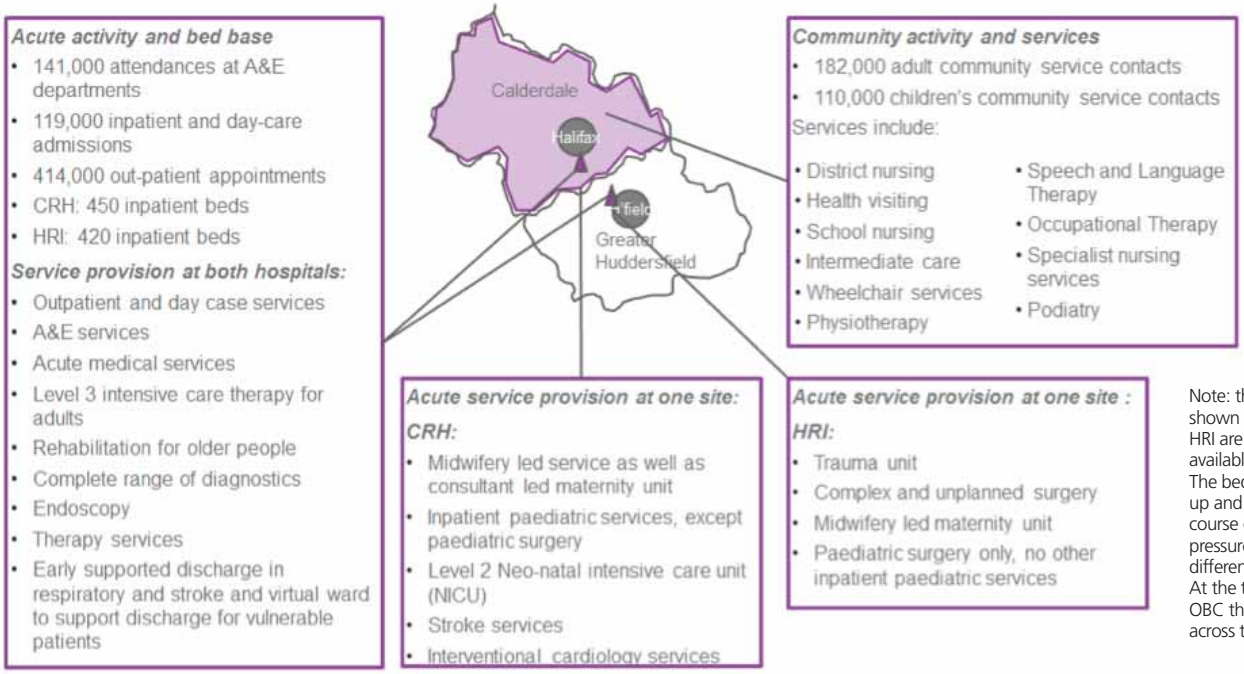
Calderdale CCG and Greater Huddersfield CCG currently commission acute care, mental health care and community care health services from three main providers, as shown on the map below. In addition there are a number of private and third sector providers available for individuals, these are outside of the scope of this OBC and therefore not shown.

Current view of the main sites and providers for acute, mental health and community health service provision in Calderdale and Greater Huddersfield



Calderdale and Huddersfield Foundation Trust provide acute services at Calderdale Royal Hospital and Huddersfield Royal Infirmary, as well as community services for Calderdale. The figure below provides greater detail on the services provided and activity levels for these services.

Calderdale and Huddersfield Foundation Trust
Acute and community service profile and high level activity information



Note: the bed numbers shown above at CRH and HRI are the estate capacity available for number of beds. The bed requirement is flexed up and down during the course of the year to cover pressures in the system at different times of the year. At the time of preparing the OBC there are 802 beds open across the two sites.

SWYPFT provide mental health services for Calderdale and Greater Huddersfield region and Locala provide community services for the Greater Huddersfield region. The figure below provides greater detail on the services provided and activity levels for these services.

Locala Community Partnerships and SWYPFT
Community and mental health service profile and high level activity information

SWYPFT – South West Yorkshire Partnership Foundation Trust

- 45,194 bed days of inpatient care
- 161,821 patient contacts across Calderdale and Greater Huddersfield

Service provided across Calderdale and Greater Huddersfield include:

- Mental health services for adults of working age (18 to 65)
- Child and Adolescent Mental Health services
- Services for Older people (over 65) with a mental health problem
- Services for people (mainly adults)) with a learning disability whose behaviour challenges services, with intensive support needs and/or a mental health problem
- Medium secure forensic services for people with a mental health problem and/or learning disability

In Calderdale additional services include:

- Substance misuse/alcohol services
- Health improvement services

Locala Community Partnerships

- 800 intermediate care in-patient admissions
- 3,500 day-case admissions
- 3,500 out-patient appointments
- 285,000 adult community service contacts
- 75,000 children's community service contacts
- 20,000 Health & Well-being contacts

Services provided include:

- District nursing
- Health visiting
- School nursing
- Musculoskeletal services
- Community dermatology services
- Speech and Language Therapy
- Occupational Therapy
- Continence services
- Contraceptive and sexual health services
- Intermediate care
- Walk-in Centre
- Health Promotion and Improvement

In addition to the acute, community and mental health services detailed in figures above, there are also NHS dental, pharmacy and optician services commissioned for the residents of Calderdale and Greater Huddersfield, these are commissioned by NHS England and are outside the scope of this OBC so are not detailed.

Voluntary Sector Organisations

Across Calderdale and Huddersfield there are a range of third sector / voluntary organisations that support and provide services to improve the health and wellbeing of the population.

Summary of Social Care

Kirklees Council and Calderdale Council are responsible for the commissioning and provision of social care services and support across Calderdale and Huddersfield. The two Councils directly provide some services but many services are commissioned and delivered by the voluntary and independent sector.

Adult social care covers a range of services to support vulnerable adults with a focus on reducing dependence and where possible offering a range of, often integrated, support. To help people stay in their own homes social care support may be provided for a short period of time e.g. to try and prevent an admission to hospital, or support someone who is recovering from an illness or injury potentially following discharge from hospital (re-ablement). However, for some people long term support may be required to facilitate them staying in their own home e.g. domiciliary care. Where it is not possible for someone to remain in their own home, adult social care services also provide residential and nursing home placements.

Calderdale Council and Kirklees Council both use technology, Telecare, as part of the social care offering. Telecare refers to a range of detectors, sensors and alarms that can help people to remain in their own home. Examples include 'Careline' buttons that can be worn by a service user and pressed if the user needs help (e.g. falls and is unable to get up). Pressing the button connects the user to a 24/7 monitoring centre who can arrange appropriate help for example a neighbour, accommodation warden or ambulance. Other examples of Telecare include bed and chair occupancy sensors and automatic medication reminders and medication dispensers. The table below illustrates the social care service activity provided in Kirklees and Calderdale. It is important to note that the Kirklees data relates to a larger population. The information is provided for illustration only.

Measure	Kirklees	Calderdale
Number of care and nursing home placements for older people.	Permanent admissions for 13/14 were 534 per 100,000 population.	Permanent admissions for 13/14 were 667 per 100,000 population.
Number of hours a month of homecare	An average of 17,685 hours per week.	An average of 10,573 hours per week.
Number of assessments completed a month	4217 assessments completed in 13/14 = 324 per 4 weeks / month.	3511 assessments completed in 13/14 = 292 per 4 weeks / month.
Number of referrals received	18,748 referrals for new clients received during 2013/14.	14790 referrals for new clients received during 2013/14.
proportion of critical and substantial	The critical and substantial represent 73.8% of those with a FACS criteria.	80.9% (52.2% critical, 28.7% Substantial).
Number of care-phone users.	4,842	2974

3.7 Access to Services

The following provides an overview of current access to services provided across Calderdale and Greater Huddersfield. This is described with reference to

- Access to Community Health services
- Access to Mental Health services
- Access to Hospital services
- Geographic access - travel by car, public transport and ambulance
- Seven day access to services

Access to Community Services

Across Calderdale and Huddersfield there are a range of community health services currently provided in people's homes, GP surgeries and other community centres. This includes: District Nursing, Health Visiting, School Nursing, Musculoskeletal Services, Community Dermatology services, Speech and Language Therapy, Occupational Therapy, Continence Services, Contraceptive and Sexual Health Services, Intermediate Care Services, Health Promotion and Improvement services, Wheelchair Services, Physiotherapy, Podiatry, Specialist Nursing services and Substance Misuse Services. There are also a number of hospital outpatient clinics held at Todmorden Health Centre.

Access to Mental Health Services

98% of service contacts with mental health service users are provided in their own home or in local community settings. The following range of services are provided in Calderdale and Greater Huddersfield: Mental health services for adults of working age (aged 18 to 65); Child and Adolescent Mental Health Services; Services for Older people (over 65) with a mental health problem; Services for people (mainly adults) with a learning disability whose behaviour challenges services, with intensive support needs and/or a mental health problem; Medium secure forensic services for people with a mental health problem and/or learning disability. Psychiatric inpatient services for adults and older people are provided at The Dales, Calderdale Royal Hospital and at The Priestley Unit, Dewsbury District Hospital.

Access to Hospital Services

Hospital services are provided at Calderdale Royal Hospital and Huddersfield Royal Infirmary. Both hospitals provide: Accident and Emergency services, acute medical services, Midwifery led Maternity services, level 3 intensive care for adults; rehabilitation for older people; diagnostic services; endoscopy services, and; therapy services.

Calderdale Royal Hospital also provides: consultant led maternity services; inpatient paediatric services; Level 2 Neo-natal intensive care; elective surgery; stroke services, and; interventional cardiology services. Huddersfield Royal Infirmary also provides: trauma services; complex and unplanned surgery; paediatric surgery, oncology and haematology.

The different services provided at each local hospital means that for some treatments Calderdale residents will access services at Huddersfield Royal Infirmary and also that Huddersfield residents will access services at Calderdale Royal Hospital. For example:

- 59% of the people that are Huddersfield residents and have a planned operation at CHFT are admitted to Calderdale Royal Hospital.
- 20% of the people that are Huddersfield residents and have an emergency admission to CHFT are admitted to Calderdale Royal Hospital
- 22% of the people that are Calderdale residents and have an emergency admission to CHFT are admitted to Huddersfield Royal Infirmary.
- Every day up to six patients (about 2200 per year) need to be transferred between the two hospital sites to be able to meet their clinical needs.

People who suffer a myocardial infarction or major trauma that are picked up in an ambulance in Calderdale and Huddersfield are taken directly to specialist centres outside of the local area in Leeds or Bradford. This is to ensure that they go directly to the specialist hospital centres that can provide all the services they need.

Geographic access – travel by ambulance, car and public transport

The geographic area of Calderdale and Greater Huddersfield covers 395 square miles. Calderdale CCG and Greater Huddersfield CCG commission services for their residents within this area and the current hospital service profile requires a degree of cross-district travel for patients to access the appropriate services for their needs.

A detailed travel analysis has been undertaken by Yorkshire Ambulance Services and by Jacobs Engineering. In summary this demonstrates that:

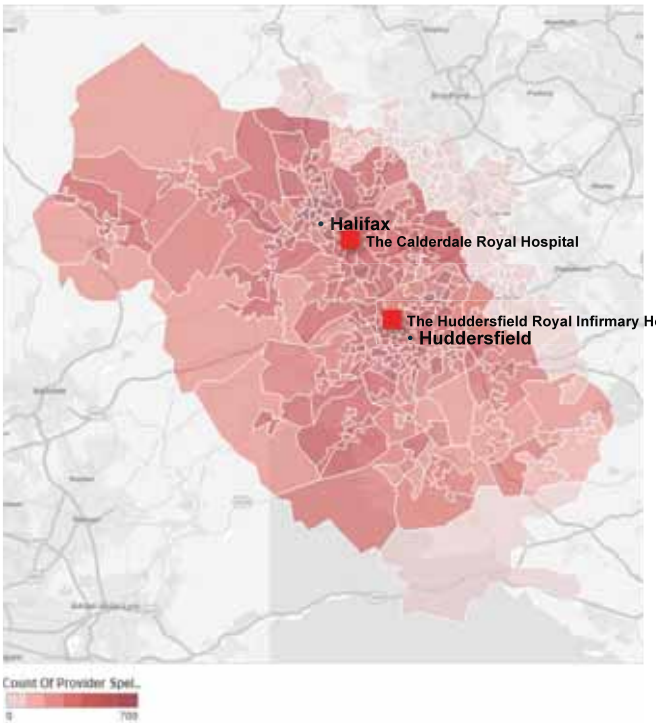
- The majority of residents within Calderdale and Huddersfield attend their most local hospital to receive their care
- All emergency ambulance journeys across the locality are less than 45 minutes with the majority being less than 30 minutes
- The key areas of deprivation are located around the main towns of Halifax and Huddersfield with a greater proportion in and around Huddersfield
- The elderly are mostly located in the suburbs of the main towns of Halifax and Huddersfield, which results in slightly longer travel times to either hospital site.

Travel analysis

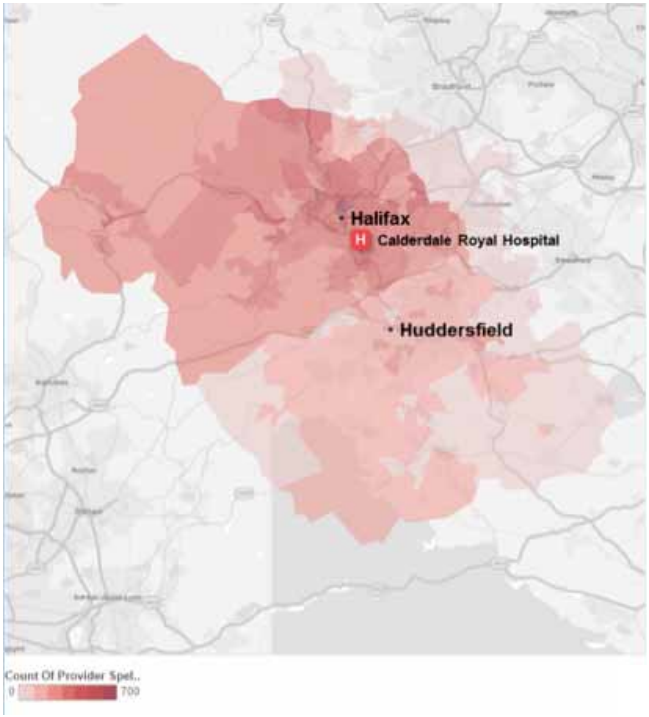
Catchment areas for Calderdale Royal Hospital and Huddersfield Royal Infirmary

The joint catchment areas for Calderdale Royal Hospital and Huddersfield Royal Infirmary are captured below in the map to the left. These are separated for each site on the next page. The map to the right demonstrates the local authority boundary areas.

CRH and HRI catchment (>25 patients per LSOA) and Local Authority boundaries



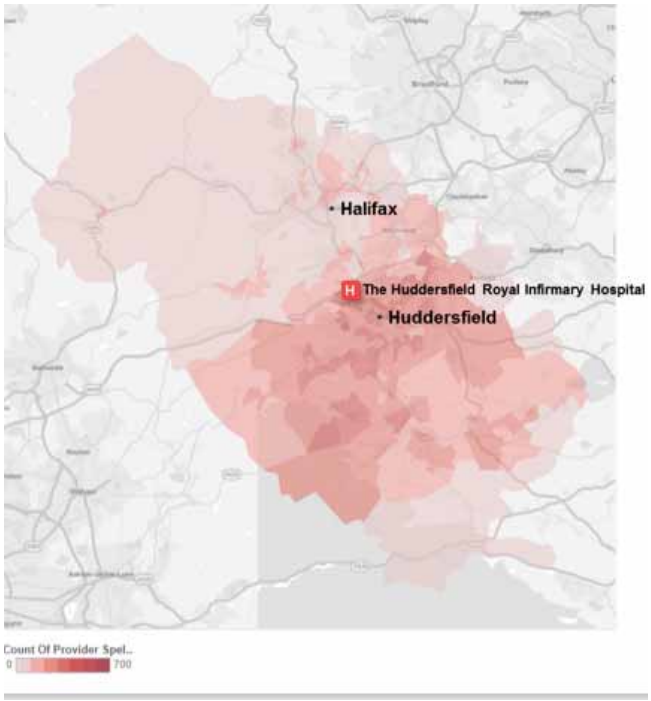
The current catchment area for the Calderdale Royal Hospital is illustrated in the map below ;



The map to the left shows the current number of patients who attend Calderdale Royal Hospital. The darker the colour the more patients who attend from that catchment area (the colour red has been used to illustrate the intensity).
This map highlights that currently patients from the Calderdale area attend Calderdale Royal Hospital.
It also highlights that a number of patients travel from Huddersfield to attend Calderdale Royal Hospital. These have been identified as those who are accessing Paediatric services* or Stroke services**.

[1] Of 746 hospital admissions with a specialty code of Stroke Medicine or TIA, 706 were at Calderdale.
**Of 12,647 admissions where the specialty was Paediatrics, 11,325 were in Calderdale.
Total admissions were 70,670 in Calderdale and 50,165 in Huddersfield 2013-14 FY

The current catchment area for the Huddersfield Royal Infirmary is illustrated in the map below;



The map to the left shows the current number of patients who attend Huddersfield Royal Infirmary Hospital. The darker the colour the more patients who attend from that catchment area (the colour red has been used to illustrate the intensity).

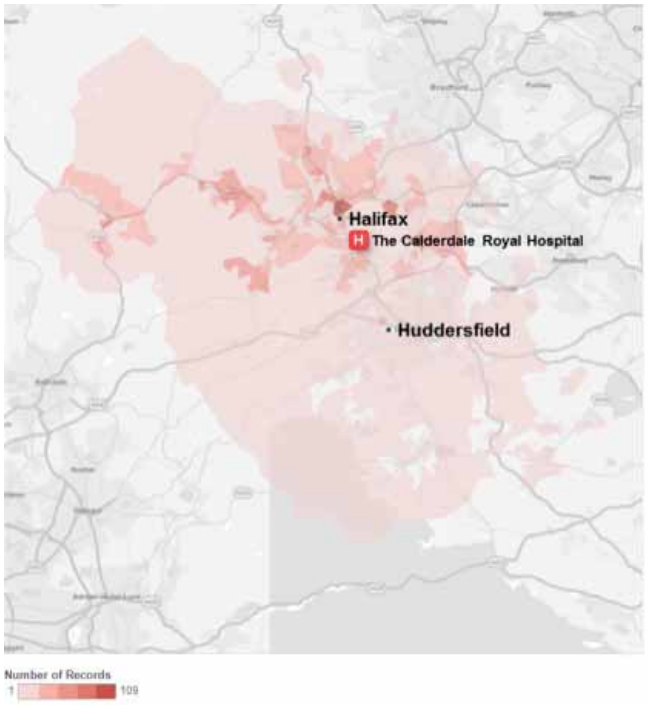
This map highlights that currently patients from the Huddersfield area attend Huddersfield Royal Infirmary Hospital.

In summary, both of these maps illustrate that currently the two hospital sites are mostly treating patients who attend from their respective localities.

Current emergency ambulance journeys

The emergency ambulance journeys from 2011 – 2014 have been plotted into the maps below. Separate maps have been developed for each hospital site. It has been calculated that fewer than 10% of journeys go out of area between 2011 and 2014.

Journeys to Calderdale Royal Hospital

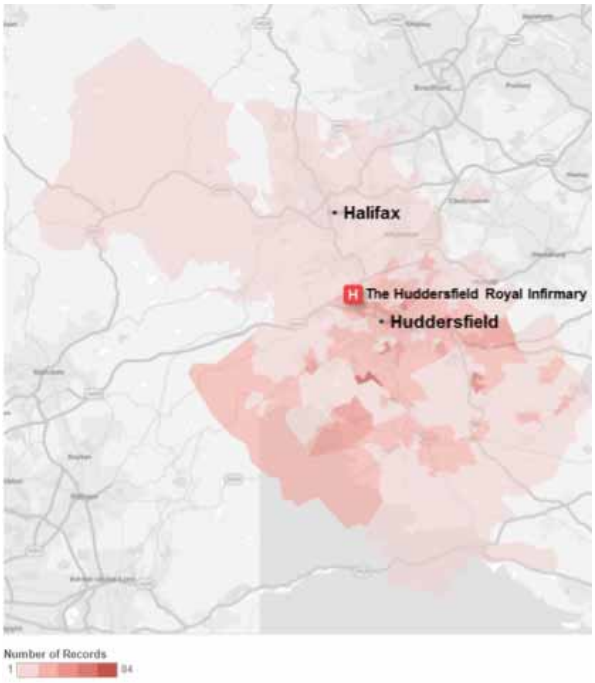


The map to the left shows the total emergency journey from 2011 – 2014 to Calderdale Royal Hospital.

The darker red coloured areas of the map identify where the ambulance journey originated from.

This map highlights that the majority of patients from the Calderdale area currently attend Calderdale Royal Hospital. There are a relatively small number of patients who travel from Calderdale to access general services at HRI. Some of which are accessing the trauma services.

Journeys to Huddersfield Royal Infirmary Hospital



The map to the left shows the total emergency journey from 2011 – 2014 to Huddersfield Royal Infirmary Hospital.

The darker red coloured areas of the map identify where the ambulance journey originated from.

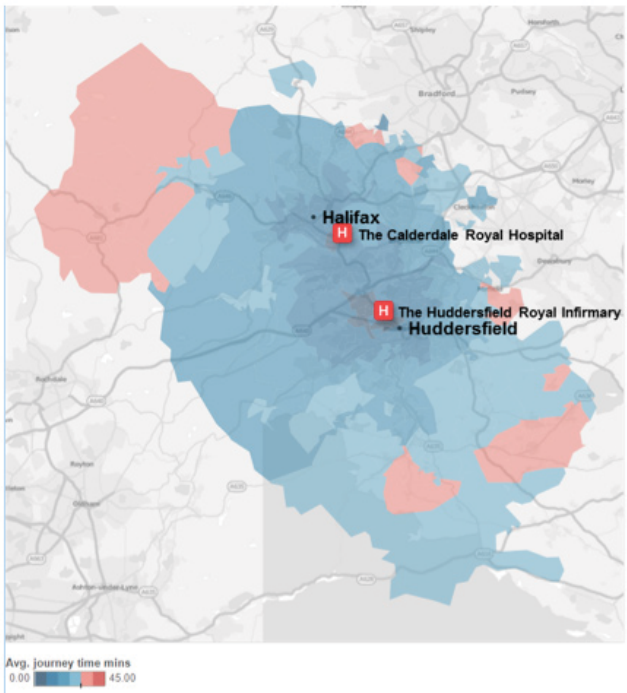
This map highlights that the majority of patients from the Huddersfield area currently attend Huddersfield Royal Infirmary Hospital.

It is important to note that while the volume of ambulance journeys is concentrated near the destination hospital, there are many journeys which don't go to the nearest hospital. This is a factor which may lower the potential impact of service concentration.

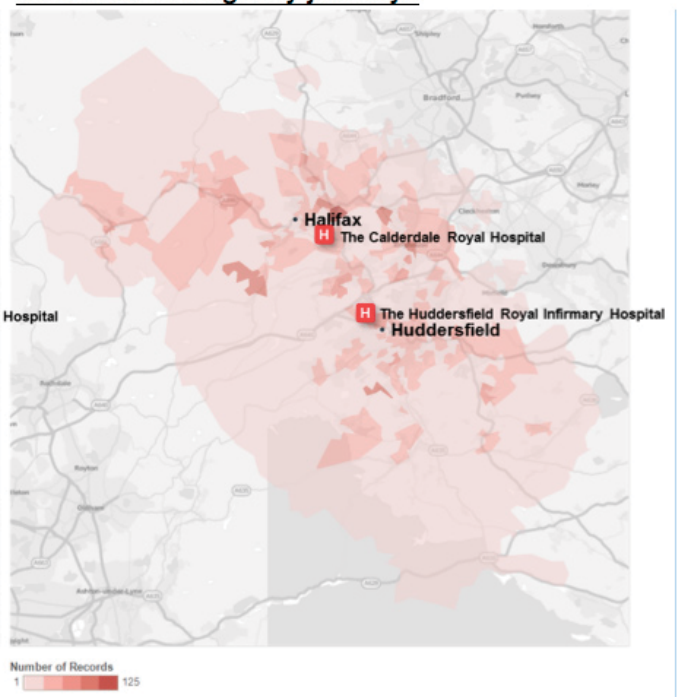
The emergency journeys within the catchment area are also detailed in the maps below. The map to the left shows those journeys that currently take under 30 minutes in blue, with those over 30 minutes but under 45 minutes in red. The map to the right shows the volume of emergency journeys, with the greater volume illustrated in darker red.

The London Major Trauma Project used a 30 minute blue light ambulance journey[2]. This is based upon the trauma system which has been operating in Victoria, Australia for over 10 years. There is no clear clinical evidence that a 30 minute journey is better than a 45 minute journey. Other established trauma systems, such as trauma systems in parts of the USA, use 45 mins as the timeframe for the transfer of suspected major trauma patients from incident to major trauma centre based on clinical evidence that journeys over 45mins may clinically impact on patients.

Emergency Journey times



Volume of emergency journeys



2 http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Travel-Times-Ambulance-Coverage-Analysis.pdf

The table below captures the volumes of journeys from within the catchment. It highlights that a greater number of emergency journeys are made to Huddersfield Royal Infirmary.

Destination	Emergency journeys	Other journeys
Huddersfield	4,053	47,399
Calderdale	3,548	51,477
Dewsbury	782	10,717

Geographic access – travel by public transport and car

The geographic area of Calderdale and Greater Huddersfield covers 395 square miles. Calderdale CCG and Greater Huddersfield CCG commission services for their residents within this area and the current service profile requires a degree of cross-district travel for patients to access the appropriate services for their needs.

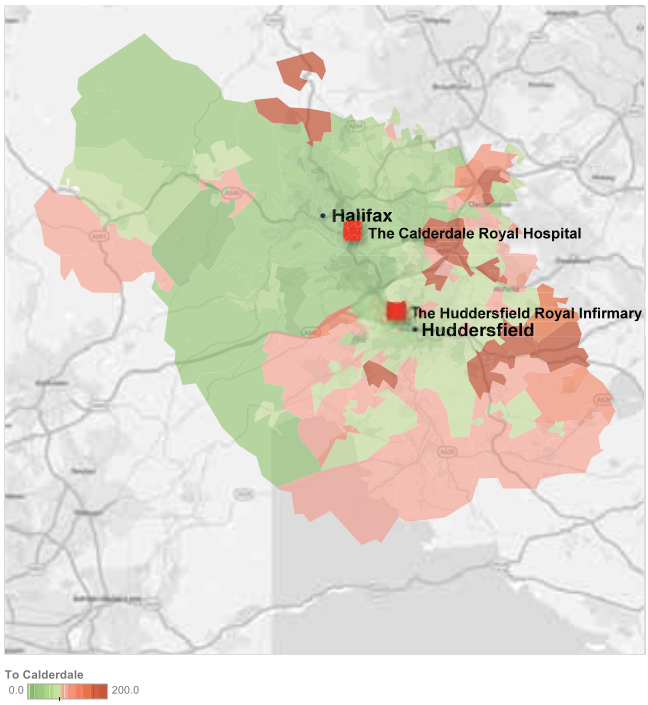
Many services (GP, community, mental health, social care) are provided in local GP practices or people's own homes. Therefore to illustrate current access and journey times this is provided with reference to hospital based services at Calderdale Royal Hospital and Huddersfield Royal Infirmary. Todmorden Health Centre and Holme Valley Royal Memorial Hospital have also been included as they are located in the most rural and geographically remote parts of the Calderdale and Greater Huddersfield area.

Travel distances and times based on AA Road Planner are shown below.

Journey by Car	Distance (miles)	Time (minutes)
Todmorden Health Centre to Calderdale Royal Hospital	11.8	15
Todmorden Health Centre to Huddersfield Royal Infimary	16.8	25
Calderdale Royal Hospital to / from Huddersfield Royal Infirmary	5	10
Holme Valley Memorial Hospital to Huddersfield Royal Infimary	7.4	16
Holme Valley Memorial Hospital to Calderdale Royal Hospital	12	22

The current public transport journey times are illustrated in the maps below;

To Calderdale Royal Hospital

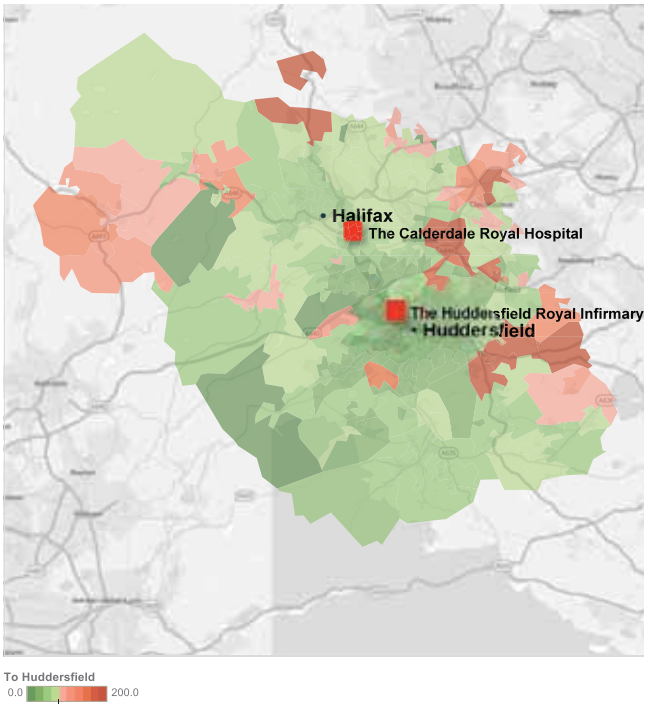


The map to the left illustrates the current public transport journey times to Calderdale Royal Hospital.

The red areas indicate where journeys are currently more than 80 minutes with the green area indicating journeys less than 80 minutes.

This map highlights that they are several rural areas where residents are currently experiencing public transport journeys of more than 80 minutes if they wish to access services at either hospital site.

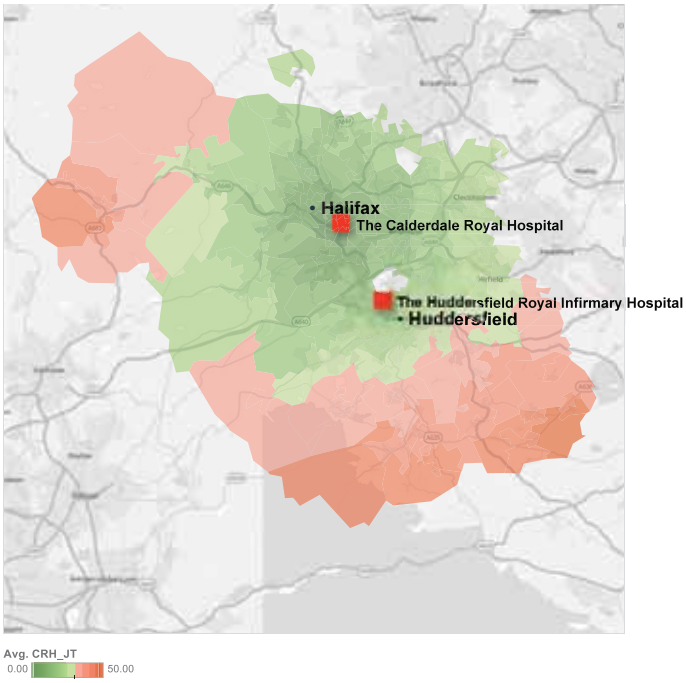
To Huddersfield Royal Infirmary

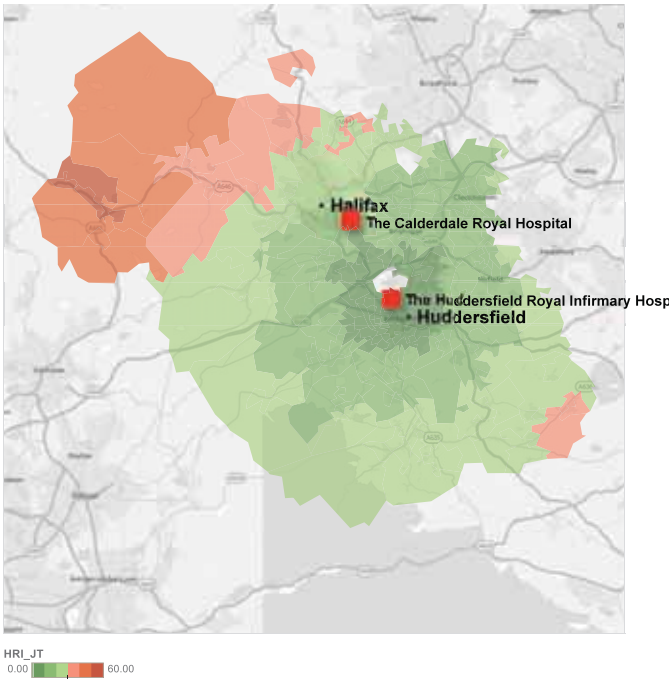


The map to the left illustrates the current public transport journey times to Huddersfield Royal Infirmary.
The red areas indicate where journeys are currently more than 80 minutes with the green area indicating journeys less than 80 minutes.
This map highlights that they are several rural areas where residents are currently experiencing journeys of more than 80 minutes if they wish to access services at either hospital site.

Current car journey times

The maps below illustrate the current car journey times to Calderdale Royal Hospital (left) and Huddersfield Royal Infirmary (right). The red areas indicate where journeys are currently more than 30 minutes and green are less than 30 minutes.





In summary, either hospital is accessible from anywhere in the catchment within a 60min journey. Only peripheral areas take more than 30mins (and they may have other, nearer, options).
The north-east quadrant (one of the areas highlighted in red in the maps above) represent <5% of the people. Currently 76% of the patients and 60% of the whole population is within a 15 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary. With 96% of both patients and population being within a 30 minute drive of CRH or HRI.

The demographic implications on access to services

When considering whether the proposed scenarios might unduly impact certain groups, there are statutory obligations about which groups need to be explicitly considered. The key groups usually considered are:

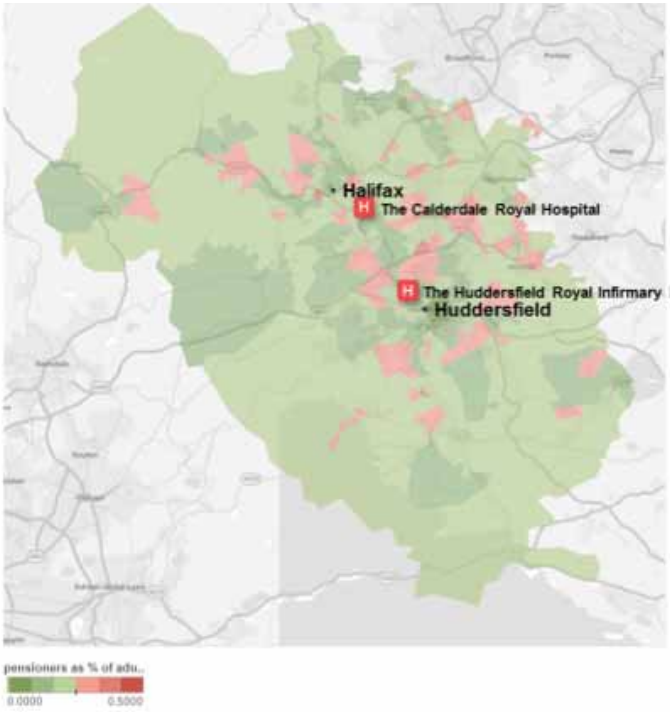
- Age (most importantly the elderly)
- Race
- The deprived (although this is not a statutory duty the geography of deprivation is well understood and is a good proxy for a bundle of other clusters of people where undue impact should be avoided)

One other group which is usually considered:
- Those without access to private transport (good quality census data exists on the geography of the carless household)

In the following section a simple analytical approach has been adopted that can combine travel analysis with census data to estimate the impact on the four groups described above.

This general approach identifies geographic groups (of Lower Layer Super Output Areas (LSOAs) where detailed census information is readily available) which represent concentrations of each group and estimate the travel impact on those areas versus the average impact across the whole population.

The distribution of older people

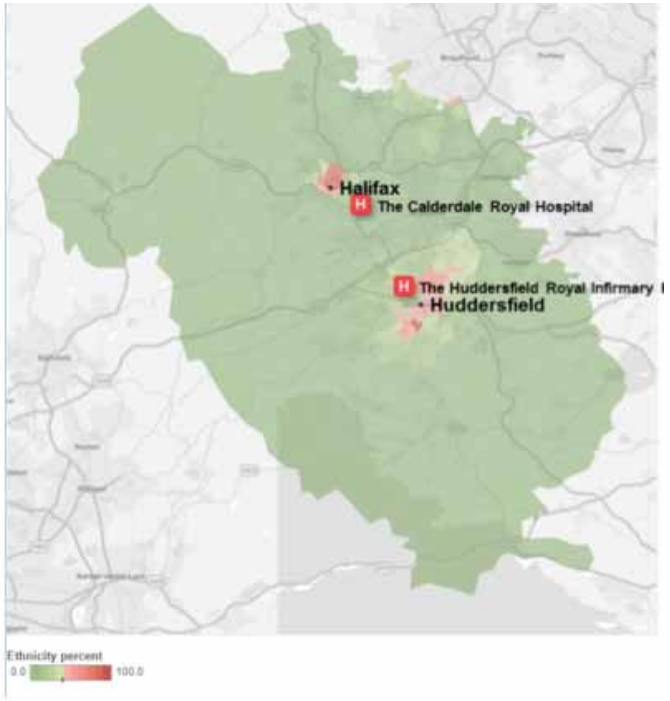


The map to the left shows the distribution of older people across Calderdale and Huddersfield. The areas in red show LSOAs where more than 25% of adults are pensioners.

The map highlights that the majority of the elderly live in the outskirts of Huddersfield and Halifax.

The small number of areas on the edges of the map with a large proportion of the elderly, suggest the potential for some significant impacts in relation to service changes.

The distribution of non-white races



The map to the left shows the distribution of non-white races across the catchment area.

The areas in red have populations where more than 40% of people are non-white.

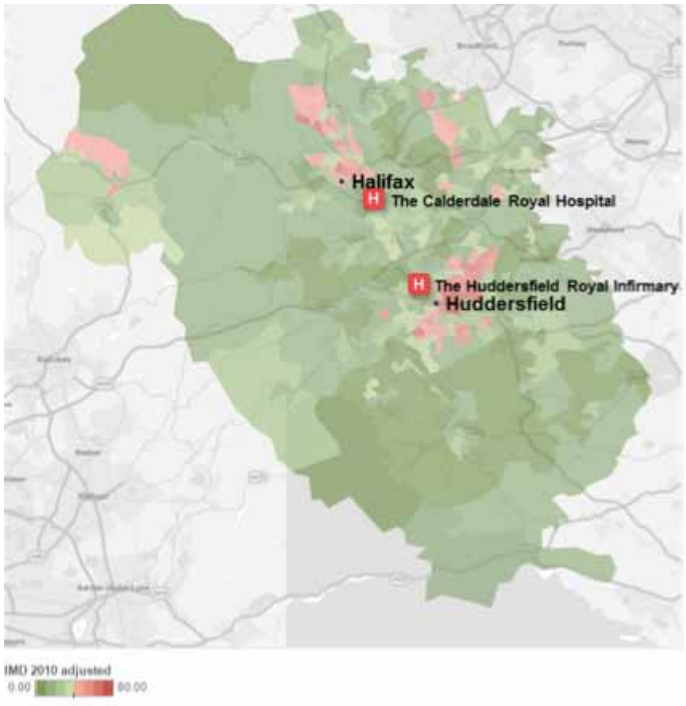
The map suggests the impact of any changes on race will be low as the key areas are centrally located in the critical town centres and are just 15 mins apart by car (longer by public transport).

The distribution of deprivation

Approximately 15% of the local population are in deprived areas and these areas are concentrated in urban centres mostly close to the hospitals as illustrated in the map below.

The table below supports this analysis and highlights the population numbers in areas where Index of Multiple Deprivation exceeds 40;

Deprived areas	Other areas
87,374	479,953

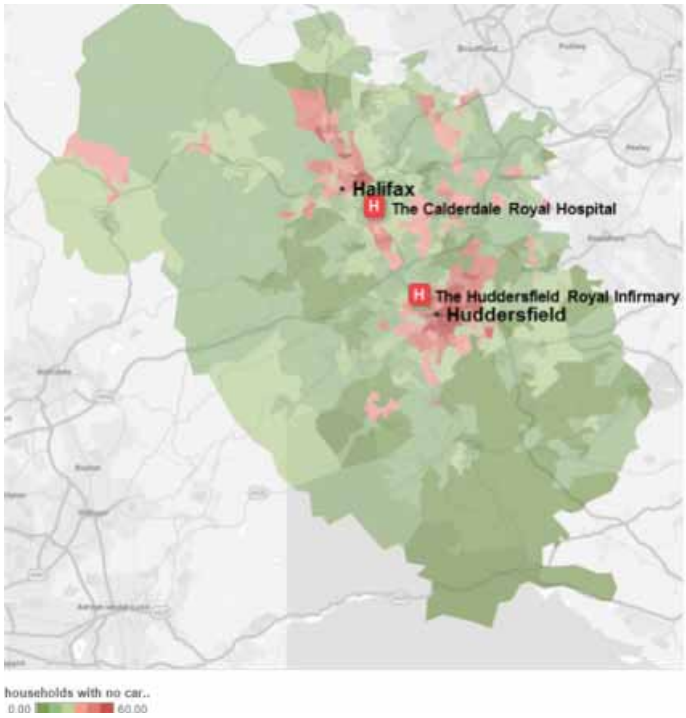


The map to the left shows the distribution of deprivation across the catchment area. The areas in red show IMD scores over 40 (which is approximately the cut-off for the most deprived 20% of areas nationally).

The analysis identifies that the areas of deprivation are predominately based in and around the centres of the two main towns, namely Huddersfield and Halifax, with the majority being based in and around Huddersfield.

There is a segment of deprivation in the north-west quadrant of the catchment area (towards Burnley).

The distribution of households without a car



The map to the left shows the distribution of households without a car across the catchment area. The areas in red show where more than 30% of households have no access to a car.
This clearly identifies that the majority of households without a car are located in the centres of Huddersfield and Halifax, with some outliners in the surrounding areas. There is also a strong link to the key areas of deprivation, as identified above.

In summary, the following statements can be made from the analysis in this section;

- The majority of residents within Calderdale and Huddersfield attend their most local hospital to receive their care
- All emergency ambulance journeys across the locality are less than 45 minutes with the majority being less than 30 minutes
- The key areas of deprivation are located around the main towns of Halifax and Huddersfield with a greater proportion in and around Huddersfield
- The elderly are mostly located in the suburbs of the main towns of Halifax and Huddersfield, which results in slightly longer travel times to either hospital site.

Seven day access to services

The NHS Services, Seven Days a Week Forum, Chaired by the National Medical Director, was established in February 2013 to consider how NHS services can be improved to provide a more responsive and patient centred service across the seven day week. The Forum's review points to significant variation in outcomes for patients admitted to hospitals at the weekend across the NHS in England. This variation is seen in mortality rates, patient experience, length of hospital stay and re-admission rates. The Forum recommends the adoption of ten clinical standards that describe the standard of urgent and emergency care that patients should expect to receive, seven days a week. Delivery of these standards should reduce the risk of morbidity and mortality following weekend admission in a range of specialties and provide consistent NHS services, across all seven days of the week.

All services are working towards meeting the standards indicated in the Keogh review.

Currently there is a limited range of community services available out of hours and across seven days week (mainly GP Out of Hours Service, district nursing and mental health crisis response). This is a constraint in being able to respond and support people's needs in the community and enable them to stay at home. It also means that in the evenings and at weekends hospital based care may be the only service option for people.

In the Hospital the provision of 7 day working in emergency and acute services is the focus of attention. In some areas (Women's services) the standards are already reached. Within surgery workforce planning and new ways of working are being designed to meet this standard, but are not currently completed. There are particular pressures in the two A&E departments related to senior doctor presence for extended working hours seven days a week. Currently at weekends the two Accident and Emergency Departments do not have on-site Consultants in Emergency Medicine. For acute medicine, whilst major changes in working patterns have already contributed to an increased consultant presence over the day, the changes inherent in this outline business case will provide the opportunity to more fully meet the expectations of 7 day services by bringing teams together.

3.8 Estate

A review of the full health and social care estate across hospital and community services in Calderdale and Greater Huddersfield is outside the scope of this Outline Business Case. A summary of five principle sites is provided below.

Site name	Site owner and providers using the site	Site information
Huddersfield Royal Infirmary 	Site owned by CHFT and services provided by CFHT. GP out of hour's services provided by Local Care Direct.	28 acre site with approximately 420 beds and 9 theatres. Development at Acre Mill of a new outpatient facility that will be opened in 2015 There is a backlog of maintenance issues in the region of £100m
Calderdale Royal Hospital 	Site owned (with PFI) by CHFT Services provided by CFHT and SWYPFT (The Dales) GP out of hour's services provided by Local Care Direct.	19 acre constrained site with approximately 450 CHFT beds and 7 theatres SWYPFT have 38 beds for adult care (18-65 year old) and 16 beds for older people care (65+ year old) on CRH site The existing PFI arrangement at Calderdale runs until 2061 (a further 47 years). The revenue cost of this is circa £10m per annum, with an additional cost of £10m per annum for hard and soft facilities management. There is a break clause in 2031 which is associated with significant exit costs.
Todmorden Health Centre 	Site owned by Assura, services provided on site by CHFT and GPs.	CFHT lease the top floor (20 year lease until 2029). CFHT also use space on the middle floor but this space is managed by NHS Property Services Ltd. CHFT services on this site include outpatient and diagnostic services, and therapy services.
Holme Valley Memorial Hospital 	Owned by NHS Property Services Ltd. Locala are main provider on site but CHFT and GPs also provide services on site.	Holme Valley MH comprises a 1,956 sq m community hospital building originally constructed pre 1948. The premises have been refurbished and extended over the years and now incorporates accommodation of differing standards. There remain some backlog maintenance issues (last costed in 2012 at a risk adjusted £87,000). Locala provide community hospital services on this site. CHFT provide therapy services on this site.
Folly Hall 	SWYPFT occupy nearly 3,000 sq m of the complex which is under a leasehold. contract which expires in 2025 (with a lease break option in 2015).	SWYPFT provides mental health services and has use of 35 consulting rooms, 7 1-2-1 rooms, 3 clinical rooms and 2 group therapy rooms as well as meeting rooms and open plan office space.

Note: the bed numbers shown above at CRH and HRI are the estate capacity available for number of beds. The bed requirement is flexed up and down during the course of the year to cover pressures in the system at different times of the year. At the time of preparing the OBC there are 802 beds open across the two sites.

3.9 Workforce

The national shortage of key elements of the workforce is one of the four main challenges recognised by the strategic review. Changing demographics, higher expectations and standards regarding access to care, (for example greater consultant presence and 24/7 access) and the shift of care outside of hospitals are contributing to the challenging workforce profile at a national level. Areas of particular concern nationally include

- Size of the nursing workforce and the potential for a decrease driven by an aging profile and fewer people training to be nurses
- Recruitment difficulties in emergency, geriatric, and psychiatric medicine
- The forecast undersupply of GPs

At a regional level, system wide problems are being addressed by organisations with the help of Health Education Yorkshire and the Humber; however the solutions are not instant. Immediate workforce challenges persist, and across Calderdale and Huddersfield organisations are already taking action to address specific recruitment and retention issues at a local level. These issues and actions include:

- Challenges in being able to provide senior doctor presence for extended (16) hours seven days a week on both hospital sites. As a result of the national workforce shortage in emergency doctors the two A&E departments have a high use of locum doctors (for example the two A&Es require a rota of 12 doctors and in the last 5 years there has only been a maximum of 7 doctors with gaps in the rota filled by locums). There is currently no on site consultant presence in the two Accident and Emergency Departments at weekends. The College of Emergency Medicine recommends a minimum of 10 Consultants in Emergency Medicine per emergency department. Currently there are 5 in Halifax and 5 in Huddersfield. This impacts on the safety of care and is not a sustainable clinical model of provision. The workforce pressure is exacerbated by the provision of A&E on two sites.
- We know that across the region there will be a significant shortage in the number of paediatric specialist doctors in training starting from August 2015. The likely impact on Calderdale and Huddersfield Foundation Trust is that whilst 11 paediatric doctors are needed to cover existing rotas there will be a 75% reduction in their availability. Currently the two Emergency Departments at Calderdale Royal Hospital and Huddersfield Royal infirmary are non-compliant with many of the standards for Children and Young People in Emergency Care settings. Provision of all the Emergency Department care on one site could allow for the provision of a dedicated Paediatric Emergency Department which would then result in compliance with many, (if not all) of these standards; this is highly desirable. It is clear that in terms of providing sufficient numbers of adequately trained and skilled staff, it would be impossible to provide this level of service on both sites.
- The shortage of elements of the workforce has required a review of how we deliver services either through the deployment of alternative practitioners into traditionally medical roles or senior medical staff filling gaps in rotas or a combination of both. This creates additional need because of constraints around working time regulations and location of the specialty especially if it operates from more than one site. The problem therefore is not only one of supply and demand but also of how flexibly and effectively we can deploy staff in our current service models.
- One possible response to the recruitment and retention challenge is to develop collaborative strategies with partners to design new ways of working and joint care pathways. This is crucial where we need to sustain medical on call arrangements to provide safe care. Examples of this approach include: vascular surgery services (CHFT partnered with Bradford), CHFT works in partnership with Leeds to deliver satellite renal services, joint working with Mid Yorkshire Hospitals Trust to provide Bariatric Surgery and Assisted Conception Services, exploring options for joint working of CHFT, Locala and GPs to provide comprehensive dermatology services for our local population.
- CHFT is considering a further overseas recruitment campaign (there was a successful campaign to India in 2011). Medical training in India is very similar to the British training programmes so maps across well.
- Locala has recognised a challenge in terms of the nursing workforce in maintaining competencies in some teams in some areas, exacerbated by a national challenge in recruiting district nurses. Locality hubs would allow there to be a better skill mix in each team.

Current workforce profile

A summary of the whole time equivalent workforce as at 31 March 2014 is provided on the next page. For South West Yorkshire Partnership Foundation Trust and Locala Community Partnerships the figures relate only to staff working in Calderdale and Huddersfield.

Staff Group	Organisation			Total
	CHFT	SWYPFT*	Locala	
Medical & Dental	532.83	34.05	11.4	**589.68**
Nursing and Midwifery	1656.6	202.00	257.5	**2373.6**
Allied Health Professionals	403.15	35.77	6.3	**451.52**
Healthcare Scientists	123.67	–	–	**123.67**
Additional Professional Scientific and Technical	150.86	28.75	5.1	**189.81**
Additional Clinical	1091.64	133.19	77.4	**1379.6**
Administrative and Clerical & Estates and Ancillary	1149.51	68.33	99.8	**1417.4**
Senior Managers	90.21	Not provided	15.3	**120.81**
Total	5198.47	502.08	472.7	**6646**

CHFT – Calderdale and Huddersfield Foundation Trust, SWYPFT – South West Yorkshire Partnership Foundation Trust, Locala – Locala Community Partnerships

** The WTE for SWYPFT data provided was for staff providing all services across Kirklees. For this view, only the services provided in Huddersfield are required and therefore the WTE have been pro-rata based on population size for Huddersfield wards compared to all Kirklees Council wards.*

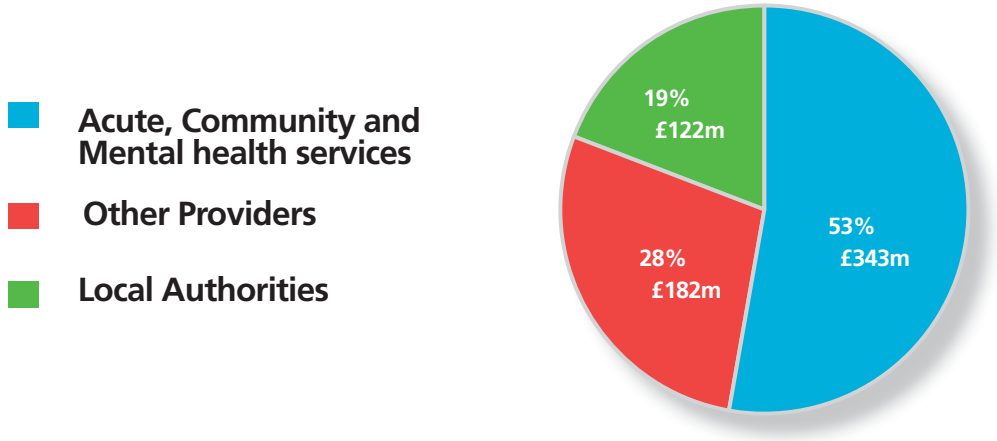
The total number of staff employed in mental health services in Calderdale and Kirklees is 502 WTE. In determining the services within the scope of this OBC, the workforce resources are related to community and hospital liaison services which total 38 WTE.

3.10 Finance

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

The current total resources across the Health and Social Care economy based on 2013-14 plans are £647m. Of which £343 (53%) is currently commissioned with CHFT, Locala and mental health services (SWYPFT accounts for the majority of mental health expenditure). The remainder is split £122m spend with Local Authorities and £182m with other providers. This analysis excludes primary care expenditure.

Spend of total resources across the Health and Social Care economy based on 2013/14

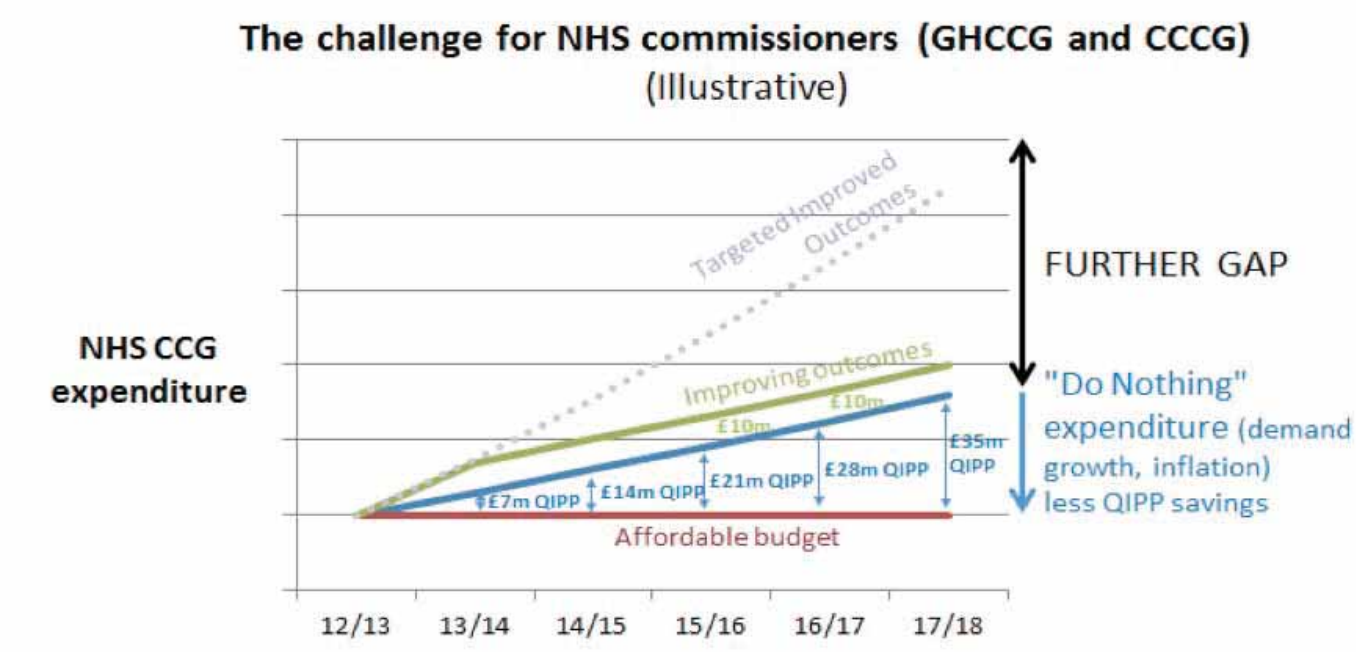


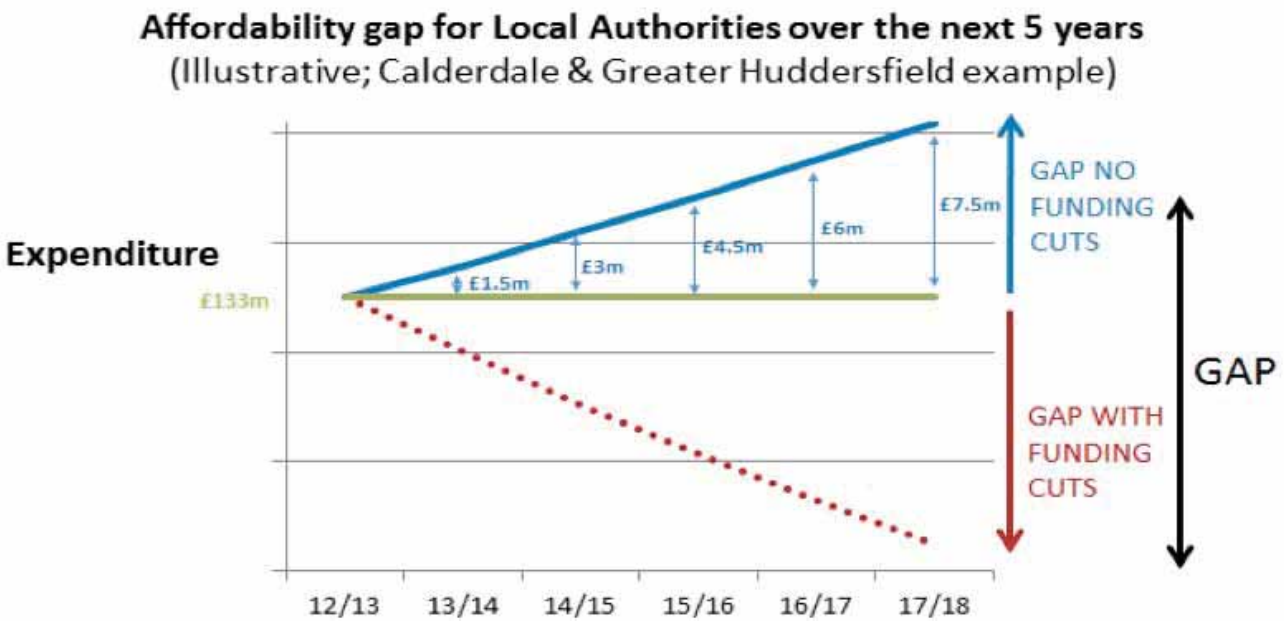
The level of financial challenge over the next 5 years is described in two ways:
- Firstly the level of internal efficiency requirement within providers of £120m; and
- Secondly a financial estimate of the impact of demographics of £43m for the whole of the health and social care spend of £647m.

The total financial challenge is therefore £163m. £120m to be generated by the efficiency programmes of providers and £43m which commissioners would need to identify (either as a productivity gain or a real saving from existing provision to be reinvested in services to meet demographic pressures).

The figures below illustrate the financial challenges facing providers, CCGs and Local Authorities.

The challenge for providers: achieving efficiencies of 4% per year while improving quality





Such significant financial challenges cannot be addressed by tweaking current services, it is necessary for system wide transformational changes to be implemented to allow the development of financially sustainable, clinically effective and high quality services.

3.11 Information Technology

Patients should have compatible digital records so their health information can follow them around the health and social care system. This means that in the vast majority of cases, whether a patient needs a GP, hospital or a care home, the professionals involved in their care can see their history at the touch of a button and share crucial information. A recent report produced by Price Waterhouse Coopers for the Department of Health (January 2013) demonstrate the potential benefits of making better use of technology. This includes national cost savings of more than £4billion, freeing up professionals' time to spend caring for patients and helping patients take control of their own care so they can spend more time getting on with life instead of visiting their hospital or GP when they don't have to or want to. The actions required are that:

- By March 2015 - everyone who wishes will be able to get online access to their own health records held by their GP.
- Adoption of paperless referrals - instead of sending a letter to the hospital when referring a patient to hospital, the GP can send an email instead.
- Clear plans to be in place to enable secure linking of these electronic health and care records wherever they are held, so there is as complete a record as possible of the care someone receives.
- Clear plans to be in place for those records to be able to follow individuals, with their consent, to any part of the NHS or social care system.
- By April 2018 - digital information to be fully available across NHS and social care services.

There is currently not a cohesive approach to information technology (IT) across Calderdale and Greater Huddersfield and as such the current IT profile for health and social care provider organisations across the region is not optimal for the provision of joined up care. Each of the organisations has their own hardware and software set up, with limited inter-connectivity between providers.
This has two main impacts on staff delivering care:

- The need for dual-entry - duplication of effort and increased potential for error
- The inability to access aspects of patient records – e.g. Locala community services can access most GP systems for patient records but cannot access SWYPFT or CHFT records.

The potential impact for patients is that as a result staff do not have all the information needed to deliver joined up and safe care. Patients may have to 'tell their story' more than once. As a consequence both the experience and safety of care is comprised. The table below sets out the current IT profile for each of the provider organisations for Calderdale and Greater Huddersfield.

	Infrastructure	Integrated Record	Telehealth	Communications	Diagnostics
CHFT	Single network provided by the HIS. Some remote working. Limited integration of clinical IT systems across the hospitals.	EPR, S1 in the community. Limited integration with primary care e.g. prescribing	Examples of remote/virtual consultations. Integrated working with other providers and nursing homes.	Cisco Limited real time clinical pathways data and early warning systems.	Full range of diagnostic, not all directly connected to EPR or S1.
SWYPFT	Single network provided by the HIS. Network support & provision will move to new IT provider from 2015. Wide Area Network provision and support currently being transitioned from the HIS to Virgin Media as part of Public Sector Network (PSN) contract. Wireless network capabilities across all sites Some remote working	RIO S1 including EPR Core	Telehealth monitoring, health coaching, care navigation, & post hospital discharge Telehealth.	Microsoft Lync 2013	Mental health related diagnostic only
Locala	Cloud data storage. Fully mobile	Use S1	Limited, relates to LA systems.	Microsoft Lync	Limited access. Some community ultrasound

	Infrastructure	Integrated Record	Telehealth	Communications	Diagnostics
Kirklees LA	Single network provided by the KLA. Some remote working & virtual desk top.	Care first Access to S1 & RIO as required	Remote vital signs monitoring. Assistive technology.	Microsoft Lync	Nil
Calderdale LA	Single network provided by the CLA. Limited remote working.	Bespoke Client Information System. limited sharing of information	Focus on assistive technology	Cisco	Nil

Whilst individual organisations are progressing with their own IT programmes to improve patient experience and service efficiency, e.g. the introduction of mobile working and real-time data entry for some community based staff, the benefits of each of these programmes in isolation will be limited. A system-wide approach for IT as part of the Strategic Review will enable significant changes to service provision benefitting service users, patients, carers and family members as well as staff across the health and social care landscape in Calderdale and Greater Huddersfield.

3.12 Performance and Outcomes

Performance data can be a useful tool to illustrate the efficiency and quality of services and can help identify areas for further investigation and direct action in the short term as well as indicating potential concerns for the longer term. For example the Keogh review identified that rises in medical workforce sickness rates were often an early warning marker for more serious performance concerns at Trusts.

Currently CHFT, SWYPFT and Locala are meeting many national performance standards and all three organisations are compliant with Care Quality Commission standards.

However the table below (which provides an overview of key indicators that tell us how well the whole health and social care system is currently performing in Calderdale and Huddersfield compared to the England average and compared to the best current reported performance in England) clearly shows that there are a number of areas of performance where improvement is needed.

Many of these indicators appear to relate to hospital utilisation / performance however achievement against these is reliant on the whole system both in the community and hospital to be working effectively. Where an opportunity for improvement has been identified the aim is to achieve upper quartile performance across the health and social care economy.

Indicator	Current Local Performance		England Average	Best in England	Opportunity for Improvement – target to achieve upper quartile performance
	Calderdale	Huddersfield			
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.	611	579	708	28	579
People discharged from hospital into reablement services that were still at home 91 days after discharge	70	85	82	98	88.5
Delayed transfers of care from hospital per 100,000 population	15.8	11.5	9.5	1.1	5.5
Avoidable emergency admissions / ambulatory care (composite measure).	1516.7	1243.6	1186.6	288.9	1002
Hospital Standardised Mortality Rate*		107	100	Range 60 -70	85.3
Population life expectancy (male)	77.1	77	78.2	85.1	80
Population life expectancy (female)	81.5	81.3	82.2	89.8	84
Hospital lengths of stay elective**		3.12	3.8	2.54	Already in upper quartile but see note below
Hospital lengths of stay non-elective**		3.82	4.5	3.82	
Hospital readmission rates	7.4	6.4	2.62	5	
Cancelled operations	0.64	0.9	0.02	0.5	
Friends and Family Test – Net Promoter A&E / Emergency Care	68	39	55	90	67
Friends and Family Test Net Promoter – Hospital Inpatient	75	69	73	97	80

Indicators where CHFT is an outlier on the National Acute Trust Quality Dashboard i.e. performance on this indicator is worse than the national picture by a degree that is unlikely to be explained by random chance

	Local Performance	England Average	Best in England	Opportunity for Improvement
Emergency readmissions - % within 30 days following non-elective admission (Same Specialty)	7.9%	6.8%	-	Yes
A&E attendances - % of patients who leave without being seen	4.0%	2.7%	-	Yes
Adult – British Association of Day Case Surgery Rates	80.4	81.2	-	Yes
Diagnostic Waits - % of patients waiting over 5 weeks	7.2%	6.1%	-	Yes
Delayed Transfers of Care per 1,000 occupied beds - NHS Responsibility	2386	652	-	Yes
Rate of written complaints per 1,000 episodes	7.6	6.3	-	Yes
Workforce - Sickness % - Nurse	5%	4%	-	Yes

Notes:

* Hospital Standardised Mortality Rates for individual Trusts are regularly updated and rebased to the England Average which is defined as 100. This means that whilst the Trust's absolute HSMR is improving if there has been a greater improvement in other Trusts then our performance relevant to this may not be as favourable. The figures shown above have been rebased using this method. The trend at CHFT over the past year is a reducing mortality rate.

** Hospital Lengths of Stay in the above table show that current performance is within the upper quartile compared to other areas. However whilst a large number of people do have a relatively short hospital stay this aggregate measure masks a significant opportunity for improvement. Over the past two years weekly monitoring has shown that across both CRH and HRI there are on average 255 people with a length of stay >10 days, 47 people with a length of stay > 50 days, 8 people with a length of stay >100 days.

The key opportunities for improvement of performance are listed below.

- The Hospital Standardised Mortality Rate is higher than the England average (this comparison takes into account differences that might be expected related to population health needs). This indicates that the care we provide could be better. For example, that more services are needed to provide end of life support in people's homes and in the community (so that they do not need to be admitted to hospital at end of life) and to improve the outcomes of care when people are admitted to hospital.
- Too many people in Calderdale and Huddersfield are admitted to long term residential or nursing home care. This could be because there are too few choices and options to support people to stay at home.
- When people are admitted to hospital too many people have to stay longer than is clinically necessary as we are not able to arrange the support and care they need quickly enough to enable them to go home.
- Too many people that have a long term condition such as asthma and diabetes are admitted to hospital – this may be because we are not offering enough timely support and advice to enable self-management of their condition – so people's health deteriorates to a point where the only option is admission to hospital – this is further compounded as currently we do not have a wide range of 7 day and specialist services available in the community.
- Too many people that are discharged from hospital have to be readmitted within 30 days. This suggests we are not providing sufficient support for people when they go home.
- Too many people have to wait over 5 weeks for diagnostic services. This could impact on the timely provision of the treatments they need.
- Too many people are reporting they do not have a good experience when they attend A&E services (the Friends and Family test) and too many people leave our A&E departments without having been seen – this suggests that services in A&E are not working as well as they could currently.
- CHFT has higher than the national average number of complaints per inpatient episode. Increased reporting of complaints can be a positive indicator that more people feel comfortable and confident to raise issues of concern and that this will lead to service change and learning. However it could also mean that more people locally have a poor experience of hospital care than the rest of England average. We do not have enough information to know which scenario is correct.
- Too many nurses are taking time off sick – this could reflect the work pressure they face in the current system.

This Outline Business Case describes proposals for service change that will enable us to improve performance and make sure that local people receive high quality care comparable or better than other parts of England. The ability to do this will be enabled by the changes described in this OBC.

High priority is currently being given to implement actions that will address the concerning performance issues (this is shown below). However the impact of these actions is constrained by the current configuration and service delivery models. This OBC explains why a transformation of services is needed to enable consistent achievement of the high quality of care and outcomes that we want for local people.

Performance Improvement Actions Currently Being Taken

Too many People are dying in our hospitals

Sadly some of the people who come into our care are coming towards the end of their natural life and pass away in hospital. This is always a sad time for relatives and hospital staff.

Since 2008/09 we have seen a steady decline in the annual numbers of people dying in our hospitals. Five years ago 1,958 died in our hospitals, in 2012/13 1,697 died in our hospitals. This reduction is as a result of many changes. Some are changes the hospitals have made such as the reconfiguration of acute surgery onto one hospital site.

This has enabled more effective delivery of surgery services and data published by Dr Foster shows that there has been a significant reduction in surgery and trauma service mortality rates associated with this, as shown below.

Speciality	Hospital Standardised Mortality Rate (HSMR)	
	2005/06	2012/13
General Surgery (non-elective)	97.2	64.1
Trauma / Orthopaedics (non-elective)	90.3	53.5

We have also implemented changes with our partners, such as improved integration between community healthcare and social care meaning people and their families can receive expert end of life care and support at home without the need for admission to hospital.

However, as people live longer the number of frail and elderly people at risk of dying in hospital increases and that's why we have put a real focus on the care of the acutely ill patient in hospital which focuses on those things that we should be doing routinely well to ensure that our patients get the very best care. We have a detailed programme of clinical improvement work that includes for example:

- Ensuring the consistent provision of evidenced based care (sometimes called care bundles) for high risk conditions such as sepsis. This will ensure that all acutely unwell patients benefit from the timely provision of the medical interventions that are known to improve their chances of survival.
- Reviewing nurse staffing levels to match the number of nurses available to the level of clinical need of patients – so that we have more nurses available to support very acutely unwell patients.
- Improving the use of technology to enhance the timeliness of information available to inform clinical decision making and to respond if a patient's condition is deteriorating.

We are also taking action to further improve the care and support available in the community at end of life.

This year in Calderdale, working with Overgate Hospice, we have established a new Palliative Care Service that is working closely with district nurses, GPs and other care providers to ensure patients with a terminal illness have access to a responsive community nursing service out of hours. This helps people (and their families and carers) to remain at home. We know that this is many people's preference and that they do not want to be admitted to hospital at end of life. The service offers a one hour response and nursing care in people's homes.

However whilst these developments are having impact and the number of people that die in hospital is reducing we know other hospitals across England have been able to make faster and more significant reductions in hospital mortality.

We believe the current configuration of services on two sites constrains the impact of the improvements we are able to make.

Concentration of services on a single site will enable seven day working and improved presence of senior medical staff over extended hours. There is a strong evidence base that this will have a positive impact on reducing hospital mortality.

Performance Improvement Actions Currently Being Taken	
People stay longer in hospital than is clinically necessary	Sometimes people stay longer in hospital than is clinically needed as we are not able to make arrangements for their safe discharge when they need it. We know that patients would like to go home as soon as possible if we are able to safely meet their needs at home. ● Examples of actions that are being taken to improve the timeliness of hospital discharge include: Plan for Every Patient – ensuring that for every patient admitted to hospital there is a clear plan from their day of admission of when they should expect to be discharged. Identifying this goal at point of admission means subsequent care plans can be implemented and worked towards to ensure that all the necessary actions to enable this are undertaken in a timely way. This is important and helpful for staff providing services across the hospital and community and also for families and carers. ● Improvement in the provision of pharmacy services so that there is no delay caused by people waiting for the drugs they need to go home. ● Each ward now has a specific discharge coordinator whose full time role is to liaise with patients, families, and services in the community and with the necessary hospital departments to ensure there are no delays in planning and arranging the safe discharge of patients from hospital – working towards their expected discharge date. ● Implementation of service developments such as the Early Supported Discharge scheme in stroke services that is able to offer enhanced support so that people who have experienced a mild stroke can leave hospital earlier and receive the therapy and support they need at home. Implementation of service developments such as the OPAT team that means people can be discharged earlier from hospital and receive any on-going treatments they need at home such as antimicrobial therapy (IV antibiotics). ● Working jointly with Calderdale Council we have implemented the Support and Independence Team that is able to provide rehabilitation services (in people's homes or in intermediate care residential settings). This enables more people to be discharged from hospital with the additional support they need for a period of recovery in a community setting with the aim that they will be supported to regain their independence to be able to go home. ● More recently we have developed a proposal to improve support for frail elderly people. The frailty team we are developing will work across the boundaries of the community and hospital care and make provision for frailty assessment at the earliest point in a patient's journey. This will include community based specialist assessment by consultant elderly care physicians. The frailty team will work with health and social care community services providing options to help reduce the need for people to be admitted to hospital and also support them to be safely discharged home with the support they need as early as possible in the knowledge that a specialist team will continue to support their recovery at home. ● Working with SWYPFT we have established a hospital based mental health liaison service. This means that specialist mental health practitioners are now available 24 hours a day to advise and support the delivery of care for patients in hospital that have both physical and mental health needs. This service is enabling both an improved quality and the more timely planning of support and care to enable people with multiple needs to go home earlier from hospital. These developments are having impact and reducing the length of time that people need to stay in hospital. However the impact of this is limited by the capacity and range of services that are currently provided in the community and also because many services are not available at weekends. The developments described in the Outline Business Case will enable provision of an increased range of support and services in the community and 7 day working both of which will further reduce delays in discharge.

Performance Improvement Actions Currently Being Taken	
People with long term conditions (such as COPD, diabetes) are admitted to hospital more than they should be	For people that have a long term condition (LTC) proactive care planning and support in the community could help people to stay well and avoid the need for them to attend A&E or be admitted to hospital. We know that the number of people that are being admitted to hospital with LTCs is reducing over the past two years. There are a number of actions that are currently being implemented to support this. Examples include: ● The pulmonary rehabilitation service. The service is designed to support people to live with their respiratory conditions, developing understanding of their condition and reducing risk of exacerbations. Similarly in other specialties such as diabetes, pain and cardiology there are patient education programmes designed to support people to live well with their condition. ● The implementation of Ambulatory Care Services at Calderdale Royal Hospital. This is a service that means that consultant physicians are based in the accident and emergency department and see people that attend with exacerbation of an existing long term condition. In many cases they are able to offer the senior support and treatment needed that means people can be treated and do not need to be admitted to hospital and are able to go home with support and advice. ● In the community we have implemented specialist nursing roles that are able to support people with long term conditions such as respiratory disease and heart failure. We currently have a telehealth pilot within the Respiratory team in Calderdale that is using technology to support people to self manage their condition with the support of nurses. ● In paediatric services we are currently working with GPs to implement a care closer to home pilot initially focused on improving support for children with asthma. There will be one clinic in Huddersfield and one in Calderdale. The clinic will comprise of consultants as well as GP's and specialist nurses. It is envisaged that by working in this way the specialty skills of the consultant can be shared with the multidisciplinary team and more children can be treated. The pilot will help reduce the number of children needing to attend A&E and the hospital. The pilot will be evaluated and if successful be rolled out on a wider basis. ● CHFT has also been piloting two National initiatives Co-Creating Health funded by The Health Foundation and People Powered Health funded by NESTA. Both the initiatives focus on Long Term Conditions and aim to support co-production to empower patients to self manage their long term condition and look at fundamentally transforming patient – care giver relationship. This allows us to look at our service provision across the care pathway for long term conditions in a different way. We have made significant progress with both initiatives allowing us to systematically implement self-management support and create an environment that nurtures innovations in service design. Benefits of these to patients have been significant improvements in quality of life, self efficacy and less reliance on health and social care. This way of working has also offered the opportunity to promote closer working links with community/primary care to enable a seamless experience for patients with long term conditions. Having demonstrated initial benefits of both the initiatives in MSK pain this is now being spread to COPD, Paediatrics, Support and Reablement services at Calderdale. The Outline Business Case will strengthen capacity for this type of pro-active support and care planning for people with long term conditions in the community and support for self care. This will further reduce the need for people with long term conditions to be admitted to hospital. Seven day working in the community will also ensure people can access timely advice and support at weekends and this is likely to reduce the need for admission to hospital.

Performance Improvement Actions Currently Being Taken	
Too many people are readmitted within 30 days.	To support people when they are discharged from hospital and avoid the need for them to be re-admitted we have implemented a number of actions to provide improved support for people. This includes: ● The virtual ward - this is a multi-disciplinary team of staff that supports people in the early days post discharge from hospital. The team makes sure patients and carers know what to expect of their condition, and who to contact if their condition worsens and provides telephone contacts for advice. The team is also able to offer an enhanced range of support and interventions at home to avoid the need for readmission such as antimicrobial therapies (IV antibiotics). For every patient discharged we now undertake a risk assessment (using the LACE tool) this identifies the issues that may arise and what action and support can be provided to support people to stay at home and not need a readmission to hospital. ● We are also working to ensure appropriate 'transfer' of patients across providers to support keeping people safely in the community once discharged. ● We are working in partnership with Commissioners to redesign services such as Respiratory, improving links between primary care, community services and hospital based services. The Outline Business Case describes a service model that will enhance the capacity and range of services available in the community 7 days a week that will support further reduction in re-admissions to hospital.
Too many people wait over 5 weeks for diagnostic services.	The aim for non-obstetric ultrasound and MRI is to offer appointments within 4 weeks. The Trust is currently providing additional services and capacity to meet this standard.
Some people report they do not have a good experience when they attend A&E	The information we are now collecting from the Friends and Family test about people's experience in A&E is very helpful. From this we know that some people are dissatisfied with their experience. Particular concerns relate to the length of time that people wait and the environment of care. A&E is an entry point to the hospital and therefore if the rest of the hospital is busy then the waiting time in A&E can increase. Therefore the work we are doing to reduce admissions to the hospital and speed up discharge from the hospital (as described above) will have benefit to the length of wait in A&E. However we also know that there are other things we can do within the A&E department to improve the experience and efficiency of the services. Examples of current actions include: ● We have undertaken a pilot study of EDIT (Emergency Department Intervention Team). This team has provided additional senior staff capacity and demonstrated this can reduce waiting and treatment times in A&E. The team ensures that senior doctors are the first people to assess people's needs. ● We have undertaken a pilot study of 'point of care testing' this has demonstrated we can reduce the time in A&E by offering more timely diagnostic services. The pilot studies we have undertaken demonstrate that the way we work can be improved and this will enhance the efficiency and experience of care. The Outline Business Case proposals will enable the consolidation of A&E services on a single site and enable these benefits to be consistently delivered. This will include the consistent presence of senior doctors 7 days a week.

Performance Improvement Actions Currently Being Taken	
Some people leave A&E without having been seen.	There are a number of reasons why patient's leave A&E without being seen. We know this is partly due to the timeliness of response and also related to the nature of the condition people are seeking advice on. As described above, we are taking steps to improve the timeliness of assessment for all people, as well as working with commissioner colleagues to ensure that only those patients who need to be in A&E attend, and we offer high quality alternate support in the community. Working with SWYPFT (the local mental health provider) we have implemented a 24 hour mental health liaison service. This means that specialist mental health practitioners are now available 24 hours a day, 7 days a week in the A&E department. This will provide early support to people with mental health problems and high risk groups such as people with alcohol/drug dependency. The mental health liaison team will ensure people get the immediate support required, as well as access to on-going support on discharge.
We have higher than the national average number of complaints per 1000 inpatient episodes.	We have set up a patient experience group reporting to the quality committee whose role is to oversee a patient experience improvement plan. The group will meet for the first time in July and have an ambitious programme of work specifically focussed on learning from the experiences of our patients and making improvements as a result of that learning. We are also taking action to implement improved standards in the quality and timeliness of responding to complaints. This will be linked to a clear and detailed response of learning from experience of when care does not meet expectations or standards required and the implementation of actions needed to remedy this.
Too many nurses are taking time off sick.	National benchmarks show that compared to other hospitals more of our nurses are taking time off sick. This is a concern to us. We know from the recent national staff survey that our staff also report higher levels of stress. To address this we have established staff focus groups to understand the reasons for work related stress and agree actions with staff to address this. The Outline Business Case service proposals will enable 7 day working and improved nurse staffing ratios in the hospital. There is an evidence base that the consistent presence of senior decision making clinical staff can alleviate wider staff stress and have a positive impact on staff morale. Seven day working will also smooth the peaks and troughs in the intensity of work over a working week and reduce peaks in workload that could be contributing to staff experience of workplace stress and resultant sickness absence. We are not able to make these changes of consistent 7 day working and improved staffing levels without a reconfiguration of services to concentrate specialist services on dedicated sites and the development of more services out of hospital.

4. The Strategic Case: The Case for Change

The case for change has been developed by doctors, nurses and therapists with involvement of all local providers, Clinical Commissioning Groups and representatives of patient groups and the public. The key elements of the case for change are set out below.

Overview

There is a compelling evidence base that the way community, hospital and social care services are currently organised and provided in Calderdale and Greater Huddersfield is not offering the most safe, effective and efficient support to meet people's needs. Local people and the doctors, nurses and therapists that currently provide services want things to change to achieve better health outcomes, a better experience of care and increased convenience and efficiency of service delivery. The current system is not able to provide the right care, in the right place, at the right time.

Our aim is to work with individuals, local communities, and partner organisations to provide exceptional standards of care to achieve optimal health outcomes, safety, and efficiency.

The areas of Calderdale and Huddersfield have seen many changes in recent years with populations and life expectancy increasing. Many people now live well into their eighties and nineties and populations are expected to increase by sixteen per cent in Calderdale and twelve per cent in Kirklees in the next 15 years. Older people are some of the most frequent users of health and social care and have more long-term conditions such as heart disease, diabetes and breathing problems. Modern lifestyles are also creating new health issues. Smoking is still the UK's largest cause of preventable illness and early death. Obesity is increasing and brings health issues such as diabetes and cardiovascular disease. There are also huge inequalities in health across the area with average life expectancy in some parts being five years longer for men and two years longer for women than in others. More needs to be done to ensure, no matter where people live, they can do so independently, in better health and for longer.

The total cost of providing health and social care to meet the needs of people in Calderdale and Huddersfield is now £650 million a year. Increasing demand, inflation and the introduction of new drugs and treatments mean costs are increasing. It is not just about how much money we have to spend, we need to look at how we spend it. For all these reasons doing nothing is not an option.

We believe changes can be made to:

- Enable people to 'live life to the full' by providing more integrated support and care in people homes and communities. This will improve people's health, quality of life and experience of support.
- Save more lives and improve people's recovery by changing the configuration of specialist hospital care provided for the most seriously ill or injured people.
- Ensure that for all patients optimal clinical outcomes and recovery are achieved.
- Ensure we can continue to provide specialist and emergency hospital services as locally as possible and demonstrate first class health outcomes.

The specific proposals for improvement identified in this Outline Business Case are:

i. Earlier support for self care provided close to home could equip people to undertake activities to enhance their health, prevent disease and limit illness. This could significantly improve people's health outcomes and quality of life (e.g. reducing social isolation and time off work).

ii. The provision of integrated specialist health and social care in people's homes or close to where they live could help people to manage their condition and mean that for many people who are unwell they do not need to be admitted to hospital. We know that by providing specialist support at home and avoiding the need for admission to hospital this will improve people's clinical outcomes and experience of care.

iii. Survival and recovery outcomes could be improved if specialist hospital services (such as Accident and Emergency services, critical care, trauma, acute and emergency surgery, obstetrics, paediatrics, and general medicine) are centralised and co-located on one hospital site. This will eliminate the current risk that occurs when patients attend one of the A&E departments in Halifax or Huddersfield with a serious illness or injury that cannot be fully treated at that hospital. Currently patients are transferred between the two hospital sites and this can cause delay and risk to their care. The concentration of acute and emergency services on a single hospital site will also enable the most senior doctors to provide care and treatment for seriously ill patients for extended hours 7 days per week. This is not currently possible as the available services and expertise are spread across two hospital sites. There is a substantial evidence base that the co-location of services and the increased availability of the most senior doctors will improve people's likelihood of survival and making a good recovery.

This section describes the rationale and evidence base for the proposed changes. The proposed new service models (based on this evidence and rationale) are detailed in section 5. The case for change described in this section covers the following:

- Why services need to change: the Reality
- How services could be improved the Response
- The benefits that could be achieved: the Result

The case for change is supported by a summary in this section of:

l The clinical evidence base and clinical support for change
l The engagement and views of the public and staff on the need for service change
l How the case for change aligns with clinical commissioning intentions
l What the case for change could mean for patient choice

4.1 Why do services need to change? – The Reality

The services currently provided across Calderdale and Greater Huddersfield could be better.

There are three key reasons why services need to change:

- Local people and staff have identified the need for service change.
- There are gaps in current services and we are not able to guarantee the safety, quality and outcomes for people.
- Services are not clinically and financially sustainable into the future.
- We cannot assume there is any funding growth available for the forseeable future. In a national period of austerity the health and social care system across Calderdale and Huddersfield must ensure and extract better value for use of public funding.

The table on the next pages provides additional information to explain these reasons.

Why do Services Need to change: Local people have identified the need for change

● The Calderdale and Huddersfield Strategic Review has undertaken significant public engagement to understand and consider the views of service users, the public and voluntary sector organisations. The findings from this were published in 2014 (Call to Action: Engagement Report for Calderdale and Huddersfield Strategic Review). The report identified key priorities for the future and what really matters to the people who use services. The changes local people want to see in the way services are provided is described below (these are direct extracts from the comments made by people). We need to respond to these issues and views that local people have told us about.

● More Self-care / Self-management – for example places where you can drop in to get advice, support, assistance and equipment in the local community, courses on self-management, involvement of wider networks such as carers and families, Community assistants, champions and buddy schemes, advice and helplines available 24/7.

● More Services in the community –more staff working with and supporting local people in their own home and community. For example more health assistants, social workers and nurses, better home care, affordable nursing and residential care, named community staff for individual people, better access to equipment to use in your own home, more day care and respite care for carers

● Better management of risk and safeguarding – keeping people safe when they are unwell. For example: increase community staff and do regular house calls, more nurses on medical elderly wards, make sure interpreters are available so people can understand information, provide more emotional and social support at home, prevent isolation, regular contact with local community, consistent staff and named key workers with skills, more health visits for vulnerable families, good sheltered housing with wardens.

● Investment in community and primary care as well as local community and voluntary groups that provide support for local people with health conditions. For example, utilise youth clubs and community centres and put services in existing community buildings, engage with work places in the local area, provide services on varying days and times, give communities choice and control – talk to us, look at transport, getting about in the area and parking, identify community representatives, reduce isolation and inequalities in health, we want exercise classes, nutrition and cooking advice that are free or subsidised.

● Improved discharge planning and better hospitals For example, bring hospital services into community settings, ensure that when people are discharged they have a robust plan that is backed up with a health and social care services 24/7, ensure patients are fully recovered before they are discharged, assign a professional to keep regular daily contact in the first week, fund and use local voluntary organisations to support the individual, train and support carers in their duties so they can manage, more staff in hospitals, hospitals need to be clean and serving nutritional food to support recovery.

● Investment in technology – use technology better and invest in future technology, especially for monitoring and sharing information between services and patients. For example, education by social media, train people to use computers and offer access to technology for those who do not have a computer, consider using apps to support people and train them in their use

● Working together all agencies, not just health, should work together to improve health and wellbeing. For example, joint teams that are managed centrally not just teams that work together, sharing of information and the ability for health and social care professionals to access a shared, patient-owned record as necessary, all public services should have a remit to improve health and well-being, third sector should be an equal partner, work with local communities on tackling inequalities and the wider determinants of health such as housing.

● Improved education and information for people – there needs to be more information about how to maintain health and wellbeing and avoid preventable conditions and how to access services. For example, more information on the services available and how to access them, education courses should be available for specific conditions and general health and wellbeing, preferably delivered by people with the condition themselves to provide peer support, education on diet, nutrition and lifestyle especially healthy eating and cooking skills, more education and information for young people – start at school, use Sure Start centres, educate people in public places – free classes in the community.

● Improved access to health services For example, have specialist staff in GP practices, one point of access for people with a long term condition, have appointments at evenings and weekends, ring fence appointments for people who work, longer appointment times for some people, spend more time with the patient and listen, awareness of building access issues to all staff, especially around disabilities, improve home visits and bring GP services to community settings, reduce waiting times for appointments and change the booking system, employ the right staff who can communicate in the right language or format.

● Staff training For example, train all staff, including medical and administrative to change the culture of the NHS, improve communication with patients and ensure they understand their condition and treatment options and are able to make informed choices about their own care, make the NHS transparent at all levels, recruit the right staff who represent the language and culture of the local population, train specialist staff (or have a matron lead) who understands different disabilities and mental health.

● Regular check-ups For example, offer a wide variety of health and wellbeing checks, many people described this as an MOT or health review, also a call for more targeted check-ups for those groups at particular risk, more routine scans and screening, early diagnosis can ensure early intervention including self help

● National solutions and campaigns are needed for changes on a national scale. For example, changes made by government, such as charging for unhealthy lifestyles such as high taxes on sugar, junk food, alcohol and smoking to help subsidise healthier lifestyles, campaigns to raise awareness of exercise and healthy food options, acknowledgement that society needs to change, rather than or along with the NHS.

● Stronger accountability – For example, clear ways of measuring quality of care in all settings, learn from mistakes and listen to peoples complaints and problems, treat everyone equally and fairly, consider equality, education on everyone's rights and responsibilities – display them in

Why do Services Need to change: Staff have identified the need for change

Senior doctors, nurses and therapists that currently provide the services in hospital and in the community have identified the need for service and system change to improve the safety and effectiveness of care for patients in the future.
Staff engagement has confirmed support for the need to change services:

- To provide more proactive and responsive care for people in their own homes or close to home and as result reduce the number of people that have to be admitted to hospital.
- To provide more specialist care in people's homes and the community so that people do not need to come to hospital for outpatient appointments and tests or to be admitted for care.
- To provide the support people need 7 days a week so that there are consistent services available in hospital and in the community. This will mean that care is available when people need it and not delayed. For example sometimes when people are well enough to be discharged from hospital this is delayed as the community support required is not available at the weekend.
- To increase the use of technology to enhance the safety, efficiency and timeliness of care provided in the community and in hospital.
- To organise staff and services so that all the necessary specialist services that need to be together to deliver the best standards of clinical care are available on the same hospital site
- To make sure people have early access to senior doctors, nurses and therapists that can make decision about the care they need and offer the best information and advice for people.

Why do Services Need to Change: There are gaps in services and we are not able to guarantee the best safety, quality and outcomes

- There is not enough support to help people to stay in control and make choices to manage their health. Earlier support could help people undertake activities to enhance their health, prevent disease and limit illness. It could also improve quality of life, reduce social isolation and time off work.
- There are not enough specialist health and social care services provided in people's homes or close to where they live and services are not coordinated. This means that for many people who are unwell (for example with asthma or diabetes) their only option is to be admitted to hospital. Often this occurs due to a crisis when their health has deteriorated and their safety is compromised. More specialist care and integrated services for long term conditions could be provided in the community.
- For people that have more than one health need there is a risk of people experiencing gaps in care. One example of this is people that have a serious mental illness. They are almost twice as likely to die from coronary heart disease and four times more likely to die from respiratory disease. People who live in nursing homes may experience repeated admissions to hospital as the specialist support they need is not available out of hospital. This is often happens at end of life. This is not the care we want for people.
- For people with multiple medical problems we know that when they are admitted to hospital too many people experience a number of moves between wards, a longer length of stay in hospital, and increased risk of a poor experience and outcomes.
- For people that have a serious life-threatening illness or injury and need Accident and Emergency services we cannot currently guarantee the consistent presence of senior doctors seven days a week. We want patients to be seen by a senior doctor as early as possible. We know that there is clinical evidence that this is important to improve the likelihood of survival and a good recovery. Fewer consultants working at weekends in emergency medicine is associated with England's higher weekend mortality rate.
- The two hospitals in Halifax and Huddersfield do not provide the same services and there is often a need for inter hospital transfer of patients as there is not a co-location of all the expertise needed on both sites (i.e. trauma and acute surgery, oncology and haematology are at Huddersfield and stroke, paediatrics and complex obstetrics are at Halifax). There is evidence that the co-location of emergency and acute medical and surgical expertise can enable significant improvements in survival and recovery outcomes despite an initial increased travel time to the A&E department. For example the recent national reorganisation of major trauma services which reduced the number of sites showed a 20% increase in survival despite increased travel time. Similar results have been reported for cardiac and stroke patients. These are the benefits we want to be able to offer for local people. The co-location of acute specialty teams on a single site could prevent potential safety events and delays in care, which are a risk in the current configuration, where medical patients are frequently transferred between the two sites.
- Currently the two Emergency Departments at Calderdale Royal Hospital and Huddersfield Royal infirmary are non-compliant with many of the standards for Children and Young People in Emergency Care settings. Provision of all the Emergency Department care on one site (with a Minor Injuries Unit on the other site) could allow for the provision of a dedicated Paediatric Emergency Department which would then result in compliance with many, (if not all) of these standards; this is highly desirable. It is clear that in terms of providing sufficient numbers of adequately trained and skilled staff, it would be impossible to provide this level of service on both sites.
- Paediatric medicine and surgery are not co-located on the same hospital site. This means that currently children that have urgent medical and surgical needs do not receive shared care from a consultant surgeon and a paediatrician. It also means that if an urgent consultant paediatric opinion is required out of hours, a consultant paediatrician on call for Calderdale Royal Hospital may have to attend Huddersfield Royal Infirmary whilst also being on call for acute paediatrics and neonatology at Calderdale Royal Hospital. If the paediatric medical and surgical services were consolidated on one site, then it would be possible to provide shared senior paediatric and surgical care for patients.

● In 2005/06 a partial reconfiguration of some hospital services was implemented to concentrate acute surgery and trauma services at Huddersfield Royal Infirmary. The clinical evidence base for this was recognised and supported by Commissioners at that time. Data published by Dr Foster shows that since 2005/06 to 2012/13 there has been a significant reduction in surgery and trauma service mortality rates (i.e. General Surgery mortality has reduced from 97 to 64, and Trauma and Orthopaedics mortality has reduced from 90 to 53). A full reconfiguration of all the acute specialities and emergency services on a single hospital site could enable even more people to benefit from similar improved safety and reduction in mortality (more lives saved).
● Sometimes people's planned operations are cancelled as the surgeons need to respond to meet the needs of emergency patients. We know this is a poor experience for people that may have arranged time off work and child care to enable them to have a scheduled operation. We can reduce the likelihood of this happening by changing the way hospital services are organised.

Why do Services Need to change: Current services are not clinically and financially sustainable into the future

● The health and care needs of people that live in Greater Huddersfield and Calderdale are increasing. People are living longer and many older people are likely to develop one or more long term condition. Modern lifestyles are also creating more ill health. The impact of this is generating additional demand for health and social care services. This growth in the need for services coupled with inflationary pressures results in an estimated £163m productivity and efficiency requirement across health and social care over the next 5 year period. This level of efficiency is not achievable without service transformation.
● There is a national shortage of emergency doctors and nationally nearly one fifth of consultant posts in A&E departments are either vacant or filled by locums. 17% of emergency departments nationwide are not able to provide the recommended level of 16-hour consultant presence on wards. This national position is reflected in the two A&E departments in Halifax and Huddersfield. The two A&E departments require a rota of 12 speciality doctors and in the last 5 years there has only been a maximum of 7 doctors with gaps in the rota filled by locum staff. The College of Emergency Medicine recommends a minimum of 10 Consultants in Emergency Medicine per emergency department. Currently there are 5 in Halifax and 5 in Huddersfield. This impacts on the safety of care and is not a sustainable clinical model of provision. The workforce pressure is exacerbated by the provision of A&E on two sites. Studies show that clinical incidents in Emergency Departments increase when there is overreliance on locum staff; analysis of recent red risk clinical incidents in the two A&E Departments in Halifax and Huddersfield confirms this.
● We know that across the region there will be a significant shortage in the number of paediatric specialist doctors in training starting from August 2015. The likely impact on Calderdale and Huddersfield Foundation Trust is that whilst 11 speciality paediatric doctors are needed to cover existing rotas there will be up to a 75% reduction in their availability. This shortfall in medical cover will require new ways of working. Concentration of all emergency, acute medical and surgical paediatric services would enable optimal use of the medical workforce.
● The current provision of A&E services on two sites in Halifax and Huddersfield also means that we are not able to provide all of the on-site hospital facilities and acute medical and surgical expertise at both sites. As a result patients may experience delay and transfers between the two hospitals. This is not a sustainable clinical model of provision.
● In June 2013 the National Clinical Advisory Team visited Calderdale and Huddersfield Foundation Trust and recommended that a one acute care site option is the best for the future safety, value and sustainability of health care. This change will enable an increased senior doctor (consultant) presence for extended hours over 7 days, minimise the use of locum middle-grade doctors and will reduce the need for inter-hospital transfer of patients. The Team also strongly supported commissioners enhancing primary and community based services for the same high quality reasons and advised that NHS services of the future cannot be of high value to patients unless more care is delivered out of hospital.
● In November 2013 NHS England published Sir Bruce Keogh's Urgent and Emergency Care Report. This report sets a direction that over the next five years there will be changes in the way that A&E services are provided. Of the 140 A&Es currently across England 40 – 70 major emergency centres will be established. There is a need to strengthen the A&E clinical and service model serving Calderdale and Greater Huddersfield to ensure this is clinically sustainable so that we can respond to this wider strategic change in the configuration of A&E services.

4.2 How Can services be improved? – the Response

The aim of this Outline Business Case is to offer integrated care and support for people in Greater Huddersfield and Calderdale that crosses the boundaries between primary, community, hospital and social care. Taking account of the specific reasons detailed in section 4.1 of why services need to change the following responses have been identified.

1. We can support more people to self-manage and self-care
2. We can provide 7 day integrated services closer to home
3. We can improve the safety and quality of hospital care

These changes will be enabled by

4. Putting people in control of their own health and wellbeing needs
5. Investing in staff capabilities and skills to enable quality improvement
6. Using information technology to support new ways of working

We believe these changes are mutually inter-dependent i.e. the provision of more services close to home and the redesign of hospital based services cannot be separated without creating significant clinical and financial risk in the health and social care system. This is also supported by the National Clinical Advisory Team recommendations.

These proposed responses have a strong alignment and correlation to the views of local people and staff about what they think is important and would like to see change. The proposed responses also reflect the national and international evidence base of the most effective service delivery models. The table below summarises the proposed changes and identifies how they link to public and staff views and the clinical evidence base for these changes.

What Can we Do? The Response	How will this Help? How it will address the Reasons for Change
We Can Support More People to Self-Manage and Self-Care We can support more self care and self-management to increase people's sense of control and wellbeing and as a result reduce their dependence on health and social care services. Self-management support could improve people's knowledge about their condition and care, how they feel about their condition, and their ability to cope day to day. This could result in both improved confidence and quality of life and alter the pattern of service use reducing healthcare costs. Evidence from the Department of Health shows the use of self-care approaches can provide the following benefits for individuals: ● increase in life expectancy ● better control over symptoms ● reduction in pain, anxiety and depression levels ● improvement in quality of life with greater independence ● increase in community activities	Local people have told us they want more options and support for self care and self-management including more information about how to maintain health and wellbeing and avoid preventable conditions. Doctors, nurses and therapists have told us that they want to improve patient experience. There is an evidence base that self-care and self-management support could improve people's health and reduce costs. This could improve efficiency and release service capacity to meet the increasing needs of more people living longer with complex multiple health needs.
We can provide 7 day integrated services closer to home We can provide integrated physical, mental health and social care in people's homes or close to their home, including some specialist services that are currently only available in hospital. This will enable people to receive more of the care they need in their own home or close to their home reducing the need for them to visit the hospital for outpatient appointments and tests or to be admitted to hospital. It will also ensure that if people are admitted to hospital that the support and care they need is available seven days a week to enable them to go home as early as possible with the support they need (reducing lengths of stay in hospital).	Local people have told us they want: ● all agencies working together ● more staff working with and supporting local people in their own home and community. ● hospital services provided in community settings. ● specialist staff working in GP practices and one point of access for people with a long term condition. ● Staff to be trained (or have a matron lead) who understands different disabilities and mental health. Doctors, nurse and therapists have told us that to improve patient safety and experience of care they want to reduce the need for hospital admissions and the length of time that people need to stay in hospital, and to provide more specialist care in people's homes and the community. Evidence shows that integrated care provided close to home could increase people's wellbeing and health and reduce their need for health and social care interventions. This could improve efficiency and release service capacity to meet the increasing needs of more people living longer with complex multiple health needs.

What Can we Do? The Response	How will this Help? How it will address the Reasons for Change
We Can Improve the Safety and Quality of Hospital Care We can improve the safety and quality of hospital care by changing the organisation of services that are provided at the two hospital sites in Halifax and Huddersfield and establishing two specialist hospitals. One hospital that specialises in acute and emergency services and one hospital that specialises in care for people who need planned treatments or surgery (e.g. hip or knee operations). By consolidating specialist services this will eliminate the need for inter-hospital transfers and duplication of services across two sites. This will enable senior doctors, nurses and therapists to work more effectively to provide: earlier access to senior doctors; consistent services seven days a week, and ensure that the right hospital facilities (acute medical and surgical expertise) are co-located with emergency services. We know from the clinical evidence base that this is important to improve the likelihood of people surviving and making a good recovery following serious injury or illness. Changing the way hospital services are organised will also improve the provision of planned hospital services and surgery to reduce the likelihood of scheduled operations and care being cancelled. This will enable the doctors and nurses delivering planned care to spend more time with patients.	Local people have told us that they want more staff in hospitals. Staff have told us that want to change hospital services to improve clinical outcomes, patient safety and improve patient experience. The clinical evidence base tells us that when people have life threatening illness or injury to maximise their chances of survival and a good recovery they must receive treatment at centres with all the necessary facilities and expertise co-located, twenty four hours a day and seven days a week. Changing the way hospital services are organised could eliminate duplication, reduce admissions to hospital and reduce lengths of stay in hospital. As a result this could improve efficiency and release service capacity to meet the increasing needs of more people living longer with complex multiple health needs.
We can put people in control of their own health and wellbeing needs We can provide greater engagement, information and communication with local people to improve people's understanding and ownership of their health. There is an evidence base that this is a stronger predictor of health status than age, income, employment status, education level, race or ethnic group. We can develop whole system approaches to strengthen engagement with local people.	Local people have told us they want more information about how to maintain their health and wellbeing and avoid preventable conditions. Evidence shows that greater engagement and communication with local people to improve understanding and ownership of their health could reduce health inequalities and reduce healthcare resource utilisation. This could deliver better population outcomes at the same time as improving efficiency and releasing service capacity to meet the increasing needs of a population living longer with complex multiple health needs.
We Can Invest in Staff Capabilities and Skills to Enable Quality Improvement We can support staff to work in new ways across organisations through a deliberate and sustained leadership strategy that focuses on quality improvement and invests in staff capabilities and skills. The shift we need to make is that all staff are equipped for two jobs – the job they do and the job of improving quality.	Local people have told us they want us to train all staff, including medical and administrative staff to change the culture of the NHS. The evidence tells us that there are examples of health and social care organisations that have achieved large scale system change and sustained high levels of performance that we can learn from.

What Can we Do? The Response	How will this Help? How it will address the Reasons for Change
We Can Use Information Technology to Support New Ways of Working We can ensure that patient information and clinical decision and support tools are securely available to staff to enable them to deliver care in people's homes, at the hospital bedside, in hospices and in ambulances. This will mean people will only have to tell their story once and all the information that is needed for professional staff to support the right decisions for people's care is available. We know that people, particularly those with long term conditions, don't want to spend time in hospital unnecessarily, they want to have more control over decisions made about their care and they want to live a normal life. To make decisions people need information and care services that respond to their needs, not the other way round. We want to make sure that people have access to services and information that help them make their own decisions and one way of doing this would be to enable people to get real time data on their own health status in real time. That is what assistive technology such as telehealth and telecare can do. The Department of Health Whole System Demonstrator sites show that if used correctly telehealth can deliver a 15% reduction in A&E visits, a 20% reduction in emergency admissions, a 14% reduction in elective admissions, a 14% reduction in bed days and an 8% reduction in tariff costs. More strikingly they also demonstrate a 45% reduction in mortality rates. An example of a service user experience is provide below. *Tom knows all too well the problems of living with a long term health condition. He has no less than six of them, including heart disease, Chronic Obstructive Pulmonary Disease (COPD) and stage three kidney disease. Tom explains: "I am on a lot of medication. I try, with the help of doctors and community nurses, to stay out of hospital by learning about my conditions and monitoring the signs so that if I do have a 'wobble' I can seek medical help quickly to stop a problem escalating. "The Telehealth equipment helps me to do this. By hooking up to the machine and taking various readings, such as my blood pressure, health professionals miles away can review my state of health with me throughout each day and react if they see a problem emerging." Tom like many within his self-care groups, is determined to remain independent for as long as possible. He strongly believes that as a society we need to support one another through voluntary groups such as his to enable people to have the courage and ability to take charge of their own health.* We can also use communication technology more in the delivery of care to offer more convenient and accessible support for people. We can reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions. For example, attending a hospital appointment to receive a test result that says everything is OK; or a visit to an outpatient clinic for something that could be discussed on the phone or via email or SKYPE.	Local people have told us they want us to use technology better and invest in future technology, especially for monitoring and sharing information between services and patients. Staff have told us they want better use of technology to support them in delivering improved safety, quality and efficiency of care for people. Evidence shows that greater use of technology could reduce health and social care resource utilisation, improve efficiency and release capacity to meet the increasing needs of a population living longer with complex multiple health needs.
We can also use communication technology more in the delivery of care to offer more convenient and accessible support for people. We can reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions. For example, attending a hospital appointment to receive a test result that says everything is OK; or a visit to an outpatient clinic for something that could be discussed on the phone or via email or SKYPE. We can use technology more in healthcare where it can deliver the same high standards in a way that is more flexible and convenient for patients, and at a lower cost. We can use technology more in healthcare where it can deliver the same high standards in a way that is more flexible and convenient for patients, and at a lower cost.	

The diagram below summarises the reasons for change (section 4.1) and the proposed response (section 4.2).

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

4.3 The Result: The potential benefits that could be achieved

This section describes the benefits that are expected to be achieved as a result of implementing the changes described in section 4.2 The provision of more support for self care, integrated care provided at home or close to home and changes in the configuration of hospital services to establish a specialist acute and emergency hospital and a specialist hospital for planned care will improve health and enable a sustainable future for the health and social care system across Calderdale and Greater Huddersfield. This will be beneficial both to people using services and those working hard to deliver them. We expect benefits to be delivered throughout the period of change, not only at the end.

The benefits we expect the changes to deliver are described in two ways:
i. The achievement of key clinical and quality standards
ii. The achievement of improved whole system performance

Clinical and Quality Standards
The proposed changes will enable achievement across a number of key quality and clinical standards. The clinical standards are based on latest evidence from Royal Colleges and NICE guidelines. The core reference documents for this are:
➤ NCEPOD (2007) Emergency admissions: A journey in the right direction?
➤ RCP (2007) The right person in the right setting – first time
➤ RCS (2011) Emergency Surgery Standards for unscheduled care
➤ AoMRC (2008) Managing urgent mental health needs in the acute trust
➤ NCEPOD (1997) Who operates when?
➤ ASGBI (2010)
➤ NCEPOD (2004) The NCEPOD classification for intervention
➤ The Royal College of Anaesthetists: Guidelines for the Provision of Anaesthetic Services (chapter 9, section 1.2)
➤ Standards for maternity care: report of a working party. (2008) RCOG, RCM, RCA, RCPCH
➤ Safer Childbirth - Minimum Standards for the Organisation and Delivery of Care in Labour (2007), RCOG
➤ Facing the Future: Standards for Paediatric Services, Royal College of Paediatrics and Child Health, April 2011.

The key seven quality and clinical standards that the changes will enable achievement of are:
1) Patient empowerment and self care
2) Patient access, convenience and response
3) Care planning and multi-disciplinary working
4) Information and communications
5) Accident and emergency services
6) Maternity Services
7) Paediatric Services
The detail related to each of these is provided below.

Quality Standards: Patient Empowerment and Self Care

Inputs
The quality standards that transformation helps us to deliver

Individuals will have access to relevant and comprehensive information, in the right formats to inform choice and decision making	Individuals will be actively involved together with the local community health and care services to support personal goals and care plans	Information and services will be available for individuals who are able to self-manage their conditions or who need care plan support

Outputs
What the changes from transformation achieve

- Patients know how and where to seek care so are treated sooner and more effectively (including transport options)
- Improved patient and carer ability to make choices about and comply with their treatment
- Improved patient ability to make decisions about their treatment
- Improved patient ability to access treatment at the most appropriate setting

- Increased opportunities for patients and carers to proactively manage their treatment and self-care at home and in the community setting
- Improved supply of equipment to patients to support self-care

- Increased proactive management of care by patients
- Increased levels of public education about healthcare
- Improved information to enable self-care by patients
- Increased awareness by patients of the status of their own healthcare and treatment
- Reduced levels of carers stress, improving their ability to provide care and support

Outcomes
The results (i.e. benefits) that demonstrate transformation has been successful

- Improved clinical outcomes for patients
- Improved patient experience, patient choice and patient satisfaction
- Improved carer experience, carer choice and carer satisfaction
- Reduced number of unnecessary investigations and duplication of assessment activity
- Reduced number of DNAs in all health settings

- Reduced unscheduled acute admissions in any setting
- Reduced in number of attendances at GP surgeries
- Improved patient condition data to support clinical decision making
- Reduced duplication of information
- Improved co-ordination and streamlining of assessment processes

Inputs
The quality standards that transformation helps us to deliver

Quality standards: Access, Convenience and Responsiveness

Individuals will have access to telephone advice and triage at all times, supported by prompt and convenient access to an appropriate healthcare professional or other agencies, including voluntary organisations

An individual who is at risk of an admission to hospital which could be prevented by advice, services, diagnostics or supply of equipment will have their needs met in less than 4 hours

Clinical protocols with access times to routine investigations will be made available and followed by service providers

Outputs
What the changes from transformation achieve

- Patients treated sooner and more effectively
- For cases assessed as not urgent (but cannot be resolved on the phone), individuals will be offered a choice of appointment within 24 hrs or an appointment to see a GP within their own practice within 48 hrs
- Improved signposting to services, including health care, social care, voluntary organisations and transport*
- Improved patient ability to access treatment at the most appropriate setting
- Increasingly streamlined processes for patient pathways
- Improved methods of communication amongst primary, secondary and community care providers
- Vulnerable groups are well directed to appropriate services
- Patients (and carers where appropriate) needing transport to get to community services have access to safe transport

- Increased levels of early and better diagnosis
- Reduction in unnecessary investigations
- Improved supply of equipment to support self-care

- Improved convenience for patients to undergo investigations and/or receive treatment

Outcomes
The results that demonstrate transformation has been successful

- Reduced mortality rates
- Reduced morbidity rates
- Improved patient experience, patient choice and patient satisfaction
- Improved carer experience, carer choice and carer satisfaction

- Reduced number of unnecessary investigations and duplication of assessment activity
- Reduced unscheduled attendances and emergency admissions
- Improved staff satisfaction
- Reduced number of DNAs in all health settings

Inputs
The quality standards that transformation helps us to deliver

Quality standards: Care Planning and Multi-disciplinary Working

All individuals who would benefit from a care plan will have one

Everyone who has a care plan will have a named co-ordinator who will work with them to coordinate care across health and social care

GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists

Outputs
What the changes from transformation achieve

- Patients treated sooner and more effectively
- Improved care coordination between all parts of the healthcare system
- Improved communication between patients, carers and healthcare professionals
- Increased proportion of people with long term conditions have a care plan
- Improved multi-disciplinary and cross-organisational working , including better information sharing - reducing duplication and improving access to care
- Multi-faceted care planning will enable vulnerable patients and groups to receive integrated care
- Improved targeting of investigations
- Improved and faster clinical decision making

Outcomes
The results (i.e. benefits) that demonstrate transformation has been successful

- Improved clinical outcomes for patients
- Improved multi-disciplinary approach to care
- Increased confidence for patients and their carers about their treatment and support
- Improved patient experience, patient choice and patient satisfaction
- Improved carer experience, carer choice and carer satisfaction
- Reduced number of 'did not attend' appointments
- Reduced number of unscheduled acute admissions by patients identified with a long term condition and from nursing homes
- Improved efficiency of service delivery through streamlined patient pathways
- Improved staff satisfaction

Quality Standard: Information and Communication about Patients

Inputs
The quality standards that transformation helps us to deliver

- With the individual's consent, relevant information will be visible to health and care professionals, available electronically and in hard copy
- Any previous or planned contact with a health care professional should be visible to all relevant health and care providers
- Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan as well as continuing care needs

Outputs
What the changes from transformation achieve

- Improved and faster clinical decision making
- Reduction in duplication of investigations and assessments
- Improved visibility of all aspects of healthcare that patient is undergoing
- Improved IT and technology capability to support improved integration between primary and secondary care and multi-location working
- Staff have the IT and technology tools (or access to tools) to support new ways of working
- Electronic discharge information is sent and received by community team within 6 working hours
- Improved discharge planning

Outcomes
The results (i.e. benefits) that demonstrate transformation has been successful

- Improved clinical outcomes for patients
- Improved confidence for patients regarding their treatment and support
- Improved patient experience, patient choice and patient satisfaction
- Improved carer experience, carer choice and carer satisfaction
- Reduced readmissions and exacerbations following discharge
- Increased ability to treat and support patients in the community setting
- Improved formal integrated working with social care, 24/7

Inputs

The clinical standards that reconfiguration helps us to deliver

Clinical Standards: Accident and Emergency Services

Improved access to senior and specialist skills

Improved access to diagnostics and multi-professional teams, including mental health services

Improved processes to support patients with their conditions and treatment

Outputs

What the changes from reconfiguration achieve

- Patients treated sooner and more effectively
- A trained and experienced doctor in emergency medicine 24/7
- Min. 16 hours/day emergency medicine consultant presence in the A&E (and a consultant on call within 30 mins of the hospital outside of these 16 hours)
- 24/7 access to the minimum key diagnostics and all abnormal reports to be reviewed within 24 hours and acted upon within 48 hours
- Decisions about treatment made earlier by senior clinicians
- Reductions in number of investigations undertaken
- Improved workflow
- A&E patients who are referred to another team have a management plan in place within one hour from referral, and admission to another ward/unit within one hour of decision to admit
- More timely discharge from hospital, including 7 day/week access to support from physiotherapy and occupational teams to support discharge
- Improved training and supervision for junior staff
- Reduction in average length of stay for non-elective admissions

Outcomes

The results (i.e. benefits) that demonstrate that reconfiguration has been successful

- Reduced mortality rates (Hospital Standardized Mortality Index)
- Reduced admission and readmission rates
- Improved patient experience, patient choice and patient satisfaction (and carer where appropriate)
- Reduced number of complaints about emergency care services
- Reduced number of serious incidents
- Improved multi-disciplinary approach to care, including community teams
- Improved support for patients with mental health problems
- Improved staff satisfaction

Inputs

The clinical standards that reconfiguration helps us to deliver

Clinical Standards: Maternity

- Improved access to obstetricians
- Midwife-led maternity pathway, except for high risk women who need obstetrician-led care
- Appropriate co-location of services and support from wider services (e.g. emergency surgery, interventional radiology and critical care)
- Staffing to provide 1-1 midwife to woman standard ratio in labour

Outputs

What the changes from reconfiguration achieve

- Patients treated sooner and more effectively
- Extended hours consultant cover of the labour ward
- 24 hour availability of a health professional fully trained in neonatal resuscitation and stabilisation in Maternity Units
- 24/7 access to a competent supervising obstetric anaesthetist and a duty anaesthetist
- 24/7 access to interventional radiology and general surgical support and onsite access to HDU level 2 care
- Availability of Consultant Obstetrician
- All women have 1:1 midwifery care during established labour
- Increased % of midwife-led births and reduced % of obstetrician-led births
- Improved co-ordination of care
- Reduced number of instrumental deliveries
- Reduced emergency and planned C-Section rates
- Improved access for all women to effective postnatal care
- Reduced staff vacancy rates and reduced staff attrition
- Increased home births
- Reduced post-partum haemorrhages

Outcomes

The results (i.e. benefits) that demonstrate that reconfiguration has been successful

- Reduced morbidity rates (neonatal, perinatal and maternal rates)
- Reduced number of serious incidents
- Improved multi-disciplinary approach to care
- Improved patient experience, patient choice and patient satisfaction
- Reduced number of complaints about maternity services
- Improved team working
- Improved staff satisfaction
- Increased breast feeding rates

Clinical Standards: Paediatrics

Inputs
The clinical standards that reconfiguration helps us to deliver

- Improved access to senior and specialist skills
- Paediatrics Assessment Units to have clearly defined responsibilities with clear pathways and to be appropriately staffed
- Staff passport to allow staff to move between sites without need to repeat CRB/safeguarding checks or utilise formal SLAs
- Appropriate co-location of services and support from wider services (e.g. emergency surgery, interventional radiology and

Outputs
What the changes from reconfiguration achieve

- Patients treated sooner and more effectively
- 24/7 consultant cover
- All emergency admissions seen and assessed by the responsible consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital
- All emergency departments which see children have a named paediatric consultant with designated responsibility for paediatric care in the emergency department.
- Decisions about treatment are made earlier
- All children admitted as an emergency are seen and reviewed by a consultant during twice daily ward rounds
- Reductions in average lengths of stay
- An estimated discharge date confirmed within 24 hours of admission
- Resources (staff & equipment) located to provide optimal service and meet fluctuations in demand
- All hospitals admitting medical and surgical paediatric emergencies have access to all key diagnostic services 24/7
- Improved information sharing across all health professionals and specialties along the emergency care pathway

Outcomes
The results (i.e. benefits) that demonstrate that reconfiguration has been successful

- Reduced number of paediatric serious incidents
- Reduced admission rates
- Reduced re-admission rates for common childhood conditions
- Improved patient experience, patient choice and patient satisfaction (and carer where appropriate)
- Reduction in number of complaints about paediatric services
- Improved staff satisfaction

Impact on Service Performance
Section 3.11 highlighted current performance across the health and social care system and where there is opportunity for improvement. This is reproduced here for context.

Indicator	Current Local Performance		England Average	Best in England	Opportunity for Improvement
	Calderdale	Huddersfield			
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.	611	579	708	28	Yes
People discharged from hospital into reablement services that were still at home 91 days after discharge	70	85	82	98	Yes
Delayed transfers of care from hospital per 100,000 population	15.8	11.5	9.5	1.1	Yes
Avoidable emergency admissions / ambulatory care (composite measure).	1516.7	1243.6	1186.6	288.9	Yes
Hospital Standardised Mortality Rate	107	100	100	?	Yes
Population life expectancy (male)	77.1	77	78.2	85.1	Yes
Population life expectancy (female)	81.5	81.3	82.2	89.8	Yes
Hospital lengths of stay elective		3.12	3.8	2.54	No
Hospital lengths of stay non- elective		3.82	4.5	3.82	No
Hospital readmission rates		7.4	6.4	2.62	Yes
Cancelled operations		0.64	0.9	0.02	Yes
Friends and Family Test – Net Promoter A&E / Emergency Care	68	39	55	90	Yes
Friends and Family Test Net Promoter – Hospital Inpatient	75	69	73	97	Yes

Indicators where CHFT is an outlier on the National Acute Trust Quality Dashboard i.e. performance on this indicator is worse than the national picture by a degree that is unlikely to be explained by random chance

Indicator	Current Local Performance	England Average	Best in England	Opportunity for Improvement
Emergency readmissions - % within 30 days following non-elective admission (Same Specialty)	7.9%	6.8%	-	Yes
A&E attendances - % of patients who leave without being seen	4.0%	2.7%	-	Yes
Adult – British Association of Day Case Surgery Rates	80.4	81.2	-	Yes
Diagnostic Waits - % of patients waiting over 5 weeks	7.2%	6.1%	-	Yes
Delayed Transfers of Care per 1,000 occupied beds - NHS Responsibility	2386	652	-	Yes
Emergency readmission - % babies within 30 days following delivery	9%	7%	-	Yes
Rate of written complaints per 1,000 episodes	7.6	6.3	-	Yes
Workforce - Sickness % - Nurse	5%	4%	-	Yes

The impact on quality for service users and on these whole system performance metrics that could be achieved as a result of implementing the changes described in section 4.2 is provided below.

Benefit	Description	Metrics
Safety	There will be specialist services available to support you in your own home or close to home so that you do not need to be admitted to hospital or to a nursing home. If you or your family have a life threatening illness or accident you will be sure that all the support and expertise you need is available on the same site as the A&E and you will not need to be transferred between hospitals. This will improve your chances of survival and a good recovery. If you are admitted to hospital the services will be organised around you and you will not need to move wards. Senior doctors will be available 7 days a week and specialist care will come to you. You will be able to go home from hospital as soon as possible with the support you need in the community available 7 days a week.	Reduction in avoidable emergency admissions / ambulatory care (composite measure). Reduction in total admissions to hospital Reduction in permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 populations. Reduction in delayed transfers of care from hospital per 100,000 population Improved Hospital Standardised Mortality Rate.
Effectiveness	We will help you and your family to take control of your health and where possible support you to make decisions to manage you own care. This will help you to stay as well as possible and improve your quality of life. We will ensure support and care is integrated around you and that there are no gaps in care. For example people living in a nursing home will not need to be admitted to hospital at end of life; people with mental health problems will have better support for their physical health needs; people with asthma or diabetes are less likely to need to be admitted to hospital to receive the care they need.	Increase in individuals self perceived self function, self-confidence to manage condition and goal attainment scores. Increase the number of people discharged from hospital into reablement services that are still at home 91 days after discharge. Decrease the number of avoidable emergency admissions / ambulatory care (composite measure).
Efficiency	We will use technology to make your experience of care more efficient and convenient. For example you may not need to take time off work or make a difficult journey to hospital to get advice and support. We can use technology such as telehealth and SKYPE to communicate. You will only need to tell your story once and we will have integrated records – so the professionals providing you with support will always have the most up to date information wherever they see you. Your operations and appointment are less likely to be cancelled as we will be able to more effectively manage emergency and planned care demands. By using telehealth and modern technology outpatient visits will be reduced saving time and inconvenience, and visits will only be required for those really needing face to face clinical review. This will reduce the number of times people have to travel to the hospital.	Decrease the number of cancelled operations. Reduce the number of times people have to travel to the hospital.

Benefit	Description	Metrics
More Timely	You will be able to access and benefit from specialist support and care 7 days a week both in the community and in hospital. You will be able to use technology to make accessing care more convenient.	Increase in the number of outpatient appointments delivered via remote technology instead of face to face.
More Choice & Control	You will have the information and support you need so you can choose the care that will meet your needs. You may be offered a personal budget that you can use on the things that will most help you. Care will be available close to home helping you to stay in control and do the things important in your life like supporting your family and going to work. The support provided will be not just medical or nursing but will focus on assisting you to live well in your community for example being able to shop again, reconnect with friends and rebuild social networks.	Patient reported outcome measures and satisfaction surveys. Improved Friends and Family test net promoter scores.
Impact on Social Capital	The proposals described in this Outline Business Case will impact on the wider determinants of health through the partnerships they forge and the approaches adopted to enable self care. This co-produced and bottom up approach lends itself to adding social value. A key enabler for this will be workforce change. By increasing the use of coaching, peer support, and navigation by third sector partners we will have the opportunity to capitalise on the social value that exists in communities.	There is potential to work with Huddersfield University Business School to help evaluate the implementation of the proposed service model. This could utilise work that has already been undertaken to develop a balanced scorecard (called the Innovation Compass). This scorecard provides a potential tool to promote and measure the development of person centred approaches and the extent to which these support wider community benefits and resilience (i.e. the social return on investment).

4.4 The clinical evidence base and clinical support for change

There is a substantial clinical evidence base and clinical support for this case for change. This is provided below and covers the following:

- The National Clinical Advisory Team Recommendations for change
- External Independent Clinical Review of the Outline Business Case
- Local Clinical Support for the Outline Business Case
- Evidence of the positive impact of the partial hospital reconfiguration implemented in 2005/06
- Literature Review - Sources of Evidence

The National Clinical Advisory Team Recommendations

In June 2013 the National Clinical Advisory Team visited Calderdale and Huddersfield Foundation Trust and recommended that a one acute care site option is the best for the future safety, value and sustainability of health care. This change will enable an increased senior doctor (consultant) presence for extended hours over 7 days, minimise the use of locum middle-grade doctors and will reduce the need for inter-hospital transfer of patients. The Team also strongly supported commissioners enhancing primary and community based services for the same high quality reasons and advised that NHS services of the future cannot be of high value to patients unless more care is delivered out of hospital.

The visiting panel in June 2013 included:

Dr David Colin-Thomé NCAT panel chair	Independent Healthcare Consultant. Former GP and former National Clinical Director for Primary Care, Department of Health.
Dr Carol Ewing Paediatric Consultant	Central Manchester University Hospitals NHS Foundation Trust RCPCH Workforce Officer
Dr Berni Garrihy, Emergency Medicine Consultant	The Dudley Group of Hospitals NHS Trust Regional representative

During their visit the panel members met with doctors, nurses and managers from Calderdale and Huddersfield Foundation Trust, GP Clinical Commissioners and Yorkshire Ambulance Services. The NCAT panel concluded and recommended the following:

1. We support a one acute care site option as the best for the future safety, value and sustainability of healthcare. We reached our conclusions drawing on our own knowledge and experience of medical care and equally as we agree with the clinically valid reasons for a one site option presented on our visit on 14 June 2013 and reproduced in this report. If the NCAT recommendation is agreed upon, the actual siting of the separate acute care and planned care option is a local management decision.
2. We also strongly support commissioners enhancing primary and community based services for the same high quality reasons. NHS services of the future cannot be of high value to patients unless more care is delivered out of hospital.
3. We recommend implementing community focused options and General Medical Practitioner access to the community paediatric service, the continuing development of community based services for those patients who have a long term condition, in particular for those who have multiple morbidity and especially if frail and elderly. The systematic adoption of case management, risk stratification methodology and multidisciplinary teams working with general practice and the implementation of the proposed 'virtual wards' would enhance care and lessen the need for in-patient hospital care.
4. Shared clinical records and clinical pathways across two hospital sites and with community based services will strongly enhance care not least in lessening duplication of care.

The rationale that informed the NCAT recommendations in June 2013 is summarised below. This is based on direct extracts from the NCAT Report (copy of the full report is publicly available).

Increased Emergency Medicine Consultant Presence	*The key driver for change is that it is not possible to maintain A&E sites at both CRH and HRI on a 24/7 7 day a week basis. Expected standards of consultant delivered care cannot be met and the 2 A&E services are already under pressure to function due to rota vacancies. There is a significant reliance on locums. Provision of all Emergency care on one site (with a Minor Injuries Unit on the other site) will allow Emergency Medicine consultant shop oor presence 16 hours a day, seven days a week, in line with College of Emergency Medicine guidance, as opposed to the current arrangement where there is no consultant shop oor presence beyond 10pm on weekdays and no consultant shop- oor presence at all at weekends. Recent studies have highlighted increased mortality in patients admitted to hospital out of hours, which is undoubtedly linked to lack of senior clinical input at these times.*
Positive impact on doctor staffing levels	*Amalgamation of the two Emergency Departments (EDs) will also have a positive impact on staffing levels; staffing both EDs currently requires a high level of locum cover. As there is currently a national shortage of Higher Specialist Trainees in Emergency Medicine (EM), and this situation is not expected to improve in the short or medium term, a reconfiguration which optimises use of middle-grade staff and minimises locum requirements is also desirable; this will enhance service delivery and will improve the training experience, due to increased consultant presence. Again, studies show that clinical incidents in ED increase when there is overreliance on locum staff; the EM team at CHFT have provided clear evidence of this by analysis of their own recent red risk clinical incidents. Reconfiguration of ED services to one site should result in increased safety and reduction in clinical incidents, improved quality of service, as well as the economic benefit of reducing very significant locum costs.*
Standards for Children and Young people in Emergency Care settings	*Currently the EDs of CHFT are non-compliant with many of the standards for Children and Young people in Emergency Care settings. Provision of all ED care on one site (with a Minor Injuries Unit on the other site) could allow for the provision of a dedicated Paediatric ED, which would then result in compliance with many, (if not all) of these standards; this is highly desirable. It is clear that in terms of providing sufficient numbers of adequately trained and skilled staff, it would be impossible to provide this level of service on both sites. However, if a Paediatric ED is established on one site, then it is obvious that this site must also be where acute Paediatric services are located, in order to support the activity of the Paediatrics ED. The co-location of Paediatrics ED and acute Paediatrics on one site would however have the benefit of integration of the two services and a more efficient use of resources. In particular, the co-location of Paediatrics and Paediatrics EM will allow for Paediatric emergency medicine (PEM) trained staff to work alongside and support acute Paediatrics which also has significant workforce issues, especially medical staffing.*
Reducing the transfer of medical patients will improve safety	*Reconfiguring of all EM services to one site (with a Minor Injury Unit on the other site) will mandate that all acute specialties required to support that EM, and its role as a Trauma Unit, will need to be co-located on that site. This includes Acute Medicine (whose capacity and workforce is currently spread over the two sites) and surgical specialties such as General Surgery and Trauma and Orthopaedics. The reconfiguration of acute medicine onto one site, to support the activity of the single ED, would also have the advantage of reducing inter-hospital transfers which currently take place frequently for acute medical admissions, when one or other site has reached its maximum medical bed capacity. Eliminating transfers of medical patients will improve safety, optimise patient ow in ED, shorten waits to definitive care, reduce ED breaches of the four-hour target, and reduce the workload on the ambulance service which is currently responsible for providing these transfers.*
Allow for shared care of paediatric surgical patients by surgeons and paediatricians	*Urgent general paediatric surgical and anaesthetic support is patchy at HRI and is dependent on who is on call. Most planned paediatric surgery is carried out at HRI. Paediatric ENT surgery and ophthalmology is provided at CRH. Patients at HRI do not have shared care from a consultant surgeon and paediatrician, and if an urgent consultant paediatric opinion is required out of hours, a consultant paediatrician on call for CRH would have to attend, whilst also being on call for acute paediatrics and neonatology at CRH. If the paediatric service was consolidated on one site, then it would be possible to provide shared senior paediatric and surgical care for patients.*

External Clinical Support for the Outline Business Case

In May 2014 a copy of this Outline Business Case was independently reviewed by external clinical experts (including the Chair of the NCAT panel that visited in June 2013). The purpose of this was to seek their opinion of whether the case for change and the proposed service models (see section 5) provided an evidenced based clinical and service response to the recommendations that were made by NCAT in June 2013. The table below summarises and confirms their support for this.

Outline Business Case reviewed by:	Comments
Dr David Colin-Thomé NCAT panel chair, Independent Healthcare Consultant. Former GP and former National Clinical Director for Primary Care, Department of Health.	*I support the proposed transformation. It is ambitious, well thought through, relevant to the referenced current policy direction and well evidence based.* *The centralisation of emergency and all paediatric care in one hospital is essential for all the reasons given in the report and the attendant evidence base gathered for the report. It is also in line with the recommendations of the NCAT panel of June 2013 which I chaired and of which Bernadette Garrihy was the emergency care specialist adviser. Equally meritorious and evidenced based is the development of a hospital specialising in planned care. The evidence base for separation of acute from planned care demonstrates many benefits including staff specialised in planned care, better access as emergency care demands do not take precedence for beds and clinical care so patient access is not compromised and bed utilisation can thereby be optimised.* *A very well-developed OBC with clinical stakeholder buy in as the necessary basis for delivery of the ambitious whole system transformation.*
Dr Berni Garrihy Emergency Medicine Consultant The Dudley Group of Hospitals NHS Trust Regional representative	*I am, in the main, supportive of the conclusions outlined in "Right Care, Right Time, Right Place-Outline Business Case". In particular I am pleased with the intention, described in the Outline Business Case (OBC) to provide A&E services from a single site, in the Acute and Emergency Specialist Hospital (supported by Minor Injuries Units (MIUs) on the Planned Specialist Hospital Site and the two Community Hubs). This accords with the recommendations the NCAT team made following our visit in June 2013. In light of the on-going national shortage in senior Medical staff in Emergency Medicine (EM) at the level of both consultant and Higher Specialist Trainee (HST), this configuration will allow for the optimal use of existing EM medical workforce in providing safe, effective, quality and timely consultant-driven care to patients.* *The intention to provide a separate Paediatric ED, co-located with the main ED in the Acute and Emergency Specialist Hospital, is also to be welcomed, and concurs with the NCAT conclusions in June 2013. This provision will allow many of the standards for Children and Young People in Emergency Care settings to be met, which is not currently the case.* *The current OBC advises the co-location of acute Specialty Teams on the Acute and Emergency Specialist Hospital site; Medicine, Surgery, Paediatrics, Trauma and Orthopaedics, Critical Care and Gynaecology being the principal ones. This configuration is not merely desirable but necessary to support the activity of the Adult and Paediatric EDs on this site. It is without doubt the best configuration for the further management of unplanned cases which are admitted to the hospital, in its ability to offer the safest, timely and effective care. It allows for the concentration of these specialties to deliver this care and also allows for the concentration of resources, such as radiology, laboratory facilities, blood bank, operating theatres and high dependency beds, necessary for delivery of unplanned care. In addition, it serves to prevent potential safety events and delays in care, which are a risk in the current configuration, where medical patients are frequently transferred between the two sites.*

Outline Business Case reviewed by:	Comments
Professor Sir Alan Craft Sir James Spence Professor of Child Health, Head of Child Health, within the School of Clinical Medical Sciences, University of Newcastle upon Tyne, Consultant Paediatrician, Royal Victoria Infirmary. National President - Royal College of Paediatrics and Child Health – 2003 - 2006	*This is a bold and imaginative plan to provide the best possible services for the population of Calderdale and Greater Huddersfield. It will address many of the issues that are being faced up and down the country of an ageing population with increasing demand and shrinking resources.* *I will specifically comment on the proposals for children. Children deserve and parents expect the best care. There is evidence across the UK that outcomes are not as good as many of comparable European countries and our position as having the worst children's mortality in Europe has just been published. Concentration of specialist resources in a smaller number of sites with dissemination of expertise closer to home are to be welcomed. All obstetric led maternity services on one site with a midwife led unit on the other is sensible but they should be managed as one unit with ready transfer between the two. Neonatal care should be on the acute site with access to a regional neonatal network of beds. All A and E services for children should be on one site and an appropriately staffed minor injuries unit on the cold site. In patient paediatrics to be on the acute site including emergency surgery.*
Dr Mark Spencer GP, Hillcrest Surgery, part of Ealing Clinical Commissioning Group, Clinical Lead for Shaping a Healthier Future Programme, Deputy Regional Medical Director, NHS England (London)	*I support the ambition of this plan and recognise the importance that the proposed changes will have upon the clinical outcomes for patients. This plan highlights how the providers across Calderdale and Huddersfield can build on their previous success of service improvement and go further in reducing variability in patient outcomes as well as create longer term stability.* *Having led the 'Shaping a Healthier Future' reconfiguration programme, across North West London, I support the evidence base for the proposed planned changes and believe they address the NCAT recommendations from the 25th July 2013.*
Dr Chris Clough Consultant Neurologist, King's College Hospital, London	*A single acute hospital for a population of about 400-500,000 makes a lot of sense. This will enable the Trust to bring together the clinical teams across the acute specialties that provide swift access to senior medical opinion. These teams will have increased capacity to deliver care and less sustainability issues. It will also aid the development of subspecialty teams, an increasing feature of the delivery of care in both adult and paediatric medicine. Hence, whilst generalist medical teams are the receiving team, swift access to cardiology, respiratory medicine, gastroenterology and neurology can be improved if all the acute services can be focused on one site. The coming together of the emergency medicine teams should ensure there are sufficient consultants being employed to have a consultant-delivered service.* *The planned specialist hospital can be strongly supported. Elective and cold site centres are a highly efficient way of providing planned surgery. They can reduce the amount of clinical risk and exposure to infection, and can operate at high levels of bed occupancy and throughput.*

Local Clinical Support for the Outline Business Case

During preparation of the Outline Business Case interviews with over 150 doctors, nurses, and therapists that currently provide the services has been undertaken. This has confirmed overwhelming support for the direction of travel proposed. Respondents identified that the proposals described in this business case will improve patient experience and safety. They provided examples of how this would happen such as reducing length of stay and improving early access to senior decision makers through 7 day working. Respondents also described the proposals as providing higher quality, safer care than the current model through greater standardisation, opportunities to improve recruitment and opportunities to integrate secondary care further into the community. Examples of comments made by doctors, nurses and therapists that currently provide the services is shown below.

The emphasis on the model of care and integrated teams with GPs in the centre is excellent. The opportunity to work with consultant colleagues in the community can only be a good thing. I fully support this development. **Dr Steven Warner – GP & Medical Advisor, Locala**	'This makes services more sustainable, it will allow very senior care to be on site for longer, 7 days a week'. **Dr John Naylor, Consultant in Geriatric Medicine. Calderdale and Huddersfield NHS Foundation Trust**	'This shared model with community and hospital services allows better understanding and more person centred care planning' **Barbara Schofield, Nurse Consultant, Older People Calderdale and Huddersfield NHS Foundation Trust**	'The on-going discussions we have re service transformation will not come to the right model without this type of collaboration /integration as well as working with the primary care. **Nisreen Booya, Medical Director, SWYPFT**
'It will ensure high quality care by providing the right care in the right place 24/7. This is good for patients, for me and my family' **Janette Cockroft, Matron Medical Admissions Unit Calderdale and Huddersfield NHS Foundation Trust**	'This will allow consultants to be more active in the community as an educator and advisor on care management.' **Sal Uka Consultant in Paediatric Medicine Calderdale and Huddersfield NHS Foundation Trust**	Supporting people to support themselves to be independent and fulfil their lives is at the heart of a therapists work. The way of working described in the model including self-care is entirely consistent with this. Combined with truly integrated teams makes me feel very positive about the future. **Carrie Bailey, Locala Therapist**	Care and compassion in community nursing is enhanced not only by being able to work closely with colleagues in health and social care, but by supporting the people we care for to care for themselves. This Strategic Outline case takes this forwards and I welcome it. **Helen Frain, Locala Senior Nurse**

In addition the work that has been undertaken to develop this Outline Business Case has engaged many provider stakeholders across the health and social care economy to discuss the proposed service models (this includes general practitioners, pharmacy providers, social care providers, Yorkshire Ambulance Services, 111, and third sector organisations). Over 120 people representing stakeholder organisations that were engaged have confirmed general support for the proposed service model.

Evidence of the positive impact of the partial reconfiguration of hospital services implemented in 2005/06

In 2005/06 a partial reconfiguration of some hospital services was implemented to provide acute surgery and trauma services at Huddersfield Royal Infirmary and consultant led obstetric services at Calderdale Royal Hospital. These changes were made for the same clinical reasons described in this Outline Business Case i.e. that the concentration and co-location of specialist expertise was necessary to improve the safety and clinical outcomes of these services. The clinical evidence base for this was recognised and supported by Commissioners at that time. The changes made in 2005 have resulted in improved outcomes. Data published by Dr Foster shows that since 2005/06 to 2012/13 there has been a significant reduction in surgery and trauma service mortality rates. This is shown below.

Speciality	Hospital Standardised Mortality Rate (HSMR)	
	2005/06	2012/13
General Surgery (non-elective)	97.2	64.1
Trauma / Orthopaedics (non-elective)	90.3	53.5

The partial reconfiguration of services implemented in 2005/06 has therefore clearly demonstrated the clinical benefits that can be achieved through the reorganisation of specialist hospital services. The proposals described in this Outline Business Case are to deliver the full reconfiguration of all acute and emergency services on a single hospital site. The clinical evidence supports that this will enable more people to benefit from improvement in mortality and recovery outcomes.

Literature Review of the Evidence Base

Case for Change Issue	Summary of Rationale	Examples of Evidence
Self Care and Self-Management	There is an evidence base that self-care and self-management can improve people's knowledge about their condition and care, how they feel about their condition, and their ability to cope day to day. This results in both improved confidence to self-manage and quality of life. There is evidence that about 80 per cent of health problems can be treated or managed at home. A Department of Health study found that self care courses can be effective at improving patient outcomes and also reducing subsequent utilisation of health services. The evidence suggests it may be possible to achieve a seven per cent decrease in GP consultations, a sixteen per cent reduction in A&E attendances, and annual cost savings per patient of £1,800.	➤ The Health Foundation May 2011. Helping people help themselves, A review of the evidence considering whether it is worthwhile to support self-management. ➤ Expert Patients Programme Community Interest Company, 2013. The Evidence: Self Care Reduces Costs and Improves Health. ➤ Department of Heath 2005 Self Care – A Real Choice: Self Care Support – A Practical Option ➤ Phillips et al 2010. Self care reduces costs and improves health - the evidence ➤ Sainsbury Centre for Mental Health 2008: Geoff Sheperd et al. Making Recovery a Reality. ➤ Sainsbury Centre for Mental Health 2012. Rachel Perkins et al. Implementing Recovery through organisational change. ➤ Journal of Epidemiology & Community Health 2007 61:254-261 Kennedy, A et al The effectiveness and cost effectiveness of a national lay-led self care support programme for patients with long-term conditions: a pragmatic randomised controlled trial
Integrated Community Services and reduction of hospital admissions.	There is evidence that ensuring that people receive integrated and coordinated care close to home delivers benefits associated with the experience and quality of care, a reduction in hospital admissions, shorter lengths of stay in hospital and a reduction in out-patient attendances. Examples of this are Torbay Care Trust and Kaiser Permanente and the Veterans Health administration in the US. The Veterans Health Administration reduced bed day use by over 50 per cent. Kaiser Permanente uses one-third of the bed days the NHS uses for comparable conditions for people aged 65 and over. Nationally it is estimated that one in five patients could be treated equally well or better out of hospital. Nationally 40 per cent of patients who attend an A&E department are discharged requiring no treatment. Many of these individuals could have been helped just as well closer to home.	➤ The Kings Fund 2011; The evidence base for integrated care ➤ The Kings Fund, 2010; Avoiding Hospital Admissions, Lessons from Evidence and Experience. ➤ The Kings Fund, 2010; Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme ➤ NHS England 2013 The Keogh Urgent and Emergency Care Review, ➤ The Kings Fund 2014, Nigel Edwards. Community services: how they can transform care. ➤ Sainsbury Centre for Mental Health 2008: Geoff Sheperd et al. Making Recovery a Reality. ➤ Sainsbury Centre for Mental Health 2012. Rachel Perkins et al. Implementing Recovery through organisational change. ➤ The Kings Fund 2013. Nicholas Timmins, Chris Ham. The quest for integrated health and social care. A case study in Canterbury New Zealand. ➤ Health Service Management Centre. University of Birmingham, 2009. Chris Ham. Integrating Care and Transforming Community Services. What Works? Where Next? ➤ The Kings Fund 2013. Chris Ham. Making Integrated Care happen at scale and pace.

Case for Change Issue	Summary of Rationale	Examples of Evidence
Integrated Community Services and reduction of hospital admissions. (continued)	In September 2013 the Royal College of Physicians published the report Future Hospital: Caring for Medical Patients. This provides an evidence base and case studies of the benefits associated with changing the way we care for people with medical needs by integrating care across hospital, community and social care service. This report provides evidence that we can reduce the number of people that need to be admitted to hospital by specialist medical teams spending part of their time working in integrated community teams providing proactive care planning and coordinated support for people. The evidence also shows there is a clear link between mental and physical health. Sixty per cent of people over the age of 65 who are admitted to hospital have, or will develop, a mental disorder during their admission. On average, people with mental illness die five to ten years younger than the general population. There is strong evidence that provision of integrated physical and mental health services, offering liaison psychiatry interventions both in hospital and the community can improve patient outcomes and reduce healthcare costs.	➤ The Kings Fund 2011. Chris Ham. Integrated Care. What is it? Does it work? What does this mean for the NHS? ➤ Nuffield Trust, 2012. Integrated Care for patients and populations: improving outcomes by working together. ➤ Nuffield Trust, 2011. Sara Shaw, Rebecca Rosen, Benedict Rumbold. An overview of integrated care in the NHS: What is integrated care? ➤ The Royal College of Physicians 2013. Future Hospital: Caring for Medical Patients. ➤ Royal College of General Practitioners (2011) Care Planning: Improving the Lives of People with Long Term Conditions ➤ The Kings Fund 2010. Avoiding hospital Admissions: What does the research evidence say?; Kings Fund ➤ Health Affairs 2011. How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts. Brent C. James and Lucy A. Savitz ➤ The Kings Fund 2011. Peter Thistlewaite. Integrating Health and Social Care in Torbay. ➤ HM Government. 2011. No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.
Specialist Hospitals and A&E Services	The National Clinical Advisory Team (that visited Calderdale and Huddersfield Foundation Trust in June 2013) recommended a one acute care site option as the best option for the two hospitals in Halifax and Huddersfield to secure future safety of patients, the best use of resources and for keeping services local into the future. There is evidence that consistent services across all seven days of the week are required to provide high quality and safe care. Reduced service provision, including fewer consultants working at weekends, is associated with England's higher weekend mortality rate. There is evidence that when people have a serious or life threatening injury or illness, to improve the likelihood of survival and better recovery outcomes it is important that the right hospital facilities and acute medical and surgical expertise are co-located with emergency services and provided twenty four hours a day, seven days a week.	➤ National Clinical Advisory Team June 2013. Report of visit to Calderdale and Huddersfield Foundation Trust. ➤ NHS England 2013 The Keogh Urgent and Emergency Care Review, ➤ NHS England 2013 High quality care for all, now and for future generations: Transforming urgent and emergency care services in England. The Evidence Base from the Urgent and Emergency Care Review. This document cites 376 sources of evidence. ➤ NHS England 2013. NHS Services Seven Days a Week. ➤ The Royal College of Physicians 2013. Future Hospital: Caring for Medical Patients. ➤ The College of Emergency Medicine (2013) The drive for quality; How to achieve safe, sustainable care in our Emergency Departments? ➤ The College of Emergency Medicine (2012) Reconfiguration of Emergency Care System Services. ➤ Emergency Medicine Journal 2012;29:366-371Sen, A. et al. The impact of consultant delivered service in emergency medicine: the Wrexham Model.

Case for Change Issue	Summary of Rationale	Examples of Evidence
Specialist Hospitals and A&E Services (continued)	There is evidence that for seriously ill patients treatment starts in the ambulance and paramedics will sometimes drive past the nearest A&E to get the patient to the right place. The recent national reorganisation of major trauma services which reduced the number of sites showed a 20% increase in survival despite increased travel time. Similar results have been reported for cardiac and stroke patients. There is also evidence locally. In 2005/06 non-elective general surgery services and trauma and orthopaedic services were transferred from Calderdale Royal Hospital and provision of these services was consolidated at Huddersfield Royal Infirmary. Data published by Dr Foster shows that since 2005/06 to 2012/13 there has been a significant reduction in mortality associated with this.	➤ Emergency Medicine Journal, 2010;27:262-265 White AL, Armstrong PAR, and Thakore S. The impact of senior clinical review on patient disposition from the emergency department. ➤ Centre for Health Economics University of York. 2011. Rosalind Goudie, Maria Goddard. Review of the evidence base on what drives economies of scope and scale in the provision of NHS services focusing on A&E and associated hospital services.
Putting People in Control	Research has reported that people with low levels of engagement and health knowledge: are at greater risk of hospitalisation and have longer hospital visits; have higher rates of admission to emergency services; are less likely to adhere to prescribed treatments and self-care plans; have more medication and treatment errors; have less knowledge of disease management and health-promoting behaviours; have decreased ability to communicate with healthcare professionals and share in decision-making; are less able to make appropriate health decisions; make less use of preventive services, and; incur substantially higher healthcare costs.	➤ The Health Foundation 2006. Patient Focused Interventions: A Review of the Evidence
Whole system Change and leadership	There is evidence that leadership for large scale improvement involves reforming the whole system from ward and hospital department to the GP, community services and social care, involving the whole spectrum of care professionals through a sustained leadership effort. There is evidence of the leadership approaches and systems that have been successful in delivering improvement and sustaining high performance.	➤ The Kings Fund 2012 Leadership and Engagement for Improvement in the NHS. ➤ The Kings Fund 2011. The Role of Leaders in High Performing Health Care Systems. ➤ The Health Foundation 2011. 1 ©1000 Lives Plus, 2011 Quality, Development and Leadership - Lessons to learn from Jönköping http://plus.lj.se/index.jsf?childId=7378&nodeId=35103&nodeType=12#Documentation_festival_2004
Technology	There is evidence that the use of information technology by members of the public, patients and health and social care professionals can improve the safety, quality and efficiency of services. The National Demonstrator Sites provide a clear evidence base that the use of technology can deliver a reduction in A&E attendances, hospital admissions, and mortality rates and also improve service user experience.	➤ The Nuffield Trust, 201. The Impact of Telehealth on Use of Hospital Care and Mortality, ➤ The Department of Health 2011. Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS. ➤ BMJ 2012;344:e3874 Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial ➤ Price Waterhouse Coopers –report for the Department of Health 2013. A review of the potential benefits from the better use of information technology in health and social care.

4.5 Evidence of responding to the views of the public on the need for service change

Over the past two years all seven organisations involved in the Calderdale and Huddersfield Strategic Review have been working together to extensively engage service users, members of the public and stakeholders to develop proposals for service improvement. This has been concerned with asking people: Can we do things differently but maintain high quality services? Can we keep people out of hospital for everything but the most serious illness by improving the way we care for them at home? The table below summarises the public engagement activity over the past two years and the common themes raised by members of the public about what matters them.

Number of People Engaged (approximate figures)	Consistent Themes Raised
7,000 people in direct conversations 25,000 people contacted (reach of engagement) 12,000 people's comments, complaints, and suggestions analysed from across all seven partner organisations.	• Care Closer to Home • More Care Out of Hospital • Integrated and Coordinated Care • Better Use of Technology • Timely and consistent access to services • Coordinated and integrated care • Involve us in decisions about our care and in planning care • People only have to tell their story once and all the information that is needed for professional staff to support the right decisions for people's care is available.

The case for change described in this Outline Business Case has used this feedback to inform the proposals ensuring that they are underpinned by a strong patient, service user, and public and stakeholder voice. The table below provides examples of how the proposed service changes described in this Outline Business Case (see section 5) correlate to the views and issues that have been raised by service users and members of the public.

Public Views	Summary of how this business case responds (see section 5)
Local people have told us they want more options and support for self care and self-management.	Community locality teams will be established with staff that are trained and skilled to enable people to self-manage and self-care. The Locality teams will offer support to individuals, families and communities to undertake activities that will enhance their health, prevent disease, limit illness and restore health.
Local people have told us they want: • all agencies working together • more staff working with and supporting local people in their own home and community. • hospital services provided in community settings. • specialist staff working in GP practices and one point of access for people with a long term condition. • Staff to be trained (or have a matron lead) who understands different disabilities and mental health.	The community Locality teams will provide 7 day integrated physical, mental health and social care support in people's homes or close to home. This will include a single point of access. Specialist doctors, nurses, therapists and social care professionals will work with the teams to provide expert advice and support for people. More services that are currently only provided in hospital will be available in the community. Two specialist community hubs will be established to enable this. Specialist services will also work with GP practices and in other community health centres.
Local people have told us that they want more staff in hospitals.	Changes to hospital services will enable more effective delivery of workforce capacity. This will enable 7 day working and the increased presence of senior doctors for extended hours.
Local people have told us they want us to use technology better and invest in future technology.	The service changes will be supported by the use of shared records and the use of technology (such as telehealth) to support care delivery.

Publication of the Strategic Outline Case in February 2014 has attracted significant public interest and concern regarding the possible changes in the future provision of hospital services. The comments and views of local people are important and we recognise the strength of the views and concern people have expressed regarding local access to high quality A&E services. The aim of this OBC is to enable the provision of an increased range of services close to where people live and to ensure that the provision of hospital services including A&E is of a consistently high standard. The proposed changes in the configuration of A&E services has taken careful account of the need to balance access and the significant clinical evidence that patient safety and improved survival and recovery outcomes could be achieved through the concentration of planned and unplanned services on two separate hospital sites.

4.6 Evidence of how the case for change aligns with clinical commissioning intentions

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

The Health and Social Care Strategic Review vision states:

'to do this we need to change the way we provide health and social care service so that:

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

This Outline Business Case is consistent with this vision. The table below highlights commissioning priorities that are identified in the Calderdale Commissioning Prospectus and the Greater Huddersfield Clinical Commissioning Prospectus and how this Outline Business Case addresses these.

Calderdale Clinical Commissioning Group Commissioning Intentions and Priorities	How this Outline Business Case Addresses these Priorities
Reduced reliance on unplanned hospital based care. Maximise integrated, community based planned care.	There will be more specialist services, and integrated physical, mental health and social care community locality teams to support people in their own home or close to home. These services will be available 7 days a week. This will reduce the number of people that need to be admitted to hospital.
Deliver best in class urgent, critical, specialist, community and primary care models which provide specialist knowledge and facilities to deliver 24/7, high quality care.	The establishment of two specialist hospitals (for planned and unplanned care) and integrated community locality teams that will work closely with GPs is based on a significant clinical evidence base that this will enable improvement in the safety, quality and outcomes of care. The model of care responds specifically to the National Clinical Advisory Team recommendations regarding this. The changes will allow for the optimal use of the existing specialist workforce in providing safe, effective, quality and timely (7 day) care for patients.

Calderdale Clinical Commissioning Group Commissioning Intentions and Priorities	How this Outline Business Case Addresses these Priorities
Integrate paediatric care. High quality paediatrics - integrating medical and surgical care (inc assessment, and maximising community based delivery).	The service model proposed will provide a separate Paediatric Emergency Department, co-located with the main Emergency Department in the Acute and Emergency Specialist Hospital. This provision will allow the standards for Children and Young People in Emergency Care settings to be met, which is not currently the case. It will also mean that paediatric medical and surgical services are co-located on a single site allowing for integrated and shared care of children with medical and surgical needs. These changes directly respond to NCAT recommendations in June 2013. As well the service model will enable more specialist paediatric care to be provided out of hospital in shared care models with general practice.
Develop community based unscheduled care Facilities. Community provision for minor injuries.	The proposed service model will establish minor injuries services at Todmorden Health Centre and Holme Valley Memorial Hospital. Minor injuries services will also be available at the two hospital sites (planned and unplanned).
Integrated medical and surgical assessment. Single access point for adult medical and surgical assessment. Pathways focusing on care provided outside hospital wherever possible, and shared care.	The service model will enable the co-location of acute hospital specialty teams on the Acute and Emergency Specialist Hospital site (e.g. Medicine, Surgery, Paediatrics, Trauma and Orthopaedics, Critical Care and Gynaecology). Currently these services are split across two sites. This co-location will enable integrated medical and surgical management of unplanned cases which are admitted to the hospital and offer safe, timely and effective care. The service model will also establish integrated physical, mental health and social care community locality teams to support people in their own home or close to home. These services will be available 7 days a week and include the provision of more specialist services out of hospital. This will reduce the number of people that need to be admitted to hospital.
Care Management and integrated care processes which deliver results which are in line with the best in the country.	The proposed community locality teams will provide proactive care planning and care coordination. Specialist doctors, nurses and therapists will work with GPs to support care planning to ensure optimal care and avoidance of crises. Anticipatory or emergency care plans will be agreed.
Electronic records. Shared electronic planning, single shared assessment, care co-ordination and record keeping, maximising choose and book and advice and guidance.	The service model proposed will ensure that patient information and clinical decision support tools are available to staff to enable them to deliver care in people's homes and in hospital. The multi-disciplinary community locality teams will have a single integrated shared record and undertake agreed single joint assessment processes. There will be the ability for this record to be viewed and used in all care settings including people's homes, in hospital, in hospices, in residential care and nursing homes and in GP practices.
Pathways integrated across multiple providers Integrated pathways delivering care across the care continuum – from specialist to low level support – led by a 'host' provider	This Outline Business Case has been jointly developed by CHFT, SWYPFT and Locala. It describes the provision of future models of care that are fully integrated across provider organisations and care settings.
Promote independence and resilience through effective use of assistive technology Maximise opportunities for integrated; tele-consultation, tele-health and tele-care in a range of settings	The service model proposes an increased use of telehealth and telecare to deliver services in more effective and convenient ways for people.

Calderdale Clinical Commissioning Group Commissioning Intentions and Priorities	How this Outline Business Case Addresses these Priorities
Significant increase in proportion of care provided at home or close to home Shift in balance of provision away from hospital based care into integrated community models with flexible in-reach/ outreach.	This Outline Business Case describes a service model that will enable a significant shift and investment of resources from hospital care to provide specialist and integrated services in people's homes and the community. Specifically this will include hospital in-reach and out-reach models of care delivery.
Focus on prevention and lifestyle changes – utilising every contact counts to maximise impact on both children and adults	The service model will provide more options and support to enable self care and self-management including more information about how to maintain health and wellbeing and avoid preventable conditions.

Greater Huddersfield Clinical Commissioning Group Commissioning Intentions and Priorities	How this Outline Business Case Addresses these Priorities
Improving the quality of healthcare services and each individual's experience of care.	The service model proposed in this Outline Business Case will improve people's experience of care. For example: The community locality teams will provide integrated and specialist services to support people in their home or close to home so that they do not need to be admitted to hospital or to a nursing home. The establishment of a specialist acute and emergency hospital will mean that for people that have a life threatening illness or accident all the support and expertise needed will be available on the same site as the A&E and people will not need to be transferred between hospitals. For people that are admitted to hospital the services will be organised around them and people will not need to move wards. Senior doctors will be available 7 days a week and specialist care will come to people. People will be able to go home from hospital as soon as possible with the support needed in the community 7 days a week.
Ensuring our providers deliver high quality services.	The establishment of two specialist hospitals (for planned and unplanned care) and integrated community locality teams is based on a significant clinical evidence base that this will enable improvement in the safety, quality and outcomes of care. The model of care responds specifically to the National Clinical Advisory Team recommendations regarding this. The proposed changes will enable achievement across a number of key quality and clinical standards (see section 4.3).
Ensuring our patients get timely & appropriate access to services Increasing service integration across health & health & social care; primary & secondary care.	The service model described in this Outline Business Case offers fully integrated care and support for people in Greater Huddersfield and Calderdale that crosses the boundaries between primary, community, hospital and social care. The changes will allow for the optimal use of the existing workforce in providing safe, effective, quality and timely (7 day) care for patients.

Greater Huddersfield Clinical Commissioning Group Commissioning Intentions and Priorities	How this Outline Business Case Addresses these Priorities
Addressing the increasing demands on health and social care (demographics and expectations).	This Outline Business Case responds to the increasing demands on health and social care. It recognises the opportunity to reduce hospitalisation and improve efficiency in the use of hospital services by delivering community based integrated support for people with long term conditions and by applying efficient working in the hospital (e.g. through reduction in length of stay and admission avoidance). The Outline Business Case also recognises there is scope to improve the efficiency of community based services e.g. through service improvement approaches and optimising the use of technology. The Outline Business Case also identifies that more people can be supported to self-care and manage their condition reducing the overall reliance on statutory services through the promotion of alternative capacity and models of self-care.
Supporting people to manage their conditions and live independently	The service model described in this Outline Business Case will offer more self care and self-management support. This will improve people's knowledge about their condition and care, how they feel about their condition, and their ability to cope day to day. This will improve people's confidence, quality of life and independence.
Making sure that the right care is delivered at the right place at the right time when people need professional help.	The proposed service model will enable achievement of right care, right place, right time. Services will be more effectively co-located in two specialist hospitals and there will be an increased level of integrated and specialist services provided in the community. The changes in the configuration of services will enable optimal use of the existing workforce and facilitate the delivery of 7 day working.
Make sure people can access high quality, safe, specialist care when needed	The proposed service models will improve access to specialist care both in the community and in hospital over 7 days.
Building sustainable health and social care systems by making the best use of limited resources.	The proposals in this Outline Business Case will support sustainable delivery of services into the future. There is a significant clinical evidence base that the proposed service models will enable improvement in the safety, quality and outcomes of care. In addition the proposals will reduce the number of hospital beds, by improving internal efficiency and by providing alternative provision in the community. The proposals will improve the efficiency and productivity of community services by having an integrated provider service based on community localities. The service model will reduce the overall reliance on statutory services through the promotion of alternative capacity and models of self-care.

4.7 What the case for change could mean for patient choice

Patients should have access to the right treatment, at the right place and at the right time, and be offered a choice of treatment as a matter of course, except where this is clinically inappropriate or unfeasible. It would not be sensible for patients to be able to choose services that fell far short of modern healthcare standards, or where services are not able to treat patients safely.

The proposals in this Outline Business Case represent increased integration of the provision of physical, mental health and social care services both in the community and in hospital. The Health and Social Care Act 2012 (2012 Act) places a duty on CCGs to promote integration. CCGs have a duty to ensure that the provision of health care services is integrated with the provision of health related services and social care services. The introduction of the Better Care Fund from 2015/16 onwards is a significant step towards achieving this and clearly signals that the pooling of health and social care resources to jointly commission services is the national direction of travel.

The proposed changes in community services described in this business case will potentially provide a significant improvement in choice and control for people. This will include more information, service options and support available in their own home or close to home. The proposals will enable people to access personalised help and support to meet their needs.

The proposed changes in the configuration of emergency and hospital services described in this business case has taken careful account of the need to balance access and the significant clinical evidence that patient safety and improved outcomes can be achieved through the concentration of planned and unplanned services on two separate sites. According to the evidence this will result in better treatment and reduced mortality from serious illnesses and injuries.

5. The Strategic Case: New Service Models

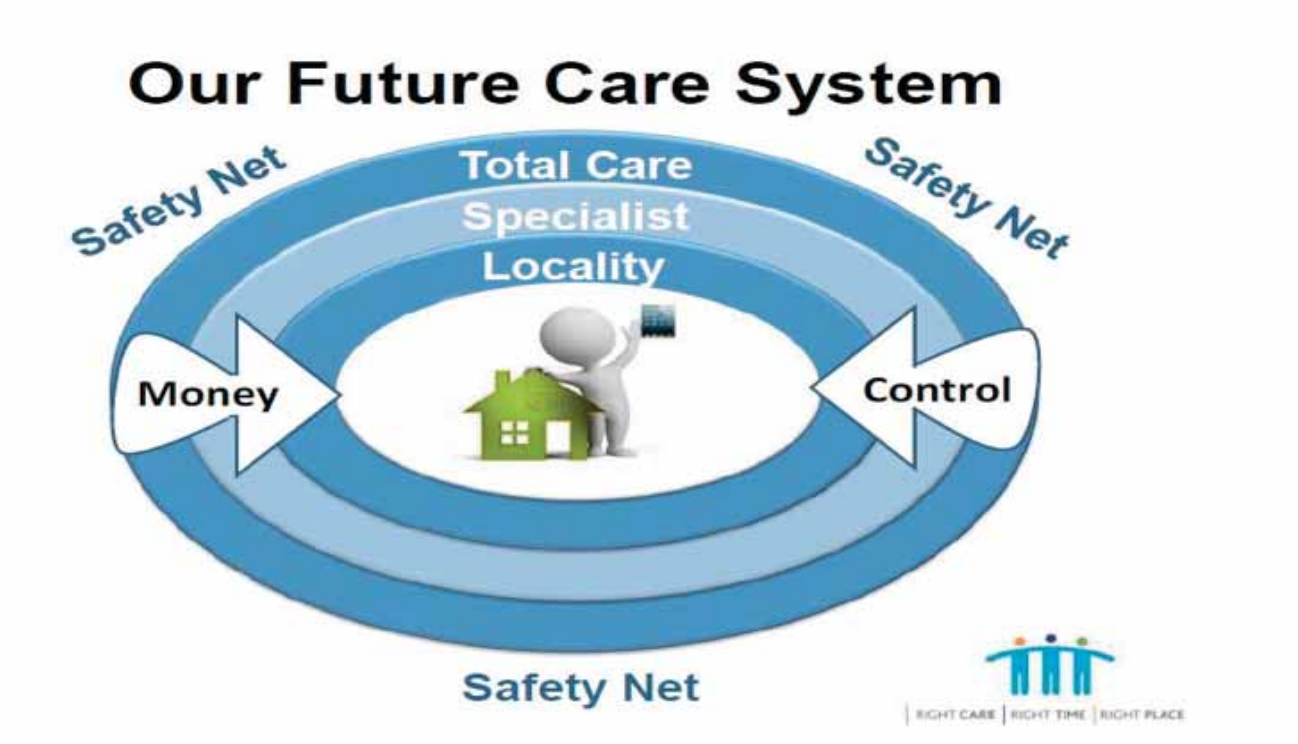
5.1 Principles and Goals

The aim of the service proposal described in this Outline Business Case is to offer integrated care and support for people in Greater Huddersfield and Calderdale that crosses the boundaries between primary, community, hospital and social care.
Integrated care means improving the quality for individual patients, service users and carers to ensure that services are well coordinated around their needs and that their views and choices are the organising principle for the delivery of support; i.e. putting the patient at the centre of everything we do.

This will require the whole system working together from primary to community to hospital to social care, and; whether working as public employees, independent practitioners, or private and not-for-profit contractors; recognising that there is one integrated system that will support people to achieve the best possible outcomes within the resources available.
To do this will require us to equip and support staff to work in new ways and establish new behaviours. This proposal section of the Outline Business Case therefore also describes how staff will be supported to embed the cultural change needed and the important role of new technologies to enable this.

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

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



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

5.2 Overview of the Service Model

The proposal for changing services across Huddersfield and Calderdale was described in the Strategic Outline Case and is to establish:
Community Locality Teams

The majority of services in the future will be provided close to home by community locality teams. The teams will work closely with GPs to provide integrated physical health, mental health and social care for extended hours over 7 days a week. This includes 24 hour rapid response services for times when someone's condition deteriorates or there is an increased social care need, but without the need to go to hospital. The teams include specialist doctors, senior nurses, therapists and social care that will be able to provide advice, treatment and care in the community. People will stay well at home and either not need to be admitted to hospital or enable people to be discharged home earlier from hospital. The teams will support people to make full use of technology so that patients and team members have the right information to support care delivery. This will include telehealth, and mobile working.

Two Specialist Community Centres / Hubs

There will be two Community Hubs for the provision of integrated and specialist community services. One of the hubs will be Todmorden Health Centre in Calderdale and the other one will be Holme Valley Memorial Hospital in Kirklees. These hubs in the future could offer more local services such as: walk in centres; outpatient appointments; pharmacy; mental health services; patient support and social groups; sexual health services; community nursing and therapy services, and diagnostics (blood tests and x-ray). The centres will offer a focus for social and patient support activities and will work with voluntary, community and self-help groups to do this.

Two Specialist Hospitals
There will be two specialist hospitals in Greater Huddersfield and Calderdale. Both hospitals will serve vital roles in the years ahead and will continue to provide a range of general hospital services at both sites. This will include outpatient care for children and adults, urgent care and minor injuries, midwifery led maternity units, and ante-natal and post-natal care. Both hospitals will also provide specialist psychiatric liaison services. This means that the services that people use most frequently will continue to be available at both hospitals or in a local community setting.

In addition each hospital will have a specialist focus. One hospital will specialise in acute and emergency services and one hospital will specialise in care for people who need planned treatments or surgery (e.g. hip or knee operations).

The acute and emergency hospital will specialise in providing treatment for people who have a serious or life threatening emergency care need and will provide accident and emergency services. Trauma, major surgery, critical care, acute general and specialist medicine, inpatient paediatric services and complex maternity services will be provided at the acute and emergency hospital. The hospital will bring together on one site the necessary acute facilities and expertise, twenty four hours a day and seven days a week to maximise people's chances of survival and a good recovery. For example, if you or a member of your family are experiencing a loss of consciousness; acute confused state and fits that are not stopping; persistent, severe chest pain; breathing difficulties; severe bleeding that cannot be stopped, the Acute and Emergency Specialist Hospital is where you would be taken or directed to.

The planned specialist hospital will provide scheduled support, treatments and surgery. It will also provide urgent care and minor injury services that will offer walk-in access. For example, if you or a member of your family are requiring treatment for sprains and strains; broken bones; wound infections; minor burns and scalds; minor head injuries; insect and animal bites; minor eye injuries; injuries to the back; shoulder and chest, you will be able to get care at the Planned Specialist Hospital.

The following table summarises the key elements of the overall model of care that is proposed in this business case.

Overall Models of Care

What will the Changes Mean for Adults and Older People's Services?
The table below shows an overview of what the service changes described in the Outline Business Case will mean for Adult and Older People's care and support in Calderdale and Greater Huddersfield.

Adults and Older People's Services		
From now……	**To services in the future……..**	
Routine care and support available 5 days a week 9-5. Some urgent or essential care available 7 days a week. Some specialist nursing support available 5 days per week 9-5.	**Home** 	More care available at home 7 days a week – nursing, therapy, social care, mental health. GPs will have access to specialist medical and nursing advice to support providing care to enable more people to stay at home. Some home visits will also be available. More support to self-manage and self-care to stay well at home. More use of technology to enable convenient care and support at home. Provision of equipment 7 days a week to enable independence at home. Crisis response available 24 hours 7 days a week. People will have anticipatory care plans to support appropriate response in a crisis or emergency. More short term intensive support available to help people to stay at home. Support for carers.
More than 20 separate professional teams working across Calderdale and Huddersfield (e.g. district nursing, health visiting etc.). Integrated mental health and social care teams. Twenty four hour and seven day district nursing services. Day time (9-5) therapy services 5 days a week (e.g. physiotherapy, occupational therapy). Access to specialist medical opinion mostly via hospital with some clinics at Todmorden. Multiple referral and access points. Some examples of support for self care. Some examples of use of technology to support care e.g. in Calderdale telehealth pilot within the Respiratory team. Separate patient information and assessment systems used across hospital, community and GP services.	**Locality CommunityTeams** 	Locality teams offering fully integrated physical, mental health and social care. Services available 7 days a week and extended hours. Single point of access for community services. Specialist doctors, nurses and therapists will work in the community with GPs. The locality teams will be skilled and trained in enabling people to self-manage and self-care. Early intervention for people that have multiple needs to ensure care is targeted for the most vulnerable people. Proactive care planning and care coordination. Carers' assessments and carers support will be provided. Routine use of telehealth services for patients with long-term conditions to enable more responsive and timely care. Single information system and assessment process so that people only have to tell their story once.

Adults and Older People's Services		
From now……	**To services in the future……..**	
Some specialist clinics and services provided at Todmorden and Holme Valley Memorial Hospital. Majority of specialist services, diagnostics and minor injury services provided at Calderdale Royal Hospital and Huddersfield Royal Infirmary.	**Community Hubs**  	Two specialist community Hubs at Todmorden Health Centre and Holme Valley Memorial Hubs will offer a focus for social and patient support activities and work with voluntary, community and self-help groups to do this. Local provision of enhanced services to support the management of more specialised conditions which can be managed outside of hospital, including urgent or rapid assessment clinics. Provide outpatient services across a range of specialities. Provide minor surgical day case procedures. Provide mental health and psychological therapy support and sessions. Provide a range of diagnostic services. Provide minor injury services for adults..
Two general hospitals at Calderdale Royal Hospital and Huddersfield Royal Infirmary. Accident and Emergency services and medical assessment services are provided on both sites. Acute surgery and trauma services, oncology and haematology are provided at Huddersfield Royal Infirmary. Stroke inpatient services, cardiology inpatient services and complex maternity services are provided at Calderdale Royal Hospital. The different services provided at each local hospital means that for some treatments Calderdale residents will access services at Huddersfield Royal Infirmary and also that Huddersfield residents will access services at Calderdale Royal Hospital. For example: 59% of Huddersfield residents currently go to Calderdale Royal Hospital for elective in patient procedures. 20% of emergency admissions for Huddersfield residents go to Calderdale Royal Hospital. 22% of Calderdale residents' emergency admissions go to Huddersfield Royal Infirmary. Every day up to six patients (about 2200 per year) need to be transferred between the two hospital sites to be able to meet their clinical needs. People who suffer a myocardial infarction or major trauma that are picked up in an ambulance in Calderdale and Huddersfield are taken directly to specialist centres outside of the local area in Leeds or Bradford. This is to ensure that they go directly to the specialist hospital centres that can provide all the services they need.	**Specialist Planned Care Hospital** 	Specialise in providing scheduled support and treatments, outpatients and diagnostic services. Provide planned operations for adults (e.g. cataracts, hip and knee surgery). Provide nurse led minor injury services that will offer walk-in access. For example, if you or a member of your family are requiring treatment for sprains and strains; broken bones; wound infections; minor burns and scalds; minor head injuries; insect and animal bites; minor eye injuries; injuries to the back; shoulder and chest, you will be able to get care at the Specialist Planned Hospital.
	Specialist Acute and Emergency Hospital 	Specialise in providing treatment for people who have a serious or life threatening emergency care needs. The hospital will bring together on one site all the acute medicine and surgical services 24/7, to maximise people's likelihood of survival and a good recovery. This will reduce or eliminate the need for people to transfer between sites. For example, if you or a member of your family are experiencing a loss of consciousness; acute confused state and fits that are not stopping; persistent, severe chest pain; breathing difficulties; severe bleeding that cannot be stopped, the Acute and Emergency Specialist Hospital is where you would be taken or directed to.

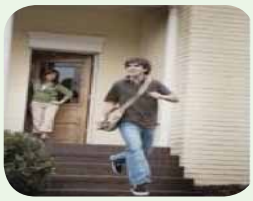
What will the Changes Mean for Children's and Young People's Services?
The table below shows an overview of what the service changes described in this Outline Business Case will mean for Children's and Young People's care and support in Calderdale and Greater Huddersfield. These changes are consistent with the vision statement from the Calderdale and Greater Huddersfield Health and Social Care Strategic Review, Children's Working Group i.e.

"Every Child will have a healthy start and continue to lead a safe, happy life with every opportunity to achieve their potential within their families and communities"

Children's and Young People's Services

From now……	To Services in the Future……	
Routine care and support available 5 days a week 9-5. Some urgent or essential care available 7 days a week. Some specialist nursing support available 5 days per week 9-5.	**Care Closer to Home** 	An increased range of services for children provided in the community and at home. This wil include. Self-Care - educating and encouraging families and Children and Young People to maintain healthier lifestyles whilst understanding how and when to seek appropriate professional support. Universal offer - delivery of a coordinated campaign of health promotion and early interventions delivering public health messages pertinent to the local population. The emphasis will be on community-wide health and well being with ongoing support to promote families making the right choices and life styles utilising a multi professional team. Community Nursing Plus - a criteria based referral system from Primary care to Children's Community nursing. This will aim to reduce admissions and readmission of children into hospital. This service will also include a Children's Phlebotomy service. Community Specialists - Locality based Paediatric care. Health professionals will work togther within a community setting to deliver child health services shifiting the focus of care from the hospital setting to the community. Uniquely this will bring GPs, Paediatricains, Children's Community nurses and Paediatric nurse practitioners (PNPs) together to form a multi-dIsciplinary team working jointly to deliver specialist paediatric care closer to families homes. Cascaded Learning and Development – this will include a programme of training, bridging the gaps in paediatric expertise whilst forging stronger relations between hospitals based services and community/primary care practitioners.
Multiple referral and access points for children's care. Some examples of support for self care. Separate patient information and assessment systems used across hospital, community and GP services.	**Single Self Management Care plans** 	The overall aim is to develop a single self-care management plan for children and put in place the systems, process and training that enable implementation in an integrated manner. All children and young people aged 2-18 who have some additional needs either health, social or educational will have a single and integrated care management plan. The main benefit will be the ability of children and young people to manage their condition, leading to reductions in: A&E Attendance, Hospital admissions, Length of Stay in Hospital, Outpatient appointments, and readmissions; Compliance with Ofsted and British Thoracic Society Guidance on prescribing; and an increase in User satisfaction; school attendance and life expectancy. The child and parents will understand and own the Care Plan, being in control of their own care and working with professionals via the plan to develop the skills to do this e.g. Self Care for children with long term conditions, starting with Asthma

Children's and Young People's Services

From now.....	To Services in the Future.....	
Many people who become parents have additional vulnerabilities that put them at increased risk of poor outcomes for themselves and their children. The Children's Society describes 'vulnerable families' are those with at least five of seven key vulnerability indicators (worklessness, poor quality housing, no qualifications, maternal mental health problems, long term illness or disability, low income and material deprivation).	**Support to enable nurturing and positive parenting** 	The overall aim is to develop a 'nurturing/positive parent' programme to build self-reliance and resilience in children, young people and families by supporting parents to bond, nurture and communicate with their child from pregnancy, through the first year of their baby's life and through key transitional stages of their child's development. The 'nurturing/positive parent' programme will build on existing delivery (e.g. antenatal classes which prepare parents for birth, Family Nurse Partnership evidence, The Child's Journey), evidence of good practice and social marketing 'insight' by engaging parents in prioritising the issues they want to address through the programme and in designing and delivering their own methods, content, venues, etc. The programme will aim to develop safe, healthy and empowered children and young people by supporting parents to understand their child's development from conception to adulthood and to build better relationships with them, through attachment, communication, play, stories, positive and protective behaviour approaches and confidence building. The overall aims are to: • Increase the level of support available for families reflecting their level of need • Reduce health inequalities in health and wellbeing, both locally and against national outcomes • Increase skills and capacity in communities generating energy for change
Transition from children's and young people services to adult services can be difficult for vulnerable adolescents. Currently people may experience gaps in care during transition and feel that services have failed to meet their needs.	**Supporting Transition from Yong People's to Adult Services** 	**Transition from children's to adult services should be a purposeful, planned process that addresses the medical, physiological, educational and vocational needs of adolescents with chronic physical and medical conditions as they move from child-centred to adult orientated health care systems" (DH NSF for Children's 2006)** The overall aim of the Outline Business Case is to develop a transition process, with clearly defined roles, responsibilities, processes and training, which are integrated into existing primary and secondary care, and ensure young people have the necessary skills and information to transition from adolescent paediatric-based services and function in an adult environment.

Children's and Young People's Services

From now.....	To Services in the Future.....	
Tier 3 care and support available 5 days a week 9-5. Crisis support available 7 days a week. Specialist medical, nursing and psychological support available.	**Supporting Children and Young People's Mental Health and Emotional Resilience** Healthy Young Minds CAMHS	Working in partnership including young people, their families and carers, the service will respond to all requests and either signpost to other services or provide an appointment in a time and place of the Child and Young Person's choosing to deliver evidence based interventions to meet their emotional and mental health needs in: • Emotional Disorder / Challenging Behaviours • Eating Disorders, • Learning Disabilities, • Attention Deficit Hyperactivity Disorder • Specialist support in specific physical health needs e.g. • epilepsy • Safeguarding In a range of settings and approaches that supports Children & Young People to live well in their communities and supports seamless transition into adult services
Two general hospitals at Calderdale Royal Hospital and Huddersfield Royal Infirmary. Both hospitals provide paediatric outpatient services. Accident and Emergency services for children are provided on both sites. However they are not fully compliant with the standards for Children and Young people in Emergency Care settings Paediatric surgery is provided at Huddersfield Royal Infirmary. Paediatric inpatient medicine is provided at Calderdale Royal Hospital. This means that currently children that have urgent medical and surgical needs do not receive shared care from a consultant surgeon and a paediatrician. The different services provided at each local hospital means that some Calderdale children need to access services at Huddersfield Royal Infirmary and also that children in Huddersfield need to access services at Calderdale Royal Hospital.	**Specialist Planned Care Hospital** H	Paediatric outpatient services will be provided at the planned hospital Provide nurse led minor injury services for children that will offer walk-in access. For example, children will be able to receive treatment for sprains and strains; broken bones; wound infections; minor burns and scalds; minor head injuries; insect and animal bites; minor eye injuries; injuries to the back; shoulder and chest.
	Specialist Acute and Emergency Hospital H	A specialist Paediatric Emergency Department will be provide at the emergency and acute hospital this will enable compliance with the standards for Children and Young People in Emergency Care settings. Paediatric Surgery and Acute Inpatient Medical care will be co-located on a single site this will enable shared care from a consultant surgeon and a paediatrician. Paediatric outpatient services will be provided at the specialist acute and emergency hospital.

5.3 Action taken to develop the service model from the Strategic Outline Case

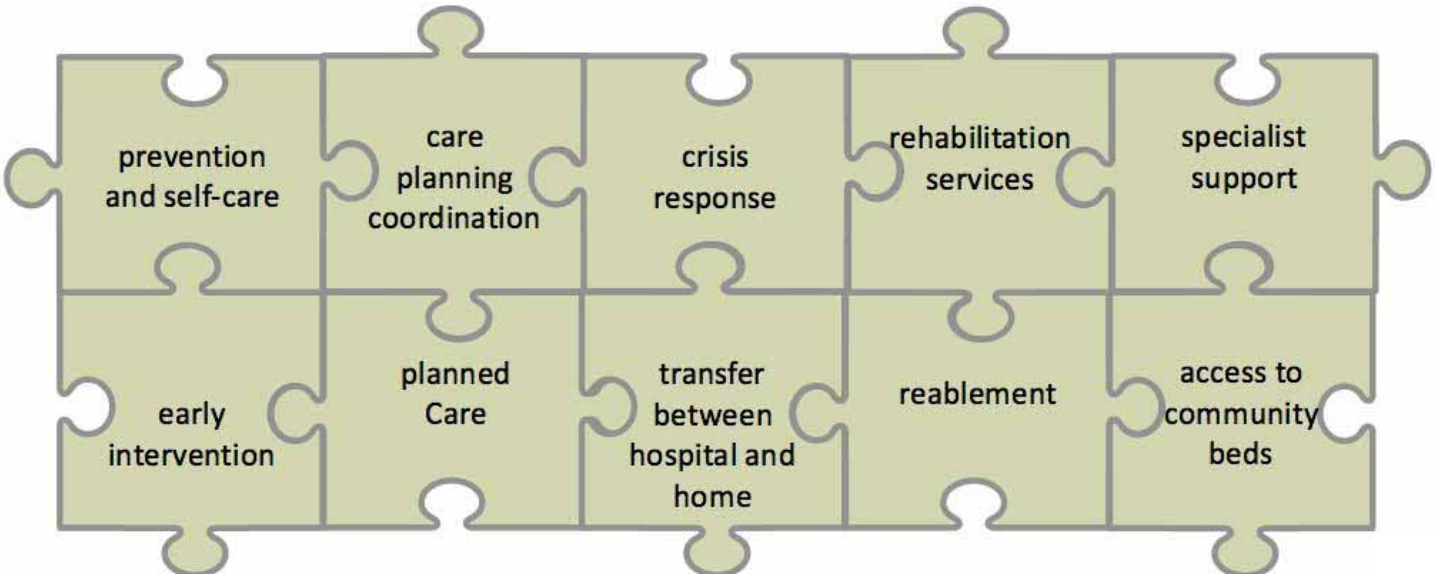
Following publication of the Strategic Outline Case in February 2014 further work has been undertaken to develop the service model. CHFT, SWYPFT and Locala have jointly held five stakeholder engagement events to discuss the proposed service models with providers across the health and social care economy (this includes general practitioners, pharmacy providers, social care providers, Yorkshire Ambulance Services, 111, and third sector organisations). The five events focused on: the locality teams and community services, the two specialist hospitals, self care, emergency and minor injury services, and the specialist community hubs. In addition specific focus meetings have also been held with social care provider staff in Huddersfield, 3rd sector providers and with GPs. The engagement has also included discussion with representative committees (such as the Local Medical Committees and Local Pharmaceutical Committees) and with trade unions. Extensive staff engagement has also been undertaken including 100 1:1 interviews with the doctors, nurses and therapists that currently provide the services. All the stakeholders that were engaged have confirmed general support for the service model. The contribution and feedback from the process of stakeholder engagement has informed and enabled the development of the more detailed description of the service model that is provided below.

5.4 The Adult and Older People's Community Locality Teams

How many teams will there be and where will they be located?

The number of locality teams is not defined in this OBC. This is because we want to be able to work with Commissioners and ensure there is flexibility to determine the optimal number and geography for the locality teams. It is likely that this will be in the range of 5 to 10 across Calderdale and Huddersfield. It will be important to ensure these are of sufficient workforce size to ensure resilience. The areas covered by locality teams needs to be aligned with GP practive populations so that there is clarity for every GP practice of which locality team they will be working with.

What will the Locality Team do?



Support Prevent

Prevention and Self Care

The locality teams will provide information to support people about how to maintain their health and wellbeing and avoid preventable conditions. They will use brief intervention techniques to encourage individuals with risk factors such as diet, exercise and smoking to address their health and wellbeing needs. They will refer into appropriate support services e.g. weight management or stop smoking to support people in their own self-management. There will be specialist support from health and wellbeing practitioners/specialists for locality team staff and at a community level support through health trainers, community health champions and GP champions. A key principle will be to support people to be as independent as possible to be managed at the lowest level of need possible for them.

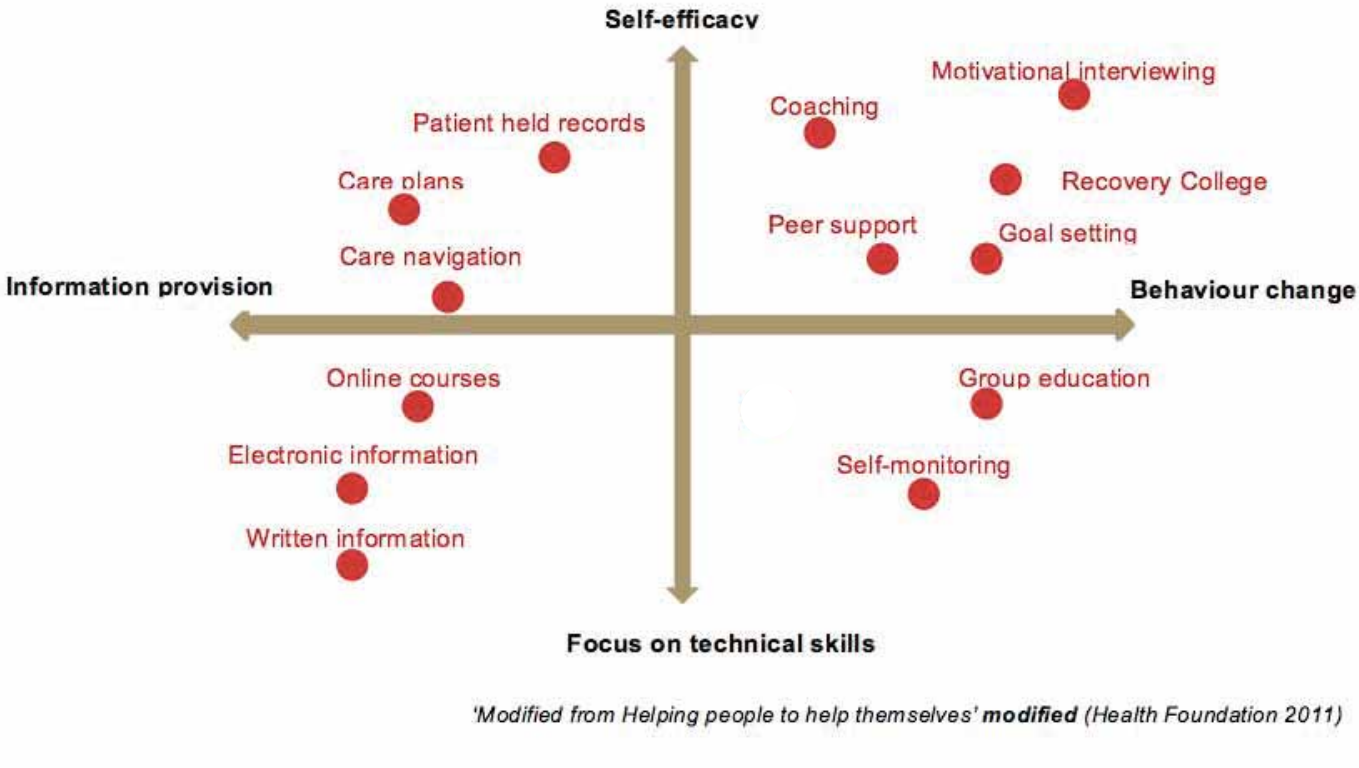
The key factors that help people to help themselves mean that the teams will support people to:
- be active partners so they are fully involved in decision making
- develop a self-authored plan which includes self-assessment so they can identify their priorities
- easily access timely and consistent information which offers positive support
- be aware of the support and services available to them
- feel they have ownership of their own care plan
- talk confidently with members of the team about their needs.

All members of the locality team, professionals, carers and managers, will be trained so they are skilled in enabling people to self-manage and self-care. This will be the first option considered. The approach will be to support individuals, families and communities to undertake activities that will enhance their health, prevent disease, limit illness and restore health. Based on people's needs a range of approaches will be used. The key features of the approach to self-care that the teams will provide include:

Skills	Resources	Behavioural and cultural change	Communication
Support for self-advocacy, goal setting, motivational support to increase self-awareness, resilience, understanding psychosocial needs and identifying and managing risks, creating a self-authored management plan.	Support to access information and networks so people, their families and carers can talk to others in similar situations. Also support people to use information technology to develop skills and knowledge for getting help and monitoring own health.	Ensure timely, consistent and effective experience of support, enable risk management and appropriate risk taking to maximise independence and choice.	Ensure effective communication at the front line with an individual, throughout services and across communities.

Based on people's needs a range of approaches will be used. People will be supported to undertake activities individually or in participative collaboration. This will include coaching and care navigation to enable self-care and management. Whilst it is expected that much of this can be delivered by trained volunteers, peer support workers and expert patients, it is recognised that locality team members and specialist supporting them will also play a key role.

The diagram illustrates the key enablers evidenced to support self-care that will be provided.



*'Modified from Helping people to help themselves' **modified** (Health Foundation 2011)*

Provide early intervention

The locality teams will work with GP practices to identify patients who require proactive intervention. This may be through the use of tools that predict risk of admission to hospital or identification of people based on clinical review through multi-disciplinary team discussion. The locality teams will ensure that the appropriate intensity of support and care is targeted and available for the most vulnerable people living in localities for example; by ensuring early referral to palliative care services for appropriate patients with long term chronic conditions who currently are not accessing specialist palliative care advice and support services, or teaching people to fully understand their medication to improve compliance.

The locality teams will also work closely with and support other existing care providers within the geographical area e.g. Care Homes and Home Care providers. They will have a comprehensive understanding of the health and wellbeing needs of their communities and support the community and other agencies in actions to address these. By understanding the health needs of the locality through assessment of; health observatory, risk stratification and Joint Strategic Needs Assessment, information, the locality team will be able to inform voluntary and 3rd sector organisations of the support needed in that community.

Provide Care Planning and Care Coordination

Pro-active care planning for people with multiple needs will be provided, these will be outcome focused, with patient agreed goals, supporting access to holistic therapies including emotional psychological support and access to necessary equipment. People will be supported to understand their illness and to self-author plans, if appropriate, or to co-produce plans with professional members of the team and their carer. These plans will be jointly owned by the professional and patient and be available in an Electronic Patient Owned Record. Specialist doctors, nurses and therapists will support care planning to provide advice and consultancy on optimal care and avoidance of crises. As part of the care planning process anticipatory or emergency (contingency) care plans will be agreed in partnership with people and anticipatory drugs will be made available, if appropriate.

For people with multiple or complex needs professional care coordination will be provided. Care coordination is a key role, ideally this would be a role undertaken by a service user or their carer but as care becomes more complex a professional may need to take on this role. The professional care coordinator will take into account the full range of needs of the individual, drawing on specialist support and advice as appropriate.

Deliver Planned Care

The locality teams working with the GP practice populations, will provide proactive planned management of patients with Long Term Conditions, with complex care needs or those newly transferred home from hospital. This care provision will be based on the care plans agreed. Carers' assessments will be undertaken and carers offered appropriate support linking to voluntary agencies or accessing other appropriate support e.g. respite or night sitting as required. Working with GPs and specialist palliative care services the professional team will provide expert end of life and palliative care, ensuring anticipatory care plans are in place and in the appropriate location of care is determined. Community pharmacists or advanced nurse practitioners will undertake medicine reviews for patients with complex prescriptions.

Provide Urgent Crisis Response

Even with a comprehensive range of early intervention and planned care provision by the Locality Team there will still be a requirement for a more urgent response.

The locality teams will provide:

- 24/7 provision of short term care e.g. night sitting, based on an assessment of need by a professional within the locality team, a GP, or on transfer from hospital to prevent readmission
- Urgent access to step up community beds (based on assessment of need by a professional within the locality team and with GPs).
- Urgent access to advanced assessment to support professional members of the locality teams and other care providers in a locality e.g. Care Homes or Home Care provider to prevent hospital admission. This may be undertaken virtually.

Support Safe transfer between Hospital and Home

The locality teams will have a key role in supporting the safe transfer of care between care settings (e.g. from hospital to home). People will be safely transferred to the next stage of care ensuring there are no gaps in care and that patients only have to tell their story once. A key enabler to the safe transfer of care is the integrated shared record as described earlier. This will support the flow of information between the community and hospital based teams, helping to support an accurate understanding of people's needs and medication requirements.

Provide Rehabilitation and Reablement Services

The locality team will provide active rehabilitation/ reablement in the community, within patient's homes health centres or in community rehabilitation beds. The team will use a single assessment to determine the patient's needs. If the patient is referred from an acute setting they will build on the assessment and support plan that has already been started, proactively working with the acute hospital therapists, discharge co-ordinators and social work team to ensure a smooth and timely transition into the community e.g. provision of equipment etc.. For those patients that are referred from the community they will liaise with other members of the multi-disciplinary team as required to build up an individualised assessment and care plan. Competent, multi-skilled community practitioners will then work with the patient/ carers to deliver the care plan, with regular reviews of the plan being carried by qualified staff.

Provision of Specialist Support in the Community

The locality teams will be supported by specialist clinical staff working in the community. This will include specialist nurses, pharmacists, psychological therapy staff, therapists, social care colleagues and specialist doctors and their teams. These highly specialist staff will work across the localities seven days a week. They will provide expert support and guidance in a consultancy

manner and proactive planning with GPs and other members of the team to optimise people's care and avoid crises, to support care at home through hospital admission avoidance or supporting people newly discharged from hospital. This will enable locality team members and GPs to have more confidence in supporting people with complex needs within their own home. In addition specialist doctors, nurses and therapists will see people at home (either face to face or using technology), or within rapid assessment clinics in the community to provide expert interventions and advice. Complex medicine management assessment and advice will be undertaken by the pharmacy colleagues within this specialist resource. It will be the norm for a GP to pick up the phone and ask for immediate advice to support patients to remain in the community.

The specialist medical staff will also offer the medical and specialist components of care for people admitted to Community Intermediate Care Beds. They will review the causes of all admissions to hospital to identify whether there is learning that could be used to prevent the need for a hospital admission in the future.

The table below summarises the role of specialist staff working across the locality teams.

Clinical advice and education	Coordination	Leadership	Direct clinical care
•Virtual ward rounds and MDT case discussions •Advise teams on safe hospital transfer •Provide advice to GPs •Upskilling and support Locality team members •Supporting Primary care services	• Work with the hospital, GPs and the locality teams to facilitate safe care transitions between hospital and community	•Work with GPs and Locality Teams to support: •LTC self-management programmes •Clinical input into disease prevention / health promotion activities. •Quality assurance for protocols and pathways. •Support for whole population needs assessment.	•Community located consultations and assessments. •Home assessments, either face to face or virtually. •Outreach to residential and nursing homes. •Specialist input to community bed based services.

Provide Mental Health Services

Mental Health Community Liaison staff will be part of the multi-disciplinary locality team. The staff will assume a broader skill set for a community liaison role. They will also form part of the overall liaison services based on the hospital sites. The staff will support assessment and intervention by Locality Team M.D.T, provide education, knowledge and skills to wider locality workforce. They will reduce the need for acute and mental health inpatient admissions by early intervention and supporting other staff and providers. They will link up other providers of care to ensure that community intervention and care at home is designed to safely support people's recovery. Their knowledge will assist in providing people access to recovery colleges and in linking mental health patients, with a number of long term conditions, to the prevention, self care and wellbeing resources in the Locality Team.

Provide Access to Community Beds

Currently there are 90 community beds provided across Calderdale and Greater Huddersfield. These consist of:

- 20 in Maple Ward at Holme Valley Memorial Hospital, offering 24 hour nursing care, supporting rehabilitation, with limited medical support on site (3 hours daily Mon – Fri)
- 20 at Oakmoor, offering 24 hour residential care, with health input to support nursing and rehabilitation needs and limited medical support (3 hours 3 times a week Mon – Fri)
- 50 in Calderdale

It is envisaged that this bed base will need to expand and the emphasis changed to provide a better balance between those assessed by primary and locality teams to avoid admission and those to support safe transfer from hospital. As more complex patients are cared for within community beds the skill mix supporting them and the medical cover needs to be reviewed to enable safe optimum use 7 days per week, along with the appropriateness of the estate. This can be developed in the Full Business Case and clarifies the model of care for increased support across the existing community bed base (i.e. residential, nursing and intermediate care).

Who will be working in the Locality Teams?

Across Calderdale and Greater Huddersfield there will be a range of professionals including nurses, therapists, care workers, primary care and community mental health staff working together within localities.

The teams will bring together health and social care staff into multidisciplinary teams offering integrated physical health, mental health liaison, psychological health and social care. This will allow people to be supported so they can enjoy a good quality of life, maintain their independence and only use hospital services when absolutely necessary. When a hospital visit is necessary these teams will support people to come home safely as soon as possible.

The specific design of locality teams will be undertaken at a local level, ensuring that the local geography and challenges within the area are considered and key relationships are established with others, especially GPs. A key test for the success of each of the locality teams will be "how are we supporting a reduction in health inequalities and improved health outcomes in your local area?"

The locality teams will be professionally led through an integrated management structure and include general nurses, therapists, community mental health and psychological therapy staff, community matrons and social workers, working closely with GPs. The health and social care professions will work in Integrated Community Care Teams to support GP practice populations. Although it is likely that these teams will cover more than one GP practice each GP practice will have named practitioners to support coordinated working. Working across each locality will be advanced practitioners, generic support workers, alongside volunteers. The locality teams will incorporate intermediate tier and reablement services and will work closely with hospital discharge coordinators to support safe transfers of care.

The locality teams will be supported by more specialist expert opinion when needed. These specialists will include specialist nurses, pharmacists, psychological therapy staff, therapists and doctors that will provide advice and consultancy to the teams. In some cases these specialists will be based in the community and in-reach to hospital and for others this will be a hospital out-reach model. Physicians and specialist medical teams will spend part of their time working in the locality teams focusing on proactive care planning with GPs and other members of the team to optimise people's care and avoid crises.

The current community model encompasses over 20 individual teams in both Calderdale and Greater Huddersfield working to support individual patients. The future model will integrate services by moving to between five to ten locality teams supported by joined up community specialist support. This integrated working will reduce current duplication of appointments/visits in the system and support a whole system perspective with an appropriate skill-mix.

The figure below illustrates the locality team staffing model.

When will services be available?

The locality teams will operate between 8am to 10pm over 7 days per week. This enhanced provision of core services will dramatically increase access to services that support people within a community setting. Not all roles will be delivered until 10pm, seven days a week or even across all seven days but rapid assessment and advanced practitioner skills to support admissions avoidance and early transfer home from hospital will be, along with 7 day support from specialist colleagues to advise primary care and community practitioners in the locality teams.

There will be a robust 24 hour service to support people with complex needs, along with crisis intervention assessment and support services. These services will include enhanced out of hours nursing services, specialist palliative and end of life support and advice, and rapid response caring services.

How will people access the teams?

An integrated single point of access (SPA) will be available 24/7 so that either electronically or via one phone call an appropriate response can be quickly provided ensuring that people can access the care, support or advice they need. The SPA will work virtually to ensure all aspects of health and social care are linked to provide a seamless service to the caller. There will be professional/ clinical support within the SPA to ensure an appropriate and timely response. The SPA will mobilise the locality team to deliver the appropriate assessment and support usually with 2 hours and a maximum of 4 hours. The locality teams will provide feedback for the referrer to support on-going care planning.

The SPA will be able to access specialist support, advice, and guidance and enable this to be available directly for GPs and locality team professionals. The clinical staff in the SPA will also offer consultation, as appropriate e.g. video conferencing with care home staff or locality team generic workers out of hours. The SPA will also work closely with Yorkshire Ambulance Service who will be encouraged to contact them if an ambulance is called and they feel a hospital admission can be avoided e.g. a patient that has fallen, but could remain at home if urgent support is provided in their home. The SPA will also support the efficient utilisation of the intermediate care bed base across Calderdale and Greater Huddersfield.

How will the team work?

The teams will work as a single integrated unit in order to deliver all components of community care for a locality. This will be enabled by an emphasis on the following ways of working:

Multi-disciplinary team working including Specialist Services

The teams will provide multi-disciplinary integrated care. Specialist care will not be confined to inside the hospital walls. Specialist staff will work closely with GPs and the locality teams to make sure that patients have swift access to specialist care when they need it, wherever they need it. Guidance and care pathways will be clear so as to support the locality team to understand what can be managed by the locality team and primary care and what should be referred to a specialist. Much specialised care e.g. consultation, assessment and drug treatment will be delivered in or close to the patient's home. Physicians and specialist medical teams will spend part of their time working in the community, with a particular focus on caring for patients with long-term conditions and preventing crises.

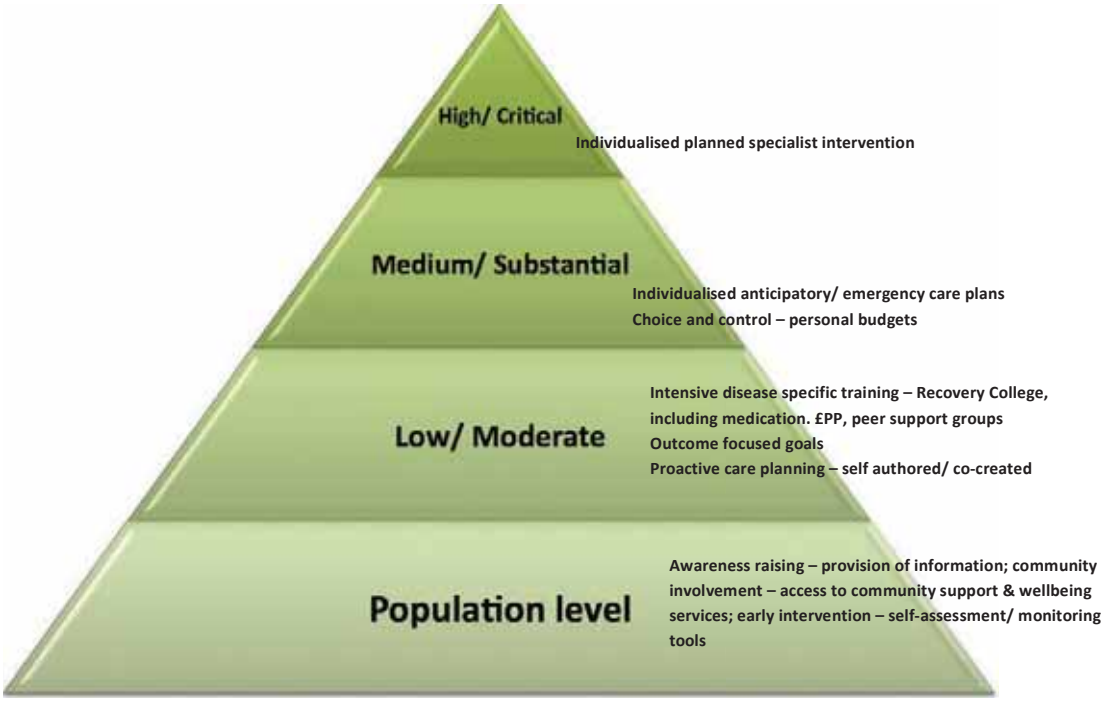
Use of Integrated Shared Records

The multi-disciplinary team will have a single integrated shared record and undertake agreed single joint assessment processes. This will lead to a care plan jointly owned by the professional and patient. There will be the ability for this record to be viewed and used in all care settings including people's homes, in hospital, in hospices, in residential care and nursing homes and in GP practices. Work will be undertaken to ensure all relevant information is captured to support timely decision making by the appropriate professional without duplication. Electronic tools will be used to highlight care needs for key groups of patients e.g. the identification of palliative care or dementia patients through an Electronic Care Coordination system. This will enable GPs, specialist services, and Out of Hours primary care medical cover to identify easily those most vulnerable in the community.

Use of Population Risk Identification Tools

The teams will use risk stratification tools to identify those people living in the community that have complex multiple needs and are at high risk of admission to hospital (such as long term conditions e.g. dementia, diabetes, respiratory conditions, heart failure) to ensure that the appropriate intensity of support and care is targeted and available for the most vulnerable people living in localities.

It is recognised that approximately 1% of GP practice patients, at any time, will be in the last year of their lives. By supporting the identification of these patients and proactively planning care, using shared end of life care registers and advance care planning tools, the coordination and quality of care will be significantly improved whilst avoiding unnecessary emergency admissions to hospital or hospice.



Use of Technology

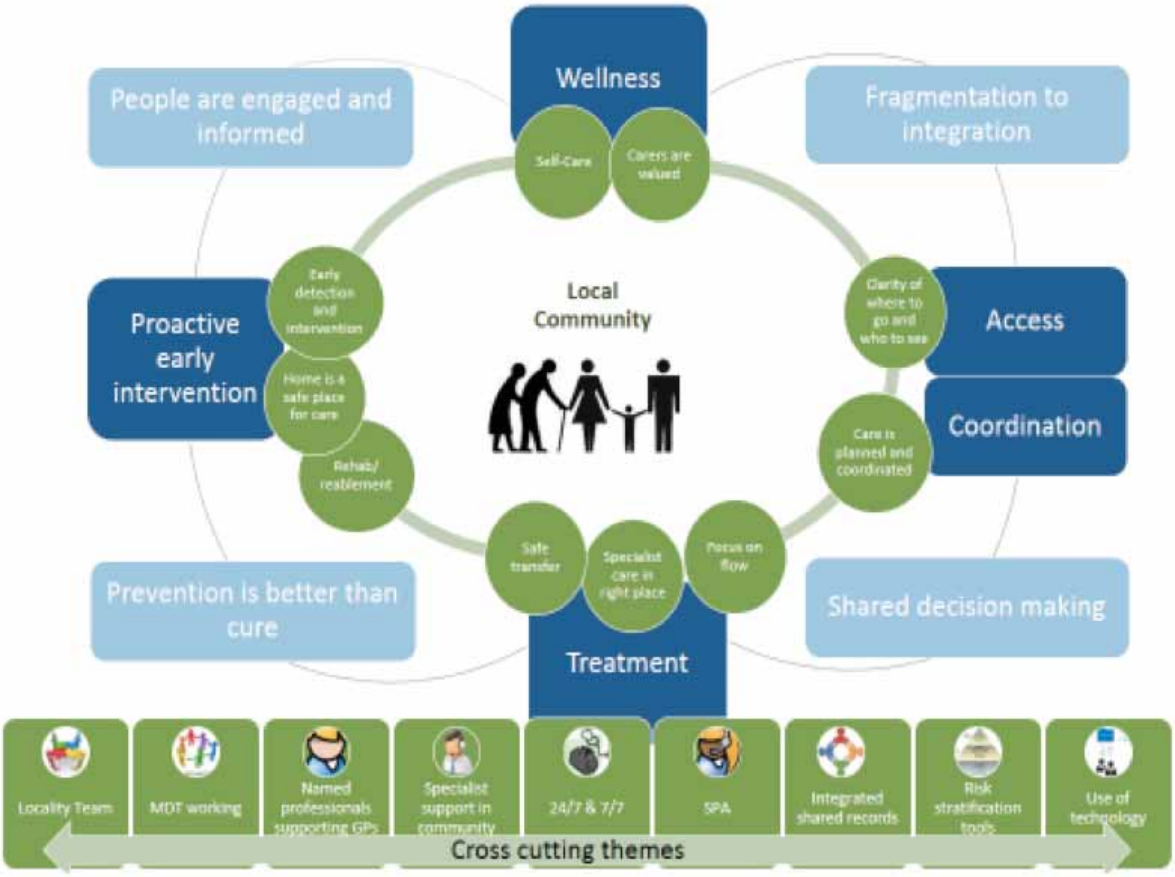
The locality teams will use mobile technology to work in a flexible more efficient manner, reducing travel time and increasing available clinical delivery time. They will be able to access and capture clinical information in real time and to communicate with colleagues through technology. They will be skilled in understanding when technology can support self-care, for instance; tele-health e.g. blood glucose monitoring to support stabilisation of diabetes, or tele-care e.g. use of GPS by carers to track individuals with dementia. Not only will they make full use of technology to optimise care delivery and efficient working, they will support individuals and carers to take advantage of technological solutions, referring to voluntary agencies if individuals require training and support. The locality teams will ensure timely access to specialist advice and support and this will be enabled through the use of technology such as video consultation, instant messages or emails.

Work with the wider community

The locality teams will work closely with Kirklees and Calderdale Council to support initiatives to empower the community to take control of their own health and wellbeing. They will also support initiatives that identify those within the locality who are health vulnerable and jointly support schemes, with the community, to address need e.g. an isolated elderly population. In addition they will proactively identify areas where 3rd sector support is required and stimulate delivery. This model recognises the need to engage colleagues from the third sector in the planning of care by engaging them at the earliest opportunity. A comprehensive directory of services will be available to colleagues across Health and Social Care. Building on the 'connect to support' model partnership arrangements between the locality teams and the voluntary sector will be established to enhance the support options available for people. The locality teams will work seamlessly with primary care independent contractors such as GPs, community pharmacists and opticians and also with not for profit organisations such as the hospice, drawing on advice and expertise as required; and all the private sector partners that deliver care and support to people in the locality (e.g. home care providers, residential and nursing home care). It is known that in Kirklees and Calderdale there are currently recruitment and retention issues for care providers leading to insufficient market supply for care services, such as home care, to meet the demand to support the provision of more care closer to home. To enable the new model for locality teams to succeed will require effort to stimulate the supply market for local care provision in both districts.

Support for Carers

The locality teams will recognise and support the value of the carer's contribution and involve them from the outset both in designing local care provision and in planning individual care packages. The teams will support carers to remain healthy and emotionally strong.



The table below shows what the establishment of locality teams might mean for services Users, Carers, GPs and for residential care and nursing homes.

What will this mean for Service Users and Carers?	"The services will draw on my skills, knowledge and expertise to co-design improved services and support in partnership with me" "I only need to tell my story once to get the support I need" "I will have access to information about my condition and what to do when my condition deteriorates" "I can view my clinical record and plan the treatment I'd like to receive" "I use the most up to date and innovative technology to track my condition and get advice when needed. In the past I needed to go to hospital to do this. Now I can do this from my own living room" "I understand the range of support services available to me and know where I can go to access these and share and learn with others in a similar position to me" "Services are available 7 days a week when I need them – not when it's most convenient to provide them. When I need support at other times there are services available outside of the hospital that will help me to stay in my own home where possible" "There are a range of services that support and recognise the work I do as a carer and the reward and burden this brings me. I know how to access these services and can share my experiences" "As a carer, my needs are assessed separately to those of the person I am caring for"
What will this mean for GPs	"The integrated teams work closely with my practice to understand the specific issues facing my local population. The support is designed around these challenges not simply a one size fits all approach" "I am clear who is responsible for caring for my patients care at any time. This may be me, the locality team, secondary care, or the individual" "The shared care record supports me to support my patients in the easiest, safest way" "I can clearly see the improvements for my patients and my team delivering care. Working in an integrated way has reduced the burden on my team through reducing unnecessary visits to primary care. I can use this time to see those most in need" "I have direct access to specialist colleagues through a range of communication methods to suit the circumstance such as Email, Telephone, Video link, conference , face to face" "Single Point of Access has continued to develop further and now includes all providers under this model. When I call the service my call is dealt with quickly, by a competent call handler who takes just enough information to ensure the right support is provided first time. "I can easily direct my patients to information and support on self-care, independence and wellbeing. I feel informed and have more information at my fingertips"
Social care services	"Our local residents are supported to remain live an independent life in their own home" "Our local population understand where to access a range of support groups and resources to support them to maintain their independence" "These teams are well placed to understand and respond to the unique differences, inequalities and challenges within our population" "The system supports the integrated delivery of care between health and social care patients. These services are seamless – our patients only see a single service" "The services we provide are personalised and tailored to meet indidivual needs."

5.5 The Specialist Community Hubs

In addition to the Locality Teams two specialist community hubs will be established at Todmorden Health Centre (Calderdale) and Holme Valley Memorial Hospital (Greater Huddersfield).

These hubs will play a vital part in the delivery of local healthcare services allowing convenient access to a range of hospital services which have traditionally been provided only from a hospital base. The hubs will ensure local provision of enhanced services to support the management of more specialised conditions which can be managed outside of hospital, including urgent or rapid assessment clinics. The hubs will provide outpatient services across a range of specialities, minor surgical day case procedures and mental health and psychological therapy support and sessions. There will be a range of diagnostic services available.

The community hubs will also offer a focus for social and patient support activities and will work with voluntary, community and self-help groups to do this linking with other centres and community support (e.g. Kirkwood Hospice). There will be access to technology to guide people to information, advice and support and enable people to self assess, self monitor and self manage their condition.

The Hubs will provide minor injury services for adults seven days a week 8am to 10pm.
This will be staffed by Emergency Nurse Practitioners (ENPs) who have had specific advanced training in the assessment and management of minor injuries. ENPs currently see and treat the vast majority of minor injury patients that attend the Accident and Emergency Departments in Huddersfield and Halifax and it is estimated that this accounts for approximately 50% of the people that currently attend the two A&E departments. The minor injury service provided in the Hubs will be for adults and will not be able to provide a service for children. Children will need to attend the specialist acute and emergency hospital to access Paediatric A&E service or the specialist planned care hospital to access minor injury services. The table below shows the minor injuries that can and cannot treated in the Community Hubs.

Minor Injuries Unit in Community Hubs	
Can Treat:	**Cannot Treat:**
Adults	Any Children (all conditions)
sprains and strains	chest pain
broken bones	breathing difficulties
wound infections	major injuries
minor burns and scalds	problems usually dealt with by a GP
minor head injuries	stomach pains
insect and animal bites	gynaecological problems
minor eye injuries	pregnancy problems
injuries to the back, shoulder and chest	allergic reactions
	overdoses
	alcohol related problems
	mental health problems
	conditions likely to require hospital admission

The full range of services that will be provided in the Hubs is shown below.

Todmorden Hub	Holme Valley Hub
Minor Injuries Service for Adults **General Practitioner Services** **Children's Services:** General paediatric clinics Paediatric Asthma Care Health Visiting Child Development Services **Women's Services:** Colposcopy Severe nausea and vomiting in pregnancy (hyperemesis) Maternity and Midwifery Services **Diagnostic Services:** Radiology – Ultra sound and plain film x-ray Pathology – anticoagulation, phlebotomy, lipid clinic, point of care testing Clinical pharmacy support **Clinics:** HIV/ Sexual Health services Assisted Conception Cardiology Respiratory Elderly Care Stroke Rehab Diabetes Haematology Rheumatology Dermatology Pain ENT Ophthalmology Musculoskeletal Therapy Service **Day Case Procedures:** Minor Orthopaedic Surgery Minor Plastic Surgery **Mental Health and Psychological Therapy** Individual and group assessment and therapy sessions	**Minor Injuries Service for Adults** **Intermediate Care in-patient beds** **Community Dental Services** **Cafe** **Children's Services:** General paediatric clinics Paediatric Asthma Care Health Visiting School Nursing (base) Child Development Services **Women's Services:** Colposcopy Severe nausea and vomiting in pregnancy (hyperemesis) Maternity and Midwifery Services **Diagnostic Services:** Radiology – Ultra sound and plain film x-ray Pathology – anticoagulation, phlebotomy, lipid clinic, point of care testing Clinical pharmacy support **Clinics:** HIV/ Sexual Health services Assisted Conception Cardiology Respiratory Elderly Care Stroke Rehab Diabetes Haematology Rheumatology Dermatology Pain ENT Ophthalmology Musculoskeletal Therapy Service **Day Case Procedures:** Day Surgery Minor Orthopaedic Surgery Minor Plastic Surgery **Mental Health and Psychological Therapy** Individual and group assessment and therapy sessions

5.6 Children's and Young People's Services

The proposals described in this Outline Business Case are consistent with the vision of the Calderdale and Greater Huddersfield Health and Social Care Strategic Review, Children's Working Group i.e.

"Every Child will have a healthy start and continue to lead a safe, happy life with every opportunity to achieve their potential within their families and communities"

The children's working group is part of the Calderdale and Greater Huddersfield Health and Social Care Strategic Review. The seven partner organisations have been working together over the past 2 years to identify joint priorities that will improve and transform the care for children and families.

As a result of this work five key areas have been identified: Care Closer to Home, Single Care Plan, Transitions, Resilience and Navigable Services. Work is already taking place to test and implement these changes.

The following provides a summary of the projects that are already being implemented that this Outline Business Case is aligned with and will support progress on.

Care Closer to Home	This project was established to improve access to care for children and families by placing consultant clinics within the community. May 2014 will see the first clinic of this type in the locality. There will be one in Huddersfield and one in Calderdale. The clinic will comprise of consultants as well as GP's and specialist nurses. It is envisaged that by working in this way the specialty skills of the consultant can be shared with the multidisciplinary team and more children can be treated. The pilot will help reduce the number of children needing to attend A&E and the hospital. The pilot will be evaluated and if successful be rolled out on a wider basis.
Single Care Plan	The single care plan is a care plan for children with asthma that can be shared with health and social care workers, family and schools. This enables adults working with the child or young person to be aware of their care needs and what to do to support them. The single care plan means that all agencies will have access to the same information ensuring greater continuity of care. It is expected that by providing the single care plan that children and families will be able to manage their asthma better and are less likely to need emergency care. Good management of asthmatic conditions will continue to benefit young people as they continue into adulthood.
Transitions	Transitions refer to children moving from children's services to adult services. For some conditions the move may mean switching from one consultant to a number of specialists. Adolescence is a particularly challenging time, but even more so for young adults with long term and complex conditions. The transitions project has been set up to look at how we can make this transition much easier for young people.
Resilience	The resilience project looks at how health and social care can support children, young people and families to look after themselves, access the right care and prevent the occurrence of ill health. The resilience project is currently looking at how whole system wide speech and language therapy can support children to obtain higher results in school, understand health conditions and seek sufficient support to address their needs. This project will involve all 7 partner organisations but will certainly work very closely with schools and parents.
Navigable Services	This project has been set up to enable children, young people and families find suitable services for their care needs

5.7 The Specialist Hospitals

Huddersfield Royal Infirmary

Calderdale Royal Hospital

Overview

There will be two specialist hospitals in Greater Huddersfield and Calderdale. Both hospitals will serve vital roles in the years ahead and will continue to provide a range of general hospital services at both sites. This will include outpatient care for children and adults, minor injury services, midwifery led maternity units, and ante-natal and post-natal care. Both hospitals will also provide specialist mental health liaison services. This means that the services that people use most frequently will continue to be available at both hospitals or in a local community setting. In addition each hospital will have a specialist focus. One hospital will specialise in acute and emergency services, caring for those people who are most seriously or suddenly ill. One hospital will specialise in care for people undergoing planned treatments or surgery, such as hip operations.

These changes will go hand in hand with the development of the community locality services and minor injury services (see section 5.4 and 5.5) to enable more people to be supported and receive specialist care closer to where they live and reduce the need for unnecessary hospital visits and admissions.

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

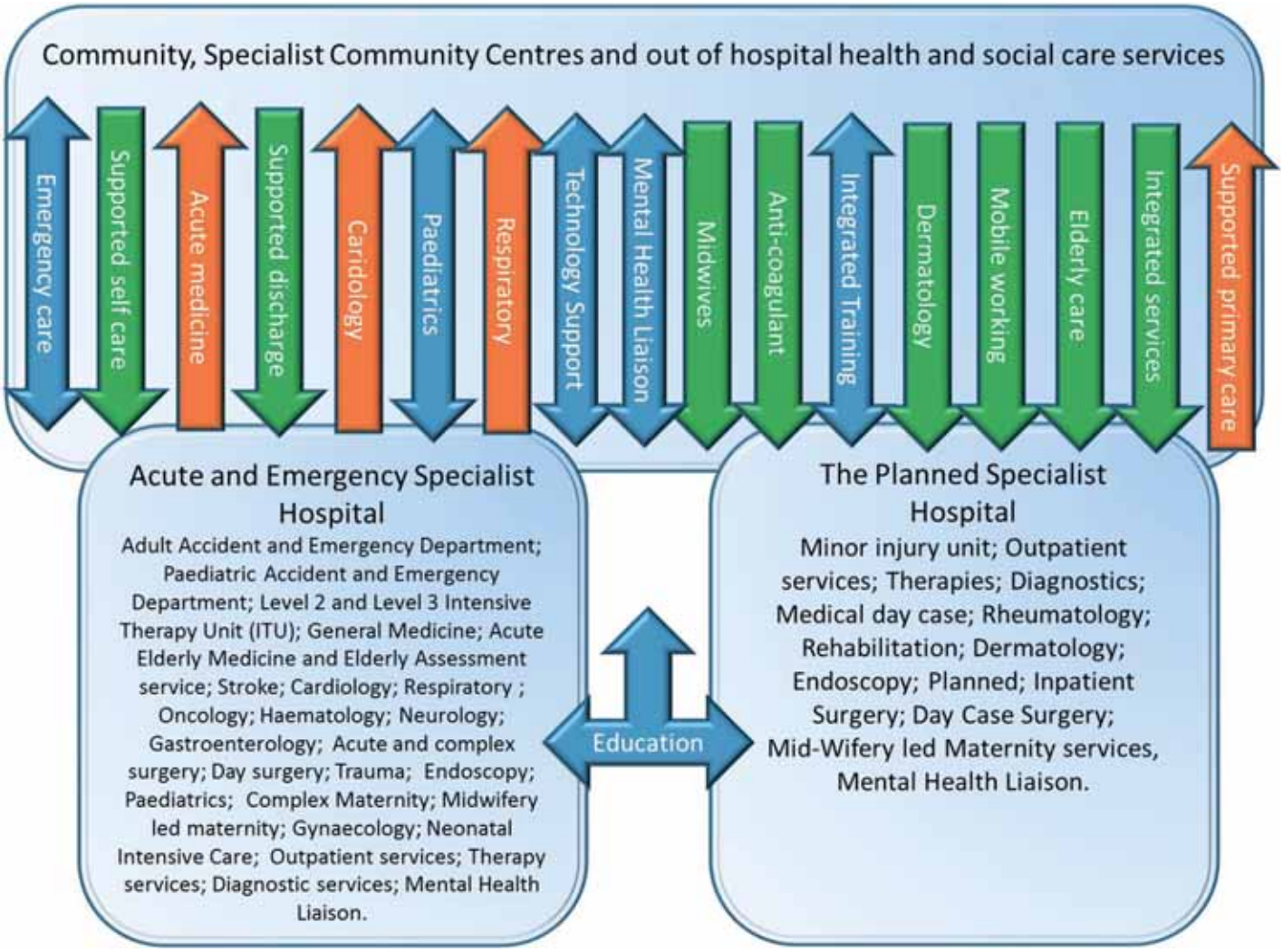
Better care from specialist doctors, nurses and therapists. Each hospital will do different things and have NHS staff who specialise in those services. If a patient has a road accident or heart attack, they will go to a hospital geared up for that urgent care. If they need a planned operation such as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

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

Better bedside contact from doctors and nurses. The separation of urgent and non-urgent hospital care will reduce the likelihood of a doctor being called away from delivering planned care because, for example, a serious road accident has happened.

The Proposed Service Configuration

The diagram below provides an illustration of the proposed change in hospital services and the increased provision of specialist services in the community (see section 5.4 and 5.5). The direction of the arrows on this diagram illustrates which services will be hospital based and out-reach to community locality teams and the services that will be community based and in-reach to hospital. The proposed configuration of services at the specialist acute and emergency hospital or at the specialist planned hospital is based on clinical evidence of the benefits of the co-location of Accident and Emergency services with critical care, medical, surgical, paediatric and obstetric services. The evidence confirms the importance of this co-location for patient safety. Along with the proposed change to co-locate all acute and emergency services on a single hospital site is the proposed provision of minor injury services at the Specialist Planned Hospital and at the two Community Hubs in Todmorden and Holme Valley.



The Services Provided

The Acute and Emergency Specialist Hospital	The Planned Specialist Hospital	Minor Injuries Service at the Community Hubs
The acute and emergency hospital will specialise in providing treatment for people who have a serious or life threatening emergency care need. The hospital will bring together on one site the necessary facilities and expertise, 24/7, to maximise people's likelihood of survival and a good recovery. For example, if you or a member of your family are experiencing a loss of consciousness; acute confused state and fits that are not stopping; persistent, severe chest pain; breathing difficulties; severe bleeding that cannot be stopped, the Acute and Emergency Specialist Hospital is where you would be taken or directed to.	The planned specialist hospital will provide scheduled support and treatments. It will also provide nurse led minor injury services that will offer walk-in access for adults and children. For example, if you or a member of your family are requiring treatment for sprains and strains; broken bones; wound infections; minor burns and scalds; minor head injuries; insect and animal bites; minor eye injuries; injuries to the back; shoulder and chest, you will be able to get care at the Specialist Planned Hospital.	The two Community Hubs at Todmorden and Holme Valley (see section 5.5) will provide minor injury services. for adults seven days a week 8am to 10pm. This will be staffed by Emergency Nurse Practitioners (ENPs) who have had specific advanced training in the assessment and management of minor injuries. The minor injury service available at the community hubs will be for adults only and will not be able to provide a service for children. Children will need to attend the specialist hospitals.
• Adult Accident and Emergency Department • Paediatric Accident and Emergency Department • Level 2 and Level 3 Intensive Therapy Unit (ITU) / Critical Care • Orthopaedics and Trauma • Vascular surgery • General Medicine • Acute Elderly Medicine and Elderly Assessment service • Stroke • Cardiology • Respiratory • Oncology • Haematology • Neurology • Gastroenterology • Acute and complex surgery • Day surgery • Endoscopy • Paediatrics • Consultant led complex Maternity • Midwifery led maternity • Gynaecology • Neonatal Intensive Care • Outpatient services • Therapy services • Diagnostic services • Mental Health Liaison	• Minor injury unit • Outpatient services • Therapies • Diagnostics • Medical day case • Rheumatology • Rehabilitation • Dermatology • Endoscopy • Planned Inpatient Surgery • Day Case Surgery • Mid-Wifery led Maternity services • Assisted Conception • Mental Health Liaison	The minor injury service at the community hubs will be able to treat adults with: • sprains and strains • broken bones • wound infections • minor burns and scalds • minor head injuries • insect and animal bites • minor eye injuries • injuries to the back, shoulder and chest

Key features of the change in configuration of services

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

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

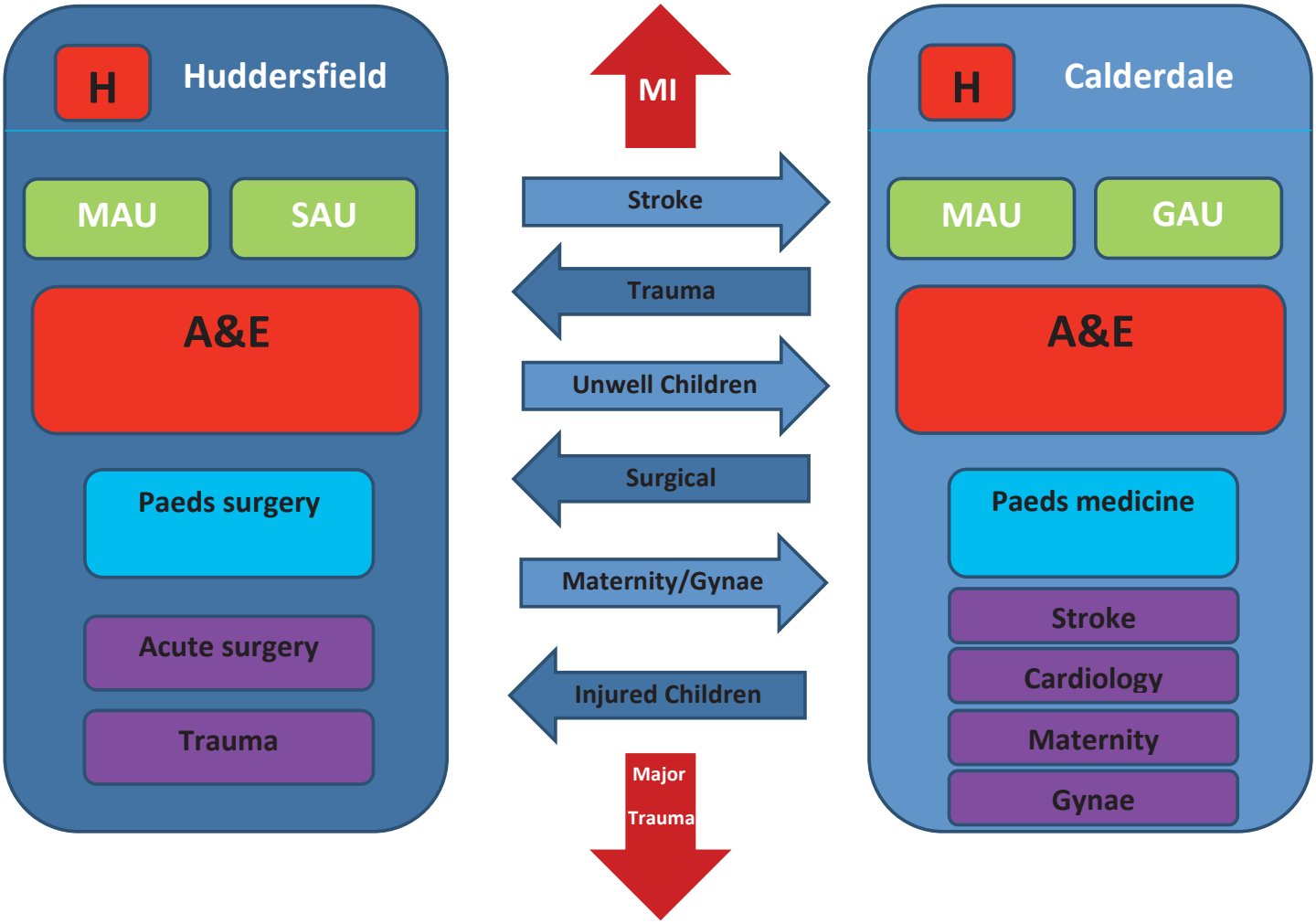
The table below provides a summary description for each service speciality area.

A&E and Minor Injuries	Accident and Emergency services for adults and children will be provided at the Specialist Acute and Emergency Hospital. This will be available twenty four hours a day, seven days a week. Minor injury services for adults will be provided at both specialist hospitals and at the two specialist community hubs. Minor injury services for children will be provided at the specialist planned hospital. The minor injury services at the planned hospital and the community hubs will be a nurse led service available 8am to 10pm seven days a week.
Children's Services	Closer collaboration and working between hospital paediatricians and general practitioners will strengthen child health expertise in the community. There will be shared care pathways and services organised to support the Locality Teams. Paediatric staff will provide advice and support to GPs to enable more children to be cared for at home and avoid the need for admission to hospital. There will be Paediatric outpatient clinics provided in the community hubs at Todmorden and Holme Valley. Paediatric Emergency Services and inpatient medical and surgical services will be integrated with adult accident and emergency services at the Specialist Acute and Emergency Hospital. Nurse led minor injury services for children will be provided at the planned hospital site 8am to 10pm. This has been decided following very careful consideration. The provision of all acute children services at the unplanned acute and emergency site is the clinically preferred option as this would offer the most safe service configuration. However consideration has taken into account the importance of local service provision and the fact that other areas do provide stand alone minor injury services for children. Very clear public communication of the criteria for the minor injury service and clinical protocols to respond to children that may attend that do not meet the criteria will need to be developed as part of the full business case.
Maternity	Women will be supported by a Single Point of Access telephone service so that they are routed to the right care in the right place without delay. A Maternity Assessment Centre will be introduced to support women who choose a midwifery- led birth either at home or in the Birthing Centres, which will be provided at both Specialist Hospitals. Obstetric services (for women that have complications in pregnancy) will be provided at the Specialist Acute and Emergency Hospital. Maternity Services will work with partner agencies to develop a perinatal mental health service.

Surgery	Planned surgery will be provided at the Specialist Planned Care Hospital. Emergency surgery, paediatric surgery and surgical procedures that may require access to critical care facilities will be provided at the Specialist Acute and Emergency Hospital. Rehabilitation following surgery will be provided as close to home as possible in communities and localities. This will mean patients will not stay in hospital as long as they do currently. Outpatient surgical services will be provided at both Specialist Hospital sites and in the community. ENT outpatient procedures will be provided at Acre mill, HRI, with ENT services provided in community hubs. Ophthalmology outpatient procedures will be provided at Calderdale, supported by services provided at Acre Mill, community hubs (localities) and Westwood Park. Pain services will be centralised at the Specialist Acute and Emergency Hospital and also provided in the Specialist Community Hubs.
Medicine	Acute medical services will be provided at the Specialist Acute and Emergency Hospital. The services will provide early acute assessment and initial treatment of patients 7 days per week. Patients will be supported with early care plans so that people that do not need acute hospital care are able to return to their usual place of residence without delay. Community services will be provided in the hospital to support the timely care and transfer of patients to home. Hospital consultants and general practitioners will discuss patients, to jointly consider options to best meet the needs of each patient, prior to referral to hospital. Patients with cardiology, respiratory, gastroenterology, Acute stroke, elderly complex care, orthogeriatric care, neurology or oncology care needs, will have direct access to specialty beds. These services will be provided on the same site as acute medicine 7 days per week. Through early care planning it is expected that specialty medical patients will not stay in hospital as long as they do currently. Outpatients and general rehabilitation services will be provided as close to home as possible in localities and communities. Hospital staff will work with the primary and community multidisciplinary locality teams to meet the needs of patients.
Diagnostics	Diagnostic and Technical Services will be provided at both Specialist Hospitals. Service like radiology, pathology and pharmacy, will provide access to investigations early in each patient pathway with timely results reporting to progress each patient's care pathway with minimal delay. Access to plain film X-ray and ultrasound will be provided in the Specialist Community Hubs.
Gynaecology and Sexual Health	Sexual Health services will be provided in the community. Women will have improved access to on-line self-help information and resources. Acute and inpatient gynaecology services will be provided at the Specialist Acute and Emergency Hospital on a 7 day per week basis. Outpatient gynaecology services will be provided at both Specialist Hospitals.

Impact on the provision of acute and emergency services.

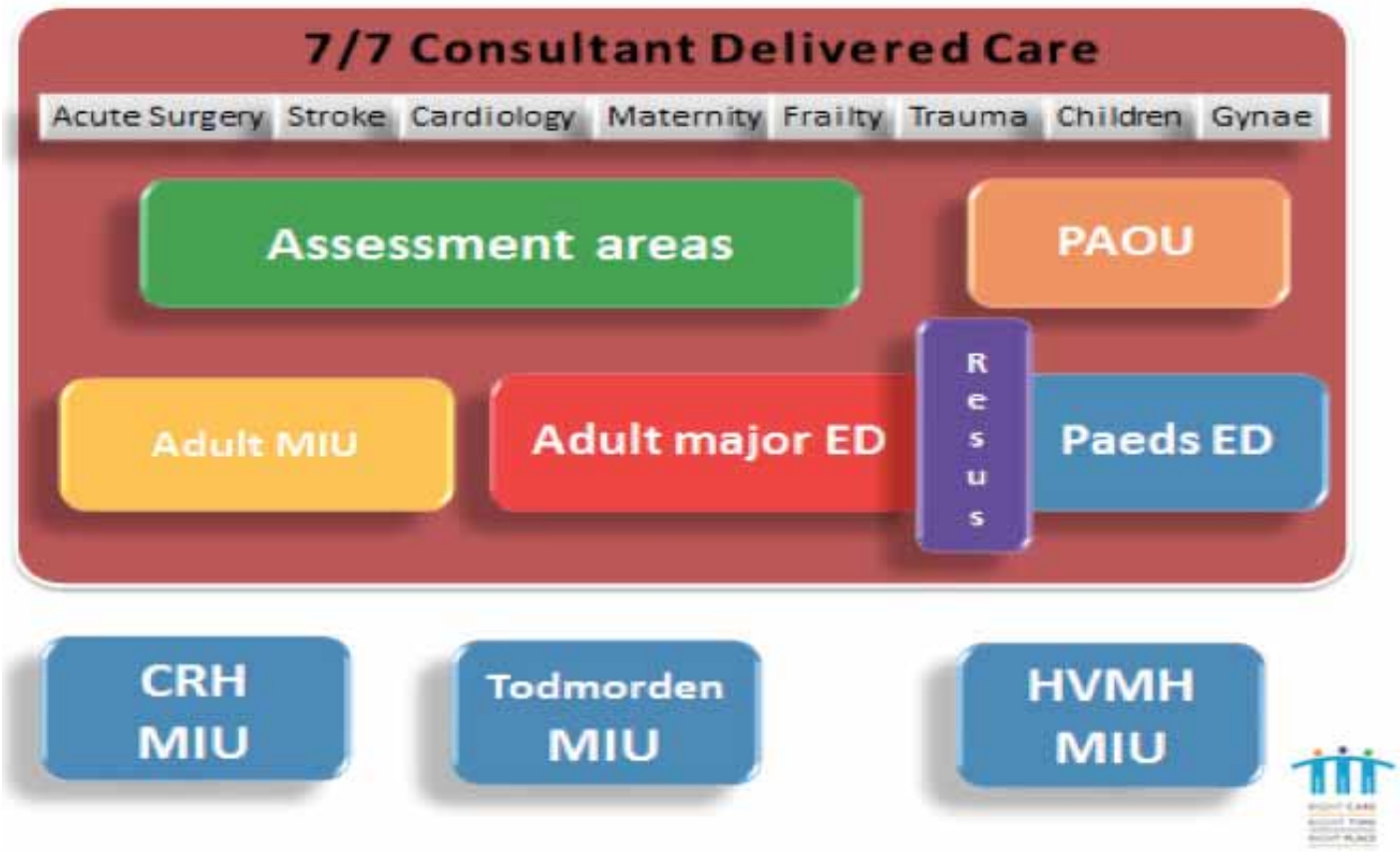
The Current Configuration of Acute and Emergency Services is shown below



Footnote: MAU – medical assessment unit, GAU – gynaecology assessment unit, SAU – surgical assessment unit, Paeds – paediatrics, Gynae- gynaecology, MI – myocardial infarction (heart attack)

The illustration above shows the current configuration of emergency and acute services provided at each hospital in Calderdale and Huddersfield. This shows that accident and emergency services and medical assessment services are duplicated on both sites. However other acute services are not currently provided on both hospital sites. Paediatric surgery, acute surgery and trauma services are only provided at Huddersfield Royal Infirmary. Paediatric medicine, stroke inpatient services, cardiology inpatient services and complex maternity services are only currently provided at Calderdale Royal Hospital. As a result this means that patients that arrive at either A&E in Halifax or Huddersfield may need to transfer between the two sites. The arrows illustrate the current movement of people between the two sites e.g. children that are seriously unwell and attend the A&E in Huddersfield will be transferred to Halifax. In the current system 22% of the people that live in Calderdale and require an emergency admission to CHFT are admitted to Huddersfield Royal Infirmary and similarly 20% of Huddersfield residents that require an emergency admission to CHFT are admitted to Calderdale Royal Hospital. The vertical arrow shows that people who suffer a myocardial infarction or major trauma that are picked up in an ambulance are transferred directly to specialist centres outside of Calderdale and Huddersfield in Leeds. This is to ensure that they go directly to a specialist hospital that can provide all the services they need.

The Future Configuration of Specialist Acute and Emergency Services is shown below



Footnote: PAOU – paediatric assessment and observation unit, ED – emergency department, MIU – minor injuries unit, Resus – resuscitation

The illustration above shows the future configuration of acute and emergency services that is proposed in this business case. This shows the entire specialist acute and emergency services co-located on a single hospital site and the provision of minor injury services at the Specialist Planned Hospital and at the two Specialist Community Hubs in Todmorden and Holme Valley. This change in configuration of services will reduce the need for the transfer of seriously ill and injured people between the two hospital sites. All the treatment and care that they need will be available at the Specialist and Acute Emergency Hospital. This will improve their experience of care, reduce risks and improve their likelihood of survival and making a good recovery. People that have a myocardial infarction or suffer major trauma will continue to be transferred by ambulance to specialist centres in Leeds.

Impact on the provision of Planned Hospital Care.

The specialist planned care hospital will provide scheduled support and treatments. This will include non-complex elective surgery services, including operations such as hip and knee replacements, hernia repair, gall stones and cataract operations.

The benefits of concentrating the provision of planned operations on a single hospital site are:

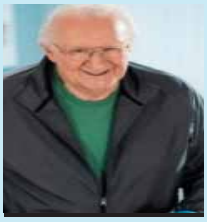
- It will ensure that operations are not cancelled or delayed due to the surgeon being called away to an emergency or because the theatre is needed for an emergency.
- It will ensure that there is dedicated bed capacity and that emergency patients do not require the beds and prevent a patient being admitted for a planned operation.
- Hospital-acquired infections can be reduced by the provision of protected planned surgery wards and avoiding admissions from the emergency department and transfers from within/outside the hospital - thus improving patient safety.
- It will enable earlier access to investigations, definitive treatment and better continuity of care.
- It will also enable other aspects of patient experience such as the environment of care and post-operative rehabilitation to be optimised.

As well as providing operations the planned hospital will offer a range of out-patient, diagnostic and therapy services.
The planned hospital will also offer in patient services to support the rehabilitation of some patients that no longer require the intensity of clinical care provided at the acute and emergency hospital but do require some additional assessment, time and support before they are able to go home. Providing this on a separate site to the acute hospital will enable the environment of care to be one that supports greater independence and will also ensure that the staff providing this support and care have the specialist rehabilitation skills and experience to do this and that they will not be called away to support another patient that may be more acutely unwell.

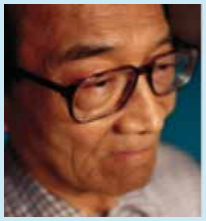
5.8 Illustrative Patient Stories

The following tables illustrate and give examples with patient stories of the benefits of the proposed new service models. There are examples of where these services are already available. The proposals described in this OBC will enable the consistent delivery of these type of benefits 7 days a week.

Self care

From now……		To services in the future……..
Jane was living with chronic pain, and was unable to take part in work and struggling to sleep. She was also was taking a lot of tablets every day including Gabapentin 300mgs 6-8/day. Co-codamol 500/30 8tabs/day, Amitriptyline - 50mgs at night, Citalopram 2 tabs, Ibuprofen 400mgs three times/day In addition Jane received spinal injections to relieve her pain symptoms. Jane continued to live with chronic pain. It affected all areas of her life, she was unable to work, had lost contact with most of her friends and her relationship was in real trouble. She regularly visited her GP and the pain clinic, but it seemed nothing could help.		Jane took part in a self-management programme offered as part of the co-creating health programme. This included advice on websites that she could access from home that contained useful information. This supported and taught her how to manage her own condition and symptoms. At the same time her GP also received training in co-creating health with patients. Jane was able to talk to her partner about her chronic pain and how it was affecting her which helped them to understand. Together Jane, her partner and her GP developed a care plan for Jane. The care plan included attending a course at the Recovery College on 'sleeping well' which Jane enrolled on for the start of the next term. Jane also benefited from linking up with other people that were on the programme and reported much improvement in her life. Jane has since been able to reduce her medication. As a result she has not needed to see her GP as often. Following the self-management programme Jane felt more positive and confident to manage her own condition. She is sleeping better and is now looking into getting employment. In preparation for work Jane is now a volunteer at the college helping out on reception.
Ray is 54; he has been struggling with breathing problems for some weeks and goes to his GP. They discuss his symptoms and the way they affect his life. Ray's lack of breath and inability to sleep mean he misses out on activities with his wife and family. His GP arranges for some lung checks and a blood test. They show that Ray has COPD. His heavy job in haulage is over. Ray doesn't know what COPD is, or how it may impact on him in the future. He feels confused and a bit down. He sees the practice nurse to explore his situation and what he could do to have better control over his breathing. However Ray continues to struggle to manage his own condition and does have to go to A&E at times. He finds this very scary.	 	Ray's practice nurse uses motivational interviewing techniques which she learned on a self-care training course. She is able to support Ray to explore his issues and find his own solutions and set some goals for the future. Ray wants to: understand what COPD is and what it means for him, improve his breathing and manage setbacks, improve his sleep and do something about his income. The nurse prescribes the most appropriate medications and checks that Ray knows how to use them, and points him to the self-care hub as other people have found it helpful. The hub contains a really useful video on using your inhaler which Ray is able to watch as many times as he needs to help improve his technique so that, within a month Ray is using his inhalers better. However, he needs to set new goals to improve his breathing, get fitter and give up smoking. Ray's goals are recorded on his care plan along with his medical/treatment information. These are stored using cloud technology and can be viewed on his smartphone. Ray has given his permission to share his patient data with his health and social care team via his smartphone. Ray only needs to tell his story once. The first time Ray uses the self care hub, he arranges to see a health trainer who suggests he might want to join a fitness programme for people that have health problems. Ray starts his first fitness session and really enjoys meeting other people some of whom have COPD too. One of them, Mick, he discovers was on an Expert Patient Programme which Mick said really helped build confidence. Ray decides to join as well. He gets a lot of insight into managing his condition and support from the other participants. Ray and his health trainer review how things are going and Ray agrees that his breathing is better since he started using some relaxation techniques he found on the hub. Ray is now managing his condition pretty well and he is able to set goals that he achieve that show him how his health is improving and also how the changes in his lifestyle are contributing to this. He sees his practice nurse and together they agree plans of what to do if he has a flare up and the changes in medication he should take if that happens. Ray has also joined a quit smoking support group which takes place at the local gym that he has now joined. Ray has not needed to go to A&E recently. His priority now is to get back to work and he is exploring options and skills training.

Self care

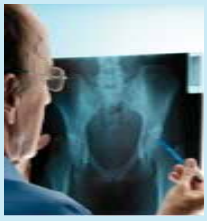
From now……		To services in the future……..
Last winter David started feeling really out of breath and it got worse very quickly. Following a hospital stay David was diagnosed with heart failure and discharged home with limited community support. He struggled at home with little support and after a series of complications was readmitted to hospital. His hospital stay was longer than it needed to be whilst a package of care was arranged to support him at home.		Last winter David started feeling really out of breath and it got worse very quickly. Following a hospital stay David was diagnosed with heart failure and discharged home with support from the heart failure nurse. The heart failure nurse, set David up with a monitoring machine at home. David uses it every morning "it has sensors that can take my temperature and blood pressure, and record my weight. Then it sends the results to the Care Navigators. I understand a lot more about heart failure now and it's made me feel more confident about coping with it myself." If there is a problem with the information the care navigators and David have a chat and together work out why this may have happened and plan the course of action to try and reduce it happening again. In this ways David can work with the team to prevent the little problems becoming big problems. Once David started to feel better he was offered an appointment with the Health Trainer. She used a simple six questions booklet to identify what was important to David and what support he might need to feel confident and able to manage his condition. He attended an Expert Patient Programme to learn more about managing his condition and keeping well. He was able to meet other people with heart failure and share his concerns as well as get support from people in the same situation as him.

Integrated community care 7 days a week

From now……		To services in the future……..
Sophie Smith is 78 and lives alone. She is very independent but district nurses do visit her to look after a leg ulcer she has. Over the past few days she has been feeling increasingly tired and on the Friday when she wakes up she feels unwell. When Sophie's GP comes to see her later that morning she adjusts Sophie's medication . However Sophie's GP is worried about leaving her at home alone whilst she is unwell over the weekend. She is not able to arrange any additional support at home for Sophie on Friday afternoon. Sophie's GP therefore arranges for an ambulance to take Sophie to A&E and she is admitted to hospital.		Sophie's GP contacts the Locality Community Team via the single point of access and asks for a rapid response. A community matron comes to visit Sophie within 2 hours and . is also able to arrange for the Home Care Provider (social care) to visit Sophie over the weekend to check she is OK or if she needs any extra help. The matron encourages Sophie to contact her daughter to let her know what has happened and leaves her number so that her daughter can phone her if she is concerned. When the District Nurse visits she sits with Sophie and via the nurses lap top computer is able to have a video conversation with the community matron who provides expert advice and support that reassures Sophie. As a result Sophie felt confident to stay at home and was very relieved that she did not have to be admitted to hospital. A few days later Sophie felt much better and back to normal.

Integrated community care 7 days a week		
From now……		**To services in the future……..**
Maria is 56. She lives with her husband (Tom) and has early stages of dementia. Tom has booked an urgent appointment for Maria with her GP as she is experiencing pain on urination Marie meets with her GP who prescribes antibiotics to to address the infection. Marie is confused by the medication she needs to take and is unable to take the antibiotics, her condition worsens and 2 days later Tom calls an ambulance. Marie is admitted to hospital and she is there for 5 days while she recovers from her infection.		Maria meets her GP who arranges for the local pharmacy to deliver the medication in a dosette box so it is easy for Maria and Tom to see what she needs to take. The GP also asked the Locality Team to review support for Marie and Tom. As a result Marie and Tom found a local community group that offers social activities on Sundays that Marie now goes to. This has given Tom a welcome break. The Locality Team also arranged for community mental liaison staff to visit Marie and Tom and offered advice about living with dementia. During the visit Marie and Tom explain how they used to enjoy listening to classical music together so they are given details of a new club that has opened in the local village hall Marie soon recovered from the infection and felt better. Tom felt more confident to continue to support Marie at home knowing he now had some extra support and advice available if he needed it.
Bill is 82 and has lived in a nursing home for the past 5 years. He is very frail and is bed bound. For the past four days Bill has had a cough that is not improving. His GP visited him earlier in the week but the antibiotics don't seem to be working. On Saturday afternoon Sue his nurse notices that Bill has a temperature and is becoming confused. She phones the GP out of hour's services and a doctor that has not met Bill before visits him in the nursing home. The GP is concerned about Bill. He knows Bill does not want to go to hospital but he explains that he needs IV antibiotics that cannot be provided in the nursing home. After discussing with Bill the GP phones for an ambulance that takes Bill to A&E and he is admitted to hospital. Bill spends 10 days in hospital.		Sue (Bill's nurse) uses a video conference to contact the Locality Community Team and together with Bill they talk to a Community Matron and explain his symptoms. During the video call the Community Matron asks Sue to use the remote monitoring devices so that she is able to review Bill's vital signs during the conversation. The Community Matron agrees that it would be a good idea for a GP to review Bill and she contacts Bill's practice that is open on Saturday mornings and arranges for a GP to visit along with an advanced nurse practitioner from the locality team. When the GP visits he decides that Bill needs IV antibiotic therapy for his chest infection. The advanced nurse practitioner is able to set this up and provide this in the nursing home. Bill is relieved he does not have to go to hospital. Sue feels confident that Bill's needs are being met in the nursing home. The next morning he is starting to feel better. He no longer has a temperature and his coughing has reduced.

Safer better hospitals		
From now……	**To services in the future……..**	
Sam is 8. He fell off the trampoline in his garden and injured his arm. His parents took him to the nearest A&E where he was assessed and given pain relief. He then had to be transferred by ambulance to another hospital with a paediatric A&E and trauma surgeons together in one place. There doctors assessed him again. He received surgery to repair his arm and was discharged home the next day.		Sam was taken straight to the paediatric A&E. He was admitted under the care of a paediatrician and surgeon throughout and did not need to transfer to another hospital site. His arm was repaired in theatre, and he was discharged back home the very next day.
Chris is 64 he has COPD and has been struggling with his breathing. A few days later on a Saturday evening his breathing becomes particularly difficult and his wife takes him to A&E. In the A&E department he is seen by a locum registrar doctor who decides to admit him to hospital. He stays on the medical assessment unit over the weekend. On Monday he is moved to a respiratory ward. He stays in hospital for 5 days.	 	When Chris arrives at A&E he is seen by a consultant doctor who is able to access his electronic care plan that Chris's GP and community locality team have agreed with him. The A&E consultant knows from the care plan what symptoms are normal for Chris, and also his medication, and the support he has at home. This saves time and ensures the doctor can arrange the right treatment immediately. Chris's symptoms improve whilst he is in A&E and because the doctor knows the support that Chris has at home he is able to discharge him without the need for an admission to hospital. The doctor is able to update Chris's care plan so that when he goes home the community locality staff have all the up to date information of his visit to hospital and the new medication he has been given. Chris feels much better and is pleased to be able to go home.
Lisa is 23 years old and generally considers herself healthy. She has had 36 hours of stomach aches and a temperature and on Saturday morning she wakes up with worsening symptoms. At 8am she phones 111 and is advised to go to her nearest A&E. Once at CRH A&E Lisa is examined by a locum doctor and is then transferred to Surgery at at HRI. At HRI an A&E doctor sees and examines Lisa and is concerned she may have appendicitis. She is transferred to the surgical assessment unit Lisa then receives diagnostic tests to confirm the diagnosis, and proceeds to surgery. Before she leaves the hospital she is given an emergency helpline number to contact in case of complications. Her GP is sent a discharge letter.	 	At 8am on Saturday morning Lisa phones her GP and gets a morning appointment. The GP examines her, is concerned about her high temperature and abdominal pain and refers her directly to the acute admissions unit for further investigations. She is reviewed by a consultant surgeon, who suspects appendicitis. All information is recorded on the electronic patient record that can be viewed by the appropriate clinician as and when required. Her GP is informed that she has been admitted via an electronic message to the GPs patent record system. Lisa then receives diagnostic tests to confirm the diagnosis, and proceeds to surgery. Before she leaves the hospital an appointment with her GP is booked for three days later. She is given information on recommended websites to access for after care information along with an e-mail address and an emergency helpline number to contact in case of complications. Her GP is electronically sent her full patient record and discharge information on the same day she leaves the hospital

Safer better hospitals		
From now……	**To services in the**	**future……..**
Stephen is 69 and lives alone. He's been enjoying an active retirement, but over the last couple of years he has found walking increasingly painful. It's got so bad that he finds leaving the house difficult – and with so little exercise, he's also struggling with his weight. He goes to see his GP and describes his pain and difficulty walking. His GP refers him to the hospital for an outpatient appointment. Stephen is put on the waiting list for hip surgery. Stephen attends an outpatient pre-op assessment appointment to assess his fitness for surgery 2 weeks before his scheduled procedure and also has an opportunity to ask the nurse questions about the procedures. Stephen wants the operation but is quite anxious about it. On the day of his surgery Stephen's operation is cancelled as there are acutely ill patients in the hospital beds and so there is no room for Stephen. This happens once more before he is finally admitted. On both occasions Stephen's son has arranged time off work to be there and this had needed to be rearranged. Stephen feels worried about this. During this time Stephen finds it difficult to cope with the pain and has been missing out on his usual social life and activities. He also feels increasingly anxious about the operation and a bit depressed and frustrated. By now he has forgotten what he has been told at the pre-op assessment appointment which was several months ago. There are no complications in the operation, and Stephen is transferred to the wards for recovery. Stephen's rehabilitation is going well; by the time he is discharged 3 days after the operation he can manage stairs and has a home exercise programme.	 	Stephen is referred by his GP and attends an outpatient pre-op assessment appointment in a community hub to assess his fitness for surgery 2 weeks before his scheduled procedure and also has an opportunity to ask the nurse questions about the procedure. He is also given information on websites to access for additional pre op advice. The date of his operation arrives and Stephen goes to the hospital in the morning and his operation takes place as planned. An anaesthetist and the surgeon who will be carrying out the operation come to see him. There are no complications in the operation, and Stephen is transferred to the wards for recovery. Stephen's rehabilitation is going well; by the time he is discharged 3 days after the operation he can manage stairs and has a home exercise programme. After 3 months Stephen joins a local walking group
Kirsty is 6 years old and has asthma. On Sunday, Kirsty starts wheezing badly and has some difficulty breathing. She has a temperature and Kirsty's mother take her to the nearest A&E. Kirsty is seen by a locum doctor who starts her treatment immediately and her wheezing improves. However within 4 hours and whilst still in A&E her symptoms suddenly deteriorate. The doctors are able to stabilise her condition but decide she needs to be transferred to another hospital where the A&E has on-site specialist paediatricians. Kirsty and her Mum travel in a blue -light ambulance which is scary for them. On arrival treatment is effective and Kirsty goes to the children's ward.	 	Kirsty's mother calls 111. She speaks to a nurse who asks questions to understand Kirsty's condition, and advises her to go to the children's A&E at the specialist acute and emergency hospital. Within 10 minutes of arriving Kirsty sees a consultant who starts her treatment immediately. Within an hour Kirsty has stopped wheezing. In an hour she goes to the children's ward with a paediatric nurse. A revised asthma action plan is agreed between Kirsty, her parents and the consultant. Inhaler technique and information of what to do if it Kirsty becomes breathless again are taught to both Kirsty and her parents. She has access to a video on line that shows her how to use her inhaler and a game that she can play to practise her technique. There is also a short video available on u tube that she can show to her friends so that they can help too. Her best friends mum has watched it and now feels more confident having Kirsty to stay for a sleep over. A follow-up appointment is booked at the outpatient clinic close to where Kirsty lives, a discharge letter is written to the GP and the GP receives an electronic update to Kirsty's patient record about her admission to hospital. Kirsty's parents are given a phone number to call, if Kirsty's condition deteriorates again. They have also been given details of a Facebook support group of other parents of young children with asthma

Some services we've already changed		
How it was……		**How it is now……..**
Rachel had been in and out of mental health services for years, living with a bipolar and depressive disorder that feels like living in a fog. Rachel's problems were becoming more serious and she had been referred for Psychological Therapy support. Whilst waiting to be seen Rachel had not been able to access other services. She had been feeling unwell and her family were worried.	 	Rachel saw a poster advertising Creative Minds. She started attending an 'art for wellbeing' programme at the local recovery college. 'Each week I felt more confident and was actually excited about going to art. I had nothing but the support of the Creative Minds and the wonderful tutors and other students in the group to keep me going through a very tough time of my life'. After joining Creative Minds Rachel said 'I was hooked, instead of taking sleeping tablets, I got my art pad out and sketched when things were on my mind. I was sleeping like I have never slept before, in fact I have volunteered to co-produce the next sleeping well course in the college Rachel has recently presented her art work on the Creative Minds online gallery /shop and has sold her first piece of work this was been such a boost to her confidence and self-esteem.
Tony lives alone. He has a healthcare assistant that visits him to support his healthcare needs. Tony has a wound that requires specialist support. The healthcare assistant can provide general healthcare support, however is unaware of Tony's care plan and may be unable to offer advice on the wound. Therefore in the past Tony would have been visited by the health care assistant and then needed to see the community matron too.		Now Tony's healthcare assistant can use her laptop to start a video conversation with the community matron, this enables a three way conversation. The community matron can see Tony's wound and advise the healthcare assistant on the care needed. Also they can all see Tony's electronic care plan and can make any changes needed during their conversation. Following the video conversation Tony's new wound care medication is ordered using electronic prescribing. This sends a direct prescription request to Tony's local chemist. Everyone is aware of Tony's treatment plan, and he receives the care he needs more quickly.
Derek is 75 and lives with his wife in Huddersfield. At home one morning at the weekend he suffered symptoms of a stroke. His wife knew to call 999 In the past Derek would have been taken to the nearest hospital and may have been cared for by the acute physicians on the medical assessment unit, then transferred to the medical ward. He may not have been able to access the diagnostic tests he required, and may not have been able to have thrombolysis, should he require it. He would have been reviewed by a stroke specialist within 24 hours He would have needed to stay in hospital for several weeks for rehabilitation.	 	Now, on identification of stroke symptoms by paramedics, Derek would be taken straight to the stroke centre at CRH, passing HRI on the way. Once there he would receive all necessary diagnostic tests to allow a decision to be made on emergency treatment within the clinically recommended time. If treatment (thrombolysis) is required there are specially trained nurses available all the time, supported through telehealth by stroke consultants from across the region. Having all the stroke and other acute services on one site means Derek receives more timely and effective treatment. His wife has used the time whilst he has been in hospital to learn more about strokes and how she can best help him when he gets home Finally, once Derek's acute treatment is over there is a team of therapists and nurses who can support Derek to go home much earlier and receive his on-going therapy in his own home, a real boost to his recovery. He receives support from various members of the rehabilitation team who co-ordinate the visits to Derek to make sure that he does not become overtired and he still has time to see his family.

5.9 The Strategic Case: Key Enablers of the New Service Models

Implementation of the new service models will require new ways of working, in particular:

We can put people in control of their own health and wellbeing needs
We can provide greater engagement, information and communication with local people to improve people's understanding and ownership of their health. There is an evidence base that this is a stronger predictor of health status than age, income, employment status, education level, race or ethnic group. We can develop whole system approaches to strengthen engagement with local people.

The vision for delivery of self-management is to enable more people particularly those with long term conditions to become increasingly independent, self-sufficient and resourceful. Ultimately this means they will be able to increase their sense of control, confidently assess and manage their health needs and live as active participants in their local communities. To enable self-management to be embedded within our communities, health providers need to support people be active partners in their own care. This includes being fully involved in decision making, able to access timely and accurate information and devise a self authored plan that enables them to self assess and identify priorities. To achieve these outcomes, a self-management approach is supported by four key enablers of change:

Skills – Equipping both the individual and the practitioner with the necessary skills to increase self-awareness, resilience, gain insight into their own needs, problem solve, set goals and create a self-authored care plan

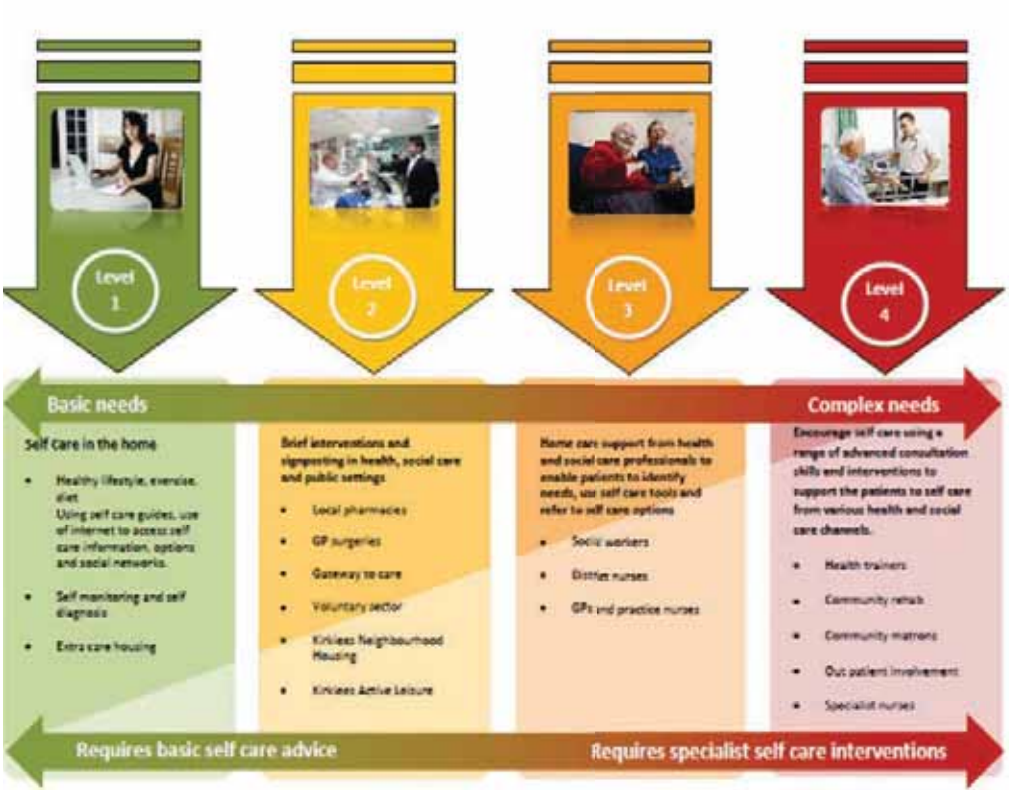
Resources – Access information including technology enablers to support people to build networks, get support and gain knowledge in developing skills to monitor own health

Behavioural and cultural change in systems – that will result in change across systems to enable people to experience timely consistent and effective experiences that maximises independence and choice

Communication – at the front line with the individual, throughout services and across communities

A roadmap for self care has been developed (see below) which addresses the above priorities. This includes development of a comprehensive training programme using a range of interventions tailored to level of need, integration of health and social care through providing clear pathways and consistent self care approaches, and technology enablers that ensures people have the right skills, tools and resources to self manage their health and wellbeing.

Spectrum of self Care



We Can Invest in Staff Capabilities and Skills to Enable Quality Improvement

We can support staff to work in new ways across organisations through a deliberate and sustained leadership strategy that focuses on quality improvement and invests in staff capabilities and skills. The shift we need to make is that all staff are equipped for two jobs – the job they do and the job of improving quality.

We will work together as a system to create new workforce planning arrangements designed to maximise opportunities for better and more integrated health and social care solutions.

We will consider priorities across professional and non-professional groups and the needs of the current and future workforce, with respect to numbers, skills and behaviours, so that we can better respond to the current and future needs of patients.

We will realise the potential for staff to drive service improvement and transformation through greater investment in our current workforce through the delivery of care with a focus on removing out-dated practice.

We will in the longer term, move away from a workforce planning process that is largely driven by numbers as seen through the lens of the registered professions and move towards a process that enables us to view the workforce needs through the eyes of patients and their families, such as children and vulnerable older people. Our processes will need to reflect changes in technology, science and medicine as well as what this will mean for the 'doctor/patient relationship' and the models of care we deploy.

We will align ourselves closely to the work being undertaken by Health Education England to support these ambitions.

We can Use Information Technology to Support New Ways of Working

There is a growing dichotomy between how people use digital technology in their everyday lives and how digital technology is used to enable the provision of health and social care.

There is an opportunity to change the way we work to provide more efficient, safe and high quality services using technology, and also for people to use technology to support self-care. The table below provides a summary of these opportunities.

	What we will do	What difference will it make to people
Using technology to share records	Make it easy for people to view their record	The clinical record is the patient's clinical record, it is their information. Currently some people can view their clinical record on line. SystmOne and EMIS have Apps that people can download to access their record subject to security and validation checks. This will become common place and be a route to people eventually owning and holding their own records. As a minimum we will develop systems that allow all patients and service users to view their care plan, including medications, jointly set goals and appointments.
	Make on-line checking of investigations and results available	Alongside access to the person's record, people will have specific access to the results of investigations and tests.
	Allow entering of your own information into your health record	In addition to the above we will make it possible for people to enter their own data where the circumstance is appropriate. For example, a patient with diabetes will be able to enter their diabetic measurements on a daily basis. This will give a much more rich record for patient and clinician alike in order to better manage the condition.
	Make on line booking of appointments available	Some people are able to book appointments with their GP using their GPs website. We will make on line booking of appointments much more wide spread both for hospital and community service. So when a patient needs to see a clinician and in the right circumstances, the patient can book their appointment directly into an available slot.
	Send reminders for appointment	Reminders for appointments are common place in everyday life and in some health services. Reminders will be common place and via a variety of media; text, email, automated phone calls and social media.

	What we will do	What difference will it make to people
Using technology to support self-care	Have access to 'Follow me' the self-care hub	Self-care and people having more control of their condition and being able to manage their condition themselves is a key feature of the community model. Technology can support this. Follow me is an on line tool that anyone can use. It allows a person who may want more knowledge about their long term condition to review suitable information as well as techniques they can use to help them manage their condition. Importantly there is a journal that is specific to each person that they can log into and enter information about their condition, how they feel and what their symptoms are for example. Over time the person then builds up a deeper understanding the impact of what they do and how they live their life on their condition and are therefore more able to manage it.
	Telehealth	There will be a range of different Telehealth services. These will build on the existing services but also we will introduce new ones. There will be Telehealth for patients with long-term conditions where monitoring a condition can more readily detect an exacerbation that can be acted upon more quickly. There will be Telehealth where by virtual check-ups with patients can give advice and assurance. There will be Telehealth for specific clinical settings, for example links between care homes and outpatient services, or virtual clinics between hospital services and the hubs bringing specialist care closer to the community.
Technology to support improved communication	Make video conferencing available	The ability to communicate and share information is paramount for teams of clinicians, carers and non-clinicians as well as with people who access our services. Technology exists now, and is used now, this will become more wide spread. How can it be used effectively? An example would be for a patient with a complex condition that needs to be discussed by a variety of individuals such as the GP, hospital consultant, social worker, community matron and importantly the patient and their family. Instead of complicated arrangements to get all these people in a room together, a video conference call can simply be established. This being much more convenient for the patient and their family.
	Have remote minor injury assessment	When someone has a minor injury, a cut, graze or felling unwell and they may just want some advice, instead of going to their local minor injury unit they can have their condition assessed remotely. How would this work? These days devises with high quality cameras are not uncommon (iPhones, tablets, smart phones etc.). A simple video discussion between a minor injury unit and an individual is simple to initiate. This would be an assessment and advise session directing the person to either self-care options or to be seen by a clinician.
	Have virtual Pre-operative screening	For some surgical procedure the pre-operative assessment can be done remotely. Using the same technology as for a minor injury assessment, pre-operative screening can take place. A real example that happens now is for a minor surgical procedure such as toe nail surgery in Podiatry. The clinician can assess the toe nail via a web cam and discuss the condition with the patient. If required the patient would then be directly listed for treatment, removing an unnecessary appointment for pre-assessment and more convince for all. This approach would be expanded for other suitable conditions.
	Hold virtual clinics	For patients that are having a routine check-up, for example, post-surgery or as part of their long term management of a condition, it is possible if appropriate for all, to hold this appointment remotely. A planed phone call of video call can be held with the patients thus removing the need for the patient physically attending an outpatient clinic when there is no need.
Technology to support better care	Community staff that are fully mobile	Community colleague's main work is in people homes, directly caring for people. Having hardware, such as lap tops, that can connect to the clinical record as well any other information that is required allows for greater patient facing time. There is less need to go 'back to base' to access information, the clinical record is updated there and then and if there is a requirement to discussed the patient with another member of the team then this can be done quickly and easily. Mobile working of community colleagues makes for a much more efficient and effective clinical team.

6.The Strategic Case: Capacity Plan and Implications

The services described in Section 5, have been modelled against forecast demand and activity and this has identified the implications for workforce, and hospital and community capacity. This has included informed assumptions about opportunities for improved efficiencies as a result of working differently together as a health community. These are reflected in the economic evaluation in Section 9.

The Strategic Outline Case used a number of evidence based assumptions to forecast the likely impact of the service changes on capacity and efficiency. The work that has been undertaken in preparation of this Outline Business Case has involved the doctors, nurses, therapists and operational managers across CHFT, SWYPFT and Locala that currently provide the services to test the assumptions used in the Strategic Outline Case in terms of deliverability and quality impact. Very detailed activity modelling has been undertaken and is available in supporting papers. This section of the Outline Business Case summarises the key outputs from this that have been used in the economic and finance cases.

6.1 Headline Messages

Over the next ten years there will be growth in demand for hospital activity due to the increasing needs of the population. However the increased demand for hospital based services can be mitigated by new ways of working and implementation of the new service models that are described in this OBC.

The key capacity issues identified in this section are summarised below and additional detail of assumptions and modelling provided on the following pages.

- The forecast impact of demographic growth on non-elective inpatient activity over the 10 year period is 11%. Detailed modelling has shown this can be reduced to 3% through new ways of working that will enable fewer admissions, reduced lengths of stay in hospital and greater levels of support for patients that need it closer to home.
- The forecast impact of demographic growth on Accident and Emergency services over the ten years is 7%. Detailed modelling has shown this can be reduced to 3% through new ways of working.
- A 20% net reduction in hospital beds (from 802 to 636) is possible by working in new ways in the hospital and providing more care and support in the community i.e. decreasing the number of planned care beds by increasing procedures undertaken as day case rather than inpatient procedure, and reduced lengths of stay because patients can be discharged with support in the community.
- 85 beds will be required on the planned hospital site.
- 551 beds will be required on the unplanned hospital site.
- There will be a 5% growth in demand for community services due to more care and support provided out of hospital.
- There is a 7% forecast demographic growth in demand for community services.
- There is a 12% community services efficiency opportunity that is possible from working in new ways.
- A high-level assessment of the impact on GPs and Social Care capacity has also been undertaken this estimates a 5% additional capacity requirement to meet the needs of people in the community. An assessment of the requirement for investment related to this has been included in the economic and financial case.

6.2 The Impact on Hospital Activity

The tables below show the forecast change in hospital based activity over the ten year period 2014/15 to 2023/24.

CHFT Total – new ways of working & demographic growth	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	% Change
Elective inpatients	9,129	8,697	8,800	8,904	8,986	9,068	9,149	9,233	9,317	9,402	3%
Elective day case patients (Same day)	41,456	41,879	42,352	42,830	43,193	43,559	43,930	44,302	44,678	45,057	9%
Non-Elective	50,273	50,039	49,789	49,456	49,398	49,347	49,900	50,459	51,027	51,603	3%
Outpatients - first attendance	112,274	113,406	114,399	115,173	116,184	117,203	118,232	119,270	120,317	121,374	8%
Outpatients - follow up	213,409	214,027	215,942	217,521	219,456	221,409	223,380	225,369	227,376	229,401	7%
A&E	141,512	146,259	145,608	144,952	144,396	143,836	143,274	144,324	145,382	146,448	3%
Other NHS activity	1,697,314	1,775,161	1,861,720	1,955,000	2,055,052	2,163,483	2,280,727	2,407,274	2,543,662	2,690,488	59%
	2,265,367	**2,349,469**	**2,438,611**	**2,533,837**	**2,636,665**	**2,747,906**	**2,868,591**	**3,000,231**	**3,141,759**	**3,293,772**	

CHFT Total - just Demographic Growth)	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	% Change
Elective inpatients	9,129	9,238	9,348	9,460	9,546	9,633	9,721	9,810	9,899	9,990	9%
Elective day case patients (Same day)	41,456	41,919	42,388	42,862	43,222	43,585	43,952	44,322	44,695	45,071	9%
Non-Elective	50,273	50,805	51,343	51,887	52,480	53,080	53,690	54,307	54,934	55,569	11%
Outpatients - first attendance	112,274	113,257	114,249	115,250	116,260	117,280	118,309	119,347	120,395	121,452	8%
Outpatients - follow up	213,409	215,315	217,240	219,181	221,127	223,091	225,072	227,071	229,089	231,125	8%
A&E	141,512	142,447	143,389	144,337	145,395	146,461	147,535	148,617	149,707	150,805	7%
Other NHS activity	**1,697,314**	**1,786,477**	**1,880,821**	**1,980,652**	**2,086,384**	**2,198,352**	**2,316,927**	**2,442,500**	**2,575,486**	**2,716,323**	**60%**
	2,265,367	2,359,459	2,458,778	2,563,629	2,674,414	2,791,484	2,915,206	3,045,975	3,184,204	3,330,335	

Change in activity	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	% Change
Elective inpatients	0	(541)	(548)	(555)	(560)	(565)	(572)	(577)	(582)	(588)	-6%
Elective day case patients (Same day)	0	(40)	(35)	(31)	(29)	(26)	(22)	(20)	(17)	(14)	0%
Non-Elective	0	(766)	(1,554)	(2,431)	(3,082)	(3,733)	(3,790)	(3,848)	(3,907)	(3,966)	-8%
Outpatients - first attendance	0	149	150	(76)	(77)	(77)	(77)	(78)	(78)	(79)	0%
Outpatients - follow up	0	(1,288)	(1,298)	(1,660)	(1,671)	(1,681)	(1,692)	(1,702)	(1,713)	(1,724)	-1%
A&E	0	3,812	2,219	615	(999)	(2,625)	(4,262)	(4,293)	(4,325)	(4,357)	-3%
Other NHS activity	0	(11,316)	(19,101)	(25,652)	(31,332)	(34,870)	(36,200)	(35,226)	(31,823)	(25,835)	-2%
	0	**(9,990)**	**(20,167)**	**(29,791)**	**(37,749)**	**(43,577)**	**(46,615)**	**(45,744)**	**(42,445)**	**(36,563)**	

The assumptions that have been used are:

Demographic Growth / Future Demand

The capacity modelling predicts an increased demand for services based on changes in demography and the increased needs of an ageing population with multiple health needs. The growth assumptions have been applied by speciality and the range is a predicted annual growth in various specialities of between 1.5% and 0.2% per annum over the ten year period. The model has also taken account of the changes in reconfiguration at Mid-Yorkshire Hospitals and that this will result in an additional 7 A&E attendances per week at CHFT transferred by Yorkshire Ambulance Services of which 38% will require admission to hospital.

Demand Management & Reduction in Non-Elective Inpatient Activity

The model has made assumption for a reduction in non-elective medical admissions to hospital associated with an increased provision of ambulatory care and services out of hospital. The assumption used is a 40% reduction in admissions to Geriatric Medicine and a 15% reduction to Neurology, Respiratory Medicine, Stroke Medicine, Cardiology, Hepatology, Haematology, Gastroenterology, and General Medicine.

Outpatient Activity

The model assumes a reduction in outpatient follow up attendances related to new models of care provided closer to home (e.g. paediatrics, rheumatology).

Accident and Emergency Attendances

The modelling includes a reduction of paediatric A&E attendances enabled by the new models of delivering care closer to home.

Increase in Day Case Surgery
The model assumes a shift from inpatient surgery activity to day case activity. The assumption is based on movement to best in class.

Impact on Activity Provided at Different Sites

The table below shows the high level split of activity at different locations.

Site Split 2023/24	Planned	Unplanned	Todmorden	Holme Valley
Elective inpatients	4,863	4,539	-	-
Elective day case patients (Same day)	24,278	20,778	Some minor surgery procedures will be provided at these sites at this stage the activity split has not been assessed. This will be clarified in the Full Business Case	
Non-Elective	1,129	50,474	-	-
A&E or minor injuries	22,563	117,364	3,365	3,156

6.3 Impact on Hospital Bed Capacity

The table below shows the impact on the number of hospital beds required in the future related to the forecast change in activity (described above), the implementation of more efficient ways of working in the hospital and the new models of care described in section 5. The assumptions that have been used to determine the bed requirement are:

Length of Stay
An assumed reduction of 20% in length of stay in medical specialities. This will be enabled by 7 day working both in the hospital and in the community.

Increased Future Access to Community Rehabilitation Bed
The provision of a further 14 beds at the Heatherstones development.

Bed Occupancy
A move to 85% occupancy in medical specialities.

Growth in Demand
The modelling includes assumptions related to demographic growth and the impact of Mid Yorkshire hospitals reconfiguration of services.

Changes in Hospital Bed Numbers 2014/15 – 2023/24	
Number of Beds 2014/15	788
Additional bed capacity open May 2014	14
Starting number of beds open	802
Additional beds related to Mid Yorks changes	16
Additional beds related to demography	34
Additional beds related to quality – shift bed occupancy to 85%	83
Total beds needed in 10 years if no efficiency or service change	935
Reduction in beds related to more efficient working in hospital	(166)
Reduction in beds related to OBC new service models	(133)
Total bed reductions	(299)
Number of beds 2023/24	636

Explanation of Bed Number Table

The Trust currently has 802 beds open.
Over the next ten years in the absence of any other action an additional 133 beds would be required to meet additional demand related to demographic growth, the changes in service provision at Mid Yorkshire Hospitals Trust and to enable delivery of an 85% bed occupancy rate.
Internal changes in ways of working and improved efficiency will enable a reduction of 166 beds. The reconfiguration of services and increased provision of out of hospital care as described in this Outline Business Case will enable a further bed reduction of 133.
Overall over the ten year period there is a total bed reduction of 299 beds which is offset by growth requirement for beds resulting in a 20% net bed reduction over the period from 802 to 636.

The table below shows how this compares to the assumptions that were made in the Strategic Outline Case.

	Strategic Outline Case	Outline Business Case
Total Bed Reduction	300	299
Net Bed Reduction (off set by Growth, Quality)	100	166

Number of Beds on the Planned and Unplanned Site

Of the total bed number of 636 it has been determined that 85 beds will be required on the planned hospital site and 551 beds on the unplanned hospital site.

6.4 The Impact on Community Services

The table below shows the capacity impact for community services associated with implementing the service changes described in this Outline Business Case. The assumptions used are:

Demographic growth
The projected increase in the population has been calculated, as has the anticipated impact on community health and social care services.

The population is projected to grow by approximately 4% by 16/17.
Within community services this growth is expected to create an additional 7% activity (due to particular growth in high frequency service users) which equates to a growth of circa 35,000 contacts delivered in the community from 16/17.

More Care Closer to Home
The impact of more care provided out of hospital on community services activity equates to a 5% growth or circa 24,000 additional patient contacts delivered in the community.

Efficiency assumptions
Moving to locality based integrated teams holds significant potential to improve the way in which services are provided for our local populations. These efficiencies include reducing duplication by providing integrated care, the benefits of remote working and technology, and supporting self-care. The benefits equate to a 12% reduction in activity demand.

Community locality model		**Activity (contacts) – CHFT/Locala**
Baseline	- current position	**464,924**
Demographic increases	- 3 year growth to 17/18	**35,269**
Acute activity shift	- 17/18 more activity out of hospital	**24,714**
Efficiency assumptions	- 12% reduction across all services in scope	**(62,989)**
	Totals	**461,918**

This analysis indicates that new ways of working could potentially absorb the increased demand for services in the community. However, it does not address the transitional costs which are associated with this or seven day working implications. This will require additional investment in community, primary and social care provision and this is reflected in section 11 (The Financial Case).

6.5 The Capacity Impact for General Practice and Social Care

A high-level assessment of the impact of delivering more care out of hospital on GP and social care capacity has been made and this has been factored into the economic and financial case described in sections 9 and 11. This is a key area that will need to be developed and refined in the development of the full Business Case.

7. The Strategic Case: Workforce Plan and Implications

The purpose of this section is to explain the workforce impact and requirements of implementing the proposed new service models. The information provided in this section includes:

- the workforce capacity required to deliver the new model.
- the impact of the proposed new service model on workforce clinical and quality standards.
- The approach to support workforce transition and new ways of working.

7.1 Introduction

Calderdale and Huddersfield Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership Foundation Trust know that the current clinical workforce of doctors, nurses and therapists that provide services across Calderdale and Huddersfield are their most valuable asset.

During preparation of this Outline Business Case there has been extensive engagement and involvement of clinical staff. This has confirmed overwhelming support for the direction of travel proposed and the benefits this will deliver to improve the quality and safety of patient care.

The implications of the service changes and new ways of working described in this Outline Business Case are significant for the workforce. Our aim is to ensure that:

- workforce resources are deployed in the most effective and efficient way to enable implementation of the new service models
- staff are supported through transition to the new service models
- staff are equipped with the necessary skills and training to work in new ways.

We are committed to supporting the health and wellbeing of all staff and where possible the continuing employment of the current permanent workforce now and into the foreseeable future.

We also understand our important role as significant and good employers in the districts we serve and we share an intention to continue to support the employment and training opportunities that we currently provide that we know support the community and local economy resilience.

7.2 Workforce Capacity Required to Deliver the New Service Model

Method

The workforce capacity required to deliver the new service models has been determined based on the activity and bed capacity modelling described in section 6.

This work has been undertaken with significant clinical and operational engagement and professional human resources advice to model the workforce requirements. Specific advice from Nursing and Medical Directors has also informed the workforce model to assess and assure the quality impact and that there are not any unintended consequences for patient safety. The key general assumptions that have been used to determine the workforce requirement are that:

- The new model will enable seven day working both in the community and in the hospital.
- The new model will ensure improved and appropriate nurse to patient staffing ratios.
- The changes in ways of working will enable a net reduction of hospital beds over a ten year period. This means that over the next ten years there will be a requirement for fewer staff working in the hospital.
- Community based services in the new model will need to deliver additional face to face contacts related to a reduction in delivery of the number of hospital bed days. Some of this additional activity can be delivered through improved and new ways of working (i.e. efficiency) however there will also be a requirement for additional primary and social care capacity to enable the new model. The implications for GP and social care capacity have been described in section 6.

Current workforce profile

A summary of the whole time equivalent workforce as at 31 March 2014 is provided below. For South West Yorkshire Partnership Foundation Trust and Locala Community Partnerships the figures relate only to staff working in Calderdale and Greater Huddersfield.

Staff Group	Organisation			Total
	CHFT	SWYPFT*	Locala	
Medical & Dental	532.83	34.05	11.4	589.68
Nursing and Midwifery	1656.6	202.00	257.5	2373.6
Allied Health Professionals	403.15	35.77	6.3	451.52
Healthcare Scientists	123.67	Not provided	-	123.67
Additional Professional Scientific and Technical	150.86	28.75	5.1	189.81
Additional Clinical				
	1091.64	133.19	77.4	1379.6
Administrative and Clerical &				
Estates and Ancillary	1149.51	68.33	99.8	
	1417.4			
Senior Managers	90.21	Not provided	15.3	120.81
Total	**5198.47**	**502.08**	**472.7**	**6646**

* The WTE for SWYPFT data provided was for staff providing all services across Kirklees. For this view, only the services provided in Huddersfield are required and therefore the WTE have been pro-rata based on population size for Huddersfield wards compared to all Kirklees Council wards.

Modelling of the Impact of the New Model on Hospital Based Workforce

Detailed modelling of the impact of the new service model on the hospital workforce has been undertaken. The table below summarises the net impact which is a forecast reduction of 409 WTE hospital based staff over the next ten years. This model incorporates investment in staffing levels to improve quality of services related to 7 day working and improved nurse staffing to patient ratios across the smaller hospital bed base.

Issue Rationale / Description	Impact on WTE (reduction) / increase
Reduction in ward based nursing and healthcare assistants	
The new service model will enable a reduction in bed numbers associated with improved ways of working in the hospital and increased provision of out of hospital care 7 days a week.	(224)
Reduction in non-clinical ward staffing support	
The reduction in beds (wards) will have an associated impact to reduce the requirement for non-clinical ward based support (e.g. cleaning, catering, porters etc.).	(68)
Reduction in non-critical staffing posts Trust wide (efficiency)	(66)
Reduction in administrative and clerical posts	(40)
6% reduction in management posts	(17)
Increase in staffing to enable seven day working and improved nurse staffing ratios across residual bed base	106
Implementing new models of contracted-out support services (e.g. laundry)	(100)
Total Reduction in Hospital Workforce	**(409)**

Modelling of the Impact of the New Model on Community Based Workforce

Overview of Impact on Community Staff

The impact of the new service model on the community based health workforce is summarised below. This shows that the additional activity that will be provided in the community and move to 7 day working will require an additional 175 WTE community based health staff over the next 3 years. Some of this additional staffing requirement can be off-set by the assumed efficiency gain from new ways of working.

Community locality model		Activity (contacts) – CHFT/ Locala	Workforce – all providers (wte)
Baseline	- current position	**464,924**	**1,072**
Demographic increases	- 3 year growth to 17/18	**35,269**	**75**
Acute activity shift	- 17/18 shift of activity acute activity	**24,714**	**50**
Efficiency assumptions	- 12% reduction across all services in scope	**(62,989)**	**(128)**
Increased staffing for 7 day working	- implementing 7 day working	**-**	**50**
	Totals	**461,918**	**1,119**

It is estimated that the move to 7 day working would equate to a requirement for a circa further 50 WTE staff (which equates to £1.9m i.e. 5% of current staff cost). In terms of the WTEs the estimate of 50 is based on an average staff cost of £37k. However some of this additional cost relates to pay enhancements for out of hours working and therefore the WTE impact is a proxy indicator. The additional costs for 7 day working has been incorporated in the economic assessment of the model.

Impact for GPs and Social Care

This workforce model also does not include the impact of the additional out of hospital work on social care and GP capacity. Modelling of this has been undertaken that is factored into The Economic Case and Financial Case (sections 9 and 11).

Assumptions that have been Used in the Community Workforce Modelling

In order to calculate the future workforce requirements within the community a four-stage process has been used.

1. Baseline - Establishing a baseline of the community staff who would work in an integrated manner as part of locality teams
2. Demographic growth - Calculation of the impact projected demographic growth is expected to have on community services during the next 3 years
3. Shift of care to the community - Calculating the additional workforce required to support the shift of care for those patients who previously received treatment within secondary care whose care will be delivered in a community setting in the future.
4. Efficiency assumptions – the benefit moving to integrated community working will have on workforce requirements

What is our baseline?

- The community workforce baseline is made up of those services which form the integrated community locality teams.
- The health and social care input into these teams will comprise a range of health, social care and community mental health team input working together as integrated locality teams
- These teams will include a range of multi-disciplinary roles including district nurses, community matrons and advanced practitioners, specialist nurses, therapy support, pharmacists and community mental health teams,
- Those services provided in the community which have not been included in the scope of future workforce calculations would continue to work in an integrated manner with the locality teams

Demography

- The projected increase in our local population has been calculated, as has the anticipated impact on community health and social care services.
- Our local population is projected to grow by approximately 4% by 16/17.
- Within community services this growth is expected to create an additional 7% activity (due to particular growth in high frequency service users) which equates to a growth of circa 35,000 contacts delivered in the community from 16/17.

Acute shift

- Enhancing community service provision will in the future support more care to be delivered in the community as opposed to within secondary care.
- We have calculated the impact this growth will have on local community services using evidence based assumptions to calculate the impact that secondary care activity will have if delivered in the community in the future.
- This shift in secondary care activity equates to a 5% growth or circa 24,000 contacts delivered in the community.

Efficiency assumptions

- Moving to locality based integrated teams holds significant potential to improve the way in which services are provided for our local populations.
- We have assessed and quantified these benefits in detail in order to assess the future workforce requirement to deliver these services once future activity has been calculated (demographic growth and the volume of work moving from secondary care).
- These efficiencies can be summarised as:

i. Improved efficiency of services – we know that some patients currently receive multiple visits from multiple care providers. We will reduce this duplication by providing integrated care which is coordinated across different providers.
ii. We will utilise the benefits of remote working and technology to communicate in innovate ways with patients and service colleagues to decrease the time staff are required to spend travelling.
iii. Self-care – we will support culture change amongst service users allowing them to take control of their care through the use of technology including telehealth and telemonitoring and allowing individuals to own their electronic patient record to plan their treatment.

- The benefits stated equate to a 12% reduction in the calculated workforce requirement within the community services evaluated.

7. 3 Impact on workforce clinical and quality standards

The workforce modelling assumptions that have been used are based on enabling achievement of the service models described in previous sections of this Outline Business Case.

The table below summarises the impact of the workforce model on clinical and quality standards.

Workforce Impact	Description of Benefit
7 Day Working	The service and workforce model is based on enabling 7 day working across community and hospital services. This will enable achievement of the ten national standards of urgent and emergency care that patients should expect to receive, seven days a week. Delivery of these standards will reduce the risk of morbidity and mortality in a range of specialties and provide consistent NHS services, across all seven days of the week.
Extended Hours Working	The service and workforce model is based on enabling extended hours working. For example 16 hour senior doctor presence in the hospital. This will reduce the risk of morbidity and mortality in a range of specialties.
Compliance with the College of Emergency Medicine Guidelines	The College of Emergency Medicine recommends a minimum of 10 Consultants in Emergency Medicine per emergency department. The changes in service and workforce model will enable this workforce standard to be achieved. This will improve the likelihood of survival and a good recovery for patients.
Multi-Disciplinary and Shared Care Working	The changes in service and workforce model will enable for example shared surgical and medical paediatric care in the hospital and multi-disciplinary working in the community. This will improve the quality and outcomes of care.
Improved Nurse to Patient Staffing Ratios	The changes in service model will enable achievement of the NICE nurse guidelines that are currently being consulted on. This will improve the quality, outcomes and dignity of care that people experience.

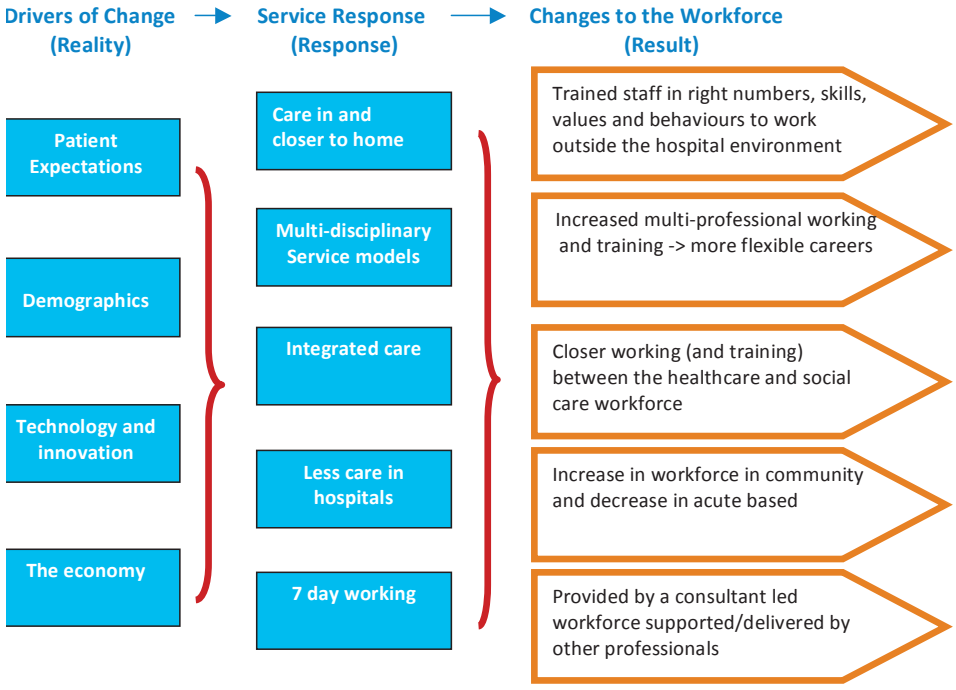
7.4 Transition and supporting New Ways of Working

Most of the workforce that will deliver the new models of care are already working within Calderdale and Huddersfield Foundation Trust, Locala Community Partnerships, and South West Yorkshire Partnerships Foundation Trust. So our workforce development strategy must focus on building a sustainable clinical community across our organisations and with other providers in Calderdale and Huddersfield.

To do this it is important that there is an under-pinning philosophy of the behaviours and values we expect of all employees. We can support staff to work in new ways across organisations through a deliberate and sustained leadership strategy that focuses on quality improvement and invests in staff capabilities and skills. The shift we need to make is that all staff are equipped for two jobs – the job they do and the job of improving quality.

The diagram below summarises the key impacts of the service transformation for the workforce.

The table below provides a summary of the key elements of the workforce transitional issues and support that will be provided.



Workforce Issue	Approach
Staff allocation and deployment	The changes to the service model mean that over the next ten years fewer staff will be required to work in the hospital. Staff will be concerned whether this means job losses. Our approach will be to equip staff with the skills they need to work in new ways that means they may be able to move to new roles. We know the current turn-over of staff across our organisations is circa 10% (this equates to potentially 600 posts that are vacant compared to the overall staff reduction identified of 409 posts). Whilst this will not offer the whole solution and there is complexity in redeployment we will where possible work with staff to support redeployment to new roles and minimise the need for job losses.
Service Base and Travel	The new models of care will require staff to work in new settings – potentially a move between the two hospital sites at Huddersfield Royal Infirmary and Calderdale Royal Hospital or a move to a community locality based service. For some staff these changes may involve split site hospital and community working. Plans will be put in place to support staff travel arrangements regarding these changes.
Out of Hospital Care	Training of clinical staff in out of hospital settings will be provided to support developing skills to support patients in the community
Use of Technology	The new service models are based on the use of technology to enable safer, more efficient and convenient care. Staff will be supported in training to enable this.

8. The Strategic Case: Estates and Travel Plan Implications

This section of the Outline Business Case describes:

- the estate requirements and implications in relation to the development of two community hubs at Todmorden Health Centre and Holme Valley Memorial Hospital.

- the estate requirements and implications in relation to the proposed reconfiguration of hospital services to establish a specialist acute and emergency hospital and a specialist planned care hospital utilising the current hospital sites at Calderdale Royal Hospital and Huddersfield Royal Infirmary.

- the travel implications for service users and carers related to the proposed reconfiguration of services.

The overall aim of the service model is to deliver more services in people's homes or close to home. The aim of the estates model to support this is that when people do need to come to hospital or community facilities that:

- The estate is high quality and supports people to receive clinical services at the right time in the right place and that the environment of care is high quality and therapeutically appropriate.
- Technology is available both on the hospital sites and in the community to support the proposed service model.
- The estates model is sustainable for at least the next 30 years.
- Significant energy savings will be achieved as the Trust more intensively uses its modern, energy efficient, estate and reduces occupancy within the older estate.

The proposed service changes will require an increase in capacity and facilities on the unplanned hospital site and rationalisation of estate elsewhere in the system. The overall effect of the changes will mean:

- Optimising and fully utilising the estate facilities available at Todmorden Health Centre and Holme Valley Memorial Hospital to provide care closer to home.

- Upgrading the facilities at Holme Valley Memorial Hospital.

- Additional hospital bed capacity and associated facilities are required on the unplanned hospital site.

- There will be a reduced need for beds on the planned hospital site, presenting the opportunity to either rationalise the estate or provide a broader and alternate range of services on the planned site.

Even in the absence of any service reconfiguration there is still a requirement to bring the current estate to a good (level B) standard. There are a number of buildings within the estate which require upgrades, or re-provision, and some that will become surplus to requirements once the health community has better access to, and use of technology.

8.1 The Current Estate

The table below provides an overview of the current estate in relation to this Outline Business Case.

Site name	Site owner and providers using the site	Site information
Huddersfield Royal Infirmary 	Site owned by CHFT and services provided by CFHT. GP out of hour's services provided by Local Care Direct.	HRI was completed in the 1970s. It is a 28 acre site with approximately 420 beds and 9 theatres. It requires a significant amount of work to get the infrastructure fit for purpose and of a good standard. The recent 6 facet and asbestos surveys indicated that it requires improvements to its engineering services, as well as full upgrades of wards and departments so that they are modern and compliant. This work is estimated at circa £100 million. Development at Acre Mill of a new outpatient facility that will be opened in 2015
Calderdale Royal Hospital 	Site owned (with PFI) by CHFT Services provided by CFHT and SWYPFT (The Dales) GP out of hour's services provided by Local Care Direct.	CRH underwent significant refurbishment through the Private Finance Initiative. The hospital was built and opened in 2001, on the site of the original Halifax General Hospital, following the merger with the Royal Halifax Infirmary. It is a 19 acre constrained site with approximately 450 beds and 7 theatres SWYPFT have 38 beds for adult care (18-65 year old) and 16 beds for older people care (65+ year old) on CRH site. The existing PFI arrangement at Calderdale runs until 2061 (a further 47 years). The revenue cost of this is circa £10m per annum, with an additional cost of £10m per annum for hard and soft facilities management. There is a break clause in 2031 which is associated with significant exit costs.
Todmorden Health Centre 	Site owned by Assura, services provided on site by CHFT and GPs.	CFHT lease the top floor (20 year lease until 2029). CFHT also use space on the middle floor but this space is managed by NHS Property Services Ltd. CHFT services on this site include outpatient and diagnostic services, and therapy services.
Holme Valley Memorial Hospital 	Owned by NHS Property Services Ltd. Locala are main provider on site but CHFT and GPs also provide services on site.	Holme Valley MH comprises a 1,956 sq m community hospital building originally constructed pre 1948. The premises have been refurbished and extended over the years and now incorporates accommodation of differing standards. There remain some backlog maintenance issues (last costed in 2012 at a risk adjusted £87,000). Locala provide community hospital services on this site. CHFT provide therapy services on this site.

Note: the bed numbers shown above at CRH and HRI are the estate capacity available for number of beds. The bed requirement is flexed up and down during the course of the year to cover pressures in the system at different times of the year. At the time of preparing the OBC there are 802 beds open across the two sites.

8.2 The Hospital Estate requirement related to the proposed service changes

The table below summarise the potential estate implications of the proposed service reconfiguration.

	Estate requirement if this is the Planned Hospital Site	Estate requirement if this is the Unplanned Hospital Site
Huddersfield Royal Infirmary 	An 85 bed planned unit. Possibly provided via a new development on the Acre Mill site and disposal of some parts of the existing site. The development would need to include theatres, a day case facility, diagnostic services, endoscopy, additional outpatient space, therapy services to support elective inpatient care, a birth centre, and a minor injuries unit. Reduction in total beds required on this site from circa 420 to 85.	Upgrade of existing facilities related to recent 6 facet and asbestos surveys A new ward block with circa 130 additional beds from 420 to total beds required approx. 551. A bigger Intensive Care Unit. An expanded A&E with a dedicated children's A&E. A new Women's and Children's unit Additional day case theatres
Calderdale Royal infirmary 	A 85 bed planned unit. No additional estate works required. Reduction in total beds required on this site from circa 450 to 85.	A new ward block with circa 100 additional beds from 450 to total beds required approx. 551. A bigger Intensive Care Unit that can deliver level 3 care An expanded A&E, with a dedicated children's A&E. A multi-storey car park Additional diagnostic services - including MRI and CT Expanded pathology space

Note: the starting number of beds shown above at CRH and HRI are the estate capacity available for number of beds. The bed requirement is flexed up and down during the course of the year to cover pressures in the system at different times of the year. At the time of preparing the OBC there are 802 beds open across the two sites.

8.3 The Community Hubs Estate Requirements

The estate implications of the use of Todmorden Health Centre and Holme Valley Memorial hospital as Specialist Community hubs are:

Todmorden Health Centre – no additional estate requirements as this site already offers modern facilities including minor surgery and x-ray facilities.

Holme Valley Memorial Hospital – will require upgrade related to backlog maintenance estimated at circa £87k. Will also require improvement to provide x-ray facility and some increased consulting space for minor injuries unit. This is estimated as an additional 2 / 3 consulting rooms and associated waiting area.

8.4 Risk and Benefits Matrix Related to Hospital Estate Options for Reconfiguration

The following table provides detail of the potential risks and benefits associated with the estate development of a specialist unplanned and planned hospital at either the Calderdale Royal Hospital or the Huddersfield Royal Infirmary sites. This information has informed the economic evaluation in section 9.

Calderdale	Huddersfield
Alterations non PFI	
The majority of the Calderdale site is subject to a PFI agreement, however, should the Trust be able to undertake non PFI works, the site constraints mean that any capital cost at Calderdale could be higher than for corresponding works at Huddersfield.	
Alterations PFI	
The Calderdale site is a PFI site and any works within the area owned by the PFI Provider will be subject to their own procurement procedures which historically have taken longer and cost more. Within the PFI Contract there is an identifiable 12.5% overhead cost. The programme costs may also increase due to taking a longer period to procure the works. The type of subcontractors used may also lead to increased tender prices. Capital cost may therefore be higher at Calderdale than at Huddersfield. Should the works at Calderdale be then added to the annual PFI cost this will significantly increase the differential between Calderdale and Huddersfield when considered over the remaining 47 years of the PFI Contract.	
Future development costs & exibility	
Should the decision be made to locate the majority of the activity at Calderdale with a corresponding decrease in activity at Huddersfield, the following needs to be considered. Calderdale site is smaller than Huddersfield with little space for future development. It is unlikely that there is enough space currently available to allow decanting of departments to facilitate significant development, this means any development would need to be done on a piecemeal basis thus increasing cost. In reality it may mean needing to seek additional land adjacent to the site to facilitate future development. If Huddersfield became the planned site only, the activity currently forecast could be accommodated on the Acre Mill site thus allowing the Trust to exit the main HRI site with possible disposal. Should this happen there is little flexibility going forward in terms of decant space and ability to deliver new capital works. It would therefore seem prudent to retain the HRI site, however, this in itself has attendant backlog maintenance and other costs.	
Income drift	
The relocation of activity to Calderdale may result in a significant decrease in people choosing to access services at CHFT and more people choosing to go to Sheffield or Barnsley due to the demographics in South and East of Huddersfield. The ability at Calderdale to attract additional patients out with the current cohort is limited by the geography to the West of Calderdale and the location of other Trusts immediately to the East who currently attract activity away from Calderdale. Conversely development on the HRI site may mean patients to the North and East of Calderdale who currently use CHFT services may instead access provision from other Trusts. However this would be more than outweighed by the ability to draw in additional activity to HRI from Denby Dale, Holmfirth and the Penistone areas all of which under the new Government initiatives have plans for additional new homes in the near future. These factors are important to long-term viability.	
Backlog maintenance	
The relocation of activity to Calderdale will still mean unless HRI is sold the Trust has an on-going liability for the backlog maintenance at HRI. If capital projects are not forthcoming and patient activity at HRI is reducing the burden of the backlog maintenance on the Trust remains and a proportion of the income at Huddersfield is adversely impacted.	
Equipment cost	
On the basis that irrespective of site location any policy on equipment reuse versus provision of new will be the same across the site there should be no significant difference in cost and therefore this should not be a major differentiator between the sites. Consideration will need to be given to any double running required during the transition period as this may attract some interim additional cost.	
Energy cost	
This should be similar across both sites, however, consideration needs to be given on the Calderdale site if the energy costs are paid through the PFI Contract. Whether the Trust have the same ability to renegotiate tariffs or agree savings which could be achieved on the HRI site.	

Site acquisition
Significant increase in activity at Calderdale may necessitate the need for additional land. Consideration was given over 10 years to acquiring the allotments, however, the costs at that time were prohibitive. Experience of negotiating with allotment holders on previous projects is laborious and disproportionately expensive. Conversely the HRI site has significant space for expansion and development of services. The site configuration also means new capital projects can be undertaken and delivered to allow services to decant seamlessly from one building to another. This is not the case at Calderdale where it would have to be done in a piecemeal manner.
Clinical safety
The patient pathways, staffing ratios and support services will be equal no matter which site the activity Is undertaken on. Therefore the key differentiator on clinical safety could be considered as the volume of activity needed to maintain a safe service due to the ability of the staff to maintain the necessary skill sets. The ability of the HRI site to attract additional activity is considered superior to that at the Calderdale site and therefore could be argued clinical safety and therefore patient outcomes would be better at HRI than at Calderdale.
Population usage
The population served by Calderdale is less than that served by Huddersfield and whilst the transport links between the two hospitals are similar the reality of patients moving to one site or another means that the ability at HRI to attract more activity is considered better than at Calderdale for the reasons cited above. Consideration also needs to be given to the location of other A & E departments. The closure of A&E at HRI with a relocation of service to Calderdale would have a detrimental impact to the population south of the M62 whose closest A & E would currently be Dewsbury (which is earmarked for conversion to a Minor Injuries Unit) therefore leaving patients needing to travel to Wakefield, Barnsley or Sheffield. Consideration also needs to be given to the adjacency of the major arterial route of the M62. Any significant incident here would result in the most severely injured going to the major trauma centres, however the less severely injured would need to be accommodated in a local A & E and the communication link to HRI is superior to that to Calderdale.
Ability to reduce cost for commissioned activity
The current PFI arrangement at Calderdale limits the flexibility of the Trust to negotiate savings whereas activity at HRI can benefit directly from any cost savings the Trust are able to make.
Double running costs & speed to implementation
The lack of flexibility of the PFI contract at Calderdale means the relocation of activity to HRI may incur less double running costs over a shorter period of time. The Trust have a proven track record of being able to deliver capital projects at HRI using traditional procurement routes much faster than has been the case through the PFI arrangement at Calderdale.
Staff moving costs and recruitment
Relocation of services from Calderdale to HRI may incur the Trust in one off staff relocation costs and may lead to some staff choosing to leave whose journey to work becomes significantly more difficulty. However a potential benefit of locating increased services at HRI is the larger population in the immediate vicinity and in the northern part of South Yorkshire which may provide an increased potential staff base and an advantage for workforce recruitment.
Compliance with long term strategy
Selecting Calderdale as a primary site going forward for the reasons given above may seriously impair the ability to deliver a comprehensive long term service strategy due to the restrictions of the estates provision. The development of any future "specialisms" to attract activity from out with the immediate area would be limited by lack of available estate.
Potential to increase income and use of void space
Siting activity at HRI as stated elsewhere provides CHFT with a much larger demographic to use services going forward. Consideration also needs to be given to the creation of specialisms for drawing further activity. An example of this may well be at Calderdale where if this was the planned hospital this would not require use of the full estate and existing facilities. The current PFI Agreement means the Trust will still have to pay the PFI provider. The layout of the building and configuration of rooms at Calderdale may lend itself to alternative uses. Current demographics and the wider scale demand mean the current residential home provision in Calderdale is lacking as is the hospice provision. Calderdale hospital is ideally suited to meet such demand and could provide additional source of income as well as providing a much needed service to the wider population. There is potential to link up with other Care Home or Hospice providers in a joint venture.

8.5 Travel Plan Implications

The potential impact of the hospital and community service reconfiguration has been assessed by Yorkshire Ambulance Service and by Jacobs Engineering. Section 3.2 provides detail of the current access to services.

The analysis has assessed the travel implications for emergency ambulance, car and public transport journeys to hospital. Specific analysis in relation to the population impact relative to deprivation, age, and race has been included.

The calculations are based on the average times across the day to avoid the complexity of repeating every analysis for multiple times during the day (this highlights any disproportionate impacts requiring further analysis in the FBC without introducing undue complexity).

Jacobs Engineering has calculated times for car journeys and public transport weighted by the number of patient journeys typically arising in each area (this ensures the analysis is not unduly influenced by the small numbers of patients who attend from peripheral areas).

The journey time analysis has been carried out using industry-standard Geographical Information Systems (GIS) software at the Lower layer Super Output Area (LSOA) level of detail (the most detailed available). LSOAs are built up from groups of output areas. LSOAs are defined as having a population of between 1000 and 3000 people, and between 400 and 1200 households. Within Kirklees and Calderdale there are 387 LSOAs. It is these LSOA boundaries that have been used to build the journey time maps.

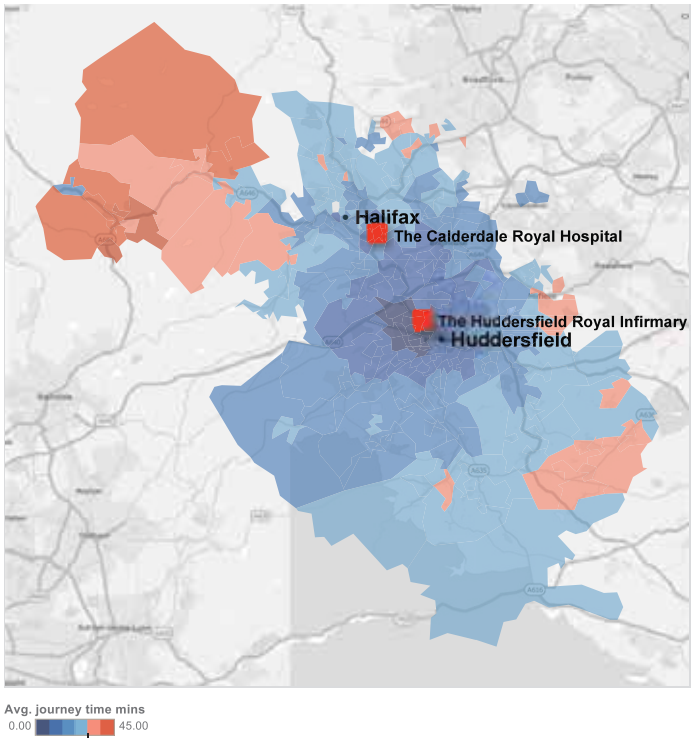
The conclusions of the analysis are that there are no disproportionate impacts of the change in travel time related to whether HRI or CRH is the planned or unplanned hospital care site.

Currently 76% of patients and 60% of the whole population are within a 15 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary. With 96% of both patients and the population being within a 30 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary.

Travel Analysis

Implications of Scenario 2 - HRI Acute and Emergency and CRH Planned care
Impact on Ambulance emergency travel times
If scenario 2 were to be implemented then this would have the following effect on the ambulance emergency travel times (as illustrated in the map below);

Impact of Scenario 2 (HRI Acute and Emergency and CRH Planned care)



The map to the left shows the ambulance emergency journey time to Huddersfield Royal Infirmary. The blue illustrates journeys which would take 30 mins and under and the red highlights the areas where the journey time would take over 30 mins.

If we assume that if this scenario was implemented then all emergency patients would be transferred to Huddersfield, it is clear to see that the clinical impact would be low with few journeys exceeding 30 min. (note that even 45 min journeys for serious trauma are not thought to be problematic* as long as the patient gets prompt appropriate care on arrival).

It is possible that the population living in the north-west quadrant of this map could be taken to a closer hospital (i.e. less than 45mins if appropriate).

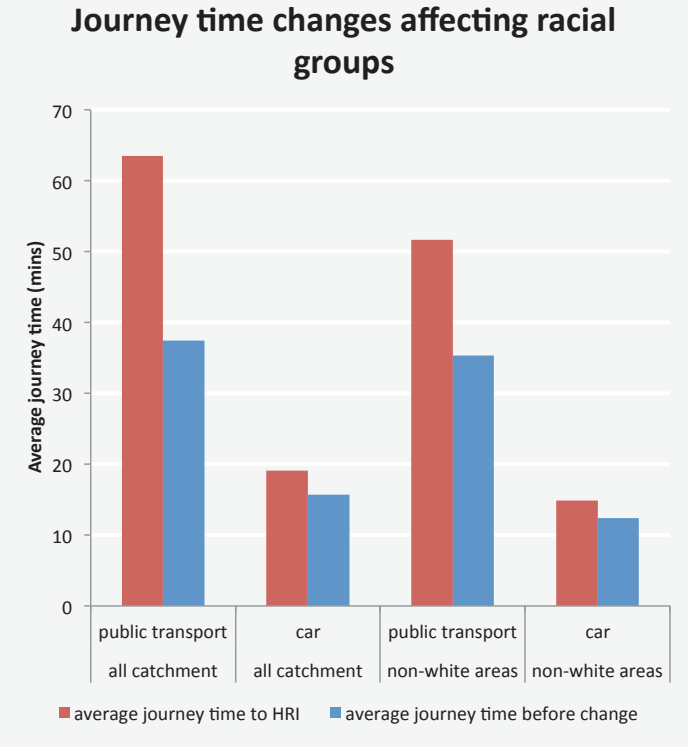
[1] This was concluded by clinicians as part of the Healthcare for London programme (Stroke and Major trauma programme)

Impact on demographic groups

In the following section a simple analytical approach has been adopted that can combine travel analysis with census data to estimate the impact on the four groups (described below. The emphasis of the analysis is to identify if demographic groups will be disproportionately affected in comparison to the population in the whole of the catchment area The following sections highlight any impacts and potential issues.

[1] http://www.londonprogrammes.nhs.uk/publications/the-shape-of-things-to-come/background-papers/

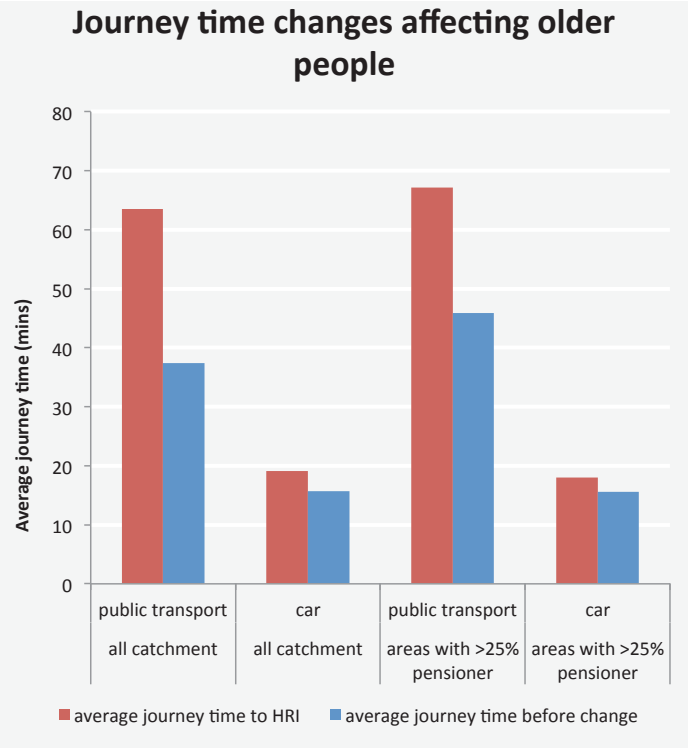
Impact on Racial groups of changes to emergency journeys



The chart to the left shows average car and public transport journey times for patients from racial groups before and after the proposed change. The two columns to the left show the anticipated effect before (blue) and after (red) to the whole catchment area population. The two columns to the right show the anticipated effect before (blue) and after (red) to those belonging to racial groups.

Although Journey times are moderately longer after the change the impact is not large. Moreover, areas where racial minorities are concentrated have on average shorter journey times before and after reconfiguration than the overall catchment population due to their concentration in urban centres. Both these facts suggest there is no disproportionate impact on racial minorities.

Impact on older people of change to emergency journeys

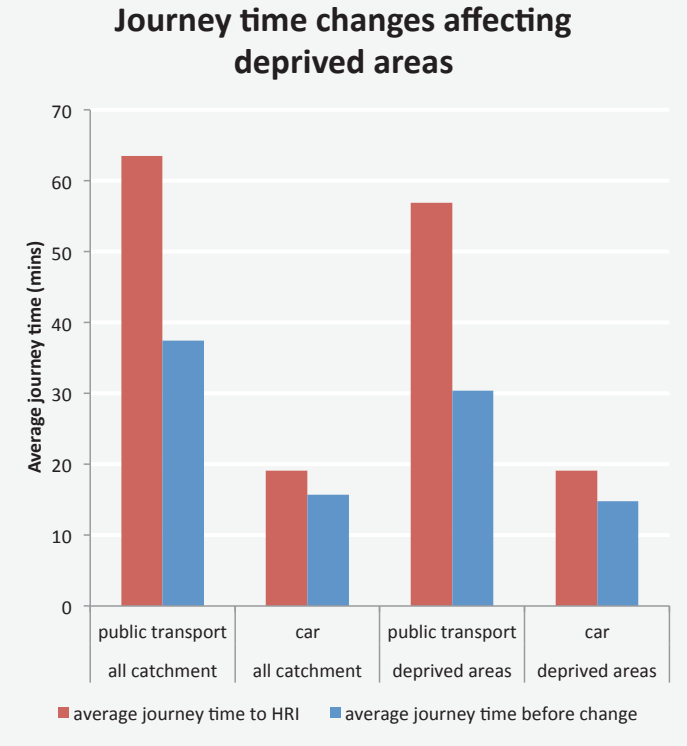


The chart to the left shows the effect on journey times for elderly patients. The two columns to the left show the anticipated effect before (blue) and after (red) to the whole catchment area population. The two columns to the right show the anticipated effect before (blue) and after (red) to the elderly population.

It highlights that they are already experiencing moderately longer journey times than the average when using public transport across the whole catchment area before the change.

The journey times after the reconfiguration, when using public transport, are likely to be longer but not significantly different to the impact on the whole catchment. This would occur for each trip undertaken. Again this argues that the impact is not disproportionate for this group.

Impact on deprived areas of changes to emergency journeys

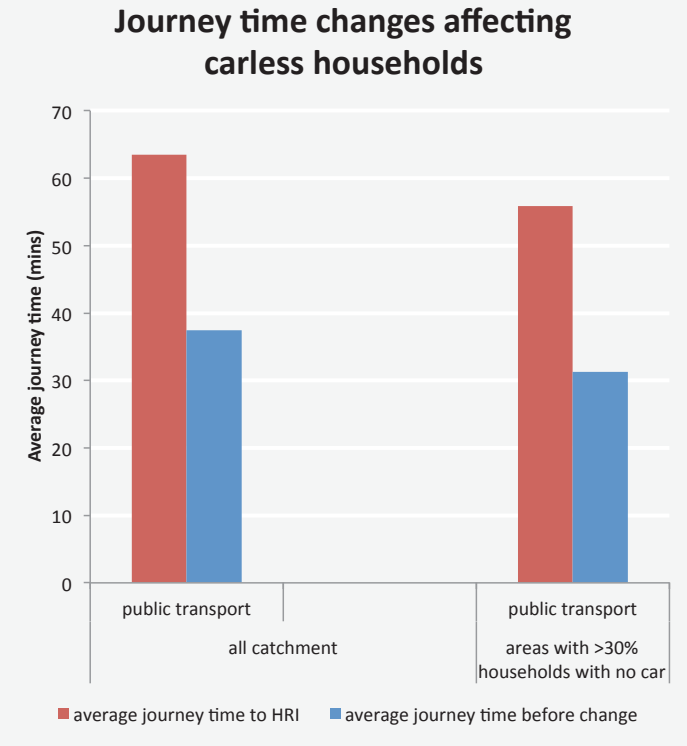


The chart to the left shows the impact on journey times, on areas of deprivation. The two columns to the left show the anticipated effect before (blue) and after (red) to the whole catchment area population. The two columns to the right show the anticipated effect before (blue) and after (red) to those living in areas of deprivation.

Previous maps in section 3.2 have highlighted that the areas of deprivation are concentrated in urban centres and, as a result, are closer to HRI than the average population across the catchment. As there are a greater number of areas of deprivation near Huddersfield.

The degree of impact is similar in magnitude to the impact on the overall catchment. Again, the proportionate impact on journey times is not large enough to trigger concerns that this is not a disproportionate change.

Impact on areas with high number of carless households of changes to emergency journeys



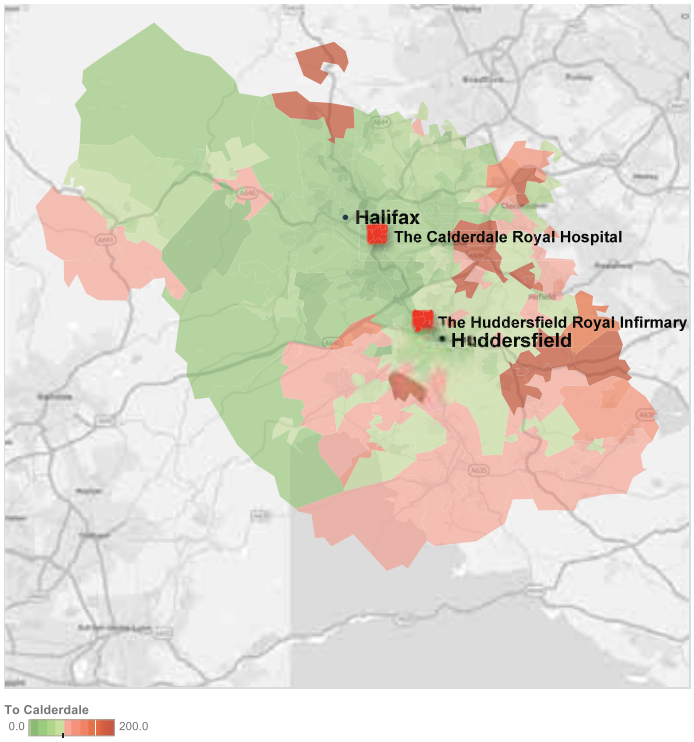
The chart to the left illustrates the effect of the scenario on households who do not have a car. The two columns to the left show the anticipated effect before (blue) and after (red) to the whole catchment area population. The two columns to the right show the anticipated effect before (blue) and after (red) to those belonging to racial groups.

As illustrated in section 3.2, carless households are distributed in similar manner to the households in areas of deprivation. The impact of the changes on them is similar to the impact on the whole catchment, again suggesting that they are not unduly affected by the changes. This is reinforced by the fact that the increase in journey times is not disproportionately large.

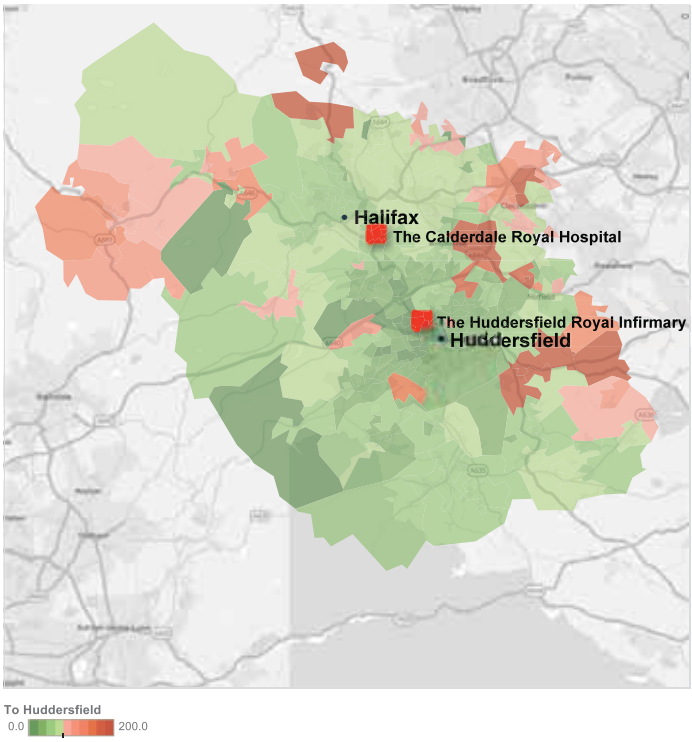
Impact on car journey times

The results of the assessment for car journeys showed that the likely increases in journey times were between 15 and 20 minutes. Changes are likely to be similar whether patients have to travel to Huddersfield instead of Halifax, or vice versa.
Either hospital is accessible from anywhere in the catchment within a 60min journey. Only peripheral areas take more than 30mins (and they may have other, nearer, options). As illustrated in maps below (green indicates a journey time of 30 minutes or less). The map highlights that Huddersfield is more accessible to car users than Calderdale with a higher proportion of the population able to access the hospital taking less time.

Car Journey times to CRH



Car Journey times to HRI

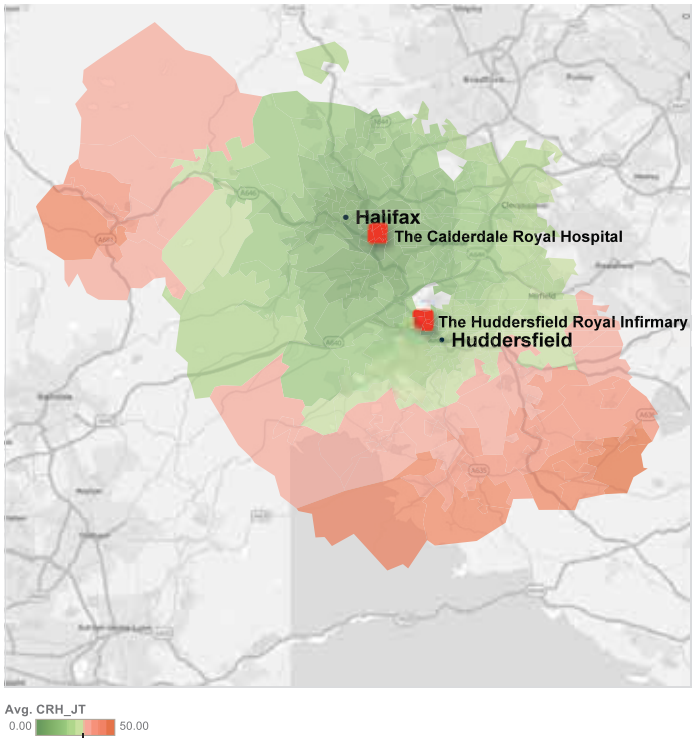


Currently 76% of the patients and 60% of the whole population is within a 15 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary. With 96% of both patients and population being within a 30 minute drive of CRH or HRI.

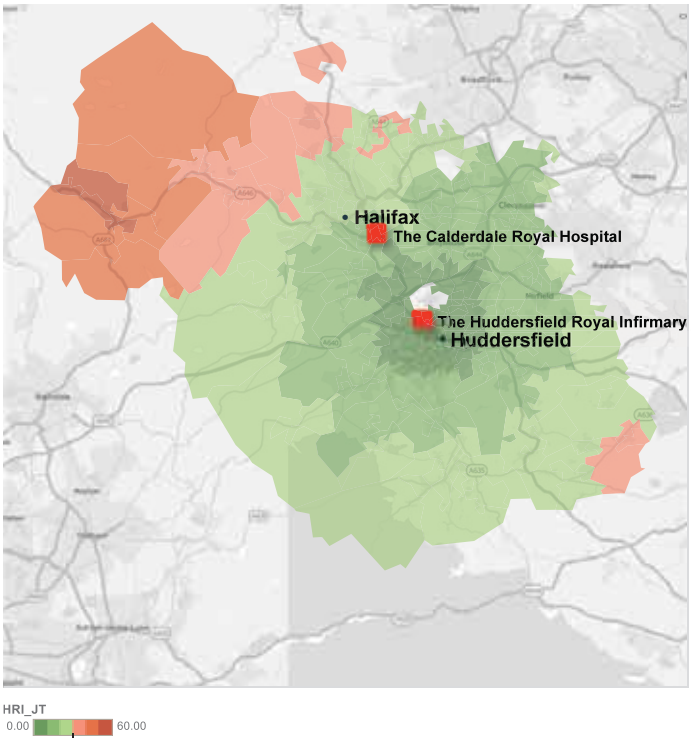
Impact on public transport

The maps below illustrate the current public transport journey times to Calderdale Royal Hospital (left) and Huddersfield Royal Infirmary (Right). The red areas indicate where journeys are currently more than 80 minutes and green are less than 80 minutes.
The results of the assessment for public transport users showed that the impact on journey times is likely to be higher than that for car users, and more varied depending on the time of day and day of the week under consideration. The areas to the south of Huddersfield, the south of Halifax, the Queensbury/ Ovenden area, Stainland, Hebden Bridge and Todmorden are estimated to have a public transport journey time in excess of 45 minutes. Therefore there are better public transport journey times to Huddersfield Royal Infirmary than Calderdale Royal Hospital (which is a moderately longer journey).
A more detailed breakdown of the impacts on the main users of public transport can be found in the section above on impact on demographic groups.

Public transport journey times to CRH



Public transport journey times to HRI

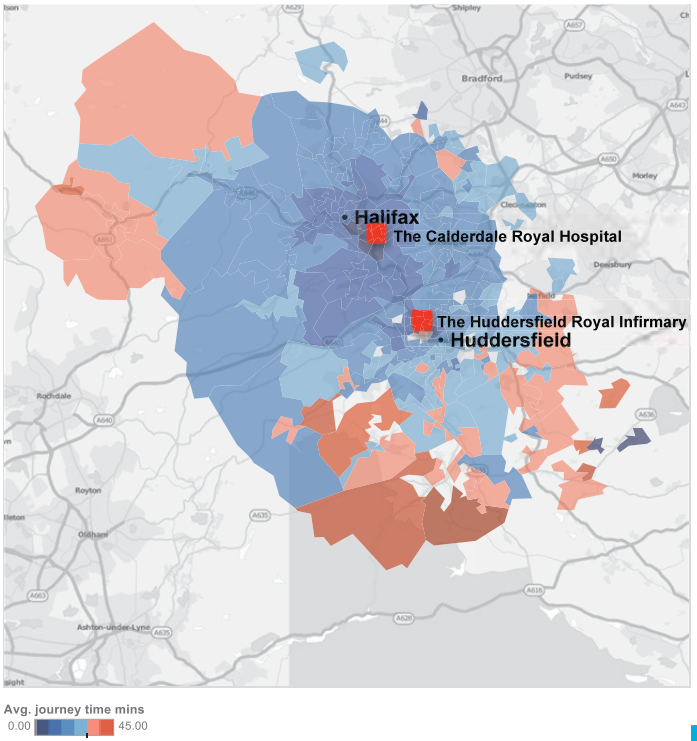


Implications of Scenario 3 - CRH Acute and Emergency and HRI Planned care

Impact on Ambulance emergency travel times

If scenario 3 were to be implemented then this would have the following effect on the ambulance emergency travel times (as illustrated in the map below);

Impact of Scenario 3 (CRH Acute and Emergency and HRI Planned care)



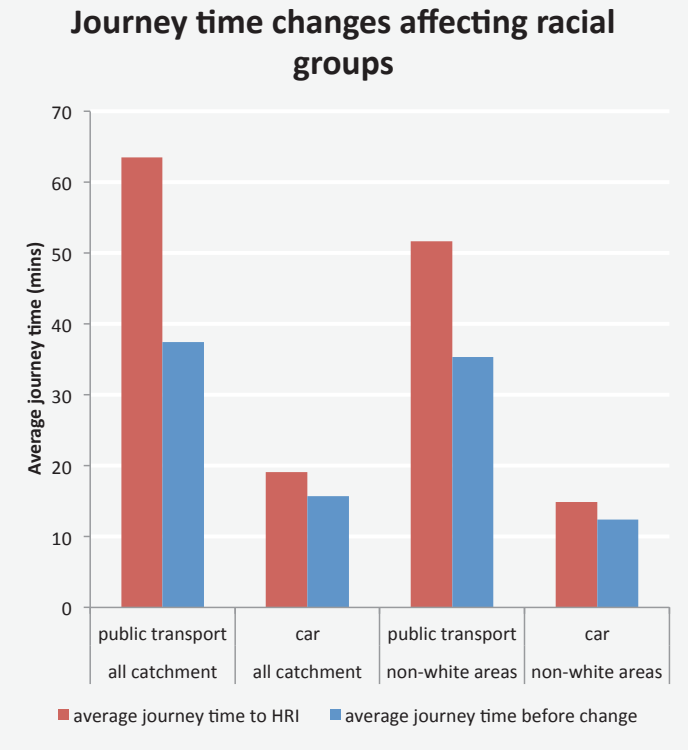
The map to the left shows the ambulance emergency journey time to Calderdale Royal Hospital. The blue illustrates journeys which would take 30 mins and under and the red highlights the areas where the journey time would take over 30 mins.

In this scenario we assume that if this scenario was implemented then all emergency patients would be transferred to Calderdale. Looking at the coverage in comparison with that offered from HRI, it can be seen that CRH would have slightly less coverage than HRI for emergency travel times within 30 minutes.

It is possible that the population living in the north-west quadrant of this map could be taken to a closer hospital (i.e. less than 45mins if appropriate).

Impact on demographic groups

Impact on Racial groups of changes to emergency journeys

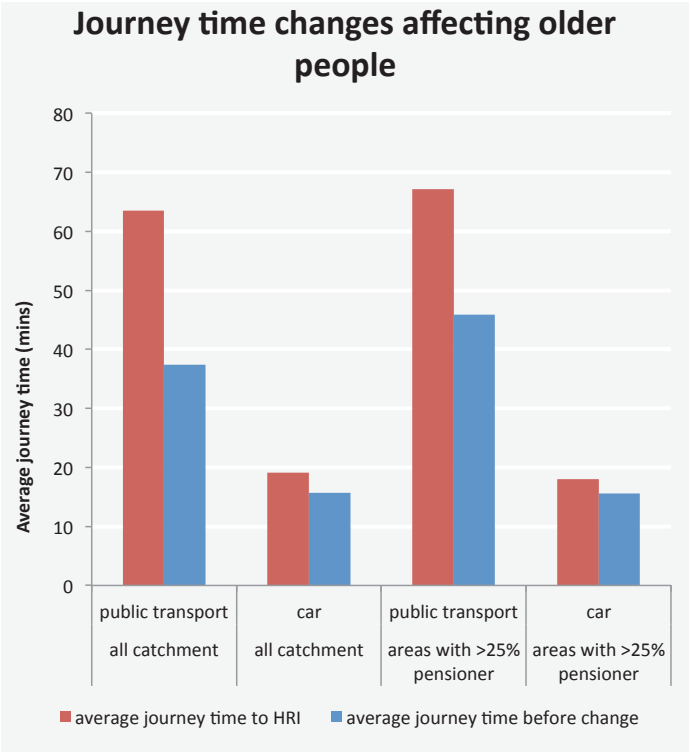


The chart to the left shows the effect on journey times for racial groups. The two columns to the left show the anticipated effect before (blue) and after (red) to the whole catchment area population. The two columns to the right show the anticipated effect before (blue) and after (red) to those belonging to racial groups.

The analysis in the chart suggests that if CRH is the emergency centre, the proportionate changes in journey times are larger than the alternative of HRI. Average journey times for the whole catchment are somewhat shorter, though.

Significantly the journey times for non-white areas are affected proportionately much more in this option than for the whole catchment population. This maybe because there are more racial groups closer to Huddersfield than Halifax.

Impact on older people of change to emergency journeys

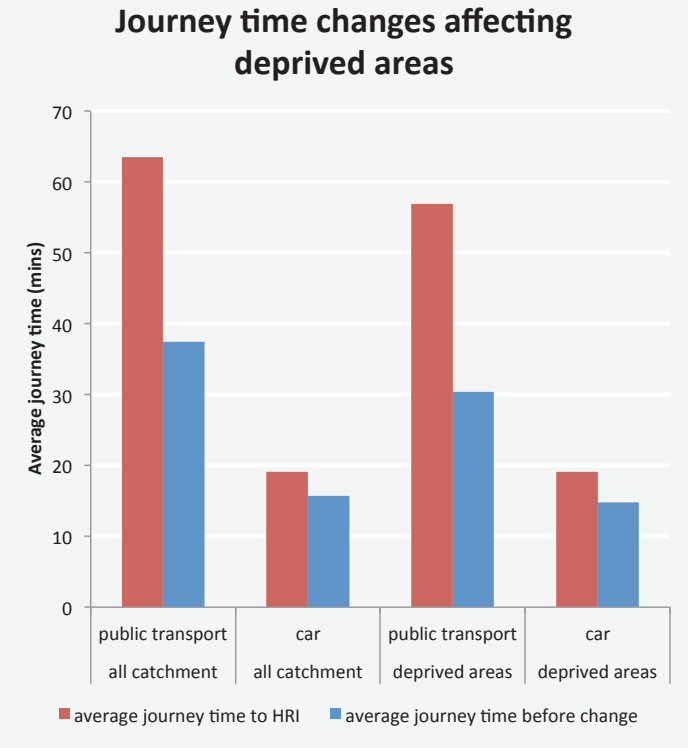


The chart to the left shows the effect on journey times for older people. The two columns to the left show the anticipated effect before (blue) and after (red) to the whole catchment area population. The two columns to the right show the anticipated effect before (blue) and after (red) on the elderly population.

It highlights that they are already experiencing moderately longer journey times than the average when using public transport across the whole catchment area before the change.

The journey times after the reconfiguration, when using public transport, are likely to be longer but not significantly different to the impact on the whole catchment. This would occur for each trip undertaken. Again this argues that the impact is not disproportionate for this group.

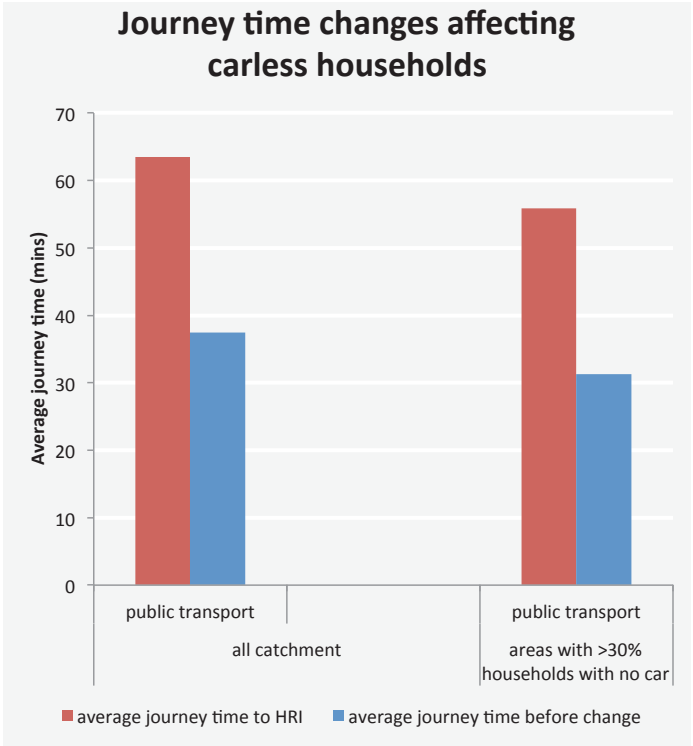
Impact on deprived areas of changes to emergency journeys



The chart to the left shows the effect of the scenario on journey times for people living in areas of deprivation. The two columns to the left show the anticipated effect before (blue) and after (red) to the whole catchment area population. The two columns to the right show the anticipated effect before (blue) and after (red) to those living in areas of deprivation.

The chart highlights that the relative impact of the CRH option on people living in deprived areas, although proportionately larger in comparison to the impact on the whole population, it is not likely to be a cause for concern as they have lower journey times than the general population across the catchment.

Impact on areas with high number of carless households of changes to emergency journeys



The chart to the left shows the effect on households without a car. The two columns to the left show the anticipated effect before (blue) and after (red) to the whole catchment area population. The two columns to the right show the anticipated effect before (blue) and after (red) to households without a car.

It highlights that carless households continue to see shorter public transport journeys than the general population in the catchment again suggesting that the impact on them is not concerning as they are not adversely impacted.

Summary table
The table below summarise the potential travel plan implications of the proposed service reconfiguration.

	Travel plan implications if this is the Unplanned (emergency) Hospital Site
Huddersfield Royal Infirmary	Ambulance – no significant impact. All areas are still within a 45 minute travel time Demographic groups • Racial groups - no disproportionate impact • Older people - no disproportionate impact • Deprived areas – the proportionate impact on journey times is not large enough to trigger concerns that this group is being unduly affected by the proposed changes • Carless - the proportionate impact on journey times is not large enough to trigger concerns that this group is being unduly affected by the proposed changes Car - likely increases in journey times were between 15 and 20 minutes. Changes are likely to be similar whether patients have to travel to Huddersfield instead of Halifax, or vice versa. Public transport – There are better public transport journey times to Huddersfield Royal Infirmary than Calderdale Royal Hospital (which is a moderately longer journey) for a larger proportion of the population within the catchment area.
Calderdale Royal infirmary	Ambulance – no significant impact. All areas are still within a 45 minute travel time Demographic groups • Racial groups - The journey times for non-white areas are affected proportionately much more in this option than for the whole catchment population • Older people - There is not a disproportionate impact on older people • Deprived areas - the proportionate impact on journey times is not large enough to trigger concerns as they continue to have lower journey times than the general population across the catchment • Carless households - no disproportionate impact Car - likely increases in journey times were between 15 and 20 minutes. Changes are likely to be similar whether patients have to travel to Huddersfield instead of Halifax, or vice versa. Public transport – There are better public transport journey times to Huddersfield Royal Infirmary than Calderdale Royal Hospital (which is a moderately longer journey) for a larger proportion of the population within the catchment area.

Key conclusions
- Currently 76% of patients and 60% of the whole population are within a 15 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary. With 96% of both patients and the population being within a 30 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary.
- The results of the assessment for car journeys showed that the likely increases in journey times were between 15 and 20 minutes. Changes are likely to be similar whether patients have to travel to Huddersfield instead of Halifax, or vice versa.
- Racial minorities are concentrated in a small number of areas and see proportionately larger impacts in Option 3 (emergency services at Halifax) than in Option 2 (emergency services at Huddersfield) as they are concentrated in the Huddersfield area. But in both options they still have shorter average journey times than the whole population. This suggests they are not unduly affected by either option.
- The analysis does not indicate large impacts that would rule out an option. But, although the average journey times after either option are not greatly different, the proportionate changes in some groups are larger for Option 3. While this suggests a marginal preference for option 2, the overall journey times after each proposed change are not very different and therefore don't provide a clear basis for choosing one option over the other.

9. The Economic Case

The section describes the possible options (or scenarios) that respond to the case for change described in section 4 and the proposed service model detailed in section 5. This section includes an evaluation of the options using criteria that have been informed by the views of stakeholders.

9.1 The Options / Scenarios

Through a process of discussion with the doctors, nurses and therapists that currently provide the services and with Clinical Commissioners five possible options / scenarios have been identified.

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

9.2 Appraisal Criteria

Analysis of the potential options needs to be undertaken using an agreed set of evaluation criteria, developed by clinicians and informed by wider stakeholders.

An engagement event to develop the evaluation criteria was held on 28th April 2014.

Clinical and management representatives from provider organisations, local GPs and Social Care participated in the workshop and identified the criteria they thought were important to evaluate the options. The output from the workshop has been collated against 5 evaluation criteria as shown in the table below.

The Evaluation Criteria			How this Links to Stakeholders Views
1.	**Quality of Care**	Which options would provide better clinical quality and safety? Which options would provide a better experience for patients?	Reduce the need for people and staff to transfer between hospital sites. Ensure deliver critical co-location of services. Use the clinical evidence base on safety and effectiveness. Must provide 7 day service. Must support self care. Take account of impact on wider multi-agency working e.g. police, safeguarding. Must enable integrated service provision. Environment of care is therapeutically important to achieve best outcomes.
2.	**Access to Care**	Do any options significantly minimise the average and/or total time it takes people to get to hospital by ambulance, car (off-peak and peak) and public transport?	Distance of travel, transport links and frequency of visits is important. Must provide more services in community and use technology to reduce the need to visit hospital. Take account of health inequalities and ensure any changes do not make these worse or disadvantage vulnerable people.
3.	**Value for Money**	Which options would have the lowest capital costs? Which options will give the largest Net Present Value (overall financial benefit) over the next 20 years?	Need to understand the cost of options. Lowest cost not always best solution.
4.	**Deliverability & Sustainability**	Which options would have the lowest transitional cost (double-running costs) of transferring services between hospitals? How long will it take to deliver the proposed changes in each option? Which options will offer a solution for the next 20 years.	Estate and site flexibility for development is important. Must offer a sustainable solution for next 10 – 20 years. Must enable a resource shift and not transfer workload from hospital to other parts of system without investment.
5.	**Co-dependencies with other strategies**	How much does each option fit with what is happening, or may happen, nationally or in West Yorkshire.	The future location of other A&E departments in West Yorkshire is important. Impact on local economies is important – local jobs and regeneration. Keep services local to Calderdale and Huddersfield.

9.3 Initial Shortlist of Scenarios

The table below shows an overview of preliminary assessment of the five scenarios against these criteria.

The providers have evaluated scenarios 2 and 3 to progress. Clinical Commissioning Groups will determine the final options for public consultation.

The Evaluation Criteria	Do Nothing	HRI Unplanned CRH Planned	CRH Unplanned HRI Planned	Out of Area Transfers	New Ideas
Quality of Care	No	Yes	Yes	Query	--
Access to Care	No	Yes	Yes	No	--
Value for Money	No	Yes	Yes	Query	--
Deliverability & Sustainability	No	Yes	Query	Query	--
Co-dependencies with other strategies	No	Yes	Query	Query	--
Evaluation Summary	Discount	Take Forward	Take Forward	Discount	Discount

The reasons for this preliminary assessment of the scenarios is set out below.

Scenario 1
This scenario is to continue with the current model of services. The outcome of the appraisal of this scenario is that it should be discounted and not progressed.

The case for change described in section 4 provides significant clinical evidence and detail of why this conclusion has been made i.e.

- Local people have identified the need for service change to enable more services to be provided out of hospital that will increase access to specialist services close to home.
- The doctors, nurses and therapists that currently provide services have identified the need for service change to improve quality and safety.
- There are gaps in current services and we are not able to guarantee the safety, quality and outcomes for people. The National Clinical Advisory Team has recommended that the configuration of hospital services needs to change.
- The current service configuration is not clinically or financially sustainable into the future.

The table below provides description of the appraisal against each of the criteria for scenario 1.		
The Evaluation Criteria	**Do Nothing**	**Appraisal Summary**
Quality of Care	No	Section 4 of this OBC provides detailed information of the case for change and why continuing with the current service configuration is not clinically sustainable and does not offer high quality and safe services into the future. Scenario 1 does not respond to the recommendations of the National Clinical Advisory Team.
Access to Care	No	Scenario 1 offers provision of services at HRI and CRH. Currently 96% of both patients and the population are within a 30 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary and therefore this option does offer good local access to hospital services. However scenario 1 does not offer access to an increased range of services in people's homes and out of hospital and therefore does not meet this criterion.
Value for Money	No	Scenario 1 does not offer a financially sustainable model of care into the future. This scenario continues the duplication of services on two hospital sites and does not provide opportunity for significant reduction in admissions to hospital and increased self-management in the community. Section 3 of the OBC describes the current financial challenge of the current service configuration and the need for change. The financial analysis of this do nothing option is also described in section 9.5 and demonstrates that scenario 1 does not meet this criterion.
Deliverability & Sustainability	No	Continuation of the current service configuration is neither clinically or financially sustainable into the future. Detailed reasons for this are provided in section 3 (the financial challenge) and section 4 (the clinical case for change) of this OBC.
Co-dependencies with other strategies	No	Scenario 1 does not take account of the wider regional and national strategic context and drivers for change. In particular the continued provision of two A&E departments just 5 miles apart is not consistent with the Keogh Review of Urgent and Emergency Care that will see a national reduction in the number of A&E departments. Scenario 1 also does not reflect national policy direction of the Better Care fund and the provision of more integrated community based services.
Evaluation Summary	**Discount**	**The conclusion of assessment of scenario 1 is that it does not offer a clinically or financially sustainable model into the future and does not re□ect the wider strategic direction for the future delivery of urgent and emergency services and more integrated care close to home.**

Scenario 2
This scenario is to implement the community and hospital service model proposed in this OBC with Huddersfield Royal Infirmary as the site for acute and emergency care and Calderdale Royal Hospital as the site for planned hospital care. Appraisal against the criteria has determined that this option should be progressed. The reasons for this are described below.

The Evaluation Criteria	HRI Unplanned CRH Planned	Appraisal Summary
Quality of Care	Yes	Scenario 2 responds to the National Clinically Advisory Team recommendations to establish a planned and unplanned care hospital and to deliver an increased range of integrated services in the community. Scenario 2 therefore meets this criterion.
Access to Care	Yes	Detailed travel analysis undertaken (see section 8.5) has shown that there are not any large impacts that would rule out whether either HRI or CRH is the planned or unplanned hospital. For both options the travel impact is not greatly different. The *proportionate* changes in some groups are less for scenario 2. This suggests a marginal preference for HRI as the unplanned site, however the overall journey times for either scenario 2 or 3 are not very different and therefore this does not provide a clear basis for choosing one scenario over the other. Scenario 2 does include increased access to a wider range of integrated services provided in people's homes or close to home.
Value for Money	Yes	Scenario 2 enables the consolidation of hospital services on planned and unplanned sites and provides opportunity for significant reduction in admissions to hospital and increased self-management in the community. The financial analysis of this scenario is described in section 9.5 and demonstrates that scenario 2 does meet this criterion compared to the 'do nothing' option.
Deliverability & Sustainability	Yes	The establishment of HRI as the unplanned hospital and CRH as the planned hospital site is deliverable and could offer a sustainable estate and service configuration model into the future. Section 8.4 describes the considerations that have informed this conclusion.
Co-dependencies with other strategies	Yes	Scenario 2 takes account of the wider regional and national strategic context and drivers for change. In particular the Keogh Review of Urgent and Emergency Care that will see a national reduction in the number of A&E departments. Scenario 2 also reflects national policy direction of the Better Care Fund and the provision of more integrated community based services.
Evaluation Summary	**Take Forward**	**The conclusion of assessment of scenario 2 is that it could offer a clinically and financially sustainable model into the future compared to 'do nothing'. This scenario also re□ects the wider strategic direction for the future delivery of urgent and emergency services and more integrated care close to home.**

Scenario 3

This scenario is to implement the community and hospital service model with Calderdale Royal Hospital as the site for acute and emergency care and Huddersfield Royal Infirmary as the site for planned hospital care. Appraisal against the criteria has determined that this option should be progressed. The reasons for this are described below.

The Evaluation Criteria	CRH Unplanned HRI Planned	Appraisal Summary
Quality of Care	**Yes**	Scenario 3 responds to the National Clinically Advisory Team recommendations to establish a planned and unplanned care hospital and to deliver an increased range of integrated services in the community. Scenario 3 therefore meets this criterion.
Access to Care	**Yes**	Detailed travel analysis undertaken (see section 8.5) has shown that there are not any large impacts that would rule out whether either CRH or HRI is the planned or unplanned hospital. For both options the travel impact is not greatly different. The *proportionate* changes in some groups are less for scenario 2. This suggests a marginal preference for HRI as the unplanned site, however the overall journey times for either scenario 2 or 3 are not very different and therefore this does not provide a clear basis for choosing one scenario over the other. Scenario 3 does include increased access to a wider range of integrated services provided in people's homes or close to home.
Value for Money	**Yes**	Scenario 3 enables the consolidation of hospital services on planned and unplanned sites and provides opportunity for significant reduction in admissions to hospital and increased self-management in the community. The financial analysis of this scenario is described in section 9.5 and demonstrates that scenario 3 does meet this criterion compared to the 'do nothing' option.
Deliverability & Sustainability	**Query**	Assessment of option 3 against this criterion has raised a query as to whether this option could offer a deliverable and sustainable solution into the future. Section 8.4 describes the considerations that have informed this conclusion. This includes factors such as future development costs, size and future site flexibility, potential adverse population and income drift, speed of implementation.
Co-dependencies with other strategies	**Query**	Assessment of option 3 against this criterion has raised a query as to whether this option does offer a long term strategic fit. Section 8.4 describes the considerations that have informed this conclusion. In particular the importance of the location of other A&E departments. The closure of A&E at HRI with a relocation of services to Halifax would have a detrimental impact to the population south of the M62. Consideration also needs to be given to the adjacency of the major arterial route of the M62. Any significant incident here would result in the most severely injured going to the major trauma centres, however the less severely injured would need to be accommodated in a local A&E and the communication link to HRI is superior to that to Calderdale. The Keogh Review of urgent and emergency services will lead to a reduction in the number of A&E departments in the future. It is likely that consolidation of A&E services in Huddersfield will offer a stronger geographical option than the provision of services in Halifax. Scenario 3 does reflect national policy direction of the Better Care Fund and the provision of more integrated community based services.
Evaluation Summary	**Take Forward**	**The conclusion of assessment of scenario 3 is that it can meet the criteria related to quality, local access and value for money compared to 'do nothing'. This scenario also offers more integrated services closer to home. However there are queries as to whether this scenario can offer a deliverable and sustainable solution that is aligned with the longer term strategic direction for urgent and emergency services.**

Scenario 4
This scenario is to continue with the existing community service model and change emergency hospital care provided locally so that those people needing specialist treatments are transferred to a major emergency centre outside the local area. Huddersfield Royal Infirmary and Calderdale Royal Hospital would offer 'see and initiate treatment' services with people needing specialist treatments transferred to specialist centres. This would reduce demand at the local emergency centres in Halifax and Huddersfield. Scenario 4 will require a regional and possibly national reconfiguration of Accident and Emergency services. The outcome of the appraisal of this scenario is that it should be discounted and not progressed. The reasons for this are described in the table below.

The Evaluation Criteria	Out of Area Transfers	Appraisal Summary
Quality of Care	Query	At the time of preparing this Outline Business Case there is insufficient detail of proposed future regional and national configuration of A&E services to be able to undertake evaluation of this option.
Access to Care	No	This scenario represents a reduction in the provision of local emergency services across Huddersfield and Calderdale. Since publication of the Strategic Outline Case in February 2014, local people and stakeholders have clearly expressed their view of the importance of continuing to deliver local accident and emergency services
Value for Money	Query	At the time of preparing this Outline Business Case there is insufficient detail of proposed future regional and national configuration of A&E services to be able to undertake evaluation of this option.
Deliverability & Sustainability	Query	At the time of preparing this Outline Business Case there is insufficient detail of proposed future regional and national configuration of A&E services to be able to undertake evaluation of this option.
Co-dependencies with other strategies	Query	At the time of preparing this Outline Business Case there is insufficient detail of proposed future regional and national configuration of A&E services to be able to undertake evaluation of this option.
Evaluation Summary	Discount	**The conclusion of assessment of scenario 4 is that there is insufficient detail to be able to progress this option.**

Scenario 5
Scenario 5 reflects the opportunity through public engagement and consultation to identify other possible options and scenarios. At the time of preparing this Outline Business Case there is insufficient information to be able to progress an economic evaluation related to this. Additional proposals or further options that may be generated through future public consultation will be welcomed and considered at that time.

There are therefore two shortlisted options that have been taken forward for more detailed evaluation in this OBC, i.e.

- **Scenario 2 - Implement the community and hospital service model proposed with Huddersfield Royal Infirmary as the site for acute and emergency care and Calderdale Royal Hospital as the site for planned hospital care.**
- **Scenario 3 - Implement the community and hospital service model with Calderdale Royal Hospital as the site for acute and emergency care and Huddersfield Royal Infirmary as the site for planned hospital care.**

9.4 Non-Financial Comparison of the Shortlisted Scenarios

The table below provides a non-financial comparison of the two short-listed scenarios.

Criteria	Comparison of Scenario 2 and Scenario 3
Quality of Care	**The quality of the service model will be the same for both scenarios and this does not differentiate the two sites:** The new patient pathways, staffing ratios and support services will be equal no matter which hospital site the activity Is undertaken on. **A higher volume of activity may be possible at HRI and this could enhance quality and differentiate the two sites:** A key differentiator on clinical safety could be the volume of activity needed to maintain a safe service due to the ability of the staff to maintain the necessary skill sets. The ability of the HRI site to attract additional activity is considered superior to that at the Calderdale site and therefore could be argued clinical safety and therefore patient outcomes would be better at HRI than at Calderdale.
Access	**There are no disproportionate impacts of the change in travel time related to whether HRI or CRH is the planned or unplanned hospital care site.** Currently 76% of patients and 60% of the whole population are within a 15 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary. With 96% of both patients and the population being within a 30 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary. The development of all unplanned activity on the HRI site could mean some patients to the North and East of Calderdale who currently use the Trust service may access provision from other Trusts out of the area. However this is likely to be more than outweighed by additional activity from Denby Dale, Holmfirth and the Penistone areas all of which under the new Government initiatives have plans for additional new homes in the near future.
Value for Money	**Estate Development Costs (PFI and non-PFI) will be higher at Calderdale and this does differentiate the two sites:** The majority of the Calderdale site is subject to a PFI Agreement. However, should the Trust be able to undertake non PFI works, the site constraints mean that any capital cost at Calderdale could be higher than for corresponding works at Huddersfield. The Calderdale site is a PFI site and any works within the area owned by the PFI Provider will be subject to their own procurement procedures which historically have taken longer and cost more. Within the PFI Contract there is an identifiable 12.5% overhead and sub contract tender prices due to preliminaries may also be higher. The programme costs may also increase due to taking a longer period to procure the works. The type of subcontractors also used may also lead to increased tender prices. All in all capital cost will therefore be higher at Calderdale than at Huddersfield. Should the works at Calderdale be then added to the annual PFI cost this will significantly increase the differential between Calderdale and Huddersfield when considered over the remaining 47 years of the PFI Contract. **Implementation and double running costs will be higher at Calderdale and this does differentiate the two sites:** The lack of flexibility of the PFI contract, associated costs and the time taken may well mean the relocation of activity to HRI may incur less double running costs over a shorter period of time than retaining activity at Calderdale. The Trust have a proven track record of being able to deliver capital projects at HRI using traditional procurement routs or P21+ much faster than has been the case through the PFI arrangement at Calderdale.

Criteria	Comparison of Scenario 2 and Scenario 3
Deliverability and Sustainability	**The speed of implementation will be faster at HRI and this does differentiate the two sites:** The Trust has a proven track record of being able to deliver capital projects at HRI using traditional procurement routes much faster than has been the case through the PFI arrangement at Calderdale. **Future hospital financial and business model may be affected and this does differentiate between the two sites** The relocation of unplanned activity to Calderdale may result in the Trust seeing a significant decrease in persons choosing to use CHFT and more people going to Sheffield or Barnsley due to the demographics South and East of Huddersfield. The ability at Calderdale to attract additional patients out with their current cohort is limited by the geography to the West of Calderdale and the location of other Trusts immediately to the East who currently attract activity away from Calderdale. Development on the HRI site could draw additional activity from Denby Dale, Holmfirth and the Penistone areas all of which under the new Government initiatives have additional plans for additional new homes in the near future. Siting activity at HRI provides the Trust with a much larger demographic to use services going forward. **Site constraint and limited land availability at CRH will limit long term sustainability and future service development this does differentiate the two sites:** A significant increase in activity at Calderdale without the acquisition of further land will severely limit the Trust to develop services to meet future needs of the population. Reduction in activity on the HRI site and as a result the sell-off of the majority of the current HRI footprint will severely limit the ability to develop services in the future. Selecting Calderdale as a primary site may therefore seriously impair the ability of the Trust to deliver comprehensive long term services due to the restrictions of the estates provision.
Co-Dependency with other Strategies	**Consideration needs to be given to location of A&E services across the region and this may differentiate between the two sites:** Consideration also needs to be given to the location of other A & E departments. The closure of A&E at HRI with a relocation of service to Calderdale would have a detrimental impact to the population south of the M62 whose closest A & E would be currently be Dewsbury which is earmarked for conversion to a Minor Injuries Unit therefore leaving patients needing to travel to Wakefield, Barnsley or Sheffield. Consideration also needs to be given to the adjacency of the major arterial route of the M62. Any significant incident here would result in the most severely injured going to the major trauma centres, however the less severely injured would need to be accommodated in a local A & E and the communication link to HRI is superior to that to Calderdale. In November 2013 NHS England published Sir Bruce Keogh's Urgent and Emergency Care Report. This report sets a direction that over the next five years there will be changes in the way that A&E services are provided. Of the 140 A&Es currently across England 40 – 70 major emergency centres will be established. The choice of the unplanned hospital site for the A&E service must by cognisant of this future wider strategic change in the configuration of A&E services. Strategically, HRI is located in a superior geographical position in relation to the M62 corridor.

9.5 Financial Comparison of the Short-listed Scenarios

The quantitative appraisal has been undertaken in line with HM Treasury's Green Book and the Capital Investment Manual guidance. The focus is on Value for Money looking at the Net Present Cost (NPC) and Equivalent Annual Cost (EAC) of each option. The financial information has been incorporated into the Generic Economic Model (GEM) to determine the option that generates the most beneficial NPC and EAC.

The GEM is a discounted cash flow model used in public sector business cases to help assess the relative costs and benefits of the shortlisted options. It calculates, over a longer term appraisal period, the NPC and EAC of each option under consideration. The EAC is the NPC converted into an equivalent annual cash flow.

The options have been evaluated over a 60 year period, and as per HM Treasury Green Book guidance a discount rate of 3.5% has been applied for years 1-30 and 3.0% for years 31-60. By applying the appropriate discount rate to anticipated future cash flows, the "present cost" of investment can be assessed and compared with alternative uses of public money.

Option 1 has been retained within the quantitative appraisal as a benchmark for Option 2 and 3.

Capital Cost Estimates

The 10 year capital projections, for CHFT, under each of the short-listed options are summarised below.

	Option 1	**Option 2**	**Option 3**
	£m	**£m**	**£m**
IM&T	62	62	62
Estates	150	248	183
Equipment	35	35	35
Total	**247**	**345**	**280**

The capital cost associated with estates investment is the only variable between the options. The estates costs have been produced in conjunction with the Trust's costing advisors. A description of the key estate implications under each option can be found within section 8 of the business case.

Under option 2 the estates build for additional capacity is phased over 3 years commencing in 16/17. Under option 3 it is phased over 4 years commencing in 16/17. The assumption for the increased timescale is based upon the Trust's experience of PFI projects taking longer to deliver.

The costs include a planning contingency which reflects the risks and uncertainty associated with each option.

The GEM includes an assumption under each of the options for on-going lifecycle, estate maintenance, costs after the initial 10 year period identified above.

Other capital investment assumptions included within the economic appraisal are:
- £0.5m investment required in community IM&T
- £5.0m investment required in estate improvement and expansion at Holme Valley

Full details of the costs and the associated cash flows can be found within the detailed GEM (supporting papers).

Revenue Cost Estimates

The revenue costs are based on those shown within the Financial Case, but only the identified /deliverable CIP has been included within the economic analysis.

The cost and benefits have been calculated for each of the 3 options based upon detailed modelling of activity flows and the capacity impact, and the resultant workforce implications.

All costs included within the GEM exclude inflation and are expressed in a common price, with the base year being 2014/15.

The GEM excludes transfer payments, such as VAT and Capital Charges (including Loan Interest payments).

The below identifies the key generic revenue assumptions. These are explained in greater detail within the finance case.

- Investment to provide 7 day services
- Investment in nurse staffing levels
- Includes assumed activity drift from Mid Yorks. This is assumed from 2015/16 onwards. Under Option 3 this activity drift is assumed to be lost in 2020/21 if the unplanned site was to be CRH.
- No impact of AQP assumed
- No material impact of Specialist Commissioning
- Bed occupancy levels to 85%
- No activity drift or income loss assumed due to moving to a planned and unplanned configuration. This assumption will be tested as part of the FBC process.

The below identifies the key option specific revenue assumptions.

Option 2

- Includes assumed activity drift from Mid Yorks. This is assumed from 2015/16 onwards.
- Transitional costs have been estimated at £1.5m.
- Community non recurrent set up costs have been estimated at £2.6m
- Capacity modelling of acute service reprovision, as described in section 6, has identified an impact on GPs and Social Care of £0.3m. A further allowance on £1m has been built into this model to cover the estimated cost of 7 day service provision.
- Under option 2 the capacity released at CRH enables the Trust to pursue additional commercial opportunities. The net contribution associated with this equates to an estimated £6m. This opportunity is not incorporated into option 3 as the estates assumptions under this option currently assume the planned site would be a new build on the Acre Mill site, which would not have the capacity to support additional commercial opportunities.

Option 3

- Activity drift from Mid Yorks is assumed to be lost in 2020/21 if the unplanned site was to be CRH.
- Transitional costs have been estimated at £4m. The difference in assumption is due to the size and scope of services that would be required to move from their current base depending upon the location of the planned and unplanned site, as well as the anticipated increased timescale required to deliver the estate reconfiguration under option 3.
- Community non recurrent set up costs have been estimated at £2.6m
- Option 3 includes an additional provision of £1m per annum against nursing staffing. This is due to the ward layouts at CRH being more difficult to provide observations, and as such the movement of more acute activity to CRH would result in an increased staffing requirement than currently provided.
- Capacity modelling of acute service reprovision, as described in section 6, has identified an impact on GPs and Social Care of £0.3m. A further allowance on £1m has been built into this model to cover the estimated cost of 7 day service provision.

Full details of the costs and the associated cash flows can be found within the detailed GEM (supporting papers).

Net Present Cost Findings

The overall Net Present Costs (NPC) and Equivalent Annual Cost (EAC) summaries of the 3 options based on the capital and revenue flows are shown below.

The full details can be found in the GEM shown in supporting papers.

Option 1	Undiscounted	Discounted (NPC)	EAC
	£m	£m	£m
Capital	397	269	10
Service Costs	20,901	9,119	348
Net Contribution	(69)	(30)	(1)
Transitional Costs	0	0	0
Externalities	0	0	0
Total Cost	**21,229**	**9,358**	**357**

Option 2	Undiscounted	Discounted (NPC)	EAC
	£m	£m	£m
Capital	495	356	14
Service Costs	20,200	8,853	338
Net Contribution	(385)	(152)	(6)
Transitional Costs	4	4	0
Externalities	82	37	1
Total Cost	**20,396**	**9,097**	**347**

Option 3	Undiscounted	Discounted (NPC)	EAC
	£m	£m	£m
Capital	390	288	11
Service Costs	20,295	8,895	339
Net Contribution	(6)	(5)	(0)
Transitional Costs	7	6	0
Externalities	82	37	1
Total Cost	**20,768**	**9,220**	**352**

Based on the quantitative analysis, shown below, Option 2 has the lowest NPC and EAC.

Option	Appraisal Period	Rank	NPC (£M)	EAC (£M)
Option 1	60 Years	3	9,358	357
Option 2	60 Years	1	9,097	347
Option 3	60 Years	2	9,220	352

The analysis shows that both option 2 and option 3 are more economically beneficial than option 1.

Sensitivity Analysis

A number of key factors have been assessed via a sensitivity analysis to test what impact changes in key variables would have upon the options.

This has been done in two ways.
a) 'Switching Values' to test what the tipping point would be before option 2 was no longer the most economically viable option.
b) 'What if' scenarios to alter values of 'uncertain' costs and benefits to observe the effect on the overall ranking of options.

Key observations

The table below shows the change in value (in %s) to the that would be required before the most beneficial option would change from option 2 to option 3.

Change in costs (%)	Option 2 Change (%)
Capital Costs	35%
Revenue Costs	1%
Total Costs (NPC)	1%
Total Costs (EAC)	2%

- The analysis shows that the capital costs under option 2 would need to increase by 35% before option 3 became the most economically beneficial.
- The analysis shows that the revenue costs under option 2 would need to increase by 1% before option 3 became the most economically beneficial.
- The analysis shows that the overall Net Present Cost under option 2 would need to increase by 1% before option 3 became the most economically beneficial.
- The analysis shows that should the commercial strategy be removed from option 2 the NPC would be £9,219m. This would still result in option 2 being the most economically beneficial, but only by £1m over the 60 year period.

Economic Appraisal Conclusions

The GEM is a discounted cash flow model used in public sector business cases to help assess the relative costs and benefits of the shortlisted options. It calculates, over a longer term appraisal period, the NPC and EAC of each option under consideration. The EAC is the NPC converted into an equivalent annual cash flow. The costs used in the GEM are reconcilable to the costs used in the financial appraisal, adjusted as per HM Treasury Green Book guidance.

From a purely financial perspective the option that is most economically beneficial is the one that offers the lowest NPC and EAC over the appraisal period.

As evidenced in the analysis above option 2 has the lowest NPC and EAC.

It is worth noting however, that there is only a marginal 1% difference between option 2 and option 3.

Both option 2 and option 3 represent greater economic benefits than option 1.

Both option 2 and 3 will be analysed further within the finance case.

10. The Commercial Case

Introduction

This section of the Outline Business Case describes the options for procuring both a revised service offer, and the estates and facilities required to deliver this proposal. It sets out the benefits and possible dis-benefits of each approach and any preferences for procurement options expressed by the three current main providers.

The commercial case shows how the proposed procurement approach demonstrates a robust plan to source the estates and services requirements described in Section 6 – Strategic Case: Capacity Plan, and the extent to which that provides a commercially viable route for Calderdale and Greater Huddersfield. The model, outlined in Section 6, represents a significant shift of clinical work to community settings and to self-care which will have a major impact on the design of estate for hospital services and the utilisation of community assets across the strategic partnership.

In general the procurement of enabling estate and facilities is led by providers. Conversely the procurement of reconfigured services is a matter for commissioners. Therefore where this section addresses service procurement it is expressly limited to demonstrating that viable procurement options exist and does not seek to encroach on the commissioner's decision making process.

10.1 Service Procurement

Patients should have access to the right treatment, at the right place and at the right time, and be offered a choice of treatment as a matter of course, except where this is clinically inappropriate or unfeasible. It would not be sensible for patients to be able to choose services that fell far short of modern healthcare standards, or where services are not able to treat patients safely.

The proposals in this Outline Business Case represent increased integration of the provision of physical, mental health and social care services both in the community and in hospital. The Health and Social Care Act 2012 (2012 Act) places a duty on CCGs to promote integration. CCGs have a duty to ensure that the provision of health care services is integrated with the provision of health related services and social care services. The introduction of the Better Care Fund from 2015/16 onwards is a significant step towards achieving this and clearly signals that the pooling of health and social care resources to jointly commission services is the national direction of travel.

The proposed changes in community services described in this business case will potentially provide a significant improvement in choice and control for people. This will include more information, service options and support available in their own home or close to home. The proposals will enable people to access personalised help and support to meet their needs.

The proposed changes in the configuration of emergency and hospital services described in this business case has taken careful account of the need to balance access and the significant clinical evidence that patient safety and improved outcomes can be achieved through the concentration of planned and unplanned services on two separate sites. According to the evidence this will result in better treatment and reduced mortality from serious illnesses and injuries.

NHS service procurement is governed by the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013. This statutory instrument sets an objective for CCGs to use procurement to secure the needs of patients and to improve quality and efficiency, including through services being provided in an integrated way.

The Regulations provide a framework which guides commissioning decisions, including when to use procurement to deliver improvements, and when to follow other routes such as contract variations. This Outline Business Case provides a vision for the improvement of service quality and efficiency through integrated working, which will support commissioners in addressing their responsibilities under the Regulations.

This OBC, and the significant engagement activity that has supported it's development, also provides an opportunity for all providers public, private and voluntary to get involved in shaping and contributing to integrated care across Calderdale and Greater Huddersfield. For example the key roles of local authorities and NHS England as commissioners of social care and primary care are essential components of the whole.

Clearly, it is a matter for the various different commissioning organisations as to how they want to procure the revised services arising from the service reconfiguration. Commissioners will want to take this opportunity to consider how the current procurement arrangements align with the new service provision and to put forward their preferred procurement strategy.

The table below shows that there are several ways in which commissioners could choose to structure the procurement and contracting arrangements for the integrated service model proposed in the OBC.

Procurement option	Comment
Lead provider	One provider is the contracted party. The commissioners deal with this lead provider, with other providers sub-contracted to the lead provider
Alliance contract	There may be a single point of communication but all providers are equally valued and have a say in decision-making. An alliance contract is typically commissioner led and the commissioner shares in risks. An alliance contract is typically outcome based
Individual provider contracts	Contracts made by individual providers, for example reflecting the ownership structure

To make a reality of the vision set out in this OBC will need the combined efforts of many local partners in addition to the three provider organisations that have worked together on this document. Providers of primary care, social care, pharmacy and others have been involved to date and will continue to be encouraged to develop the thinking further, thus influencing the optimum mode of procurement and contracting.

10.2 Procurement of enabling estates and facilities

The scope of the provider led procurement is the estates and facilities required to support the delivery of the service model proposed in this OBC. Specifically;

- There will be two specialist hospitals in Greater Huddersfield and Calderdale. Each hospital will have a specialist focus. One hospital will specialise in acute and emergency services and one hospital will specialise in care for people who need planned treatments or surgery
- Estates and services required to support community services. This OBC addresses the development of two Community Hubs for the provision of integrated and specialist community services. One of the hubs is proposed to be at Todmorden Health Centre in Calderdale and the other is proposed to be Holme Valley Memorial Hospital in the Greater Huddersfield CCG area.
- Provision of diagnostic facilities proposed for the community hubs.

Ownership

The assets affected by the provider-led procurement of estates and facilities have different ownership arrangements.

Asset	Ownership
Calderdale Royal Hospital	CHFT
Huddersfield Royal Infirmary	CHFT
Todmorden Health Centre	Assura
Holme Valley Memorial Hospital	NHS Property Services

The legal status and the financial position of the bodies owning each of the sites will determine which procurement routes are open to them, and will also determine the laws and rules applicable to the procuring body. For example the application of EU procurement rules on public bodies.

Procurement of hospital estates

Both hospital sites Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) are owned by CHFT. CRH is covered by a PFI arrangement and HRI is owned outright by CHFT.

There are many examples of PFI contract variations to take account of changes in circumstances over the life of the contract. Potentially, the estates development at CRH could be procured through a PFI contract variation, although the changes anticipated in this OBC are of a significant scale and as such the Trust will explore all available options.
As a NHS Foundation Trust, the expected capital route will be for the trust to find its own sources of funding. The options open to CHFT for procurement are:

- Investment of Trust funds
- Prudential borrowing
- Private Finance Initiative (variation of existing PFI or new PF2)
- Joint Venture

Trust funds

NHS Trusts are able to use internally generated cash to fund investment as follows:

- Unspent capital cash brought forward from previous years (unspent depreciation and receipts from asset disposals)
- Cash associated with the charge for depreciation in year
- Receipts from asset disposals in year
- I&E surplus (both in year and cash brought forward from earlier years)
- Cash released from movement in debtor/creditor balances
- Grants or donations for the purpose of capital investment.

Prudential borrowing

The primary source of cash for capital investment, in addition to that financed from internal sources, is through interest bearing loans from the Department of Health or from banks. Loans are considered against the Prudential Borrowing Limit of the Trust. This limit is set annually by the Department and is an indication of the maximum borrowing a Trust may make.

Private Finance 2

PF2 is HM Treasury's preferred procurement strategy for involving private finance in the delivery of public infrastructure and services. It incorporates the OJEU process and includes market engagement both to ensure a robust competition and that critical requirements are fully understood by the market, which should enable the achievement of good value for money.

The estates and services requirements are consistent with the project characteristics for which PF2 is suitable:

- There is a major capital investment need, requiring effective management of risks associated with construction and delivery
- A stable policy environment and long term planning horizons exist, so there is a high degree of confidence the infrastructure and services will be required throughout the life of the contract
- The nature of the requirement allows the public sector to define its needs as service outputs that can be adequately contracted for in a way that ensures effective and accountable delivery of public services over the long term, thus ensuring risk allocation between the public and private sectors can be clearly defined and enforced
- The nature of the assets and services identified as part of the scheme, as well as the associated risks, are capable of being costed on a whole life, long term basis
- The capital investment is in excess of £50 million – as less capital intensive projects seldom justify the procurement and management costs involved
- The project is not so large or complex that the private sector is unable to bear the risks being transferred.

PF2 involves a long term contractual relationship and has the objectives of providing access to wider sources of equity and debt finance to improve the value for money of financing projects; to increase the transparency of the liabilities created by long term projects and the equity returns achieved by investors; to speed up and reduce the cost of the procurement process; and to provide greater flexibility in the provision of services.

The PF2 contract combines design, construction, maintenance and renewal in one contract (but not soft FM services).

PF2 is designed to widen the sources of equity finance and encourage longer-term investors, such as pension funds, into projects at an earlier stage. Equity funding competitions can be introduced at the preferred bidder stage to attract these long-term investors. This also has the potential to drive down equity returns over time and reduce the overall cost to the public sector.

Joint Venture

There is an option to use the 20 year Joint Venture CHFT currently has in place with Henry Boot. Pennie Property Partnership is the joint venture vehicle CHFT has a 50:50 shared ownership of with Henry Boot Developments. The same type of vehicle has been used extensively in Local Authorities to fund the development of new business parks, etc. Whilst this is an innovative partnership within the NHS, it could provide us with a further way of delivering the new buildings we will require, and enable different ways of raising the capital funding required.

The following table assesses the contribution these procurement options could make to the procurement of the hospital estates.

Funding option	Comment
Trust funds	Lowest cost option but Trust funds will be a relatively small source of funding. Scale of expenditure will to be too high to be fully funded through this source
Prudential borrowing	The Trust has a limit on prudential borrowing and there may be other projects to which borrowings are already committed. This option will be fully evaluated once the investment cost is finalised.
This option could be used in conjunction with PFI funding if there is a funding gap	
Private Finance 2	Funding option if internal sources and prudential borrowing fall short of the funding requirement. Where possible, unitary charges will be offset by proceeds from the sale of land
Joint Venture	This could provide a further way of delivering the new buildings and enable different ways of raising the capital funding required.

Whichever routes are selected it is noted that the proposed expenditure is above the OJEU thresholds and hence the procurement strategy will have to be compliant with OJEU regulations.

Whilst all public procurements are subject to EU wide rules, within these rules there are a number of options for engaging with the market to contract with supplier/s. The main factors of differentiation are:

- The number of suppliers able to compete for the tender
- The calibre / appropriateness of those suppliers to compete for tenders
- The minimum amount of time taken to run the tender (and the resources required to do this)
- The amount of supplier interaction needed / wanted to get to the optimal agreement
- The amount of flexibility required by the buyer to determine factors such as evaluation criteria and T&Cs
- How sure the buying organisation is that it has its requirements fully defined.

These factors give rise to the following OJEU options;

- Option 1 - an accelerated route. This option has been discounted because there is no compelling reason to do so in this instance
- Option 2 - open competition. Procuring through the 'open procedure' means all suppliers who respond to an OJEU must be invited to tender, as this procedure does not allow any form of pre-qualification or pre-selection. The benefit of this option is that it allows the widest possible number of suppliers, therefore maximising potential for competition and permits a high degree of flexibility of commercial terms, T&Cs and evaluation. The disadvantage with this option is that it is time and resource intensive (but with a maximum time period of 18 months between the issue of the tender and appointment of the preferred bidder)
- Option 3 - restricted route. This option is appropriate where there is a reasonable market for the goods, services or works required. The procedure takes the form of a two stage process where the first stage is used to 'pre-qualify', or select, a small number of the most appropriate suppliers to invite to tender. The benefit of this option is that it allows a large, but limited, number of potential suppliers whilst taking up less resource and time. The main drawback is that it limits the range of suppliers / consortia, and potentially financing proposals, made available to the procurement.

Procurement of Community Hub developments

Todmorden Health Centre and Holme Valley Community Hospital offer potential for use as community hubs within the community service model. Section 6 describes the range of services proposed at each community hub. To support the delivery of minor injuries services at both sites some initial investment would be required. The assumed position is that Todmorden Health Centre would not require capital investment to support minor injuries, but Holme Valley Memorial Hospital (HVMH) would require investment.

Given that this is the position the procurement routes available for HVMH are limited to those which are open to Locala CIC as the service provider operating under licence at that site, and to NHS Property Services, as the site owner. For properties owned by NHS Property Services, the capital route is customer capital from the Department of Health. The cost of this investment will be recovered from the CCGs through higher rental costs. Locala CIC will explore all available financing and procurement options. This position will be developed further through engagement with NHS Property Services and local commissioners as the FBC is developed.

Procurement of equipment at Community Hubs

In order to deliver a greater range of services at community hubs, including more diagnostic imaging, providers of those services will need to invest in equipment or make arrangements with third parties to provide the equipment.

In summary we may expect ultrasound, plain film x-ray and mobile CT scanning facilities to be made available. The routes open to providers for such equipment are to buy, lease, or sub-contract for service provision. Providers will explore all options once a service specification has been agreed with commissioners following further development of the proposals contained in this OBC. Site owners and controllers will be engaged, and NHS Property Services and Assura will have additional options open to them for investment in their properties to meet commissioner's needs in return for increased service/ rental charges.

Facilities services

The revised acute and community care arrangements will have implications for associated soft facilities management services, such as cleaning.

Contracts will be in place for these soft facilities management services but they will need review in the light of the changes in care arrangements. This may involve variations to current contracts or possibly new contracts.

Timescales

The timescales associated with the above procurement options will become clearer during the FBC development stage. Procurement can only begin once commissioners have approved the FBC, and in circumstances where procuring providers have the necessary contractual security to commit to such major investment.

Conclusions

This section demonstrates that there are a range of strategies available to procure and fund the proposed service re-configuration. Further work will be undertaken through the Final Business Case process to evaluate these options so that a preferred procurement strategy can be proposed.

11.The Financial Case

This section provides a detailed description of the financial case for change and how the options that have been considered address the financial challenges faced by commissioners and providers. Whereas the Economic Case answers the question **what is the best option**, the Finance Case considers the **affordability of the option**. This section also includes an outline of the funding sources and demonstrates the financial impact of the proposed changes upon the existing organisations.

The key messages you should take from this section are:

- There are significant long term affordability challenges for commissioners and providers of health and social care, which require system-wide changes to be made.
- The current projections suggest that the three providers have identified a £51m contribution to the efficiency challenge so far over the next 5 years and £74m over the next 10 years, based on the services identified as being in scope.
- This OBC can only consider the areas within scope of the three organisations and therefore seeks to demonstrate how the proposals compare against the assumptions that were made within the Calderdale and Greater Huddersfield Strategic review. This was previously identified as £163 million system wide efficiency savings requirement; however, this system wide requirement is currently under review to test its validity given a number of key planning assumption changes.
- A sensible approach from commissioners and providers needs to be adopted to look at alternative funding mechanisms and local tariff approaches moving forward, utilising the full flexibilities within the NHS contracts.
- There will be a need to enter into risk sharing agreements to support the sustainability of the health and social care system.
- Option 2 best contributes to the affordability challenge at a system-wide level, at the same time as improving patient care. However, further work needs to be done to fully work through the impact of the changes being proposed.
- There will need to be a collective effort to explore new options for developing financially sustainable delivery of health and social care for Calderdale and Greater Huddersfield.

In summary, given the need to invest in improving outcomes and quality for patients in addition to meeting growing patient demand, system-wide service reconfiguration is the only way to achieve financial sustainability in health and social care in Calderdale and Huddersfield.

11.1 Introduction

The health and social care economy is facing significant challenges where change will be needed to improve outcomes and quality for service users and allow for a sustainable and effective health and social care economy.

The initial impact of the national reduction in levels of funding for public sector services manifested itself as a £20bn cost reduction challenge, dubbed the 'Nicholson Challenge', for the whole NHS to be achieved by 2014/15, as well as a significant reduction in local authority central funding equivalent to ~25% over 3 years. The latest economic projections suggest that the government spending review scheduled for 2015 will result in the NHS and local authority needing to deliver savings at a similar, if not higher level than those previously achieved. This will represent a significant funding pressure.

NHS England forecasts that an additional £30bn of NHS efficiencies will need to be found by 2020/21.

"The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best." (The NHS belongs to the people: a call to action).

This will require significant change in the way the Health and Social Care system is shaped and operates to deliver the scale of what is required.

Significant change is essential to ensure that everyone gets the right care, at the right time and in the right place, whilst responding to the challenges of:

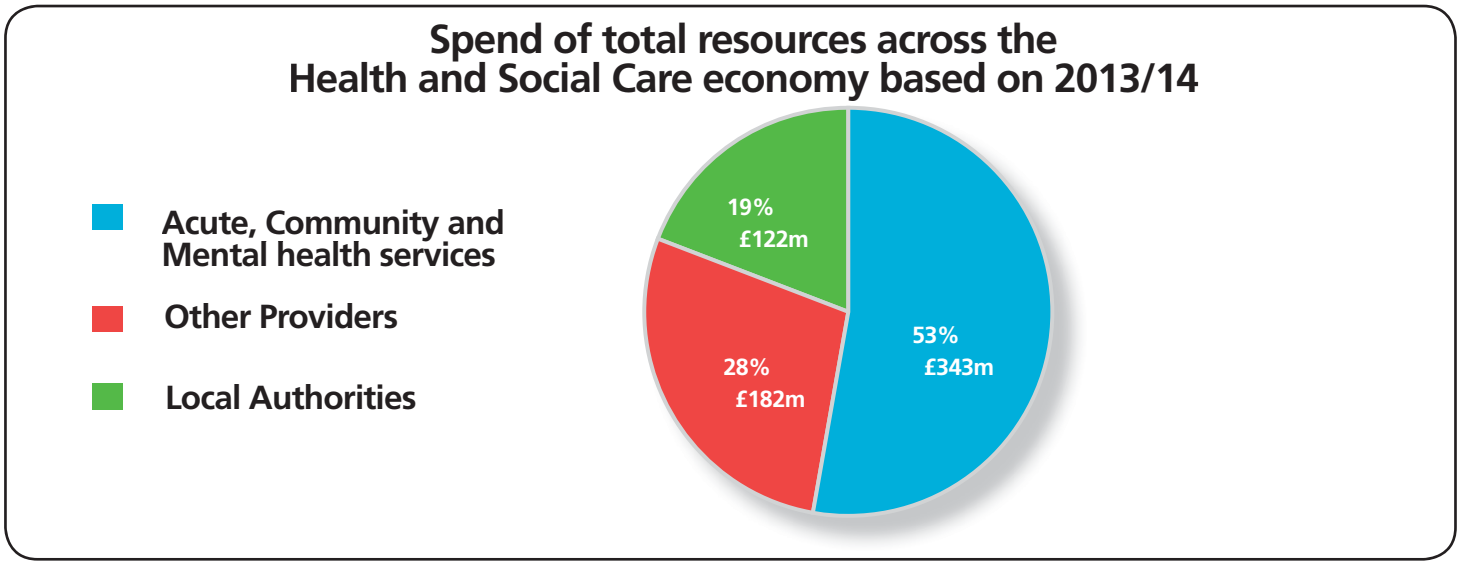
Significant change is essential to ensure that everyone gets the right care, at the right time and in the right place, whilst responding to the challenges of:

- An ageing population with increased needs
- National shortages of key elements of the workforce
- Continuing to meet ever increasing external standards
- Significant financial pressures facing commissioners and providers.

The scale of the financial and clinical challenge is a significant one as there is inadequate resource across health and social care to safely and effectively meet the increased demand for services if we continue to deliver care in the same way.

11.1.1 The Calderdale and Greater Huddersfield Strategic Review

The Calderdale and Greater Huddersfield Strategic Review identified the current total resources across the Health and Social Care economy based on 2013-14 plans as £647m. Of which £343 (53%) is currently commissioned with CHFT, Locala and mental health services (SWYPFT accounts for the majority of mental health expenditure). The remainder is split £122m spend with Local Authorities and £182m with other providers. This analysis excludes primary care expenditure.



The level of financial challenge over the next 5 years was described in two ways:

- Firstly the level of internal efficiency requirement within providers of £120m; and
- Secondly a financial estimate of the impact of demographics of £43m for the whole of the health and social care spend of £647m.

Key financial assumptions used

NHS England and Monitor planning guidance lays out expectations of providers and commissioners of Health care services, and forms the basis for which assumptions around tariff and inflation are made.

The 2014/15 and 2015/16 income allocated to CCGs and direct commissioning has been published. For 2016/17 to 2018/19 commissioners as a whole should assume a continuity of the current allocations policy, although no decisions on allocations beyond 2015/16 have yet been taken. For subsequent years, commissioners should assume that income growth increases in line with the GDP growth forecasts.

The income growth seen by CCGs over the next 5 years is shown below.

	14/15	15/16	16/17	17/18	18/19
CCG Income growth	2.14%	1.70%	1.80%	1.70%	1.70%

Providers have to make on-going savings to deliver the same activity year on year if they are to remain financially sustainable. This is primarily because the cost of activities provided by these organisations is subject to inflation each year. In contrast, the prices paid to providers by commissioners for the same amount of activity are reduced year on year through tariff deflators. This creates a financial gap of circa 5% that providers have to bridge each year by making savings.

The NHS planning guidance for 2014/15 was issued in December 2013. It lays out the expected inflation levels for expenditure (2.5%) and deflation levels for NHS Contract Income (-1.5%), equating to a total efficiency requirement for providers of 4%, prior to funding service improvements.

Tariff Assumptions	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Secondary Care Health cost inflation	2.5%	2.2%	3.0%	3.4%	3.4%
Provider sector efficiency	4.0%	4.0%	4.0%	4.0%	4.0%
Tariff de□ator	**(1.5%)**	**(1.8%)**	**(1.0%)**	**(0.6%)**	**(0.6%)**

As a result of expected inflation, population growth and budget cuts, coupled with the necessity to improve outcomes and quality for service users an significant efficiencies need to be made over the next five years in order to maintain current health and social care services for the population of Calderdale and Huddersfield; therefore in the future providers and commissioners of health and social care need to do things differently and provide more for less.

The Calderdale and Greater Huddersfield strategic review programme calculated the projected cash utilisation in the Health and Social Care system for the next 5 years, which is shown in the below table.

	14/15	**15/16**	**16/17**	**17/18**	**18/19**	**Total**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
Additional cash in the system	11.39	18.20	10.11	9.72	9.89	59.30
Growth	(12.13)	(12.76)	(12.99)	(12.04)	(11.64)	(61.57)
Quality Improvements	(8.01)	(13.32)	(4.00)	(4.00)	(4.00)	(33.33)
Inflation	(23.75)	(24.62)	(25.62)	(26.18)	(26.74)	(126.90)
Total pressure in the system	**(43.89)**	**(50.70)**	**(42.61)**	**(42.22)**	**(42.39)**	**(221.80)**
Efficiency Requirement	**(32.50)**	**(32.50)**	**(32.50)**	**(32.50)**	**(32.50)**	**(162.50)**

This system wide savings requirement will be retested with providers and commissioners as part of the full business case due to a number of key planning assumption changes since the figures were first calculated.

This efficiency requirement needs to be achieved amidst a backdrop of increasing demand for services, a requirement to provide access to services 7 days a week, increasing requirements around staffing ratios and improving the safety and quality of care people receive.

11.1.2 Movements from the Provider Strategic Outline Case to Outline Business Case

The following paragraphs provide an audit trail from the assumptions in the SOC to the financial and economic case within the outline business case. The key points are:

Previous Assumptions in the Provider Strategic Outline Case

- The period considered was consistent with the Calderdale and Greater Huddersfield strategic review planning assumptions – 5 years from 2014-15 to 2018-19.
- The overall level of system saving, previously assumed, was equivalent to a cumulative saving of 5% per year on the total resources of £647m. This was consistent with national planning assumptions. This will be retested as part of the full business case in light of revised planning assumptions.
- The level of commissioner cash releasing savings identified of £43m is consistent with achieving a 1.3% cash releasing efficiency on £647m for 5 years. For NHS contracts cash releasing efficiency is generated by the application of a tariff deflator. In recent years this has been between 1.3% and 1.8%. The strategic outline case assumed a 1.5% deflation for the 5 year period. If applied to the £647m a 1.5% cash releasing efficiency would generate £48m saving.
- Applying the commissioner assumptions to the resources assigned to the 3 NHS providers would generate an £85m efficiency saving (5%).
- The provider strategic outline case previously identified a gross efficiency savings of £74m, shown below, to be tested during the outline business case.

	Service Change	Net Saving Opportunity £m
1)	Reduce hospitalisation and improve acute service efficiency	33
2)	Improve efficiency of community services	24
3)	Enable more people to self-care	17
	Sub Total Savings	**74**
4)	Invest to enable changes	(24)
	Saving Identified in the SOC	**50**

- The Strategic outline case identified a number of areas where further work was required in the outline case to validate the financial assumptions which included:
  - Testing the efficiency assumptions against a detailed service model;
  - Defining how much of the proposed efficiency target would be delivered as cash releasing cost improvement programme and contribute to the commissioner £43m savings requirement;
  - Quantify the capital and revenue costs of the reconfiguration of the acute bed base, enhancement of community services and investment in information technology;
  - Estimate of the non-recurrent costs incurred in the transition period e.g. costs of transferring services, workforce training and reconfiguration costs.
- The strategic outline case also identified that the proposal would have an impact on social care and primary care, which were not considered in detail in the SOC as they were out of scope.

Outline Business Case

The following paragraphs highlight the key movements from the SOC to the OBC.

Provider income within scope

- Given the Business case considers the hospital provision in total the income and expenditure assumptions for CHFT are greater than just Calderdale and Greater Huddersfield, as it also includes income from other sources.
- The community model considered those elements which would be in the integrated team at practice cluster level. Those elements which would be provided on a larger footprint or are more specialised were excluded from the scope. The focus of the work was to understand the impact of the acute service reconfiguration on the running costs of the acute hospital and the impact of admission avoidance and early discharge on the workload of general community teams.

- As the work on the service model has developed it has become clear that the acute pathway for mental health and impact on community provision and more integrated care needs to be considered separately. The element of mental health services included in scope are therefore those which would operate most closely with the integrated cluster teams – this is the Liaison services within the hospital (RAID) and Liaison services in community teams. The level of resource in scope for community services (including mental health) is now £30m (original estimate £99m).
- Those services excluded from scope will be the subject of further business cases, as part of the full business case.

Efficiency assumptions

- The benchmark for the OBC is an efficiency requirement of between 4% and 5% which has a cash releasing benefit to commissioners of 1.5%. Both local authorities and CCGs are revising strategic plan assumptions in the light of changes in national allocations and planning guidance. An across the board assumption of 5% efficiency is consistent with national policy but it does not recognise that in practice the opportunity to generate savings will not be pro rata. This will result in some service areas having to save more than the national benchmark of 5% to counterbalance those areas where efficiencies cannot be generated.
- The OBC can only consider the areas within scope of the 3 organisations and therefore seeks to demonstrate how the proposals compare against the assumptions that were made within the Calderdale and Greater Huddersfield Strategic review.
- The OBC considers the impact of demographic growth and how much of this will be absorbed by internal provider efficiencies, the impact that the proposals have upon providers ability to deliver efficiencies and the impact the proposals will have on the wider health and social care system.
- The impact of increasing self-care was originally estimated as an efficiency saving of £17m over 5 years based on a reduction of total care costs of £1800 per person. The OBC reflects the contribution of general community services to self-care as £250k per year. Maximising the impact of self-care is a system wide benefit which would need to be considered in detail with partner agencies. This has been highlighted as an area for more detailed work in the FBC and will require joint work on resource planning in relation to primary care, social care and public health.
- The OBC has now calculated the projected system efficiency savings as £51m.

11.2 In Hospitals Care Modelling – CHFT

Due to the significant level of change proposed, both in terms of capital expenditure and resultant revenue implications, the following section relates solely to the financial implications for CHFT as a result of these proposals.

All options have been modelled through the Trusts 10 year Long Term Financial Model, to assess the impact on income and expenditure, cash flow, balance sheet, continuity of service risk rating and overall affordability.

11.2.1 Capital Investment

Detailed work has been undertaken to assess activity and capacity projections over the next 10 years at a service and specialty level. The outputs from this have been used to determine the level of estate infrastructure required for both a planned and unplanned hospital site. The estates costs have been produced in conjunction with the Trust's costing advisors. A description of the key estate implications under each option can be found within section 8 of the business case.

The below table shows the 10 year capital projections for CHFT under option 2.

	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
IM&T	12	15	6	5	3	6	4	4	4	4
Estates	15	13	48	49	47	14	17	15	15	15
Equipment	2	4	5	3	2	3	2	3	4	6
Total	**29**	**33**	**59**	**57**	**53**	**22**	**22**	**22**	**23**	**25**
Cumulative Capital	29	62	121	178	231	253	275	297	320	345

The below table shows the 10 year capital projections for CHFT under option 3.

	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
IM&T	12	15	6	5	3	6	4	4	4	4
Estates	15	13	41	34	33	29	6	4	4	4
Equipment	2	4	5	3	2	3	2	3	4	6
Total	**29**	**33**	**52**	**43**	**38**	**37**	**11**	**11**	**12**	**14**
Cumulative Capital	29	62	114	156	194	232	243	254	266	280

Construction costs will be refined as design progresses throughout the FBC phase of the project, and preferred site locations are determined. This will also include exploring different options for estate design and configuration within the sites.

Further work will also be progressed during this period to further review the size of the estate footprint, and the level of care that could be provided in an out of hospitals setting. The anticipation is that this would reduce the estate costs further, and the level of borrowing required.

Whilst the headline capital projections suggest option 3 to be cheaper, it is worth noting that option 2 offers different revenue benefits to option 3, and as such the capital figures in isolation cannot be taken as an assessment of overall differential affordability between the options.

11.2.2 Source of Financing

The Trust has assessed the impact of the options upon its ability to generate cash flows to finance the capital requirements. The below table sets out the capital cash flows associated with the proposals together with the sources of anticipated funding.

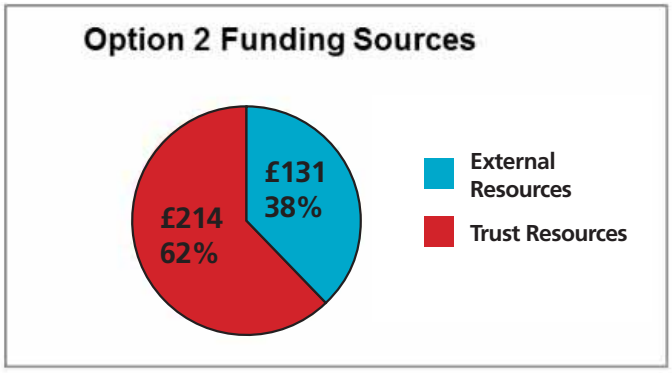
The below table shows the anticipated source of financing under option 2.

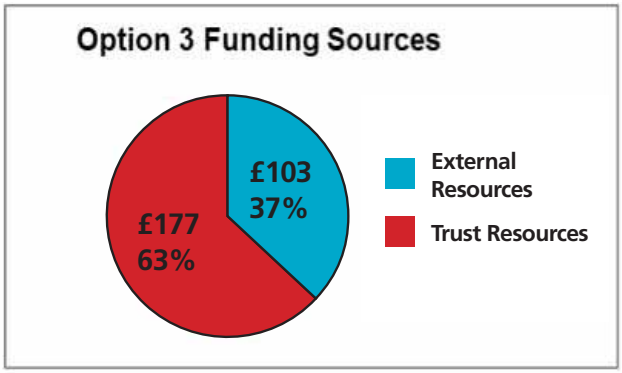
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Capital Expenditure	29	33	59	57	53	22	22	22	23	25
Funded by:										
External Financing	12	18	41	36	24	0	0	0	0	0
Trust Resources	17	14	18	22	29	22	22	22	23	25
Total Funding	**29**	**33**	**59**	**57**	**53**	**22**	**22**	**22**	**23**	**25**

The below table shows the anticipated source of financing under option 3.

	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Capital Expenditure	29	33	52	43	38	37	11	11	12	14
Funded by:										
External Financing	12	18	34	21	13	4	0	0	0	0
Trust Resources	17	14	18	21	25	33	11	11	12	14
Total Funding	**29**	**33**	**52**	**43**	**38**	**37**	**11**	**11**	**12**	**14**

- The 10 year capital projections under option 2 are £345m, of which it is anticipated that over the period £214m can be financed through the Trusts internal ability to generate cash. The remaining £131m will need to be sourced via external financing.
- The 10 year capital projections under option 3 are £280m, of which it is anticipated that over the period £177m can be financed through the Trusts internal ability to generate cash. The remaining £103m will need to be sourced via external financing.
- Capital expenditure at CRH will be financed as per the Trusts existing PFI scheme, and as such will be included in the revenue cost stream.
- The total borrowing still outstanding for repayment at the end of year 10 is calculated to be £92m in option 2 and £73m in option 3.





The Trust has held discussions with the Independent Trust Financing Facility (ITFF) with regards to access to funds. The initial discussions have indicated that this would be an option, but would be predicated upon the affordability assessment presented via this business case, and also the 5 year Strategic Plan submission to the Foundation Trust regulator Monitor.

The loan would be accessed through the ITFF at the Public Works Loan Board rates, currently at 3.28% for borrowing over a 25 year period. These assumptions have been used within the financial analysis.

11.2.3 Impact on the Organisations Income and Expenditure

The initial incremental revenue and expenditure impacts associated with the options are presented over the first 10 years of the project only. Detailed work has been undertaken to assess activity, capacity and workforce projections over the next 10 years at a service and specialty level, for each option. The plans are based upon the activity and capacity detail contained within section 6 and the workforce modelling contained within section 7.

In addition to the direct impact of reconfiguration on the Trust's income and expenditure there are a number of other related opportunities for additional income and cost savings as a direct and indirect consequence of reconfiguring services.

For the purposes of this OBC, the income and expenditure effect are based on the following:

Income

- Interserve Consulting were jointly commissioned by Greater Huddersfield CCG, Calderdale CCG and CHFT to produce a report which highlighted the levels of anticipated demographic growth over the next 10 years. The demographic growth predictions were based upon the Office of National Statistics 2010 sub-national population projections for the local area. These assumptions have been used within all options.
- The activity and income levels have been built up under PbR rules and have been subject to the price and operational changes as described within the 2014/15 National Tariff Payment System guidance published by NHS England and Monitor. The tariff deflator assumptions are described earlier within the finance case. Years 6-10 assumes a continuation of the year 5 deflator.
- No activity drift or income loss assumed due to moving to a planned and unplanned configuration. This assumption will be tested as part of the FBC process.
- Options 2 and 3 assume reduced income due to out of hospitals care / efficiency of £18.6m over the 10 year period. This is based

upon reductions to length of stay, readmissions, A&E attendances and admission avoidance described within the activity and capacity section of the business case. This is above the assumed income loss due to generic tariff deflation.

- Option 2 assumes activity drift from Mid Yorks of 3812 A&E attendances with a 37% conversion rate, resulting in 1410 admissions. This equates to £3.6m additional income. This is assumed from 2015/16 onwards. Under Option 3 this activity drift is assumed to be lost in 2020/21 if the unplanned site was to be CRH.
- Under option 2 the capacity released at CRH enables the Trust to pursue additional commercial opportunities. The additional income associated with this equates to an estimated £15m. This opportunity is not incorporated into option 3 as the estates assumptions under this option currently assume the planned site would be a new build on the Acre Mill site, which would not have the capacity to support additional commercial opportunities.

Pay

- Pay costs have been planned to increase in 14/15 and 15/16 in line with the recent announcement on agenda for change pay awards with staff receiving either an annual increment, planned at 1.3% (based on local experience) or a 1% cost of living allowance for those at the top of pay scales. Subsequent increases for incremental drift and cost of living allowances for years 3-10 have been assumed at 2%.
- Section 7 of the business case describes a net workforce reduction of 409 posts, after investing in additional staffing needed to provide quality improvements, such as 7 day working and increased nurse staffing levels on wards. This workforce impact has been modelled through into the finance case.
- The activity drift from Mid Yorks, described above, equates to an additional £1.7m. This is assumed from 2015/16 onwards. Under Option 3 this activity drift is assumed to be lost in 2020/21 if the unplanned site was to be CRH.
- Option 3 includes an additional provision of £1m per annum against nursing staffing. This is due to the ward layouts at CRH being more difficult to provide observations, and as such the movement of more acute activity to CRH would result in an increased staffing requirement than currently provided.
- The commercial strategy identified under option 2 equates to an additional cost of £9m, resulting in a net £6m contribution.

Non Pay

- Drugs costs to increase by 1% (excluding High Cost Drugs).
- PFI contract costs to increase in line with RPI estimated at 2.7% for 2014/15 and 3.0% thereafter.
- Utility contracts increased at an estimated 10% per annum.
- Rates to increase at 4% per annum.
- Other non-pay costs planned to increase at 2% per annum.
- The activity drift from Mid Yorks described above equates to an additional £0.7m. This is assumed from 2015/16 onwards. Under Option 3 this activity drift is assumed to be lost in 2020/21 if the unplanned site was to be CRH.
- An estimation of transitional costs has been made for each option. These are estimated at £1.5m for option 2 and £4m for option 3. The difference in assumption is due to the size and scope of services that would be required to move from their current base depending upon the location of the planned and unplanned site, as well as the anticipated increased timescale required to deliver the estate reconfiguration under option 3.
- Significant investment in technology through the Trust IM&T modernisation programme.

Capital Charges

- Depreciation of capital assets has been based upon the asset life, and is consistent with the Trust's accounting policy.
- Interest charges have been calculated at an interest rate of 3.28% over a period of 25 years from the date of the loan drawdown.
- Public Dividend Capital (PDC) effect has been calculated at 3.5% of the relevant changes within net assets.

Statement of Comprehensive Income

The assumptions identified above, for each of the options, have been modelled through the Trusts 10 year Long Term Financial Model to assess the impact on the Statement of Comprehensive Income.

The below table shows a summary of the Statement of Comprehensive Income over the next 10 years under option 2.

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Income	352	349	348	345	343	350	356	357	357	357
Expenditure	(343)	(339)	(335)	(319)	(308)	(299)	(302)	(305)	(309)	(316)
Deliverable CIP	17	19	1	2	8	9	4	4	0	0
Unidentified CIP	3	3	23	17	13	0	0	0	1	8
EBITDA	28	32	36	44	55	60	59	56	49	49
Non Operating Expenditure	(25)	(27)	(30)	(35)	(39)	(42)	(43)	(44)	(45)	(46)
Surplus	3	5	6	10	17	18	16	11	3	3

The below table shows a summary of the Statement of Comprehensive Income over the next 10 years under option 3.

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Income	352	349	348	345	343	341	338	338	338	338
Expenditure	(343)	(339)	(336)	(319)	(312)	(301)	(287)	(286)	(290)	(297)
Deliverable CIP	17	19	1	2	4	8	9	4	0	0
Unidentified CIP	3	3	23	13	15	9	0	0	0	4
EBITDA	28	32	36	41	49	58	59	56	49	45
Non Operating Expenditure	(25)	(27)	(30)	(34)	(37)	(39)	(41)	(41)	(42)	(42)
Surplus	3	5	6	7	13	19	18	14	7	3

Option 2 – HRI Unplanned

- The impact of the assumptions identified above result in an efficiency requirement over the next 10 years of £132m in option 2.
- The cost base shifts from direct/indirect expenditure to capital financing costs.
- Further review of out of hospitals care models and capital financing solutions should reduce the level of CIP.

Option 3 – CRH Unplanned

- The impact of the assumptions identified above result in an efficiency requirement over the next 10 years of £135m in option 3.
- Commercial opportunity limited by estate configuration.
- PFI arrangement limits scope for further CIP deliverability.

As with the economic case the analysis above, based upon required efficiencies, represents a marginal difference in favour of option 2.

The impact of the efficiency requirement and deliverability against this will be analysed in the section below.

Continuity of Service Risk Ratings

All NHS foundation trusts need a licence from the external regulator Monitor stipulating specific conditions that they must meet to operate. Key among these is financial sustainability.

Monitor's continuity of services framework aims to identify whether the financial situation of a provider could place key NHS services at risk. Providers are required to be financially viable as measured by the continuity of services risk rating.

The continuity of services risk rating incorporates two common measures of financial robustness:

1. Liquidity: days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown; and
2. Capital servicing capacity: the degree to which the organisation's generated income covers its financing obligations.

Through the calculation of these two metrics against defined thresholds the provider is awarded a continuity of services risk rating score. The overall score will inform Monitor's regulatory approach towards the provider in question. The scores range from level 4, indicating no evident financial concerns for the regulator, down to level 1 indicating significant risk.

For licence holders demonstrating a significant level of financial risk, Monitor may consider formal enforcement action as well as specific requirements within the terms of the continuity of services licence conditions themselves, including cooperating with a Monitor-appointed contingency planning team or other financial experts.

A higher risk score of level 3 or level 4 will reassure the organisation itself as well as Monitor of financial sustainability and the regulatory intervention will be a lighter touch review of financial information.

The continuity of service risk rating is a fundamental measure of financial performance for a NHS foundation trust, and as such a key measure of sustainability not only for the organisation in question, but the wider Calderdale and Greater Huddersfield system as a whole.

All models proposed within this outline business case are predicated upon maintaining a Continuity of Service Risk Rating of 3 in each year.

11.2.4 In Hospital Summary

The impact of the issues described within the above sections result in the need to deliver efficiency savings to remain sustainable as an organisation.

These are mainly driven by inflationary pressures and a reduction in the tariff paid to providers, creating a financial gap of circa 5% that needs to be found through efficiencies.

The efficiency requirement is further heightened through funding significant investments to deliver improved quality of services and mitigating the reduction of income due to out of hospitals care / efficiency models where the full cost cannot be released as tariff is released.

The below table shows the total efficiency requirement and the current deliverable and unidentified split over the 10 year period under each option.

	Option 1	Option 2	Option 3
	Year 10	Year 10	Year 10
Efficiencies	**£m**	**£m**	**£m**
Deliverable Efficiencies	53	65	64
Unidentified Efficiencies	84	67	71
Total Efficiency Requirement	**137**	**132**	**135**

Savings have been identified through internal efficiencies, as well as the ability to remove costs due to out of hospitals care models.

The proposals within the business case equate to an estimated reduction in income due to out of hospitals care / efficiency of £19m over the 10 year period for CHFT. The amount of cost releasable in relation to this is £15m, leaving a residual £4m pressure further increasing the need to deliver efficiencies.

The key quality improvements contained within this business case, which are increasing the need to deliver efficiencies, are:
- Investment in providing access to services 7 days a week - £3.5m
- Investment in improving nurse staffing ratios - £2.5m
- Investment in staffing to provide services at Todmorden and Holme Valley - £0.7m
- Investment in estates (including borrowing) - £9.2m

This is an important consideration to note when looking at overall system wide affordability.

Currently no allowance has thus far been assumed around potential additional support to alleviate some of these pressures or quality improvement initiatives.

Should there be any additional support then the level of efficiency requirement will diminish, as will the residual unidentified element of this, making the proposals more affordable.

The above demonstrates that option 2 is the most affordable based upon the residual efficiency challenge left unidentified at the end of year 10.

Option 2 has even greater potential to demonstrate affordability, following further increase in out of hospital care, a reduction in the size of the estate and further discussion across the whole health and social care system to assess overall affordability within the system.

11.3 Out of Hospitals Care Modelling

The detailed financial and capacity modelling for community services concentrated on those elements which would be part of the integrated community team at a locality level. This includes the following:

For Locala,
- District Nursing
- Community matrons and specialist nursing services
- Drugs misuse
- Intermediate Care
- End of Life
- Out of Hours service

For CHFT,
- District Nursing
- Early supported discharge and rapid response services
- Community Matrons and specialist services
- Intermediate Care

For SWYPFT,
- Acute Psychiatric Liaison services (RAID)
- Community Liaison services

The above identified services in scope gives a baseline spend for community services of £30m.

The modelling for the impact of integration of the services excluded is on a larger geographical footprint than the localities and is more specialist in nature. The largest element of the excluded services relates to secondary care Mental Health services which will be considered in a separate business case in line with the Full Business Case.

The methodology used was to consider firstly the base case "do nothing" and assess the opportunity for efficiency in existing community services over the 5 year period.

In year One 2014-15 all the community services across the three providers achieved an internal efficiency of between 4% and 5% and a cash releasing efficiency to the commissioner of between 1.5% and 1.8%. This is equivalent to £1.2m for the total contract value of community services for 2014-15.

For years 2 to 4 2015-16 to 2017-18 the model assumes a 4% cash releasing efficiency saving each year for three years as outlined below:

Efficiency Assumption	**Efficiency Gain**
Self-Care	1.5%
Integration	3.5%
Skill Mix	2.0%
Technology	5.0%
Total Efficiency Assumption	**12.0%**

The opportunity to realise these savings will be differential dependent on how far advanced each provider is in implementing these changes for example Locala is more advanced in implementing technology to improve efficiency and productivity of the workforce therefore it would be expected that the efficiency contribution from Locala for this type of efficiency would be less than 5% and therefore by implication would be greater in other providers. The detailed application of efficiency savings to each provider will require further modelling in the Full Business Case.

The annual estimate financial impact across the services in scope can be summarised as follows:

- The impact of inflationary pressures is estimated at circa 1.7% per annum, £0.5m.
- The impact of demographics is predicted to be 2% per annum, £0.6m.
- There is an estimated 4% efficiency savings on services in scope per annum of £1.2m for years 2-4. The efficiency saving is reduced to 2%, £0.6m in year 5 onwards. The reduction in efficiency assumptions reflects that the ability to drive out productivity gains recurrently beyond three years will be diminished without reducing the overall level of service.

The below table summarise the key movements for community service over the next 5 years under option 1.

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	14/15	**15/16**	**16/17**	**17/18**	**18/19**
	£m	**£m**	**£m**	**£m**	**£m**
Baseline Spend	30.3	30.3	30.2	31.6	31.5
Inflation		0.5	0.5	0.5	0.5
Demographics		0.6	0.6	0.6	0.6
7 day working			1.5		
Efficiencies		(1.2)	(1.2)	(1.2)	(0.6)
Recurrent Spend	**30.3**	**30.2**	**31.6**	**31.5**	**32.0**

The cost of community services in scope rises from £30.3m in year 1 to £32.0m in year 5. This means in year 5 the net impact is an increased inward investment to community services of £1.7m. The baseline spend of £30.3m incorporates £1.2m of efficiencies delivered within 14/15.

Summary of option 1 for out of hospital services

- Commissioner savings for year 1 2014-15 have been achieved and community contracts have absorbed inflation and demographic growth equivalent to 3%.
- For years 2 to 4 the model predicts that the internal efficiency of 4% across the three providers which will absorb inflation and demographic pressures and give a net benefit to the commissioner of £0.3m.
- For year 5 the internally efficiency predicted falls to 2% this means that it is insufficient to absorb inflation and demographic pressures and will require inward investment estimated at £0.2m.
- The impact of 7 day working has been estimated a 5% of current provider costs which will impact in 2016-17. This is equivalent to £1.5m additional investment which would need additional commissioner investment.

Out of Hospital capacity and costing model

The estimated impact of the acute reconfiguration is expected to have an impact on community services; 112 of the bed reductions represent a transfer of workload from acute to community and the following narrative outlines how the impact of this has been estimated for inclusion in options two and three.

The community providers commissioned a capacity planning exercise from Capita. This used a baseline set of data for contacts and activity from the three providers and built a model to predict the capacity and costs of alternative provision using existing benchmarking information. A reduction in bed days can be achieved either by avoiding admission or supporting early discharge.

The notable difference between the 2 outcomes is that avoided admissions has a larger potential saving as it requires no input from the acute hospital and a lower predicted use of community beds due to problems being dealt with at a sub-acute phase.

The models for the alternative provision were mapped out as shown below:

Avoided Admissions

- For 10% of bed days avoided the alternative provision would be a bed in the community split 58% rehabilitation; 14% care home; 14% other non-acute; 14% inpatient dementia provision.
- For 90% of bed days avoided the alternative provision would be community based with a range of services to include GP / Consultant visit; therapies; social care and community nursing.

Taking a weighted average of the cost of outcomes as calculated using reference costs the average cost of alternative provision is £60 per day.

Early Discharge

- For 33% of bed days avoided the alternative provision would be a bed in the community split 21% rehabilitation; 7% care home; 65% other non-acute; 7% inpatient dementia provision.
- For 47% of bed days avoided the alternative provision would be community based with a range of services to include GP / Consultant visit; therapies; social care and community nursing.

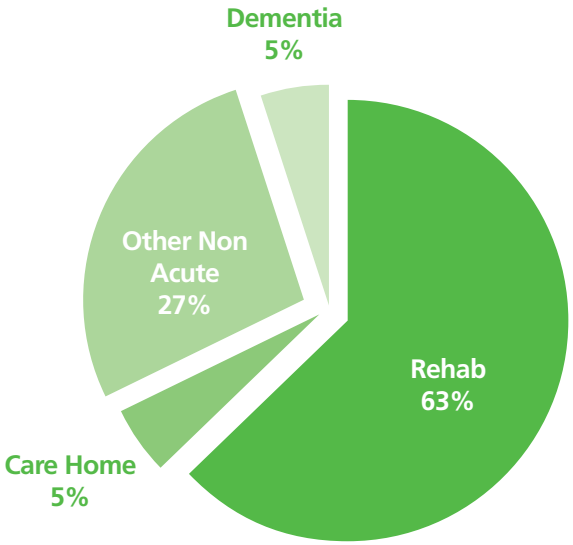
Taking a weighted average of the cost of outcomes as calculated using reference costs the average cost of alternative provision is £65 per day.

The range of outcomes includes activities beyond the remit of the three providers including cost of GP provision, social care and residential care. Whilst the business case recognises the responsibility for deployment of these budgets is not in scope the model allows an estimate of the potential costs in other sectors and therefore provides a fuller impact assessment on the overall health and social care system.

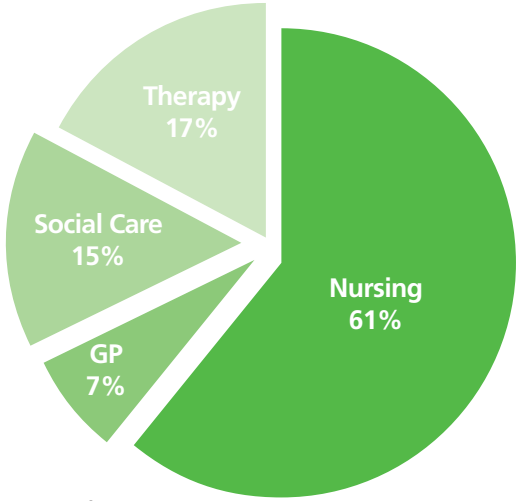
Summary output from the modelling

- Overall the average cost of re-provision of acute bed day activity in the community through either avoiding admission or accelerating discharge is between £60 and £65 per day. For this model to generate savings the amount of cost released in the acute hospital would have to be in excess of £65 per day. The current full cost of an acute bed day is around £300 per day. Therefore this work has given a working model and set of assumptions which provide a "proof of concept" that community services which provide care closer to home can be provided at lower cost than acute inpatients.
- Whilst the modelling performed to date provides a 'proof of concept' further work needs to be performed to ensure that Community services are appropriately reimbursed for costs (to include a contribution towards overheads) of handling incremental community activity following closure of acute beds. It is recognised that a reduction in tariff does not constitute costs removed from the system, and there will be residual costs that cannot be removed. Therefore we can only truly assess the impact when all the system figures based upon releasable costs are aggregated. The current assumption shows a circa 80% saving, compared to national evidence of 30%. This needs further clarity and validation to agree acute internal efficiencies that do not impact community.
- Based on bed reduction of 112 beds the estimated cost of re-provision across all sectors is £3.3m. The breakdown of this is set out below based on a split of bed days for avoided admissions and supported discharge respectively. This has been factored into the financial case for options 2 and 3.

The £3.3m reprovision is split as 57% bed based and 43% non bed based as follows:



Bed Based	£m
Rehab	1.2
Care Home	0.1
Other Non-Acute	0.5
Dementia	0.1
	1.9



Non Bed Based	£m
Nursing	0.9
GP	0.1
Social Care	0.2
Therapy	0.2
	1.4

The costs of re-provision are based on nationally available benchmark data on current costs. As part of future work these assumptions would need to be validated against local costs and incorporate any significant changes anticipated in the future.

Options 2 and 3 for Out of Hospital Services

The financial model for options 2 and 3 for community services uses the same efficiency assumptions as the "do nothing" option. The impact on community services of the acute reconfiguration is an assumed transfer of workload equivalent to 112 beds which is the same for both options 2 and 3. The location of the acute site does not impact significantly on the community provision.

The additional cost impact for community services is shown in the table below and can be summarised as follows:

Recurrent Investment Required

- Cost of re-provision packages total cost of £3.3m (Capita model)
- Additional recurrent investment in information technology of £0.5m
- A further allowance on £1.5m has been built into this model to cover the estimated cost of 7 day service provision for community services.
- A further allowance on £1m has been built into this model to cover the estimated cost of 7 day service provision for GPs and Social Care.

Non-Recurrent Investment Required

- Additional non recurrent investment in 2015-16 £0.5m Information technology and £1.1m training for the transition to new service model and capacity
- £1m non-recurrent investment in intermediate care estate to ensure sufficient capacity to meet demand.
- Non-recurrent investment required in estate improvement and expansion at Holme Valley, and other potential community estate has been estimated at £5m.

The below table summarise the key movements for community service over the next 10 years under option 2 and 3.

	Year 1	Year 2	Year 3	Year 4	Year 5	Years
	14/15	15/16	16/17	17/18	18/19	6-10
	£m	£m	£m	£m	£m	£m
Baseline Spend	30.3	30.3	31.7	36.4	36.4	36.9
Inflation		0.5	0.5	0.5	0.5	2.5
Demographics		0.6	0.6	0.6	0.6	3.1
Re-provision packages - Community		1.5	1.5			
Re-provision packages - GPs & Social Care			0.3			
7 day working - Community			1.5			
7 day working - GPs & Social Care			1.0			
IM&T			0.5			
Efficiencies		(1.2)	(1.2)	(1.2)	(0.6)	(3.0)
Recurrent Spend	**30.3**	**31.7**	**36.4**	**36.4**	**36.9**	**39.4**

The total cost of the out of hospital services in scope at the end of year 5 is £36.9m, which represents a total recurrent investment required over the 5 years of £6.6m. A further investment of £2.6m from years 6 to 10 would be required to cover continual demographic pressures, giving an additional £9.2, investment over the 10 year period.

In addition to this there is a non-recurrent investment required of £7.6m as described above.

The additional investment required is after taking into account the cost of inflation, demographic growth, provision of 7 day services, acute re-provision and an assessment of the impact upon primary and social care.

The additional £9m recurrent investment required over the 10 year period builds upon an existing £9m investment in out of hospitals provision, which is aimed at reducing admissions, reducing readmissions and supporting early discharge from hospital.

The full impact of the out of hospitals modelling will be assessed in the following section looking at the overall system wide affordability.

The model excludes

- Any significant contribution to savings from self-care. The original case assumed a potential saving of £17m based on a shift to self-care for a cohort of 10,000 people with long term conditions at an annual cost of £1,800 per person. The validation of this assumption requires a system wide evaluation involving local authority primary care, voluntary sector and public health partners and therefore has been considered beyond the scope of this OBC. The modelling work has recognised the impact of increased self-care as a reduced demand on the services within scope of the community element of the model as being in the region of £250k per year.
- Any impact on social care or primary care from the reduction of beds other than the 112 identified and estimated 7 day provision.
- Sensitivity analysis of the model to the assumptions re savings in acute versus the additional costs in community.
- Impact on other costs e.g. pharmacy costs in the community, voluntary sector due to the shift of activity from acute settings.
- Full analysis of impact on community estate costs and utilisation.
- Additional non recurrent costs for dual running or redundancy costs.
- Impact of future development in acute and community tariff.
- A detailed analysis of how the community efficiencies will be achieved and additional investment will be split between the three community providers and therefore a detailed impact of the proposal on the sustainability of each organisation.
- The efficiency and investment requirement for services excluded from the model over the 5 year period.

The above will require more detailed work in the next iteration of the Business case.

Out of Hospitals Summary:

- The community services identified as in scope equates to a cost base of £30m in 14/15.
- The efficiencies that can be delivered by community services equates to £8.5m over the 10 year period. This is made up of the £7.3m shown in the table above plus a further £1.2m already delivered within the 14/15 baseline position.
- The efficiencies delivered are sufficient to cover inflation and demographic growth until year 5, at which point the deliverable efficiency reduces from £1.2m per annum to £0.6m per annum. From this point additional investment will be required to cover continual growth. This equates to £2.6m investment over the period.
- Further recurrent investment in out of hospitals care is required of £6.6m to cover 7 day working, IM&T and acute re-provision.
- Non-recurrent investment is estimated at £7.6m to cover the cost of community estate, technology and training.

11.4 Overall System Assessment of Affordability

11.4.1 Overall efficiency requirement and deliverability

A key determinant of organisational stability and future sustainability is the ability to identify and deliver efficiency savings to meet pressures arising from inflation, cost of living allowances and reductions in tariff income.

Providers have to make on-going savings to deliver the same activity year on year if they are to remain financially sustainable. This is primarily because the cost of activities provided by these organisations is subject to inflation each year. In contrast, the prices paid to

providers by commissioners for the same amount of activity are reduced year on year through tariff deflators. This creates a financial gap of circa 5% that providers have to bridge each year by making savings.

This needs to be achieved amidst a backdrop of additional pressures, over and above the normal inflation and tariff deflation pressures. The pressures arise as a result of the need to improve the safety and quality of care people receive and mitigate the reduction of income due to alternative models of care where the full cost cannot be released as tariff is released.

Providers face this further challenge as new service models emerge and activity flows move from traditional means to alternative provision. The system primarily operates a tariff based system, resulting in payments being made for activity incurred. As such whilst 100% of the income may be removed through tariff as activity changes, there will still be circa 25% residual cost left in the system from the old services which cannot be removed. This creates additional pressure increasing the level of savings required to be made.

The proposals within the business case equate to an estimated reduction in income due to out of hospitals care / efficiency of £19m over the 10 year period for CHFT. The amount of cost releasable in relation to this is £15m, leaving a residual £4m pressure.

This is an important consideration to note when looking at system wide affordability.

The key quality improvements contained within this business case where no allowance for additional funding has been made, which increases the need to deliver efficiencies, are:

- Investment in providing access to services 7 days a week - £3.5m
- Investment in improving nurse staffing ratios - £2.5m
- Investment in staffing to provide services at Todmorden and Holme Valley - £0.7m
- Investment in estates (including borrowing) - £9.2m

Some of the key quality initiatives are as a result of national recognition that services need to change. As a result the current national tariff will provide insufficient funding to support these initiatives. However, at this stage a prudent approach has been taken and no allowance has thus far been assumed around potential additional support to alleviate some of these pressures or quality improvement initiatives.

Should there be any additional support then the level of efficiency requirement will diminish, as will the residual unidentified element of this, making the proposals more affordable.

The below table shows a summary of the provider efficiency requirement and currently identified deliverability against this requirement over the next 10 years under option 2.

	Year 1	Year 2	Year 3	Year 4	Year 5	5 Year	Yr 6-10	10 Year
	14/15	15/16	16/17	17/18	18/19	Total	Total	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Acute Services	20.0	21.6	23.6	18.8	20.5	104.6	27.8	132.4
Community Services	1.2	1.2	1.2	1.2	1.2	6.1	6.1	12.1
Total Efficiency Requirement	**21.2**	**22.8**	**24.8**	**20.0**	**21.7**	**110.6**	**33.9**	**144.5**
Acute Services	17.0	18.5	0.9	2.0	7.6	46.0	19.0	65.0
Community Services	1.2	1.2	1.2	1.2	0.6	5.4	3.0	8.5
Total Deliverable Efficiencies	**18.2**	**19.7**	**2.1**	**3.2**	**8.2**	**51.4**	**22.0**	**73.4**
Acute Services	3.0	3.1	22.7	16.8	13.0	58.6	8.8	67.4
Community Services	0.0	0.0	0.0	0.0	0.6	0.6	3.0	3.6
Total Unidentified Efficiencies	**3.0**	**3.1**	**22.7**	**16.8**	**13.6**	**59.2**	**11.8**	**71.0**

The efficiency requirement over the next 10 years for providers, based on the services identified in scope, is £145m. Of this £73m (50%) has currently been identified as being deliverable, leaving a further £71m still unidentified.

The community services efficiency requirement above is based upon the services currently identified as in scope, as described in section 11.3.

The below table shows a summary comparing the provider efficiency requirement and currently identified deliverable efficiencies against this requirement over the next 10 years.

	Option 1	Option 2	Option 3
	£m	£m	£m
Acute Services	136.9	132.4	134.5
Community Services	12.1	12.1	12.1
Total Efficiency Requirement	**149.0**	**144.5**	**146.7**
Acute Services	52.8	65.0	64.0
Community Services	5.4	8.5	8.5
Total Deliverable Efficiencies	**58.2**	**73.4**	**72.5**
Acute Services	84.1	67.4	70.5
Community Services	6.7	3.6	3.6
Total Unidentified Efficiencies	**90.8**	**71.0**	**74.1**

The efficiency requirement under each option is broadly similar, however both option 2 and option 3 demonstrate far greater potential to meet the efficiency challenge over the period than option 1.

Option 2 demonstrates the most affordability based upon the residual efficiency challenge left unidentified.

The unidentified efficiency figure at the end of year 10 would reduce by £20m should there be sufficient resource within the overall system affordability to support the investment required for the above identified quality initiatives and residual irremovable costs.

Option 2 has even greater potential to demonstrate affordability, following further increase in out of hospital care, a reduction in the size of the estate and further discussion across the whole health and social care system to assess overall affordability within the system.

11.4.2 System Affordability

Given the need to invest in improving outcomes for patients in addition to growing patient demand, system-wide service transformation is the only way to achieve financial sustainability in the health and social care economy of Calderdale and Greater Huddersfield.

The following section seeks to demonstrate the impact that the proposed changes will have at a system wide level.

	14/15	15/16	16/17	17/18	18/19	Total	6-10	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Acute Services	16.96	18.50	0.92	2.01	7.56	**45.96**	19.01	**64.97**
Community Services (in scope)	1.21	1.21	1.21	1.21	0.61	**5.45**	3.03	**8.48**
Provider Efficiencies Generated	**18.17**	**19.71**	**2.13**	**3.22**	**8.17**	**51.40**	**22.04**	**73.44**
Tariff Released	2.00	3.27	3.76	3.76	2.51	**15.29**	3.28	**18.57**
Investment in Out of Hospital Care	(9.00)	(1.41)	(4.76)	0.09	(0.52)	**(15.60)**	(2.58)	**(18.17)**
Commissioner Efficiencies Generated	**(7.00)**	**1.86**	**(1.01)**	**3.85**	**1.99**	**(0.31)**	**0.70**	**0.39**
Total Recurrent System Impact	**11.17**	**21.57**	**1.13**	**7.07**	**10.16**	**51.10**	**22.74**	**73.84**
Non Recurrent Investment								
Out of Hospital Care set up costs	0.00	1.60	1.00	0.00	0.00	**2.60**	0.00	**2.60**
Holme Valley & Community Estate	0.00	0.00	2.00	2.00	1.00	**5.00**	0.00	**5.00**
Total Non-Recurrent Investment	**0.00**	**1.60**	**3.00**	**2.00**	**1.00**	**7.60**	**0.00**	**7.60**

The level of deliverable efficiency currently identified for providers over the next 10 years is £73m. This is made up of internal efficiencies and efficiencies generated through changes in activity flows.

These changes in activity flows represent a £19m benefit to commissioners through release of tariff funding associated with reduced hospital activity. This is through admission avoidance, early supported discharge, reduced attendances over a 7 day a week service.

The recurrent investment associated with this over 10 years is £18m. This is a combination of existing out of hospitals schemes totalling £9m and additional recurrent investment required of £9m to deliver out of hospitals care 7 days a week and reprovision of care closer to home as part of further reductions in hospital activity. Should the assumptions change with regards to existing schemes or proposed future schemes, then the level of efficiencies highlighted above will diminish, increasing the level of unidentified efficiencies.

The key inclusions for Out of Hospitals Care contained within the additional recurrent funding requirement identified above are:

- Capacity modelling of acute service reprovision has identified an investment in re-provision of £3.3m; GPs and Social Care £0.3m, Community Services £3.0m
- A further allowance on £1.5m has been built into this model to cover the estimated cost of 7 day service provision for community services.
- A further allowance on £1m has been built into this model to cover the estimated cost of 7 day service provision for GPs and Social Care.
- Demographic growth from years 5 to 10 - £3m

There is also a non-recurrent funding requirement to cover:

- Community non recurrent set up costs have been estimated at £2.6m.
- Investment required in estate improvement and expansion at Holme Valley, and other potential community estate has been estimated at £5m.

As described in section 11.2.4 the key exclusions impacting acute services currently not included within the additional funding requirement are:

- Investment in providing access to services 7 days a week - £3.5m
- Investment in improving nurse staffing ratios - £2.5m
- Investment in staffing to provide services at Todmorden and Holme Valley - £0.7m
- Investment in estates (including borrowing) - £9.2m
- Un-releasable cost associated with tariff reduction - £4.0m

For the efficiencies to be achieved, an upfront investment in out of hospital resources will be required to support this. These new service models will require time to embed before they are fully able to deliver the levels of benefits that would be expected. As a result there will be dual running of both 'Old' and 'New' services, as well as a timing delay before any provider efficiencies can be realised. The timing and impact of the transitional period will be further analysed as part of the full business case.

The system primarily operates a tariff based system, resulting in payments being made for activity incurred. If the proposed new service models do not have the level of impact predicted then the system will pay not only for the new service models, but also the additional activity where it is being incurred.

If the proposed service models do have the level of impact predicted then due to the marginal cost nature of service provision whilst 100% of the income may be redirected, there will still be circa 25% residual cost left in the system from the 'old' services. This transitional period will need to be closely assessed and monitored to prevent destabilising providers and the system as a whole.

The full business case will explore in greater detail the cost / benefit impact within each provider and commissioner organisation, to ensure that financial sustainability across the system is maintained.

11.5 Finance Case Issues and Risks

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

Key financial risks

- The outline business case is rejected by partners and commissioners.
- Service proposals do not achieve the projected savings which are forecast.
- The size of the capital investment is significant and results in borrowing requirements. This is driven by the size of the estate and needs to be affordable within the system.
- After 10 years there is still legacy debt within the system for repayment due to the size of the capital programme and the cost of financing this.
- The system needs to ensure stability during transitional periods to avoid disruption to service provision. There will be risks and costs associated with maintaining services during this period.
- Savings identified are using current acute tariff income assumptions; however releasing income at tariff does not mean providers can remove a corresponding level of cost.
- The system needs to maximise the use of existing owned estate to avoid adding in duplicate costs at a later date.
- There will be an element of double running costs during the implementation of changes where there will be a requirement to fund both "old" and "new" services whilst the services are being configured and set up. This may raise affordability issues in the short term.
- The costs of implementation will be significant with issues around affordability; such as capital costs for IT and estate modernisation, and workforce restructuring costs.
- Providers must ensure that they have sufficient working capital to meet their financial obligations. This means that they need to maintain a certain cash balance and level of operational performance to remain financially viable. Therefore the timing of any reconfiguration will need to be implemented carefully.
- Central changes to CCG allocation and Local Authority targets may impact on the affordability of change proposals.

Mitigation

- Agree a risk sharing framework between providers and commissioners.
- Reduce the size of the estate requirement further, and ensure that the system maximises the utilisation of existing estate.
- Agree work programme and prioritisation of detailed analysis to support production of more detailed implementation plan to test the validity and feasibility of delivering the financial assumptions outlined above.
- Review overall system affordability to ensure best cash utilisation across the whole health and social care system.

11.6 Progressing the Finance Case

Full Business Case

Work will continue to progress during the development of the full business case. The key issues that will need to focus upon are:

- More work needs to be done to review further scope for Out of Hospitals Care (more done in the community technology driven).
- Further work needs to be done to reduce the capital build costs (reduce the size of the estate).
- Alternative capital financing options will be explored.
- Full assessment of transitional / dual running costs required.
- An outline of an implementation plan for each option.
- Further modelling of the demand, travel, activity, workforce, capacity, and estates implications of the options, which will involve the key stakeholders owning the assumptions underpinning these, to reduce the uncertainty / risk associated with the recommended programme.
- Review the efficiencies deliverable from those services currently identified as out of scope, to ensure a full system view is captured.
- Clarification of the impact of the recommended programme on the income and expenditure of each commissioner and main provider(s), to understand how the budgets and long-term financial plans of commissioners and providers will need to change to reflect the changes in the service landscape.
- Explore the limitations of the tariff based system, and alternative options to ensure overall system affordability.

Tackling the shortfall

The incremental savings forecasted for the proposals within the Service Transformation Programme are estimated to represent a £51m contribution to the efficiency challenge so far over the next 5 years and £74m over the next 10 years, based on the services identified as being in scope. This leaves a residual £71m provider efficiency requirement as unidentified at the end of year 10.

The unidentified efficiency figure at the end of year 10 would reduce by £20m should there be sufficient resource within the overall system affordability to support the investment required for the above identified quality initiatives and residual irremovable costs.

There will need to be a collective effort to explore new options for developing financially sustainable delivery of health and social care.

Risk Sharing Agreement

While the change in income flows can happen relatively quickly, reduction of costs in providers losing services may not be possible within the same timeframe or in totality. The economy must therefore be prepared to support the long-term sustainability of providers through arrangements such as risk sharing agreements.

In order to enter such arrangements providers would need to justify why a risk sharing agreement is required and have a clear downsizing plan. Risk sharing agreements will be context specific, dependant on the individual changes as well as the collective changes within a provider, and may be made between commissioners and providers or between providers.

11.7 Conclusion

The health and social care economy is facing significant challenges where change will be needed to improve outcomes and quality for service users and allow for a sustainable and effective health and social care economy. There are significant long term affordability challenges for commissioners and providers of health and social care, which require system-wide changes to be made.

It is clear from the analysis carried out during the outline business case that both from a quality of service perspective and a financial perspective 'do nothing' and staying as the system is currently configured is not a viable an option.

It is also evident that a tariff based system under its current guise has significant limitations and doesn't fully work for future health and social care models of service provision. Costs cannot be released in full as activity moves to alternative models of care or providers. This creates a danger that residual costs are left within the system, further exacerbating the efficiency requirement of providers, leaving mandated services underfunded in the future.

A sensible approach from commissioners and providers needs to be adopted to look at alternative funding mechanisms and local tariff approaches moving forward, utilising the full flexibilities within the NHS contracts. The system needs to review overall affordability to ensure that the remaining mandated commissioner requested services within a hospital setting can remain sustainable within a future integrated health and social care economy, to ensure high quality service provision remains for the population served.

Although no option analysed fully solves the efficiencies requirement over the next 10 years, option 2 best contributes to the affordability challenge at a system-wide level, at the same time as improving patient care. However, further work needs to be done to fully work through the impact of the changes being proposed.

The current projections suggest that the three providers have identified a £51m contribution to the efficiency challenge so far over the next 5 years and £74m over the next 10 years, based on the services identified as being in scope.

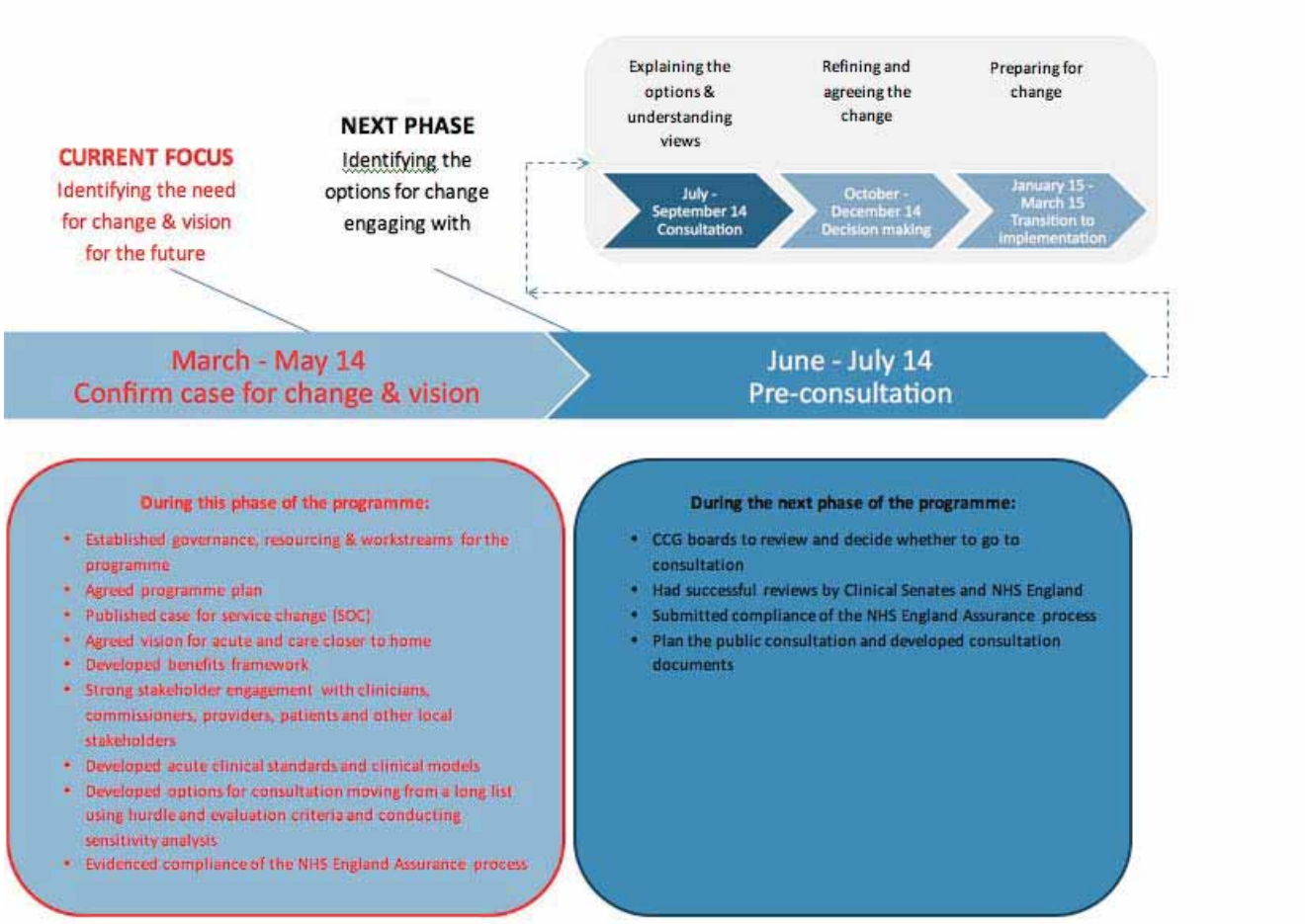
There is even greater potential to demonstrate affordability, following further increase in out of hospital care, a reduction in the size of the estate and further discussion across the whole health and social care system to assess and understand the overall affordability within the system.

There will need to be a collective effort to explore new options for developing financially sustainable delivery of health and social care for Calderdale and Greater Huddersfield.

12. The Management Case

12.1 Introduction

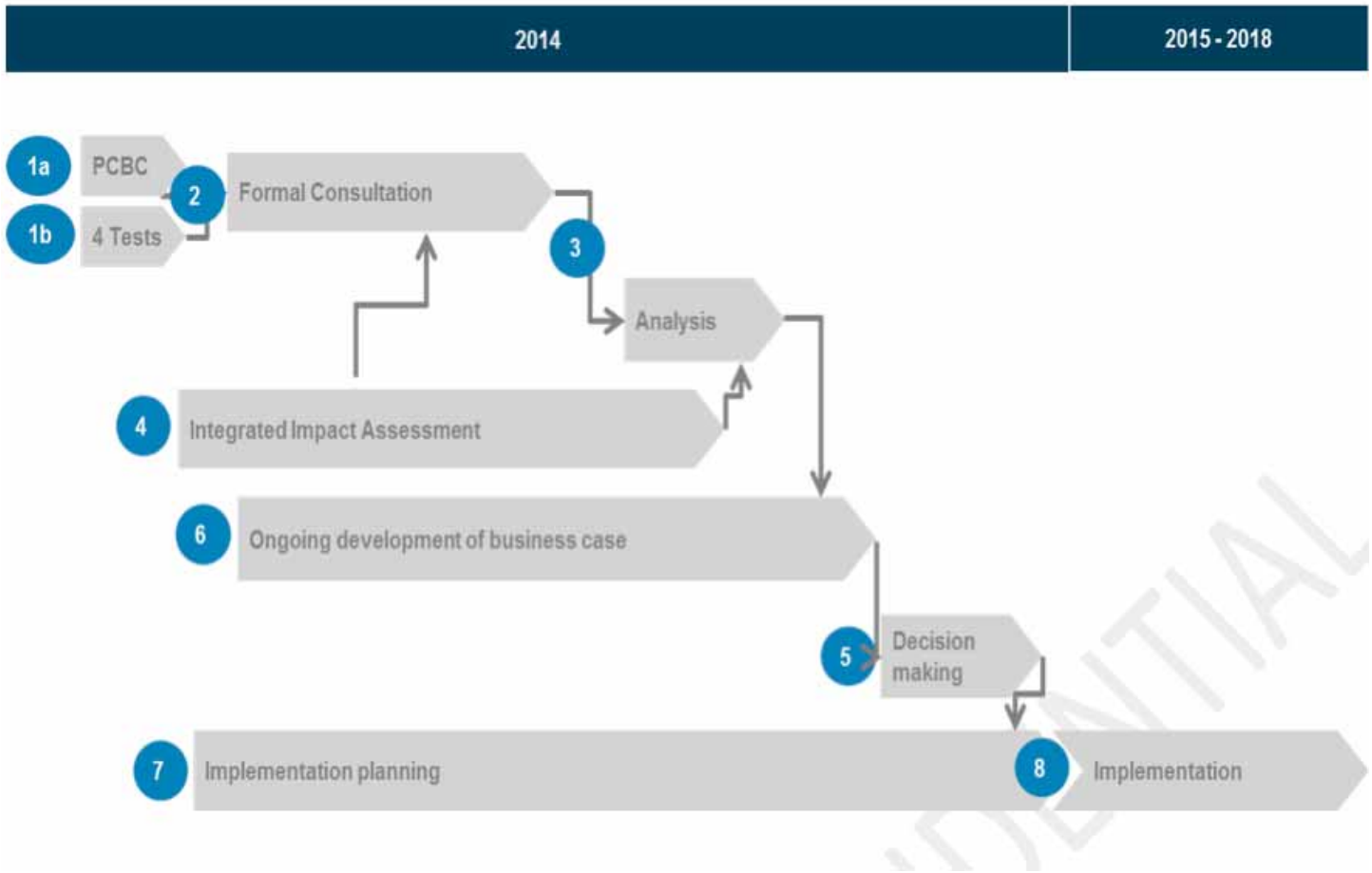
This section of the Outline Business Case (OBC) addresses the "achievability" of the transformation. The Right Care, Right Time, Right Place programme is aiming to complete the transition to the new settings of care in the next four years. The management case builds on the SOC by setting out in more detail the actions that will be required to ensure the successful delivery of the programme in accordance with best practice. This document addresses the current focus of the programme as highlighted below;



Following agreement of this Outline Business Case by the boards of the three provider organisations, a request for CCGs to consider undertaking a formal consultation as a result of this OBC will be submitted in June 2014. Assuming this is accepted a formal consultation will be undertaken across Calderdale and Huddersfield. Following a post-consultation decision by the CCGs with regard to the proposed reconfiguration, there will be a period of transition when the agreed changes to services will be planned in detail, in readiness for full implementation. A Full Business Case will be finalised post-consultation (target date September 2014).
Building on the approach undertaken to date, the implementation process will be clinically-led and will involve clinical professions from all backgrounds and organisations. Patients and members of the public will be invited to participate in the transition and implementation planning.

12.2 Decision making process following acceptance of the OBC

Prior to reaching the transition and implementation phase, a number of key activities must take place. The critical path to implementation is shown in the figure that follows.



1.a Develop the consultation documents ~ following a decision to continue to work towards formal consultation, the public consultation will be developed by all organisations.

1.b. The Four tests ~ this OBC begins to demonstrate evidence of; strong public and patient engagement; consistency with current and prospective need for patient choice; a clear clinical evidence base; and support for proposals from clinical commissioners. Therefore this will be submitted for review by NHS England following approval of this OBC.

2. Formal consultation ~ CCGs will determine if the proposals in the OBC merit further exploration through formal consultation with the public. This would then result in an intention to go to formal Consultation. It is anticipated that a formal consultation would be undertaken over a 14 week period (extra weeks have been added in recognition that this is typically a holiday period).

3. Analysis of the consultation ~ during this phase responses to the consultation will be analysed and a report produced containing the findings from this analysis. This report will be provided to the JHOSCs and made available to the public.

4. Integrated impact assessment (IIA) ~ in parallel to the consultation process there are a set of detailed analyses that need to be carried out on the proposals for consultation. Impact assessments of the proposals will be required for: travel times and accessibility, equality and environmental impact. The outputs from the IIA need to be provided to the Adult Health and Social Care committees prior to finalisation of their responses to the consultation.

5. Decision-making ~ this phase concludes with the formal decision-making by the CCGs. It includes refinement of the pre-

consultation non-financial options appraisal framework and criteria post consultation, taking account of the output from the consultation including the integrated impact assessment; updating of the benefits models to ensure that the benefits proposed in the options can be measured and monitored effectively; identification of variant options arising out of the consultation, and advice from Clinical Reference Groups to identify those that are clinically viable; use of the non-financial options appraisal framework to assess consulted proposals and clinically viable options. This process will enable the SRO to make a recommendation for consideration and decision by the CCGs.

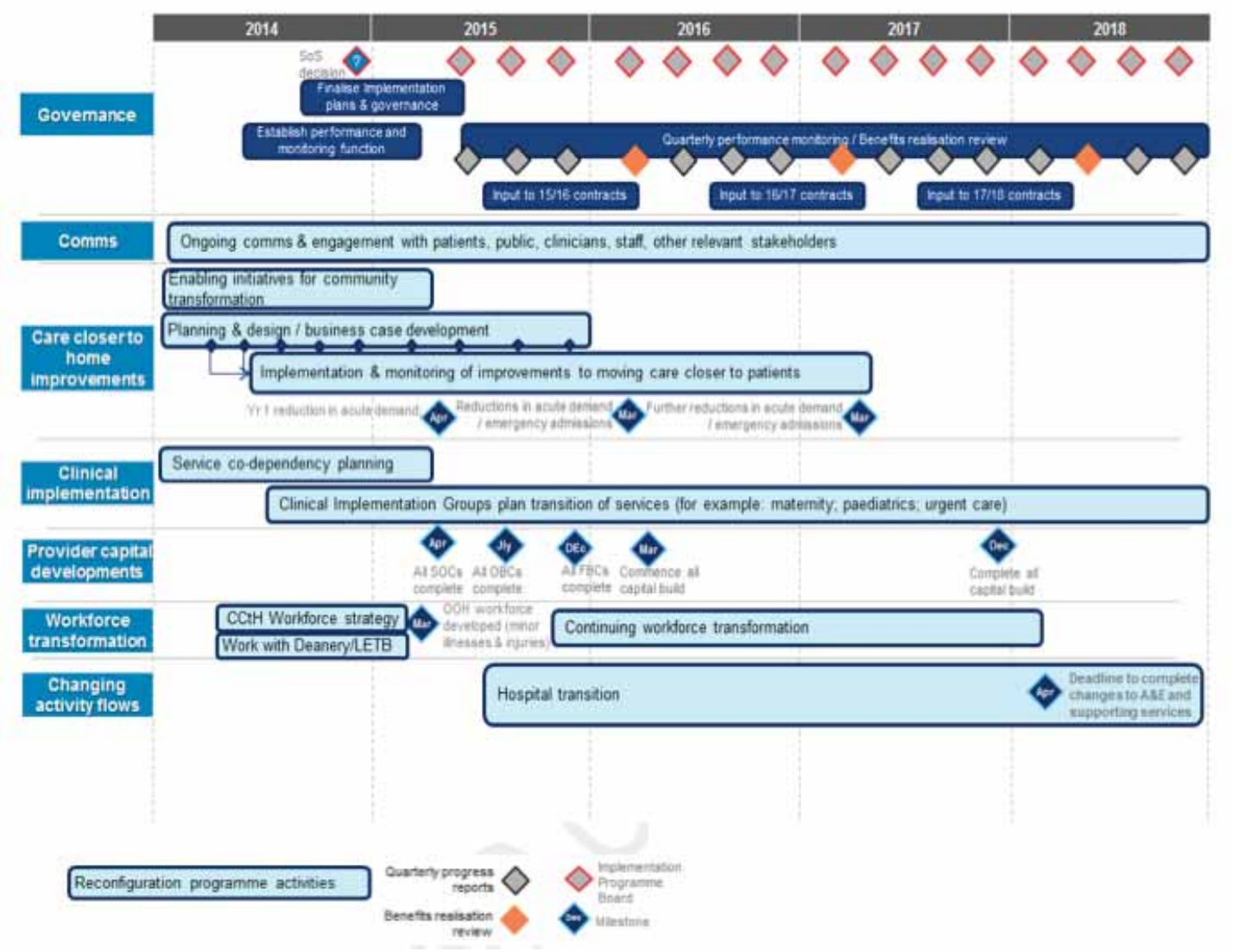
6. On-going development of the business case ~ elements of the Full Business Case will developed on an on-going basis and further detail will be populated following CCG decision-making. The business case must be further developed to take into account the full benefits model and non-financial options appraisal framework, together with all the detailed analysis carried out in support of them. In particular, the business case will set out the strategic and clinical case for the selected option; the financial assessment of the selected option including investments required and cash releasing benefits and confirmation of affordability; and an assessment of the risks and how these will be managed. Approval of the business case by the CCGs marks the start of implementation, and should be used as the baseline against which costs and benefits should be monitored.

7. Implementation planning ~ planning for implementation has commenced as part of the preparation of the OBC in order to be ready for shortly after the end of the consultation period. This will enable the programme to commence implementation at the earliest opportunity and ensure that benefits can be realised as soon as possible. This planning cannot be completed in detail until the outcome of the consultation is known and a decision is taken to go ahead with a particular option. Indeed, the outcomes may be that the preference is for a variant of option or hybrid of options. Nonetheless, there are two key implementation planning activities that should occur throughout the consultation phase: firstly, detailed implementation planning for those elements applicable to all options for change; and secondly, additional planning for the variant between the options which can then be adapted once the outcome of the consultation in known and a decision in taken.

8. Implementation ~ the implementation phase begins following approval by the CCGs of the business case, and will lead to delivery of the selected options and realisation of the promised benefits. The work will be organised into work streams to be identified in the implementation planning phase and will cover all elements of activity identified in the planning. It is expected that implementation will commence in early 2015 and continue until 2018. Some activities will be implemented prior to this period as they are not dependent on post-consultation decision-making. These activities include quality and productivity improvement programmes and the development of integrated community services. These activities have been identified as 'enabling milestones' to the reconfiguration proposals

12.3 High level generic implementation plan

At a generic level, however, the underlying activities that need to take place as part of implementation are known, as is the sequencing and timing of any proposed changes



This diagram shows the high level timeline and proposed approach to implementation of the reconfiguration proposals. It shows that work on Out of Hospital transformation should begin immediately and that this critical improvement work needs to be complete by the end of March 2017. Subject to decision making and having the necessary capacity and efficiency improvements in place, implementation of changes to acute provision could then be completed in full by March 2018.

This is an ambitious timetable but experience elsewhere has shown that once a decision has been taken to reconfigure services, staff will welcome a swift implementation to mitigate the impact of clinical safety risks that could arise during a prolonged transition. Accordingly, once changes are identified, staff will welcome a swift implementation to avoid the risk that they could need to be made in an urgent, unplanned way due to clinical safety issues. Our high level timetable has therefore been developed to help mitigate this risk.

As part of our overall approach to implementation, it is recognised that our on-going duty to public sector equality continues and further equalities impact analysis will be undertaken.

12.4 Programme and project management

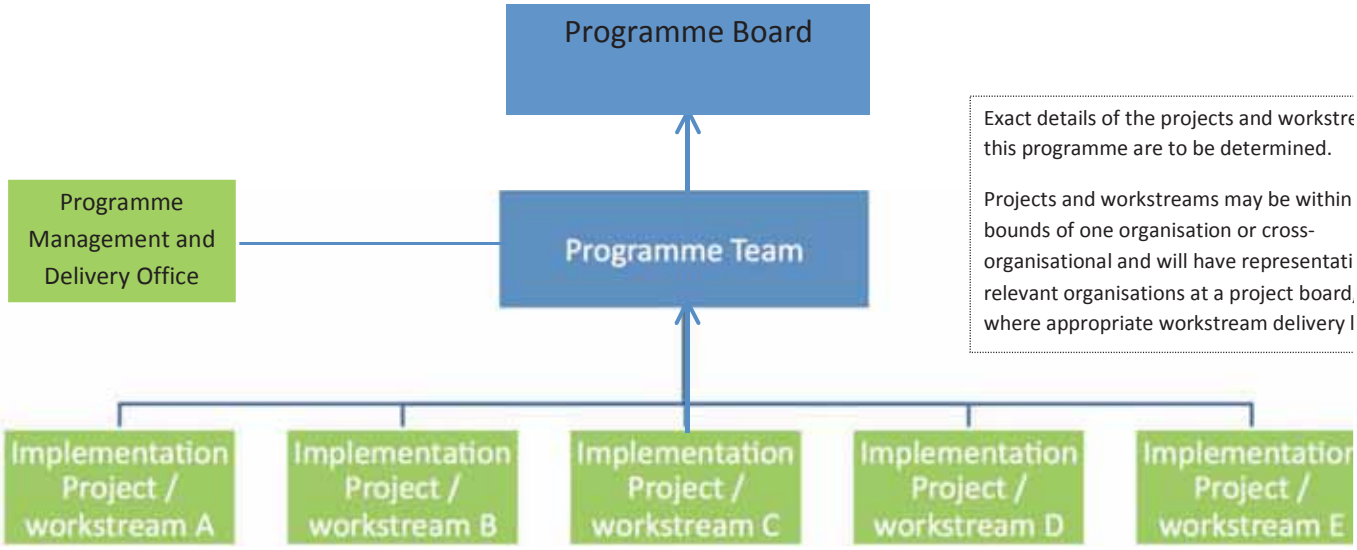
The project and programme management is based upon a partnership approach with CCGs in both Calderdale and Huddersfield. Principles have been adopted from MSP and PRINCE 2 for the creation of the SOC and OBC. They will continue to be strengthened and applied in the consultation and implementation phases.

To ensure successful project delivery a robust project and programme management structure will be established following a period of design and mobilisation. These structures will be developed to facilitate direct reporting whilst ensuring it is sufficiently robust to incorporate the detailed inputs required for each element of the project.

The structure will recognise the requirement of each of the partners to have responsibility for the delivery of its own elements, while ensuring there are flows of information to an overall group responsible for the inputs required to develop the shared elements. The structure will be designed to ensure there is one overall Programme Director and Programme Manager each with the required authority and responsibility to manage the programme on behalf of the organisations. An overarching structure above this will ensure that each of the partner's individual requirements are accommodated.

This approach will provide a single agreed control mechanism for project delivery, whilst ensuring each organisation meets its own governance requirements.

A suggested view of the overarching programme structure is shown below. Further details regarding suggested governance arrangements are discussed below.



12.5 Programme structure and resources

The resources required to deliver the FBC and subsequently implement the programme is likely to be significant and will require dedicated resource to be secured from each organisation as well as external support where sufficient capacity or capability is not available in house.

Using two recent reconfiguration programmes we can estimate the number of dedicated staff resources needed for the next phases of work. These are captured in the table below;

Key areas of work	Dedicated resources*		Anticipated resources Required
	Reconfiguration in NW London (Shaping a Healthier Future)	Reconfiguration in South East Midlands (Healthier Together)	Calderdale and Huddersfield (Right Care, Right Time, Right Place)
Programme Management	8	6	3
Clinical Model of Care (acute)	12	5	3
Community service model	5	3	2
Comms and engagement	17	7	3
Workforce modelling	16	5	3
Demand and capacity modelling	16	5	5
Financial modelling	16	5	5
Implementation	10	N/A	4

** These numbers include external resources and are identified as being dedicated to a piece of work. This does not include the time taken from other individuals who need to be involved in the work as part of their day to day role and responsibilities.*

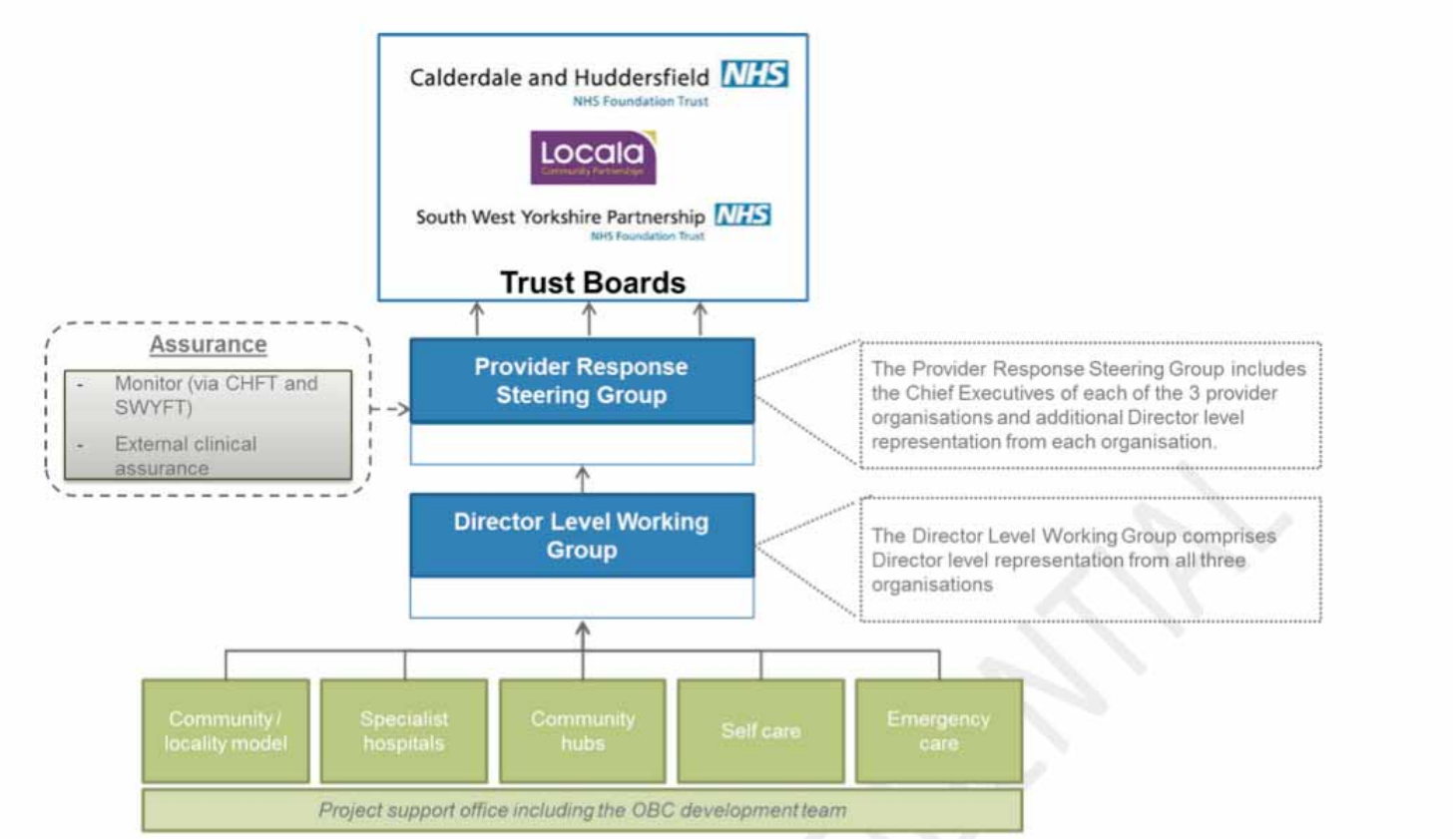
Formal programme design and mobilisation will be undertaken and during this phase the programme structure and associated resource profile will be further developed and agreed as detail regarding the programme deliverables is agreed.

The role of the Programme Management and Delivery office will be to proactively drive delivery of the programme plan and critical path. It will provide programme management support to the work streams and will be responsible for the management of all programme management processes, including preparing and managing papers for governance arrangements, proactive risk and issue management and progress reporting. It will also support the development of the business cases. The programme management and delivery office must have sufficient resource capability and capacity available to effectively support the programme, recognising the scale, complexity and likely fast-paced nature of the programme.

Each of the projects/ work streams will have a sponsor who will also be a member of the Programme Board. Whilst the sponsor will remain accountable for the work stream, it is expected that they will delegate responsibility for the day-to-day management of, and delivery against, the work stream plan and critical path, to a work stream lead.

12.6 Governance

The current governance arrangements will remain in place for this next phase of work to support the move from OBC to formal consultation, after which the governance arrangements will be reviewed to ensure that they are appropriate for the development of FBC and implementation. The existing governance arrangements for the provider response to the strategic review are captured below;



For development of the FBC and any implementation it is proposed that:

- An implementation SRO is appointed to take overall accountability for implementation, which should be provider led.
- An implementation Programme Board is established to meet at least quarterly to plan, manage progress, resolve issues and manage risks and interdependencies. This should consist of CCG and Provider representatives and be chaired by the SRO.

12.7 Risks and dependencies

The programme regularly reviews risks to delivery. Currently, there are five major risks that need to be monitored and managed to enable completion of the proposed reconfiguration to the timescales indicated. The programme would need to develop robust mitigation for the following risks:

- Delays in implementing workforce transformation, including staff training / migration from acute to community in addition to development of new roles
- Delays to the capital procurement process and/or lack of availability of capital to undertake all the enabling estates and facilities works required for implementation
- Service closure due to safety concerns, impacting on the planned sequencing of service transfer
- Risk that reducing social care resources limits the ability to deliver a comprehensive community model that enables reduction in acute hospital capacity
- Risk that necessary alignment with timescales for primary care transformation not achieved

An underlying theme of the implementation plans for each option is that the Out of Hospital services are implemented before the proposed changes are made to acute care and that capacity is created in the receiving organisation before services are moved to that site. Progress on two critical dependencies therefore requires careful monitoring to ensure this happens:

- Out of hospital transformation delivering the reductions in acute hospital activity
- Acute providers achieving efficiency and productivity improvements in their bedded services to create the required additional capacity for the planned site.

12.8 Communication and engagement

Section 4 highlights the key messages that have resulted from activities that have been undertaken to communicate and engage with stakeholders over the last 2 years. We will need to continue to actively engage stakeholders through the next phases and during implementation including the following groups:

Patients & public – we need to ensure that patients are well informed about what changes are proposed, have a say in how they are to be delivered and, ultimately, are fully aware of which services will be delivered from which locations in the future

Providers – will be taking a lead in the planning and implementation of service change, particularly to support service change impacts that need to be implemented smoothly across multiple providers

NHS staff – we need to actively engage with staff to build awareness of the reconfiguration proposals and to consider and promote their central role in making these changes happen

Clinicians – will need to be actively involved in the planning and implementation of service change to ensure patient safety is not compromised as changes are made

Local Authorities – in particular, we need to work together with our partners in social care to co-design and begin to deliver the transformation to Out of Hospital services which are critical to the success of the reconfiguration programme

Primary care providers – will need to be actively engaged and involved in shaping implementation, in particular as they will have a central role as care coordinators.

As part of the programme design and mobilisation phase the stakeholder engagement plan will be updated to provide a comprehensive view of planned events and activities throughout FBC development and implementation.

12.9 Measuring the impact of change and benefits realisation

As set out in section 4, we have established a benefits framework to describe the patient, clinical, staff and operational benefits that we expect to realise across primary and secondary care through successful delivery of Right Care, Right Time, Right Place. Our reconfiguration proposals focus on the services that the NHS commissions from local providers, however this is part of the wider strategy where we expect to see a positive impact on the wider system of services, including those provided by third sector and private providers.

The implementation of the proposed changes is expected to provide the following high-level benefits for patients:

- Reduced mortality through better access to senior clinicians
- Quicker access to treatment by more senior clinicians
- Increased ability to take control of their own health conditions
- Improved access to services so patients can be seen quicker and at a time convenient to them
- Reduced complications and poor outcomes for people with long-term conditions by providing more coordinated care and specialist services in the community
- Less time spent in hospital as services are provided in a broader range of settings.

The implementation of the proposed changes is expected to provide the following high-level benefits for staff members:

- Allow clinicians to develop their specialist skills through the provision of more opportunities to deal with specialist cases
- Improved access to information about a patient's health, reducing possible errors and avoiding asking patients to provide the same information multiple times
- Improved job satisfaction due to an increased ability to deliver high quality coordinated care.

The benefits realisation plan will enable identification of the actions required to support and execute the benefits outlined within this OBC. A trajectory will be developed showing the phasing and interdependencies affecting benefit realisation. This will be reviewed and updated throughout the programme and at agreed review points once the deliverables of each project have been completed. The benefits will only be realised if all organisations are working towards the same outcome and the benefits realisation plan will include and involve all stakeholders impacted.

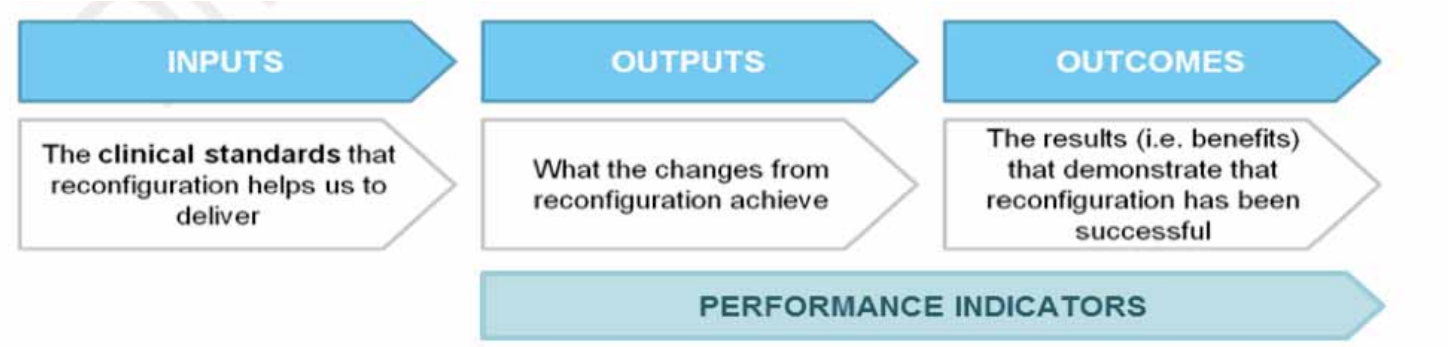
A key part of the approach to measuring benefit will be the development and use of a comprehensive and pragmatic list of measurable performance indicators, focused on patient outcomes and patient experience. These will be firmly embedded within performance management arrangements under "business as usual", both to minimise additional reporting requirements and to ensure that the performance improvements are embedded within performance management processes in the long term.

Achieving our vision and integrating services will change the way we deliver local NHS services. It will improve health and design a sustainable future for the healthcare system. Successfully implementing these changes will be beneficial across the healthcare system in Calderdale and Huddersfield, both to people using our services and those working hard to deliver them.

How the benefits framework has been developed

The benefits framework has been developed in a systematic way working closely with clinicians. The framework covers patient and clinical benefits for emergency surgery and A&E, maternity services, paediatric services and care closer to home.

The image below describes the approach used to clearly link improvements in service delivery to the benefits the new services are expected to deliver using three stages; the inputs (the clinical standards), the outputs (the changes) and the outcomes (the results or benefits of the service change).



The key inputs are the clinical standards, set out in Section 4. These have been used to help define the patient and clinical benefits, since the proposed reconfiguration changes will help Calderdale and Huddersfield to deliver these standards. For operational benefits, the inputs are the operational changes that are delivered through reconfiguration. The delivery of the proposed inputs and associated milestones (e.g. creation of additional bed capacity and moving A&E activity) can form part of the implementation plans and can provide evidence for the implementation decision making framework to ensure the transition is handled in a safe way.

By linking the benefits to the clinical standards, we are demonstrating the benefits that we expect to realise in addressing the problems and issues raised in the Case for Change described in Sections 4&5.

The final part of the benefits framework is an initial set of performance indicators for both the outputs and the expected outcomes of service change. The performance indicators will help the programme to monitor whether the expected benefits of the changes are being delivered on the ground. The performance indicators are detailed in Section 3. Wherever possible, existing NHS measures and data collection systems have been used to inform the identification of performance indicators so that benefits can be monitored without creating additional data collection or reporting burdens. The performance indicators have been written in a way that can be used by commissioners in their contracts with providers, helping to embed the process in 'business as usual' arrangements.

13.Conclusion and Recommendation

13.1 Conclusions

The current service models in Calderdale and Greater Huddersfield are neither clinically or financially sustainable into the future. The National Clinical Advisory Team has recommended that major service reconfiguration is needed to improve the safety and quality of current services. This OBC responds to these recommendations.

The service changes proposed in this OBC are derived from a strong clinical evidence base and are supported by the doctors, nurses and therapists that deliver the services and by highly respected National Clinicians as well as local provider stakeholders.

The plans have been informed by the views of local people and the changes they want to see to enable the provision of more support and care out of hospital. The proposed new service models will enable improved safety, quality and system efficiency.
Sections 4.4 to 4.7 of this OBC provide information and evidence in relation to meeting each of the four Department of Health tests in relation to major service reconfiguration i.e.:

- **Clinical Evidence –** there is evidence of a robust clinical evidence base for the proposed service model.
- **Public Engagement –** there is evidence that views of the local population have been received and considered in the development of this service model
- **GP Commissioner Support –** there is evidence that the service model proposed is in line with the commissioning intentions of the local Clinical Commissioning Groups and supported by local GPs.
- **Choice –** the service model supports the public's right to choose how they receive services and enhances the range of choices for support and services in people's homes and the community. The proposed changes in the configuration of emergency and hospital services described has taken careful account of the need to balance access and the significant clinical evidence base that patient safety and improved outcomes can be achieved through the concentration of hospital services on two separate sites.

This OBC and the recommendations it contains has been approved by the Boards of all three provider organisations (i.e. Calderdale and Huddersfield NHS Foundation Trust, South West Yorkshire Partnership Foundation Trust and Locala Community Partnerships.)

13.2 Recommendation

Calderdale and Huddersfield NHS Foundation Trust, South West Yorkshire Partnership Foundation Trust and Locala Community Partnerships joint recommendation is that Calderdale and Greater Huddersfield Clinical Commissioning Groups consider this Outline Business Case and commence Formal Public Consultation in relation to scenarios 2 and 3 i.e.:

Scenarios	
2	Implementation of the community and hospital service model proposed in this OBC with Huddersfield Royal Infirmary as the site for acute and emergency care and Calderdale Royal Hospital as the site for planned hospital care.
3	Implementation of the community and hospital service model proposed in this OBC with Calderdale Royal Hospital as the site for acute and emergency care and Huddersfield Royal Infirmary as the site for planned hospital care.

This is a provider led business case and it is understood therefore that this may not be the final decision of Commissioners on the options for public consultation. The approach used in this OBC is consistent with *HM Treasury - Public Sector Five Case Model – Delivering Value from Spending Proposals*. The approach that has been used to appraise the scenarios is consistent with successful major reconfiguration of NHS services that has been undertaken elsewhere.

Subject to this agreed way forward further work will then be undertaken to develop the Full Business Case that will be informed and enhanced by the process of Public Consultation.

The Full Business Case will develop further detail and the additional service and economic opportunities related to:

- The further scope for Out of Hospital Care – more care delivered close to home
- Optimising and maximising the service efficiencies possible in delivery of community services.
- Reducing the capital build costs (reduce the size of the hospital estate required)
- Exploring the options to reduce the cost of capital financing and procurement options
- Exploring options to reduce transitional / dual running costs

13.3 Embracing the Future – Looking Forward

As provider partners we wish this outline business case to signal a substantial development and change in the health and social care sector that will have fundamental implications on how we deliver services in the future.

These developments need to be based on the principles set out in this document – especially those of care closer to home, with more self-care at its heart. These developments are how we will deliver services in an era of fast moving technological improvements and with people getting more real time information on their health and care. There are three specific areas which we believe will have major impacts and create further opportunity for system improvement.

Diagnostics

The technology of diagnostics is developing very quickly. Products already exist which can take vital signs on a smartphone, and developments are being signalled which will impact significantly on how professionals and patients access diagnostic services. The impact of this is threefold:

- People will be able to use self-diagnosis technology more regularly. They are likely to still need professional advice on the results of diagnosis, but the real time information available will lead to more accurate results and more proactive care.
- Many types of diagnosis will become much more mobile – in particular x ray. This means that the requirement for patients to go to a specialist facility for x ray will no longer be required. Therefore, the availability of x ray in a GP practice, minor injury suite or other community setting is likely to fundamentally change the patient pathway and change the estates requirement
- The introduction of wearable connected devices will lead to a more proactive community model. For instance a microchip within a wound dressing will inform the professional when the dressing needs changing. This should lead to a better treatment regime, and reduce the time for healing. Using this type of technology will impact on the delivery of care to enable a more immediate, accurate and expert experience.

Channel shift

One of the aims of this business case is to lay the foundation on which the health sector can build a reformed future for the residents of Huddersfield and Calderdale. Key to that is embracing all the technological developments available. Channel shift refers to the system beginning to use the internet as the first means to deliver care – backed up by face to face care. At present the amount of appointments delivered using apps, video, live chat or other means is very, very small. This needs to change so that it becomes a core part of how we deliver our services. In particular there are 3 areas where this will make a difference:

- The minor injuries units. These will be nurse led, but can be supported by video links to the senior clinician. This is a model which is increasingly popular in care home, prisons and other institutions.
- Outpatient appointments. The first discussion with a senior clinician will move to video based - often supported with diagnostic information as referred to above. From this point there is likely to be a need to have some face to face involvement – however this may be with the community teams as opposed to in a hospital environment.
- Group based support. The role of group based support is critical in many areas – from stroke services to mental health support. This is all done on a face to face basis, and this will need to continue. However, social media and on line support groups can make a fundamental change to how people receive that support – all embraced and facilitated by the clinical professional where appropriate.

Modern build solutions

The business case points to some significant developments in the delivery of hospital based care, not least a major reduction in the number of beds. The implication to the actual hospital building is that there is likely to be redundant space. When this is linked to the aim of keeping people independent for longer there are some real opportunities. In various European health economies (for instance Northern Spain) the rehab model is based in non-hospital settings. This means that the patient will stay in a traditional hospital bed for a shorter time as possible. They are then likely to be transferred to a facility which enables rehabilitation much more quickly, as well as feeling more like home. These units are likely to have single rooms, with kitchen facilities and intense input from clinicians to enable the fastest possible discharge home.

These modern build solutions are very different thinking from the existing estate, and together with more mobile diagnostics and a channel shift of care signal a very different future for the people of Calderdale and Huddersfield.

RIGHT CARE

RIGHT TIME

RIGHT PLACE