Travel and Transport Group

Care Closer to Home

Purpose

- Share the vision for the work
- Context – what people want from services
- Share examples of what has been done
- Share future plans

People have told us they want :

- As many services as possible should be close to home **in local settings** such as a GP practice with improved waiting and appointment times
- Services that are **coordinated** and wrap around all the persons needs
- The **right staff, with the right skills** that are caring and competent and treat people with dignity and respect
- Services that are properly planned and that are appropriately staffed and resourced, have the right equipment and **maintain quality**
- More **information** available about health conditions and more communication about what is available to ensure people can make choices and have support to self-manage health care
- Services that everyone can **access** including clean comfortable buildings aimed at the right target audience, appropriate information and staff that represent the community they serve.

People have told us they want :

- Travel, **transport** and parking is important
- Improved **communication** between all agencies involved in a person's care and treatment including better communication with young people
- Services that are **responsive** and flexible - particularly in an urgent care situation
- Reduce delays in getting the care and treatment required and improving **waiting times**
- **Technology** that people can use to reduce travel times and unnecessary journeys – particularly for young people
- Support for **physical and mental** health conditions

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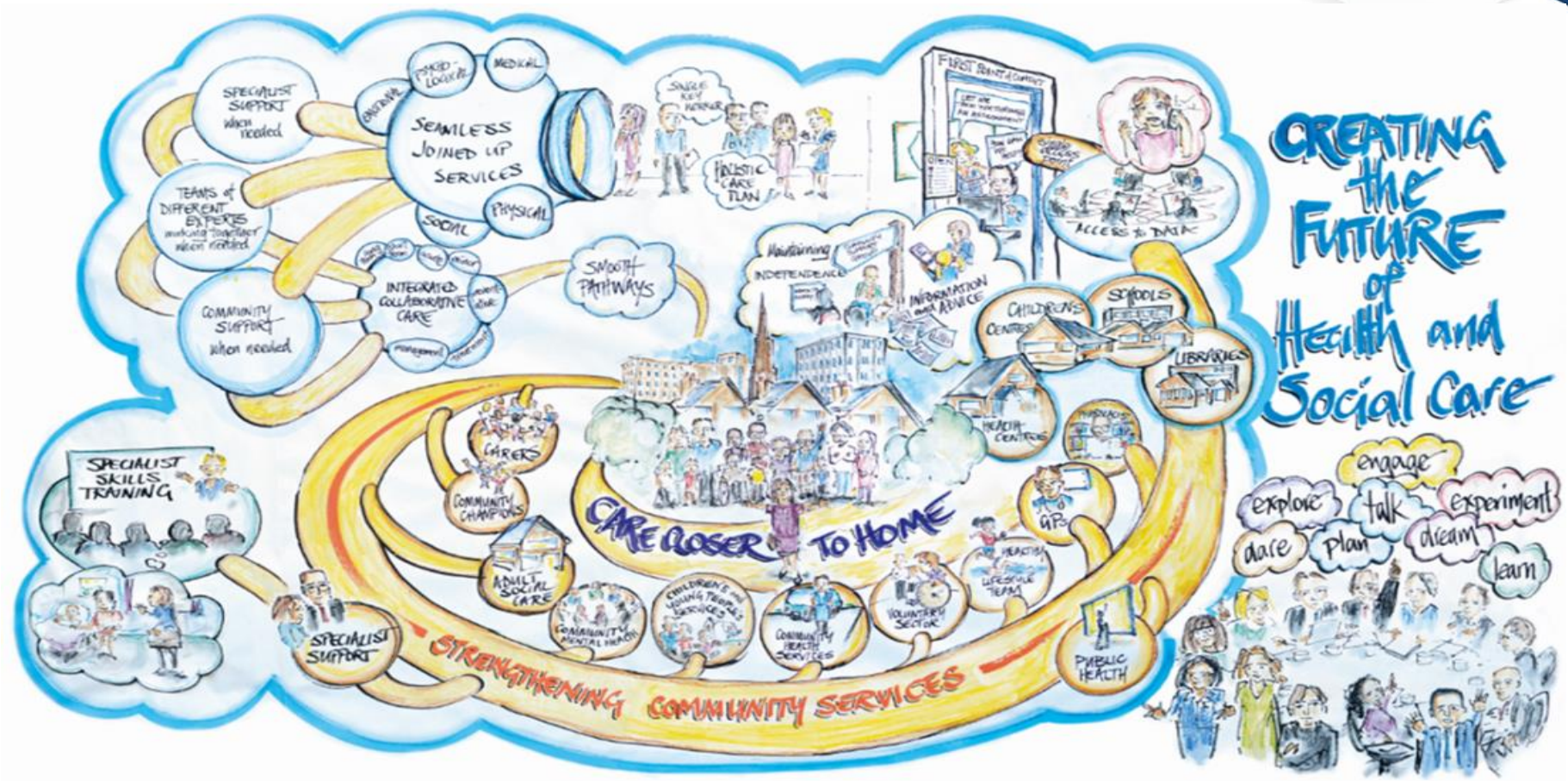
Vision

NHS



For full animation: http://www.calderdaleccg.nhs.uk/your-health/care-closer-to-home/

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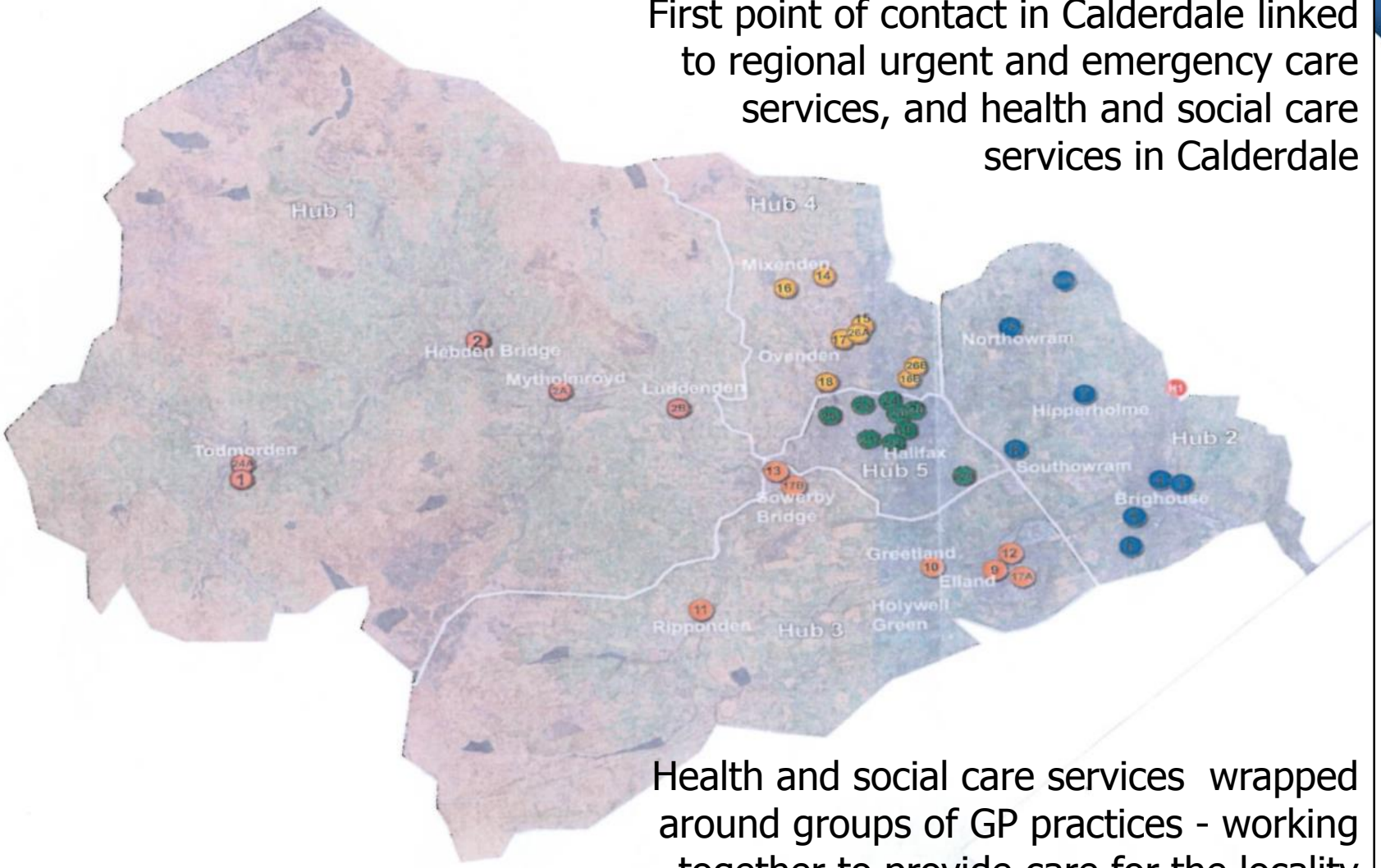
Working in Localities

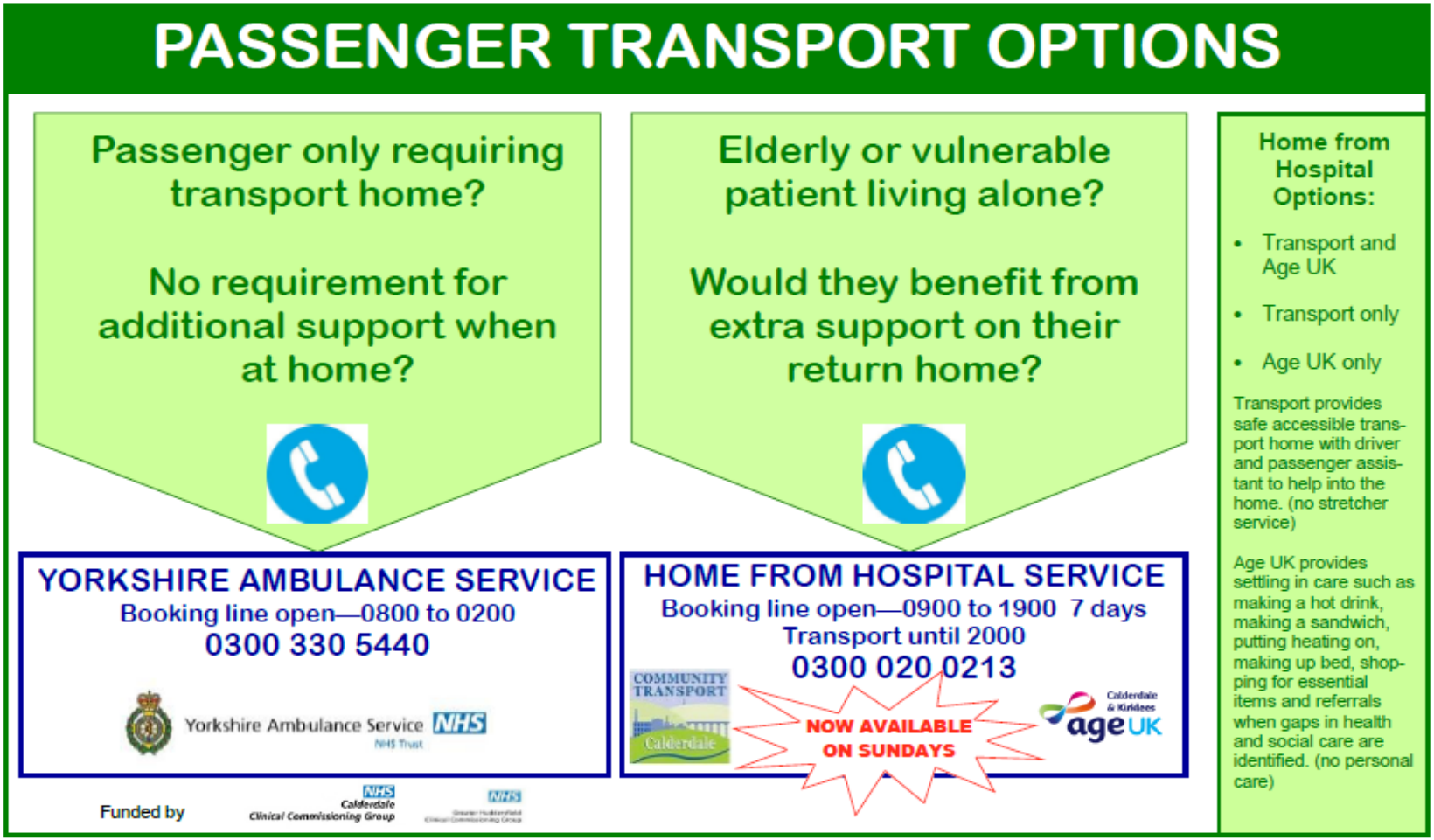
First point of contact in Calderdale linked to regional urgent and emergency care services, and health and social care services in Calderdale



Health and social care services wrapped around groups of GP practices - working together to provide care for the locality

What we have done

Seamless Home from Hospital



What we have done

Musculoskeletal Service in the community

Service provided by CHFT for people needing assessment and guidance for MSK conditions; it includes

- New Single Point of Contact for all MSK and pain referrals
- Assessment and treatment undertaken at:
  - Todmorden Health Centre
  - Lister Lane
  - King Cross
  - Brighouse Health Centre
  - Broad Street
  - Calderdale Royal
- Physiotherapy in community settings and hospital based (based on patient choice)
- CHFT orthopaedic clinics at Todmorden Health Centre

Benefits:

- Improves access and convenience for patients
- Single Point Contact ensures that patients receive the right care in the right settings from the right professional
- Reduces the need for unnecessary visits to hospital out-patients

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What we have done

NHS

Diabetes Service in the Community

The Level 3 diabetes service began on 1st December 2015, and is now in 24 out of 26 practices. The service provides enhanced care and support for 1,250 adults with diabetes stabilised on injectable therapies, some of whom previously received their care at the hospital. This included investment in new diabetes specialist nurses.

Benefits of the work:

- **Reduced utilisation of hospital services:** Reduced outpatient activity and unplanned admissions to hospital
- **Improved health:** Better control/management of condition, reduced complications
- **Improved care:** Improved experience through reduction in variations in care. Up-skilling of primary care staff
- **Improved value:** Reduced costs associated with emergency admissions

We animated a Calderdale case study to show the benefits from this work:

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What we have done

NHS

Tackling the impact of loneliness in older people

The CCG and Calderdale Council jointly invested funding to tackle the problem of loneliness, because in Calderdale

- 11,520 people aged over 65 live alone
- About 30% feel lonely
- 12% feeling trapped in their home.

In its first year the programme worked with established community organisations and development trusts across Calderdale to start to strengthen existing support across a range of community-based schemes. The aims of the initiative were to:

- Enhance bespoke activities in local communities;
- Build on existing local voluntary sector and neighbourhood initiatives.
- Have 4 community 'hubs' (North Halifax Health Alliance, Halifax Opportunities Trust, Elland & District Partnership and Hebden Bridge Community Association)
- Support local community workers, voluntary groups, health and council partners to deliver the project aims.
- Mainly focus relies on voluntary and community sector.
- Support a key priority of the Health and Well-being Board; links to the Better Care Fund, part of wider Care Closer to Home Strategy, links to sustainability agenda.

Benefits of the work:

- **Reduced utilisation of hospital services:** reduces reliance on hospital and other formal care services
- **Improved health:** reduces falls and episodes of depression
- **Improved care:** reduces medication reliance and cost
- **Improved value:** reduce utilisation of primary care services and increases use of their sector provision.

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What we have done

NHS

Respiratory Services at Home

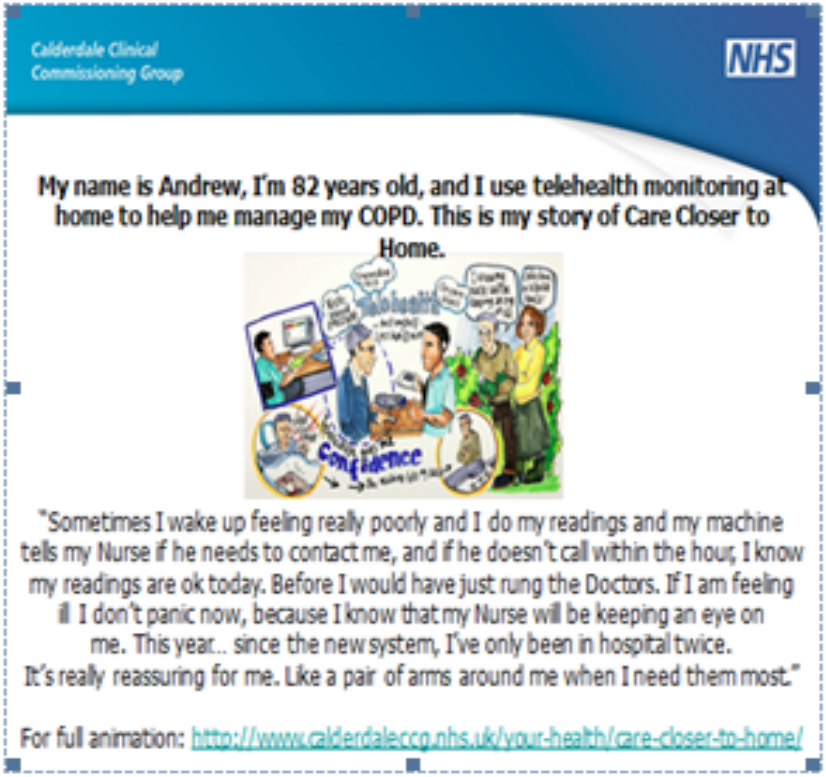
Telehealth systems were installed in the homes of people with COPD to undertake daily readings of their vital signs. These are monitored by the CHFT Specialist Respiratory Nurses. The benefits are:

The new model will includes telehealth monitoring technology to support Early Supported Discharge, and additional long-term conditions, for example; Heart Failure.

Benefits of the work:

- **Reduced utilisation of hospital services:** Prevented hospital admissions/ length of stay
- **Improved health:** Improved self-management/reduced anxiety, Enabled early intervention, Prevented future complications for those who hadn't yet started to access extensive healthcare
- **Improved care:** Improved medication compliance
- **Improved value:** Supported the COPD Specialist Nurses' workload to ensure them to be more effective and focus proactively on those at most risk.

We developed a new animation based on a real Calderdale case, which showed the benefits of technology for COPD:



What we have done

New Service for people with Respiratory Conditions – a new community team

The CCG invested significantly in the commissioning of a fully integrated service from CHFT. Its aims were to improve outcomes for people with respiratory disease and reduce avoidable hospital attendances and admissions. It will be managed through a single point of access. Key features include:

- 7 day service
- Nurse-led community clinics
- Multi –disciplinary teams
- 'Hot Clinics' - daily specialist clinics
- Post-discharge home visits and regular contact with the patient to monitor their condition

In addition, for children we asthma, personalised supported self-management plans are being developed with the child and their family – shared with their school and/or nurseries. We are aiming to expand this approach to include activity clubs.

Benefits of the work:

This year saw development of the new model and therefore the impact was not felt until subsequent years. From a relatively early stage we had a high level of patient satisfaction with a 95% survey completion rate and 75% of patients giving a positive view of their experience of the new service.

What we have done

Quest for Quality in Care Homes

The Quest for Quality in Care Homes' initiative which began in 2013/14 had grown and had been fully implemented across all Calderdale Care Homes. This work was focused on 3 high impact changes:

- **Telecare in care homes** – care home staff request equipment that they feel would benefit residents. Largest deployment of telecare into care homes in the UK, supporting safety - wireless sensors around the home which detect risks e.g. falls.
- **Telehealth** monitoring in the care homes – testing vital signs of residents in the care homes (up to 500 people)
- **MDT working** – commissioning of an integrated social and clinical approach to support anticipatory care planning

Benefits of the work:

- **Reduced utilisation of hospital services:** 25% Reduction in emergency admissions, down by 25% year-on-year
- **health:** Supported residents to improve their overall health status, particularly in relation to long-term conditions.
- **Improved care:** Care home staff feel more supported and empowered. Improved medication compliance and reduction in missed doses
- **Improved value:** Reduction in cost of hospital stays, 58% reduction in GP care home visits to Quest for Quality care homes.

What we have done

Palliative care Pilot

The pilot was aimed at creating:

- More comprehensive advanced care planning and early identification of patients at the end of life;
- Better care coordination across the pathway;
- Better planning to prepare for discharge and organise appropriate packages of care within the community; and
- Increased support to help people stay at home and avoid admissions to hospital, particularly out of normal working hours.

Four partner organisations; Calderdale CCG, Marie Curie Cancer Care, Overgate Hospice and CHFT launched a new out-of-hours specialist palliative care service in Calderdale.

Benefits of the work:

- **Reduced utilisation of hospital services:** Reduced unplanned and inappropriate hospital admissions
- **Improved health:** Improved quality of life by reducing stress and anxiety and providing quality EoL care at home.
- **Improved care:** More patients dying in their preferred place of death. Improved access to specialist nurses and to information.
- **Improved value:** Reduced costs associated with admissions avoided, GP Callouts

In Development:

- Improving GP access
- Providing more community services over 7 days, with a First Point of Contact
- Recovery at Home
- Increased home care capacity
- Phase 2; high volume specialties; example ophthalmology

QUESTIONS