Care Closer to Home in Calderdale (CC2H)
Evidence Pack (V5.0)

8/13/2015
Calderdale Clinical Commissioning Group
Debbie Graham, Head of Service Improvement
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1. High level Interpretation of the Material in the Evidence Pack

The aim of this Evidence Pack is to bringing together a broad range of information which;

- Shows how the CC2H work has been shaped by the views of stakeholders
- Describes at a high level implementation of the programme to date
- Describes the impact of the programme to date.

<table>
<thead>
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<th>Theme</th>
<th>Interpretation of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.Processes</td>
<td>▪ We have documented at a high level the CC2H chronology. This shows that the plans for CC2H started with the inception of the CCG in 2011 and have been a feature of every strategic and operational plan written by the CCG since that point.</td>
</tr>
<tr>
<td></td>
<td>▪ Whilst the introduction of the specification is a key part of the work, as it sets out our expectations within a contractual framework, this was one step on the delivery journey rather than a defining one.</td>
</tr>
<tr>
<td></td>
<td>▪ We have clarity on the huge amount of service improvement work that has been done to date in implementing the model, and the work that will follow next year.</td>
</tr>
<tr>
<td>2. Engagement</td>
<td>▪ The CC2H model has been developed using the stakeholder information gathered since 2012 – this can be evidenced by the alignment of the key engagement themes and the CC2H model itself (as set out in the specification – available on the CCG’s website).</td>
</tr>
<tr>
<td></td>
<td>▪ During 2015 a gap analysis of patient engagement was undertaken and further engagement work is being completed in order to mitigate any important engagement gaps for Phase 2 of CC2H.</td>
</tr>
<tr>
<td></td>
<td>▪ In developing the services models for the CCGs 7 clinical priorities, the engagement themes as well as specific engagement feedback have been used to shape future models.</td>
</tr>
<tr>
<td></td>
<td>▪ We have considered the 15 recommendations made by the People’s Commission, and we believe that each of the recommendations made relating to CC2H are captured within our plans. As a result of the recommendations we have picked up the need to do more work on transport as part of our work-plan for 2015/16.</td>
</tr>
<tr>
<td></td>
<td>▪ We have welcomed the opportunity for continued dialogue with the Adult Overview and Scrutiny Committee (OSC) regarding CC2H and Vanguard. We have carefully listened to their views and taken these on board as part of the development of the CC2H and Vanguard programmes. We will continue to meet with OSC and have committed to attending a further meeting in October to provide an update.</td>
</tr>
<tr>
<td></td>
<td>▪ We have provided our partners in health and social care with a comprehensive narrative and briefing toolkit in order to support their understanding of the main engagement points around CC2H. The toolkit also supports our partners communications efforts to widen the awareness and understanding of CC2H by their own staff.</td>
</tr>
</tbody>
</table>
3. Quality & Safety  
- Data shows that we are having an impact on the quality of care provided to patients as the result of our work on CC2H and 7 clinical priorities. However, it also shows that there are areas where we will seek further quality improvements over the life of the CC2H programme. The overview of high level outcomes in section 6 also provides a view on improvements to date and opportunities to be addressed as part of the next phase of CC2H.
- The Clinical Senate were very supportive of the process and scope of CC2H. Their encouragement for us to work in partnership on the development and delivery of CC2H are evidenced throughout the material.
- The patient stories captured give a powerful understanding of the benefits we have started to see from the CC2H work – particularly from some of our more long-standing programme, such as Quest for Quality in Care Homes.

4. Finances  
- The financial case for change developed by the CCG clearly sets out how transformational system change is needed to deliver a more financially resilient system. CC2H is seen as a critical part of this transformation, and therefore its delivery is inextricably linked to financial stability.
- The 7 clinical priorities that are being addressed through CC2H have generated the majority of our QIPP efficiencies over the last 2 years. Going forward CC2H is a key factor in delivering financial efficiencies that the CCG can then re-invest in models of care that improve health and well-being.
- The elements of CC2H focused on prevention, healthy lifestyles and supported self-care are important in making changes to population health that will deliver a more financially resilient system – reducing demand and dependency, and strengthening independence and recovery.

5. Relationships  
- The BCF (Better Care Fund) Plan submitted in 2014 is clearly aligned to delivery of the CC2H – it provides an important enabler for strengthening joint commissioning between the CCG and CMBC, and an important vehicle for delivering the integrated models described in the CC2H programme. The Plan evidences the common views held by the two organisations about the future service models, and the role CC2H plays in delivery of this aspiration.
- There has been considerable investment of both funding and time to ensure the third sector are able to maximise their role in delivery of CC2H, and there is evidence of their growth in terms of capacity, capability and knowledge of the CCG's commissioning intentions relating to CC2H.
- The CCG has shared the CC2H model widely with key providers and stakeholders to ensure that its commissioning intentions are clear – ensuring that providers are able to respond to those intentions now and in the future.
- Vanguard provides an important and unique opportunity to bring together partners and accelerate CC2H in Calderdale – particularly focused on testing how new models of commissioning, payment and provision can be used to implement CC2H. Our status as a Vanguard site also validates the CC2H plan we submitted in our proposal.

6. System Metrics  
- There are significant demographic pressures – with a forecasted 6.5% increase in population – particularly children and older people.
- For premature death we have a challenging 15% reduction to deliver in 5
years – but the first year’s delivery is positive.
- There are opportunities to reduce health inequalities by implementation of CC2H offers that are bespoke to communities based on need rather than the current one-size-fits-all approach.
- We have seen a 5.9% reduction in emergency admissions from April 2012 to March 2015.
- There has been an increase in community nursing activity from 2013/14 to 2014/15, and an improvement in quality related to the care of patients with leg ulcers during the same period.

7. Enablers

There is evidence that the CCG, working closely with its partners are developing new ways of working to enable the system to maximise opportunities from the CC2H Programme, particularly:

- Developing an Estates Strategy that will deliver important opportunities to deliver CC2H through the maximising of community estate and contribute to the sustainability agenda.
- Working with partners to develop a workforce strategy that will identify actions to mitigate some of the current workforce issues, particularly those in primary and secondary care.
- Developing an IT and Digitisation strategy that will seek to maximise the opportunities related to; supported self-care, sharing electronic records, telephony, telehealth and telecare.
- The CCG is seeking engagement from local transport providers in order to ensure that patient transport systems enable the full implementation of CC2H – this is a new element of work.

2. Care Closer to Home
(a) Chronology

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2011</td>
<td>The CCG (in shadow form) developed its first vision and a set of values. These were set out in the CCG’s first ‘Commissioning Plan for 2012/13’. The Plan set out our intent to commission care closer to home and the programmes of work which would be delivered during our first year as a CCG (2012/13). From the outset, these programmes of work were aimed at improving health outcomes and reducing our over-reliance of our system on unplanned hospital care.</td>
</tr>
<tr>
<td>March 2013</td>
<td>The CCG published its ‘5 Year Strategic Plan (2014/15 – 2018/19). This set out a clear intent:</td>
</tr>
<tr>
<td></td>
<td>• The focus of our change programme over the next 5 years is to continue to shift the balance from avoidable hospital admissions to integrated health and social care models delivered in community and primary care settings. To commission services that will result in fewer people being admitted to hospital, which is in line with what people in Calderdale have said they want.</td>
</tr>
<tr>
<td></td>
<td>• To define and commission the future model of community services for Calderdale – recognising that current services are fragmented with duplication and inconsistency in the way they are delivered. It also</td>
</tr>
</tbody>
</table>

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recognises the need to reduce avoidable hospital admissions and reduce pressure on the system.

- To commission safe and sustainable, effective, high quality services that provide the very best care for our residents.

- We would transform the way our system currently operates so there is a greater focus on the prevention of ill health and the empowerment of citizens who will be able to manage their health and wellbeing and access integrated community, social and primary care services that are connected by effective pathways into acute settings.

- To use the patient engagement intelligence generated in the Call to Action Initiative to shape our future plans.

| March 2014 | As part of the Care Closer to Home Programme, the CCG has a variety of mechanisms for engagement including a Community Asset model of engagement. We engaged at specific patient-group and service-user level, staff and key stakeholders in order to inform our thinking. The feedback from many hundreds of hours of face to face engagement, stakeholders events and locality based drop in sessions were supported by surveys, questionnaires, feedback forms and workshops. This forms the framework upon which a model to bring care closer to home is being built. At each stage, engagement has been absolutely key, and we continue to engage and involve our communities to seek to refine the plans as we progress. |
| March 2014 | The CCG and CMBC submit a BCF plan to NHSE which sets out how the delivery of BCF supports CC2H – the plan was given a green rating. |
| April 2014 | In recognition of the critical role of the third sector in delivery of CC2H, the CCG makes additional investment totalling more than £2m. |
| June 2014 | The CCG shared early thinking on their CC2H 2015/16 plans and priorities with Health and Wellbeing Board (HWB). |
| August 2014 | The Governing Body agreed an approach to local service transformation that placed the focus on strengthening existing community services (CC2H Phase 1) before formally considering the future of hospital services locally. This view was shaped by the extensive engagement undertaken within Calderdale as part of the CCG Commissioning intentions engagement which was delivered through a range of approaches including, asset based approach, Patient Reference Groups (PRGs), drop in sessions and wider stakeholder conversations. In addition we had already engaged on a number of different service areas. Given the level of engagement, and the fact that this was strengthening existing services by existing providers – it was agreed that no formal consultation was required. |
| September 2014 | The CCG and CMBC submit a successful BCF plan that is clearly aligned to the CC2H programme. |
| October 2014 | The CCG presents to the HWB its planning timeline and final priorities for the coming year. These priorities form the basis for the CCG’s ‘One Year Plan for 15/16’. This discussion provided further opportunities for dialogue and alignment. |
| October 2014 | The CCG commissioned winter resilience schemes to strengthen access to GP practices from November to end of April 2015. These schemes included additional Saturday morning GP sessions across Calderdale and |
also extended opening hours at GP practices (Monday to Friday). The CCG also commissioned the seamless home from hospital service from age UK and Calderdale community transport to provide additional support for people being discharged from hospital.

<table>
<thead>
<tr>
<th>Month</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2014</td>
<td>The CCG approved the Phase 1 specification and it was included in the CHFT contract for 2015/16. Through dialogue, the specification is currently being set within the SWYPFT contract for 15/16. This specification included the development of standards for community services which will be monitored through contact compliance meetings.</td>
</tr>
<tr>
<td>January 2015</td>
<td>The work carried out to date on CC2H and next steps was presented to the Adult Social Care Overview and Scrutiny Committee.</td>
</tr>
<tr>
<td>March 2015</td>
<td>The CCG publishes a detailed plan for 2015/16 ('CCG One Year Plan'), which set out in detail how the Care Closer to Home work – that started in 2012/13 - would continue. The document also re-committed the CCG to the strategic intent set out in the 5 Year Plan, and to the joint vision of integrated care developed jointly by the CCG and CMBC. The 'One Year Plan' also re-confirmed the three separate, but consecutive phases of Care Closer to Home delivery:</td>
</tr>
<tr>
<td></td>
<td><strong>Phase One (2014/15)</strong> – The strengthening of existing community services in line with a strategically developed specification. Significant engagement with service users and patient groups was undertaken to shape the specification and the desired outcomes.</td>
</tr>
<tr>
<td></td>
<td><strong>Phase Two (2015/16)</strong> - Continuing to strengthen community services and moving services out of hospital which could more appropriately be provided in communities.</td>
</tr>
<tr>
<td></td>
<td><strong>Phase Three (2015/16)</strong> - Making any changes needed and considering the initiation of formal public consultation to ensure that the model of hospital services is fit for the future.</td>
</tr>
<tr>
<td>April 2015</td>
<td>CMBC becomes formally represented on the CC2H Board. With cross-representation into the BCF Board.</td>
</tr>
<tr>
<td>April 2015</td>
<td>Calderdale receives Vanguard status to support further development of its CC2H model and new models of care.</td>
</tr>
<tr>
<td>April 2015</td>
<td>The CCG takes fully-delegated responsibility for commissioning GP services in order to ensure that design of future services supports delivery of the CC2H model.</td>
</tr>
<tr>
<td>April 2015</td>
<td>The CCG develops a new system for monitoring experience and equality monitoring to support service change.</td>
</tr>
<tr>
<td>May 2015</td>
<td>The Quality Committee and CC2H Programme Board agreed a principle-based process for determining which services will be included in Phase 2 CC2H. This work has been shared with Calderdale and Huddersfield Foundation Trust (CHFT) and work is underway to develop a joint view on future model of care for service lines where this has not yet been agreed.</td>
</tr>
<tr>
<td>May 2015</td>
<td>A gap analysis of engagement work was undertaken to identify where engagement needed strengthening, and work has been undertaken to rectify this.</td>
</tr>
<tr>
<td>July 2015</td>
<td>The CCG’s Quality Committee and Finance &amp; Performance Committee consider and strengthen the approach to decision-making for CC2H.</td>
</tr>
<tr>
<td>August 2015</td>
<td>The CCG meets with the People’s Commission and Healthwatch to discuss the approach to decision-making.</td>
</tr>
</tbody>
</table>
### Overview of Initiatives – past, current and future

| Things we plan to do |
| Things we are doing now |
| Things we have done |

#### Current initiatives
- Work across Health and Social Care in Calderdale
- Joint health and care processes
- Supporting people with learning disabilities
- Supporting children, young people and their families
- Developing local services
- Improving access to care
- Enhancing community engagement
- Improving health and care outcomes
- Developing new services and models
- Implementing new technologies
- Supporting and involving volunteers and carers
- Developing new partnerships
- Enhancing service delivery
- Improving patient outcomes

#### Future initiatives
- Developing new models and services
- Enhancing community engagement
- Improving health and care outcomes
- Developing new partnerships
- Enhancing service delivery
- Improving patient outcomes

#### Past initiatives
- Developing new models and services
- Enhancing community engagement
- Improving health and care outcomes
- Developing new partnerships
- Enhancing service delivery
- Improving patient outcomes
<table>
<thead>
<tr>
<th>Health and Prevention</th>
<th>Mental Health and Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Stories developed to guide work 4 patient stories</td>
<td>Development and sign off for Mental Health Concordia</td>
</tr>
<tr>
<td>Third Sector capability and capability building (see relationships)</td>
<td>Development of an integrated Mental Health Innovation Hub</td>
</tr>
<tr>
<td>Role of third sector</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Tackling violence - reducing repeat injuries</td>
<td>Evidence on joint commissioning of 34 recognised ECF schemes, which provides an opportunity to commission mental health pathways</td>
</tr>
<tr>
<td>Implementation of new cancer programme</td>
<td>Working in partnership with Public Health to strengthen alcohol and drugs services</td>
</tr>
<tr>
<td>Continual development and roll out of community pathways</td>
<td>Learning Disability - Inquiri for Improving Outcomes for People with Learning Disabilities</td>
</tr>
<tr>
<td>Community health model</td>
<td>Long-term mental health - Seeing Well Project -</td>
</tr>
<tr>
<td>From May 2015 (Shoalton) pathway commissioned in 3 locations</td>
<td>Recognising the benefits of the CPCH and CCM Programme</td>
</tr>
</tbody>
</table>
### 3.0 Stakeholder Engagement

The engagement and equality checklist is part of the CCG S internal assurance process for engagement. This process helps us to identify the level of engagement required for any given project, service or specification. The completed checklist for Care Closer to Home is provided below.

(a) **Engagement and Equality Checklist**

<table>
<thead>
<tr>
<th>Brief Description of Project:</th>
<th>Commissioning Care Closer to Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed by:</td>
<td>Dawn Pearson</td>
</tr>
<tr>
<td>Date</td>
<td>24.07.15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. If this project was delivered could it affect patients?</th>
<th>Yes</th>
<th>Population of Calderdale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. If yes, is it likely to specifically affect patients from protected groups?</td>
<td>Yes</td>
<td>All protected groups</td>
</tr>
<tr>
<td>2. If this project was delivered could it affect staff? (i.e. would staff work differently or could it change working patterns, location etc.)</td>
<td>Yes</td>
<td>unknown</td>
</tr>
<tr>
<td>2a. If yes, could it change the way a service was provided or delivered? (i.e change the location, opening times, facilities or services on offer)</td>
<td>Yes</td>
<td>unknown</td>
</tr>
<tr>
<td>2b. If yes, could it have a different effect on staff or the public from protected groups</td>
<td>Yes</td>
<td>unknown</td>
</tr>
<tr>
<td>3. If none of the above apply, what is the nature of the change?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Has the project had an initial Equality Impact Assessment? If no, please state why</td>
<td>Yes</td>
<td>Sarah Mackenzie-Cooper completed - work ongoing</td>
</tr>
<tr>
<td>5. Has the project been based on previous feedback from public, patients and carers?</td>
<td>Yes</td>
<td>Please see the attached data capture sheet</td>
</tr>
<tr>
<td>5a. Was this collected over the past 3 years? Do you have a clear audit trail of all evidence to support this?</td>
<td>Yes</td>
<td>Audit trail with Calderdale PMO</td>
</tr>
<tr>
<td>5b. Has the feedback from public,</td>
<td>Yes</td>
<td>Sarah Mackenzie-Cooper completed</td>
</tr>
</tbody>
</table>

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1. Protected groups; age, disability, sex, sexual orientation, race, religion and belief, gender reassignment, pregnancy and maternity, marriage and civil partnership.

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patients and carers been disaggregated by protected group? If no, please state why

<table>
<thead>
<tr>
<th>5c. Have you identified your key stakeholders by mapping who will be directly and indirectly affected?</th>
<th>yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>— please see the attached data capture sheet</td>
<td>Stakeholder mapping completed for CC2H and Right Care, Right Time, Right Place</td>
</tr>
</tbody>
</table>

(b) **Summary of data collated**

Based on all the information you have collected on this model (past and present); please describe the main themes or areas for improvement or satisfaction

- Improved access to health services
- More services in the community
- All agencies working together to deliver Health and Social Care
- Improved Discharge planning and better resourced hospitals.
- Staff Training to improve communication and transparency
- Regular Check-ups - for people with chronic conditions
- Improved management of risk and safeguarding when people are unwell
- More education and information
- Support for Self Care and
- Investment in technology

(c) **Detail on Engagement Activity**

**Capturing existing data - ‘What are our service users telling us?’**

It is important that the following sections are completed with as much information as possible. The information needs to be evidence based as it may be used to support a decision making process.

**Past engagement activity/patient experience intelligence**

1. *Has anyone in the last 3 years surveyed / engaged / talked to service users about this model? Please list below titles of any final reports of findings or activities and where to find them.*

- **September 2012:** PALS, Complaints, Patient Opinion, NHS Choices, Local and national survey information was gathered to inform four programmes of work:
- **November to February 2013:** Engagement took place on the four programmes of work:
  - Planned Care – A planned care event with 44 service users and carers attending.
  - Unplanned Care – an unplanned care survey gathering 1,700 public views.
  - Long term Care – A long term care event for 52 service users and carers.
  - Children – a survey to engage 300 young people.
- **March 2013:** Four composite reports were developed using the intelligence collected from the period September – February 2013. The information was fully analysed by a
research specialist and the key emerging themes identified.

- **June 2013**: Engagement on ‘Unplanned Care In Calderdale’ (walk in service) - just over 2,500 response received from the public and key stakeholders
- **September 2013**: Equality Delivery system – 30 attendees at an event
- **October 2013**: Diabetes services – 65 people at an event
- **October to December 2013**: Call to Action – 280 responses received
- **December 2013**: Wheelchair Services – 14 people attended a focus group and 21 people were surveyed.
- **December 2013**: Supported Self Care workshop – 22 people attended a focus group
- **January 2014**: Respiratory services – 7 people attended a focus group
- **April 2014**: Single Care Plan, Children and young people – 21 young people were engaged
- **May-August 2014** – Right Care, Right Time, Right Place – 2,475 responses
- **December 2014** – Stakeholder event – public patients and carers – 85 people attended an event at the Shay stadium.
- **March 2015** – Stakeholder Event – Staff and key stakeholders – 102 people attended the event at Todmorden Town Hall.
- **April 2015** – Voluntary and Community Services event – Third sector representatives - The engagement event had an attendance of 121 delegates representing a range of stakeholders, predominantly the Third Sector.

Audit of documents held in the Programme Management Office for Right Care, Right Time, Right Place

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2. **Over the last 3 years have you received any PALS / Complaints / Comments / Compliments about this model.**

Yes  No √ Don’t know

(If yes, what were service users telling you, what were the themes? Please provide the information below)

- n/a

2a. Have you disaggregated the information by protected group, what themes, concerns of issues emerged?

- n/a

---

3. **What does this information tell you about the model?**

3a) Public engagement with the wider public told us:

**Improve access to health services.** This included opening times and appointment availability, particularly aimed at GP practices and primary care.

- Awareness of building access issues to all staff, especially around disabilities
- One point of access for people with a long term condition
- Longer appointment times for some people, spend more time with the patient and listen
- Improve home visits and bring GP services to community settings
- Reduce waiting times for appointments and change the booking system
- Have appointments at evenings and weekends, ring fence appointments for people who work
- Have specialist staff in GP practices

**More services in the community**, the public would like to see more staff working with and supporting local people in their own home and community.

- More health assistants, social workers and nurses
- Better home 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

**Working together**, all agencies, not just health, should work together to improve health and wellbeing.

- Joint teams that are managed centrally, not just teams that work together
- Sharing of information and the ability to access a shared, patient owned record for those that need to
- Working with the third sector, as partners to improve health and wellbeing

**Discharge planning and better hospitals.** The public told us some of the things we should consider improving our hospitals there was a lot of focus on discharge.

- 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 and Community Sector (VCS) organisations to support the individual.
- Train and support carers in their duties so they can manage.
- More staff in hospitals; under resourced.
- Hospitals need to be clean and serving nutritional food to support recovery.
- Bring hospital services into community settings.

**Staff Training** including changing the culture of the NHS, communication and transparency.

- 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.
- Train specialist staff (or have a matron lead) who understand different disabilities and mental health.

**Regular check-ups** including annual check-ups or possibly more frequent depending on the age and condition for everybody.
To be offered 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.

Manage risk and safeguarding, to the public meant keeping people safe when they were unwell.

- Increase community staff and to undertake 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.

Education and information. All information from the NHS should be available in easy to understand formats and use a variety of different methods to reach the appropriate audience.

- There needs to be more information about how to maintain health and wellbeing and how to avoid preventable conditions.
- 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.
- More education and information for young people – start at school, use Sure Start centres.[now delivered through different children’s centres]

Self-Care, including prevention, was a theme arising from strategic as well as project specific engagement and included the following:

- Care that is personalised with the support of specialist staff; patients being able to access the right services at the right time.
- Getting support in being healthy and to be encouraged to self-care by providing access to information, advice and support with regards to diet, exercise, support groups/networks and contacts for ongoing support.
- Ensuring patients are involved in the development of their care plan and informed so they know what to expect, who to contact and provision of ongoing care and support.
- Involvement of wider networks such as carers and families and considering their needs.
- ‘Self-Care’ to support those who are well to ensure prevention – well-being courses for the community, particularly for young people.
- Care navigators and co-ordinators to support individuals.

Invest in technology. Use technology better and invest in future technology, especially for monitoring and sharing information between services and patients.

3b) Public engagement in the upper Calder valley told us:

- Care closer to home would better support older people and people with dementia.
Local services are needed as specialist services move further away.
People like the idea of longer opening hours
There is a need to improve current appointment systems including how people book them and the availability of appointments.
A number of comments relating to treating the whole person not just the symptom – test for other things while the patient is there.
More walk in sessions – including services such as GP and community based services.
More sessions providing information on health topics. More emphasis on a good diet with the healthcare staff and systems leading by example.
Disabled access could be improved – deaf communication highlighted.
GP communication and information systems need to be improved, more facilities such as Skype and use of email for the deaf.
Patient information shared between hospitals and GPs needed to be handled more effectively.
Enough GPs to cover the work.
GPs need to get their own services working effectively so they can be a hub for others.
A better transport system to get people back home if they are transferred to a hospital in Halifax or a hospital further away.
That people in the Upper Calder Valley are already a long way from the hospital in an emergency and would like a solution to this. Transport and travel including ambulances is a real concern to people.
More community services in Cornholme including more GP nurse services, a baby clinic and other services closer to home.
More investment in preventative medicine particularly massage and physiotherapists.
More information and involvement for families and carers if a patient has a sensory disability so they can support communication and care of the patient.
More information in schools.
Early detection of mental health and better care and treatment.
Improve the care of people with mental health problems and dementia.
More support for carers and more communication for families, visiting patients in hospital is also tiring if you have long journeys.

3c) Staff and key stakeholders - engagement told us:

That there were 18 themes which needed to be improved, addressed or delivered to provide a preferred future. The common themes for staff and key stakeholders from a wide range of organisations in the 'Upper Calder Valley' are:

- They want services closer to home, delivered by the right staff in the right setting.
- Transport networks including parking need to be considered.
- Participants want the model to reflect the diverse population 'one size does not fit all'.
- All sectors want to play a key role in developing and delivering these services at a local level in a variety of community settings in a coordinated way.
- Work force considerations need to be considered ensuring the right skill mix and staff work holistically and seamlessly together.
- Participants wanted to see a single point of access which included information sharing, but wanted to see GP practices as a more central part of the community model.
- Stakeholders want to continue being involved in decisions about future services.
- Communication and information throughout the system and to the patients’ needs improving, people need to know what is on offer and how to reach people.
- Supported self-care and prevention was less of a key focus than it was for the public but it still received a mention.

3d) Third Sector engagement told us

The key themes that emerged from the table discussions on what can the Third Sector bring to Care Closer To Home. People told us:

- **Relationships, trust, knowledge of localities and with communities and networks**

  *Examples*
  - Knowledge of communities; barriers, culture, geography
  - Grass roots experience

- **Communication avenue**

  *Examples*
  - Making connections at local level
  - Communication routes and tools

- **Knowledge and information of needs of local communities**

  *Examples*
  - Specialist local knowledge
  - High levels of knowledge of local communities; their experiences, issues and needs

- **Identify harder to reach groups and Involve those not engaged**

  *Examples*
  - Identify individuals and groups of people who are lonely, isolated and at risk
  - More connection to vulnerable groups

- **Flexibility and responsiveness to needs**

  *Examples*
  - Can be flexible to shape services for both individual and communities
  - Flexible and responsive

- **Ability to identify gaps**

  *Examples*
  - Able to identify gaps in need
- Intelligence – around gaps in provision/trends and patterns

**Innovation and creativity**

*Examples*

- Independence to innovate
- Willing to try new things

**Value for money**

*Examples*

- Added value
- Value for money

**Focus on prevention and early intervention**

*Examples*

- Access to early interventions/prevention to support CC2H objectives
- Increased involvement in prevention

**Buildings, facilities and community spaces**

*Examples*

- Provision of physical locations and home based accessibility
- Local buildings, resources, libraries

**Offer services via GP and Health Centre**

*Examples*

- GP and health facilities are often closed when their facilities could be used by VCS organisations
- Could offer services via GP and Health Centres. Some of these referrals already happen but it could be built on.

**Facilitation of partnership working and signposting**

*Examples*

- Partnerships for local service delivery
- Facilitate partnerships, not in competition

3a. **Does it tell you anything about the experiences of people from protected groups?**

- Whilst analysis of protected group’s participation was undertaken, trends were not identified in terms of their contributions.
4. **What methods did you use to engage with service users/staff and key stakeholders?**

**Methods:**

**Existing Mechanisms:**

- Calderdale CCG has a ‘relationship matrix’ which enables the CCG to engage with a number of key organisations.
- Calderdale CCG also works closely with the third sector and has invested in ‘health connections’ a third sector hub which ensures it can engage with third sector colleagues providing support to health.
- Third sector organisations are also targeted using ‘North Bank Forum’ which has a regular e-newsletter.
- Close working relationship with staff and member practices, including Patient Reference Groups and work with the Calderdale Health Forum.
- People engaged through electronic or postal surveys.

**Asset Based Approach:**

- Calderdale CCG uses an ‘asset based approach’ to engage with the local population, this means they train and fund local groups to talk to the public on their behalf using the methods and approaches appropriate to that community.

**Stakeholder Events:**

- A number of stakeholder meetings and events were arranged to gather views. These activities took place over a number of weeks and included conversations with the voluntary and community sector.

In addition to the engagement activity there was a number of other mechanisms operating in order to gather views, these are below:

- PALS and complaints service who were asked to capture public views as part of their customer facing role.
- Close working relationship with Healthwatch colleagues to ensure we listen to people’s views through consumer champions.
- Existing consumer websites were reviewed including those attached to the local media, patient opinion and NHS Choices to gather feedback.

A variety of communication channels were used to disseminate information and provide opportunities for patients and the public to give their views. The methods were supported by the communication leads for each organisation and centrally managed by the Programme Management Office. All communications have been centrally logged.

**4a. Did you equality monitor your engagement activity, what were the results?**
The engagement activity has mostly met a representative sample of the majority of the local population. It would not seem necessary to repeat the exercise to target any particular communities to address the gaps that have emerged through the analysis. There would however be learning for future activity;

- reaching the Indian population and other ethnic groups
- reaching young people
- considering the methodologies utilised to attract different groups

4b. Were any groups significantly over/under represented?

**Sex**
There was no significant difference to the local demographics.

**Age groups**
There is significant difference in the under 18’s category with only 3% of survey respondents compared to a population of 22-23%. This is to be expected as the under 11s were not specifically engaged in this exercise.

The 26-45 group was over represented 38% compared to 27%.

There is a significant over representation of Pakistani populations at 33% compared to 7%. There is a commensurate under representation of White British at 56.2% compared to local populations of 87%.

Of those who stated they had a religion, the data showed an over representation of Muslim people 36% compared to 7.3%.

There is limited data available about the local population of disabled people the census has 2 measures; ‘day to day activity limited a lot’ and ‘day to day activity limited a little’. The survey respondents were asked ‘do you consider yourself to be disabled’ and 23% responded yes. The data from the census recorded 17.9%.

Of the respondents 10.4% identified themselves as carers, the 2011 census found 10.5%

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5. What were the key themes from this engagement activity? (Please list below)

- People wanted to see more care closer to home and in a variety of community settings.
- The public in Calderdale do not want to lose their Accident & Emergency as part of services changing.
- Travel and transport needed further consideration as people could neither afford the time to travel; the cost, or find suitable parking on premises. People want services to be based locally.
- Access to services in the community needed to be 24/7 including bank holidays and there was a strong message that GP access in particular needed to be addressed if the system was to change. People also wanted services they could drop in to
- People wanted more focus on prevention and innovative opportunities to keep themselves well or be educated, particularly at a young age
- Appropriate staff are needed in the community and this included more GPs, district nursing staff and those with a particular focus on a specialty or to meet the needs of diverse communities.
- There were concerns that the model looked good on paper but would it work in
Practice, this included comments relating to capacity to deliver including social care, how information is shared and how services are coordinated
- People did not understand the detail of any of the plans and wanted to understand this further
- People wanted the community to be part of the solution including design, delivery and estates with greater community participation being the key to delivering services for each community
- Improvement to mental health services. There was a need to look at services further in both primary and community care
- Concerns about hospital waiting times.
- Concerns about the process for hospital discharge.
- There needs to be more consideration for vulnerable groups, protected groups, carers and those with a disability

5a. Were there any themes emerging from analysis of feedback from protected groups?

SOC collated results from C&GH - SOC is the providers Strategic Outline Case, the providers were Locala, CHFT and SWYFT

In terms of age groups analysed by theme the comments related to hospital services were mostly negative (31.5-55.7%) and neutral with no group giving a majority of positive comments. The most negative and neutral responses were received from those people aged between 26-45 with 55.7% comments in total being negative or neutral. From those aged 18-25 who provided comment, 51.9% of the comments received were negative or neutral. In relation to care and services in the community the majority of people made positive comments (50-60%) however those aged 66-80 were much less positive (27.8%).

In considering the themes disabled people made more negative comments about hospital services and less positive ones. When commenting on care and services in the community the difference was much less pronounced.


Q6. Did staff provide any suggestions, issues or concerns?

√ Yes (Please list below)   O No   O Don’t know
- Generally, staff are supportive
- Staff recognise the longer-term benefits of changing the way services are delivered for both patients and staff
- Staff want to work with us on the design of new services
- Staff recognised that this is one Trust with two hospitals – patients and staff are already familiar with the two hospitals
- CHFT Medical Division, had concerns over capacity and fit if HRI is unplanned site but in general a positive response and a good understanding of the need to change
- Estates staff in HRI stated spending capital in a building we own (if HRI) is good but were concerned that A&E waiting times will get worse if there is only one A&E
- Staff wanted to know if their jobs were secure
- Nursing staff wanted to see more District Nursing staff
- CHFT Nursing staff asked if A & E waiting times will get worse if there is only one and thought it was good to spend capital building on a building the Trust own (if HRI)
- Examples of services in community that could be improved.
- Queries about ISS staff if Huddersfield Royal Infirmary (HRI) is the unplanned hospital site. Will they transfer?
- What will be the impact on jobs at Calderdale Royal Hospital (CRH) if HRI is the main site?
- Conscious that more people may choose to call 999 for an ambulance due to distance to travel from Calderdale (when maternity services moved to Halifax there was a concern that more women in labour would call 999- but that has proved not the be the case)
- What are GPs doing about appointments and increased number of A&E attendances because patients can’t get a GP appointment?
- Staff understand the rationale behind the proposed changes, but want to know more about how it might work in practice
- Staff wanted to better understand the thinking behind the Trust’s stated preference
- The services proposed would need extensive new build on the current HRI site and wanted to understand PFI (Private Finance Initiative) arrangements more, there was a suggestion for one big hospital in Elland
- Senior consultant presence was needed outside daytime hours
- Staff wanted to know if the shuttle service will improve
- Staff asked if beds in the hospital would be reduced
- Social Care staff stated that a 7-day provision of Social Services is implicit in the new Care Bill and Urgent Care Agenda
- Community resources governed and managed by us, but not owned by us
- Learn from Locala example. Staff want to come back into the hospital setting as they feel isolated
- Significant Consultant presence in the community is needed to show investment of the current model
- The intermediate care teams wanted to know if Dewsbury had been factored into the A&E plans but were generally supportive of the plans

6a Were there any different issues affecting staff from protected groups?

O Yes (Please list below) O No √ Don't know

- Not aware of the membership of the protected characteristics as these were not equality monitored.

(d) Engagement Gap Analysis

As part of our approach to engagement we always ensure the engagement information we already hold is used to support our plans. In November 2014 the service areas in Phase 1 of CC2H were identified.

Using the information we already hold, services were mapped against any existing engagement activity to see if any previous engagement on the service area had taken place, who we had spoken to and what the conversation was about. The information was then
used to inform our plans based on and what the public had already told us. This mapping exercise helped to identify any gaps in information.

The service areas were no engagement had taken place were noted and plans to engage further formed part of Phase 2 CC2H delivery.

The engagement activity planned for phase 2 included any services from phase 1 that still required engagement to take place. The service areas identified as requiring engagement are:

- Cancer services
- Minor day surgery
- Cardio vascular disease
- Therapies
- Ophthalmology
- End of life care; and
- Colposcopy

An engagement plan is in place and aligns to the engagement which is also required for hospital services. The approach to engage service users, carers and protected groups will be a targeted approach and two stakeholder events and forms part of a planned pre-engagement approach to ensure we have gathered enough views to further develop our care closer to home model.

Alongside our engagement activity patient experience data is also being gathered together from the last two years for:

- PALS
- Complaints
- Patient Opinion

This data will be analysed and key themes extracted from the data to ensure individual experiences and collective views are considered in any development, design and delivery of services.

A composite report of all the engagement and patient experience information we hold from April 2013 to August 2015 is being written. Analysis of all the service areas will be included in the report and key themes will be highlighted across all service areas. This information will tell us what patients want to see us deliver as part of our plans for Care Closer to Home and also what the key areas for consideration should be in each service area.
## (e) Improving Health together Recommendations (People’s Commission)

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<tr>
<th>No.</th>
<th>Recommendation</th>
<th>Alignment with CC2H</th>
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<tbody>
<tr>
<td>1</td>
<td>We recognise that no change to the health and social care system is not an option, but any changes proposed must be right for the people of Calderdale. We recommend that the Council, NHS purchasers and providers work together to ensure that any changes proposed will produce real, tangible benefits for Calderdale people and that they have had the opportunity to comment on and contribute to any proposals that are made.</td>
<td>Care Closer to Home/Vanguard work brings together both health and social care commissioners and a range of providers in development and delivery of the new model of care. The evidence pack sets out the tangible impact to date, and future plans to improve health and well-being locally.</td>
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<td>2</td>
<td>Calderdale Health and Wellbeing Board should take a lead in ensuring that Calderdale Clinical Commissioning Group, Calderdale and Huddersfield NHS Foundation Trust and Calderdale Council work together to develop a shared plan for health and social care services that are safe and of high quality for the people of Calderdale. NHS England should also help draw up the plan.</td>
<td>Care Closer to Home, particularly through Vanguard has brought together partners who are now developing a clear plan to accelerate the strengthening of community services by the development of a plan to bring additional investment into Calderdale</td>
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<td>3</td>
<td>Calderdale Health and Wellbeing Board should consider inviting the major NHS provider organisations – CHFT and SWYPFT – to become members of the Health and Wellbeing Board.</td>
<td>This recommendation is currently being considered by the HWB. The Board are sighted on the CC2H and will be in receipt of quarterly updates on progress.</td>
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<td>4</td>
<td>People with urgent, life threatening conditions need access to the best specialist care possible. This specialist service should be planned for the population of West Yorkshire and so may not be always be located within Calderdale. NHS England and the West Yorkshire Commissioning Collaborative should prepare and publish a proposal for the provision of urgent and emergency care across West Yorkshire and set up a process for public engagement and subsequent formal consultation.</td>
<td>The CC2H model would have a clear interface with a range of emergency and urgent care pathways. The particular links will be through the development of a 7-day First Point of Contact and the potential development of a first Urgent Care Centre in the Upper Valley.</td>
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<td>5</td>
<td>People who have what they consider to be urgent, but non life-threatening illnesses and injuries should have easy and local access to advice and treatment. We consider that there should be a network of advice and support services including pharmacies and GP surgeries so that most people can access advice and treatment for urgent “minor injuries and illnesses” most of the time in their own town. The Health and Wellbeing Board should oversee the development of an urgent care services plan as an important local contribution to the wider West Yorkshire strategy.</td>
<td>Through the development of a 7 day First Point of Contact service and the potential development of a first Urgent Care Centre in the Upper Valley the CC2H model will provide a better offer for urgent but non-life threatening needs. The development of a new Primary Care Strategy as part of CC2H, fully delegated commissioning of general practice, the emergence of a new GP Alliance, and the strengthening of the role of other primary care providers; particularly pharmacists and optometrists. All provide a good basis for strengthening</td>
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<td>6</td>
<td>The People’s Commission believes that CHFT and its partners should reconsider their current proposals for hospital reconfiguration and, in doing so, work with the Calderdale Clinical Commissioning Group and the Council to develop alternative models, for public consideration. These should make the best possible use of the facilities and investment at Calderdale Royal Hospital. We believe that such an approach could retain an effective, if changing, role for both Calderdale Royal Hospital and Huddersfield Royal Infirmary, whilst complementing, at a local level, the emerging move towards greater regional specialisation. The future of Accident and Emergency provision should only be considered as part of the above review process.</td>
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<td>7</td>
<td>The PFI arrangements that were put in place to fund the construction of Calderdale Royal Hospital have sometimes seen to have driven decision making. Regardless of any proposals for hospital reconfiguration the burden of debt on CHFT finances is substantial. We recommend that CHFT, in partnership with Calderdale CCG, Greater Huddersfield CCG, SWYPFT and the Council, examine options for restructuring these financial arrangements in order to reduce the debt burden and to increase flexibility.</td>
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<td>8</td>
<td>All public services need to be planned within the finances available. But the system for financing health services should be the servant of service delivery not its master. We recommend that CHFT, Calderdale CCG and Greater Huddersfield CCG develop a shared and public plan to achieve financial stability and sustainability for the provision of acute hospital care.</td>
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<td>9</td>
<td>Transport links to health services are of considerable importance to people. This applies to ambulance journey times and to accessing health services as a patient or as a hospital visitor. Any proposals for reconfiguring community health services or hospital services should include a realistic travel analysis drawn up in partnership with Yorkshire Ambulance Service and public transport agencies.</td>
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<td>10</td>
<td>Calderdale Clinical Commissioning Group has</td>
<td>This is the focus of this evidence pack.</td>
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decided to make improvements to community health services before planning hospital reconfiguration. It will take some time for these changes to be implemented and before their impact can be properly assessed. The re-arranged community services should be given time to ‘bed in’ and given chance to show they can be a viable alternative.

11 **NHS England and Calderdale Clinical Commissioning Group** should work together to ensure that all Calderdale residents have access to an equitable and consistently high standard of service from their GP.

The development of a new Primary Care Strategy as part of CC2H, fully delegated commissioning of general practice, and the emergence of a new GP Alliance provides a strong basis to strengthen primary care. One of the key elements of CC2H is to deliver a more sustainable GP model by looking at; workforce, how services ‘wrap-around’ GP services to ensure a better offer for patients, and improving accessibility to primary care as a whole.

12 **The Clinical Commissioning Group** NHS England and providers should ensure that all GP practices are signed up to new community health arrangements and have full engagement in the development of any plans to reconfigure hospital services.

We have engaged extensively with our GP membership and the new GP Alliance about the shape of CC2H and new clinical models (particularly our 7 clinical priorities). Our membership is supportive of CC2H, and the GP Alliance are Vanguard partners.

13 **The Council’s Adults Health and Social Care Scrutiny Panel** should assess on at least an annual basis the extent to which the Better Care Fund is achieving its objectives and whether any integration of health and social care services has been effective. The Scrutiny Panel should report its assessment to the Health and Wellbeing Board.

There are clear governance arrangements for BCF and these include regularly reporting to the HWB from the BCF Board. There is a very clear and documented alignment between CC2H and the BCF Plan submitted in 2014, which was approved by NHSE. There continues to be cross-representation between the CC2H and BCF Board, and plans are being developed to further strengthen CC2H work-plans and the 34 BCF schemes.

14 **The Council’s Adults Health and Social Care Scrutiny Panel** should assess on at least an annual basis the extent to which the Council, through all its activity, is fulfilling its statutory role to improve the health of the population and consequently reduce demand for health and care services. The Scrutiny Panel should report its assessment to the Health and Wellbeing Board.

As part of the CC2H programme there is a specific element which is working with the Public Health team in CMBC to develop a new strategy on prevention and promoting healthy lifestyles. Whilst this remains a responsibility of CMBC – the joint work on CC2H will strengthen the approach and maximise potential impact.

15 We recommend that Calderdale CCG – with partners, including the Council - implement a high profile, co-ordinated campaign to help people choose options other than the Accident and Emergency (A&E) services more often.

The local system already runs high-profile campaigns at peak-times through the year to ensure local people are aware of all the alternatives to A&E. We have strengthened partnerships with CMBC and other non-NHS bodies to further enhance
current and future campaigns. With regard to prevention and getting people to know where to go to get treatment over the winter; for flu there is a West Yorkshire wide Communications Group set up to ensure there are strong communications and engagement on Seasonal Influenza. This Group, at which the CCG is represented – is coordinating a comprehensive campaign through pharmacies, major supermarkets, GPs – to reach target groups to promote the uptake of the vaccine. The campaign is scheduled to begin in September and the CCG will be involved along with social care and local hospitals. This recommendation is also being considered by the local system through the Strategic Resilience Group (SRG) partnership and Urgent Care Board (UCB) as part of their on-going strengthening of Surge & Escalation Plans and Winter Planning.

(f) Views of Adult Overview and Scrutiny Committee

We have welcomed the opportunity for continued dialogue with the Adult Overview and Scrutiny Committee (OSC) regarding CC2H and Vanguard. We have carefully listened to their views and taken these on board as part of the development of the CC2H and Vanguard programmes. We will continue to meet with OSC and have committed to attending a further meeting in October to provide an update.

Other issues relating to hospital changes are not addressed as part of this evidence pack.

Meeting - 15 July 2015

The Head of Service Improvement, Calderdale Clinical Commissioning Group submitted a written report which provided an update on the Care Close to Home Programme and provided an opportunity for closer alignment with the work of the Board and built on reports presented to the Board over the last 3 years, setting out the CCG’s strategic plans. The Care Close to Home Programme was the flagship programme for the CCG as it delivered a significant element of the strategic change set out in the CCG’s Five Year Plan. It was important therefore that the Board were sighted on its progress and had an opportunity to support its delivery.

The Care Close to Home Programme remained a critical vehicle for delivery of strategic change in Calderdale and delivery of our Better Care Fund Plans. There was a need to strengthen and integrate the programme within the work of the Health and Wellbeing Board.
During discussions the importance of “long-term conditions, those who are frail, and children with complex needs” was highlighted with regard to inequalities and the economy.

RESOLVED that:

(a) areas where further alignment could be made to be identified in the next report. Information and engagement were identified and the update be noted;

(b) the Head of Service Improvement, Calderdale Clinical Commissioning Group be requested to circulate an interim report on “Vanguard” to all Members of the Board;

(c) the Director, Public Health be requested to submit a briefing note to all Members of Cabinet and the Health and Wellbeing Board on information to be considered within the 7 clinical priorities referred to in the report; and

(d) the Head of Service Improvement, Calderdale Clinical Commissioning Group be requested to submit a further update to the Board meeting to be held on 29th October 2015.

Meeting - 16 June 2015

The Head of Service Improvement, Calderdale Clinical Commissioning Group (CCCG) provided a presentation on their 5-Year Journey and Year 2 Plans for 2015/16 along with key priorities and challenges for the year and their vision for integrated care. The presentation outlined:

- The process for identifying priorities.
- Priorities for 2015/15
- Thee three phases of delivery
- Approach to decision making for hospital changes
- Information about the Vanguard project.

People with Long Term Conditions - prevention, early intervention and self-care for those at risk and integrated working (MDT/care planning) for those with complex needs;

People who are at risk of harm as a consequence of their frailty (co-production of new care offers - with staff and patients);

Children with complex health and care needs; and

Urgent care services

Members raised the following questions:

- with regard to the phrase "everyone has a bed, and it's at home" rings alarm bells, does that mean there would be a shortage of beds in hospitals? In response, the Head of Service Improvement, advised that this phrase was developed jointly by CMBC, HWB and the CCG for the BCF submission. It was a joint quote and was influenced by the feedback from public engagement where people had said that they wanted, as far as possible, to be treated in communities;
• what was the challenge of Accident and Emergency (A&E) waiting times; In response, the Head of Service Improvement advised that delivery of the A&E Constitutional target was an important issue. There were a number of issues associated with delivery, but the key one was about the out of hospital "offer in the community", keeping people safe, well and independent and at home. There was a need to invest in areas where community services, third sector services and social services could make a difference by keeping people out of hospital and supporting a safe and effective discharge.

• why was the target allocation reduced by 8% and what effect would that have; In response, the Head of Service Improvement advised that the 8% was a formula change with less weight given to deprivation and less weight to other areas, this was a national formula change and would affect the CCG's investment pot, it was not about cutting services, but was an opportunity to do different things;

• Todmorden Health Centre was totally underused, what would you do with this and how does the CCG plan fit into that; In response, the Head of Service Improvement advised that their Vanguard plan was to fully utilise the Todmorden Health Centre and to assess what people need and what the different, integrated offers could be in that building.

• with regard to the CCG's timescale for transformation, it is not far from September, what degree of readiness were they at? In response, the Head of Service Improvement advised that they were preparing for pre-consultation engagement to make sure they were developing the right questions and talking to the right people. A full timeline could be presented to a future meeting of the Panel;

• would somebody independent be looking at the questions for the consultation? In response, the Head of Service Improvement advised that there were processes, checks and balances for the process of consultation including those developed by NHS England. The process would be open and transparent, and the CCG would welcome further discussions with Scrutiny on the source of independent voices into the process.

• were there any indicators of the impact on demand? In response, the Head of Service Improvement, CCGC advised that a range of indicators were being developed to measure confidence in service changes that had happened over the last 2 years. The system has seen a 3.8% reduction in non-elective admissions, which was not seen in other parts of the country and this was a positive sign of the changes made so far.

• would the CCG be willing and able to attend a Panel meeting prior to consultation? In response, the Head of Service Improvement advised that they would be happy to attend whenever invited;

• what is the "Calderdale Pennine GP Alliance" and what was the definition of GP Alliance? In response, the Head of Service Improvement advised that they were a collaboration of GP practices, which are small businesses, working together for the better good of the people they serve. They were a legal entity which could collaborate with other providers and were able to have services commissioned through them. They were engaged in the Vanguard discussions about bringing
primary care and acute care together and could be invited to attend a future Scrutiny Panel meeting;

- some of the "care closer to home" changes were more recent than 2 years, they were in their infancy, so it was surprising that there would be enough impact by September. Surely there was a need for significant impact in order to go to consultation? In response, the Head of Service Improvement advised that "care close to home" was what the programme the CCG had been working towards since its conception and it had taken 2 years to get to this stage. During the last 12 months more work had been done with communication and animation about the strategic direction to make it more it was more accessible to stakeholders and the public;

- was there anything specific the CCG feels that the Panel could be scrutinising? In response, the Head of Service Improvement advised that some specifics she had picked up in the discussions could be "Primary care and the GP Alliance", "Right care timeline", "Upper Valley and Vanguard";

4. **Quality and Safety**

(a) **Quality and Safety – 7 clinical priorities in CC2H**

For each of our condition-specific programmes within CC2H we have identified and have begun measuring specific quality and safety benefits.

Using data produced by the Health & Social Care Information Centre we are able to benchmark our performance on delivery of key quality performance indicators. The Benchmarking data used is from NHS Outcomes Framework. Assessment is based on latest data – published in June 2015, and it compares Calderdale with populations with similar demographics:

- NHS East Staffordshire CCG
- NHS West Essex CCG
- NHS Swale CCG
- NHS Warwickshire North CCG
- NHS Ashford CCG
- NHS North East Lincolnshire CCG
- NHS Greater Huddersfield CCG
- NHS East Lancashire CCG
- NHS Airedale, Wharfedale and Craven CCG
- NHS Bury CCG

The data below shows Calderdale is now in the upper (best) quartile compared to its comparators for the following quality indicators:
There are also a wide range of indicators which show Calderdale to be improving in a number of areas (i.e. in the middle range).

Whilst this is a positive picture, there are a number of areas where the CC2H programme will focus its efforts in order to ensure that we maximise the quality of care that results from the work we are doing.
(b) Taking Account of the views of the Clinical Senate

Summary Recommendations from the Report:

1. The Senate commends the CCGs on their vision for the future of their community services and agree that this has the potential to result in excellent patient care closer to home. In general terms, the Senate review group was very supportive of these comprehensive documents and their values and principles for delivering care closer to home.

2. The Senate was given a specific brief in relation to whether particular risks are addressed within the proposals and to appraise whether there are any missed opportunities within the proposed scope of services. The Senate did find it very challenging to assess the risks associated with the service transformation and we have raised a number of questions in relation to the risks arising from the lack of detail regarding workforce, primary care strategy and engagement with partners, for example.
We recognise that there have been extensive discussions with stakeholders during the last 2 years which was not detailed within the evidence provided, and that the detail behind the vision will be worked through in competitive dialogue. The Senate hopes that these questions assist with that procurement process. The Senate recommends that commissioners work in partnership with the providers around the development of the service models. This shared approach to the service model development is particularly important in a system undergoing such a large level of change to help mitigate against the risks to service delivery.

3. The Senate Review Group has considered the scope of services and agrees that these are comprehensive, with little that could be considered a missed opportunity.
(c) Patient Stories and Case Studies

As part of our approach to engagement, the impact CC2H has had on patient and also as part of describing our case for change, we have used patient stories generated from real stories from Calderdale residents. The first two stories have been animated

www.youtube.com/watch?v=iAwSpHit6_A
www.youtube.com/watch?v=7-jCYDwK4nA

1. Telehealth:

The first is Andrew’s story: the story of an older man who has benefited from a new telehealth services health at home for people with respiratory problems. This is the final slide of the animations

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This year... since the new system. I’ve only been in Hospital twice.
It’s really reassuring for me.
Like a pair of arms around me when I need them most.
2. Frail Elderly

The second is about Betty, a frail, elderly lady who has benefitted from a range of services provided at home, for example; home care, re-ablement and a range of equipment. This is the final slide of the animation

Jayne also arranged for me to have a falls pendent which I can press if anything happens – this makes my son feel less anxious. She also arranged for someone to come and assess my home for other equipment that might stop me from having another a fall. As I got better everything slowly got back to normal. Things are so much better now.....

3. Case Studies from Quest for Quality in Care Home.

The two case studies below come from the Quest project:

**89-year old female, receiving residential EMI care**

*In June 2015, a Quest for Quality Matron visited an 89-year old female who had been suffering with a rattling cough.*

The individual has Advanced Alzheimer’s disease, was fully bedbound, had flexion contractures to all limbs and neck extension contracture, was doubly incontinent, and took thickened fluids and a pureed diet.
The individual used very few comprehensible words, mostly making incomprehensible sounds and screams.

The individual had been on palliative care plan for just over two months, medication had been stopped and anticipatory medication prescribed in March. The individual had remained stable, not deteriorating since that time.

The individual was asleep in bed during the Matron’s visit. She appeared thin and frail, but could not be weighed. The individual was snoring loudly and a bubbly sound was noted.

On checking the individual’s chest, the Matron noted normal percussion, surprisingly good bilateral air entry, transmitted sounds from snoring, no crackles or other sounds. When the individual was sat upright, the bubbly sound reduced but did not disappear.

The Matron’s impression was that saliva was pooling in the oropharynx, secondary to abnormal neck position, and impaired swallow.

The Quest for Quality Matron spoke to the individual’s son, who was aware of DNACPR and was happy for his mother to have palliative care without invasive procedures or hospital admission. Preferred location for end of life was the Care Home.

The Quest for Quality Matron advised the Care Home of the high likelihood of aspiration pneumonia. It was advised to nurse the individual on alternate sides as much as possible in order to facilitate drainage of saliva.

The Care Home was also advised that management of illness would be via the Quest for Quality Team or the GP and that hospital admission would be inappropriate.

An Emergency Care Plan was completed, which included information about functional status and family preference for palliative management of illness.

The involvement of the Quest for Quality Matron ensured that a GP visit was avoided and inappropriate use of emergency or hospital services was also avoided. In addition, Care Home staff received clear guidance about planned palliative management of illness.

Medication Review for 93-year old female, receiving residential care

In May 2015, a Quest for Quality Pharmacist completed a Medication Review with a 93-year old female following identification of polypharmacy as part of the MDT process.

At the time of the Review the individual was prescribed Digoxin 62.5mcg every night, Bisoprolol 1.25mg once daily, Sertraline 25mg every morning, Vitaeyes twice daily, Adcal D3 chewable twice daily, Movicol as needed, and Aspirin 75mg every morning.

The individual was noted to have Atrial Fibrillation, Myocardial Infarction, low mood and dementia. She was partially sighted, had bone frailty and had suffered a fractured Neck of Femur earlier in the year.
It was established that the individual had an allergy to Digoxin, having had two episodes of Digoxin toxicity resulting in hospitalisation.

This allergy was recorded on the front sheet of the medication file and had been stopped by the hospital following the second incident of hospitalisation. However, the Digoxin had been restarted following a subsequent hospital admission in January 2015 and no monitoring of Digoxin had been completed since it was restarted.

The Quest for Quality Consultant recommended an immediate stop to the Digoxin. The Care Home and GP were informed of the decision for patient safety reasons.

In addition to the above, the Quest for Quality Pharmacist recommended review of the use of Aspirin, which is no longer indicated for use as a stroke prevention measure in Atrial Fibrillation, with the suggestion to consider Novel Oral Anticoagulant (NOAC) or Warfarin instead.

It was recommended that the individual’s swallow be reviewed with the consideration of taking Bisphosphonate and that consideration be paid to increasing the Bisoprolol, if necessary.

A referral for use of Telehealth for monitoring blood pressure and pulse was completed.

Following the Review, it was confirmed that the Digoxin was stopped with no ill effect.

The individual’s blood pressure and pulse was monitored for two weeks, after which the Quest for Quality Consultant recommended no further medication changes. Monitoring of blood pressure and pulse has been continued.

Completion of the Medication Review by the Quest for Quality service has improved patient safety by stopping medication that had caused previous toxic reactions and has optimised and rationalised medication leading to improved management of conditions.

80 year old female, receiving residential care

In November 2014, an 80 year old female was referred to the Quest for Quality service.

Initially a joint visit took place on the 21st November, between the Quest for Quality Psychologist and a Quest for Quality Matron.

It was established that the individual had been someone who saw her role as caring for her family. Due to the individual’s continued decline in her physical health, and after her children left home and her husband died, she became less and less able to do things for other people. This change led the individual to feel that she had lost her purpose as someone who cared for others and her identity as a mum and grandmother. The loss, and a sense that this would not change due to her physical health, could lead to a sense of hopelessness, low mood and a lack of motivation.

The individual explained how she sometimes found it difficult to accept care from staff, felt criticised when being cared for and as a consequence felt lower in mood. However, she said she did not feel this when care staff were very gentle, patient and kind to her.

It was noted that as the individual was used to being someone who cares for other people and not being used to having people care for her, it could be difficult for the individual to
accept care from other people. It was also noted that people with a less gentle and more critical or negative style of caring may trigger in the individual ideas that she should not be being cared for.

In addition, it was noted that the individual’s deteriorating physical health had made it more difficult for her to engage in activities she previously enjoyed. This could mean that she has fewer opportunities to do things that may raise her mood.

As a first intervention, it was agreed for the individual and her son to think of activities the individual could engage in to give her a sense of purpose that is consistent with the individual’s identity. Staff at the home were advised to ask the individual to do jobs to help them to provide her with a sense of looking after other people.

The Quest for Quality Psychologist revisited the individual on the 21st January to assess the impact of the initial intervention.

Care staff reported that after an initial improvement in mood after the joint visit, the individual’s mood had once again become low. Care staff reported that the individual had not wanted to do jobs in the home.

The individual’s daughter said that the jobs were not something her mum would want to do and this was how she presented the idea to her mum. Therefore, it seemed the proposed intervention had changed from being something to provide purpose and a sense of identity, to being something that was viewed negatively and perhaps as a burden.

A solution focused approach was proposed as a second intervention, concentrating on what would raise the individual’s mood.

It was agreed with the individual, and discussed with the Care Home Manager, that the Manager would speak to staff about taking a gentle, kind and patient approach when speaking to the individual. The manager was asked to discuss with staff how it is helpful to avoid communicating in a critical way and also to communicate to staff that if they think the individual may perceive something as critical (such as shouting), but staff think it is still necessary (so that the individual is able to hear them), they could be explicit about why they are doing this in order to reduce the likelihood of the individual interpreting what staff are saying as critical.

It was agreed staff would work with the individual and be guided by her as to what the right balance is regarding spending time on her own and socialising with others and more activities would be arranged that might raise the individual’s mood.

Staff were also advised on more positive ways to support discussion of a move to nursing care.

It was expected that the above would ensure the individual had more opportunity to engage in activities that would raise her mood, would change how care staff communicated with and about the individual and would help the individual to feel she was not being criticised.

In addition, it was hoped that care staff might consider more carefully the way they communicate with or about other individuals living at the Home.

The Quest for Quality Psychologist will continue working with this home to gain a better understanding of the home’s approach to caring for both physical and mental health problems from a psychological perspective. This will allow her to develop a systemic
formulation about the home. This formulation can then be shared with the Quest MDT and will allow discussion as to how best support the home to improve their approach to care.

The Quest for Quality Psychologist will continue to review how the individual’s relationship with her daughter impacts on the current intervention and the individual.

The Quest for Quality Psychologist noted that at a Review Visit completed on the 2\textsuperscript{nd} February 2015, both the individual and staff at the care home reported that the individual’s mood had improved.

It was also noted that care staff are talking about individuals in a more compassionate and empathetic way. Care staff at the home had started to arrange more activities that include all individuals and staff reported that they felt individuals got a lot of enjoyment from the activities and that some individuals who are usually withdrawn had become involved and were interacting with other individuals.

5 Finance

(a) Financial Case for Change

The Financial Case for Change developed by the CCG clearly sets out:

• Why change is needed
• The size of the financial challenge
• The impact of the challenge on local providers
• The role of CC2H in delivering the change required

National Challenge

The chart below graphically illustrates the size of the challenge facing NHS organisations in coming years.
The Local Challenge

For CCGs, the forecast financial challenge across both Calderdale and Greater Huddersfield is a shortfall in excess of £50m over the next five years.

The funding available to the CCGs will be insufficient to cover the rising demand for health services, the cost of inflation, and any required future investments aimed at improving patient outcomes. For this reason, the CCGs will need to find significant and recurrent QIPP (Quality, Innovation savings in the coming years in excess of £50m in order to close the gap and deliver the 1% surplus required by NHS England.

In addition to the CCG challenge for local Providers there is an ongoing efficiency requirement of at least 4% per annum.

Summary

The report concludes that:

- Significant financial pressures are facing the NHS due in part to increased longevity, improved medical treatments and technology, an above inflation rise in the cost of healthcare and budgets frozen in real terms.

- For Calderdale and Greater Huddersfield CCGs, that pressure equates to a challenge in excess of £50m over five years or a £10m recurrent QIPP requirement.

- The Calderdale and Huddersfield NHS Foundation Trust is also facing pressures that again are due in part to an increasing and ageing population driving ever higher levels of demand, increasing quality standards and a national shortage of suitably qualified staff.

- Provider efficiency savings of at least 4% are needed to keep financial stability

- As such an ‘incremental/evolutionary’ option is financially unsustainable.

The CC2H programme, alongside a hospital change programme are the critical strands of the system transformation needed to deliver a more financially resilient system

(b) QIPP Delivery

Over the last couple of years the CCG has delivered QIPP savings of approximately £4m per annum. These savings have arisen from a number of service improvement initiatives for the 7 clinical priorities that underpin CC2H.
6 Relationships

(a) Joint Work with CMBC

The BCF plan submitted to NHS England in 2014 was closely aligned to the CC2H Programme. The fund is seen as an important enabler in strengthening joint commissioning between the two organisations to ensure delivery of new integrated care models. Both the BCF and CC2H Boards have representation from both the CCG and CMBC. The following is a part of the final BCF Plan submitted:

The Calderdale Story

Hospital when I need it, Home when I want it

Hospitals, GPs, community based services and social care all play a vital role in supporting our residents and we are committed to ensuring all parts of this system are of high quality and as effective as possible. We do know, however, that sometimes people get ‘stuck’ in one part of the system and do not then get the best outcome for their own needs. In particular for some people, such as older people and those with long term conditions, our current system can mean admissions to hospital that could be avoided, admissions to care homes that are not appropriate and unnecessarily extended time in hospital that undermines independence.

This is bad for our residents’ long term health and it’s also an inefficient use of money. The cost of inappropriate care in hospital and in care homes means health and local authority commissioners struggle to fund preventive and community based services, yet these are the services which will help people to remain independent, either at home with their families for as long as possible, or in homes that mix independence with specialist support when it’s needed.

To change this we need to be more proactive in recognising holistic environmental, social and health support needs at an early enough stage to ensure people are in control and can coordinate care and support around themselves as experts of their own condition. We need to support a mind shift which means we stop thinking we are here to provide reactive care in acute, 24 hour settings and focus instead on how we help people to keep themselves healthy, well and in control of their lives. Our Better Care Fund Plan is our opportunity to set out a joint vision and a set of expectations which will guide our joint planning towards truly integrated commissioning of integrated services.

The Calderdale Better Care Fund story is not just about health and social care, it is about the wider services which can support people to live independently at home, the third sector, community groups, housing and civic sector. It is about communities and our society. Our vision for the future for people in Calderdale means that in five years:-

- New supported living housing developments like Extra Care will enable more people to remain in their own home and with their partners in the community, secure in the knowledge that help is on hand when they need it.

- Additional ‘step down’ developments will enable many more people to adjust to managing their disability in a safe setting with care support, out of hospital but en-route
to moving back home or into supported living accommodation (the step down accommodation in Calderdale is referred to as Heatherstones).

- People will be able to benefit from short term reablement and convalescence so that those who just need that extra time to regain their confidence will be able to manage independently at home and we will have helped reduce hospital readmissions and care home admissions.

- Re-ablement services will be jointly designed by health and social care so that they support peoples’ physical, psychological and social needs in an efficient and effective way.

- Provision to meet continuing health and social care needs will be jointly commissioned so that health and social care work together, with residents, to design coordinated care that suits their needs.

- End of life care will be sensitively planned with people and their families and wherever possible the person’s actual place of death will be where they have chosen. Support to the bereaved will be there at the right time.

- Community and social care services will be linked into general practice, which will continue to have a strong coordinating role. These joined up services will refer on to specialist pathways, when these are needed, in a properly planned and coordinated way.

- People will be able to access rapid response services through an integrated multi-agency single point of access (Gateway to Care) either directly, through a health or social care professional, via 111 or via the Ambulance Service. This means short term support can be provided within an hour, which will help reduce ambulance conveyances to hospital significantly with the consequent impact on reducing emergency admissions to hospital.

- The transition for individuals between children’s and adult services will be seamless and be planned from the earliest point.

- Social care will continue to be provided for people with moderate needs, reinforcing our conviction that early intervention and prevention is critical if we are going to maintain people’s health and wellbeing for as long as possible.

- The financial burden on families will be reduced as a consequence of fewer people being placed in long term residential care.

- The care home sector will have been developed to support people with more complex needs and those with residential care needs only will be supported in extra care.

- We will have invested in community based, wrap around support. Many more people will have personal health and social care budgets for their long term condition and social care needs which will be enhanced by assistive technology in their own home.

- Integrated approaches to assessment and record keeping will mean information is only collected once, will be kept securely and will be available to those providing care and support when it is needed.
• Services provided by the voluntary and community sectors will have a greater prominence as part of holistic care and supporting our duties of wellbeing and wellness.

• Through our Better Care Fund Programme we will have implemented the operating model illustrated below by investing in six evidence-based schemes which shall combine effect to reduced readmissions and admissions to hospital and admissions to care homes: potentially to the levels suggested from the integrated care evidence base by 20% for hospital emergency admissions and 40% for care home admissions. As a consequence acute beds will close.

Our Better Care Fund Schemes will be the mechanism by which we transform the system and release investment from acute, reactive care to proactive, community based support. The operating model for BCF has a strong alignment with the large system change - Closer to Home model. The key elements of the Closer to Home system model we are implementing across Calderdale are:-

1. Information and advice, supported self-managed care and primary prevention
2. Early intervention
3. Multi-disciplinary working
4. Intermediate tier/urgent response
5. Specialist support
6. Supported discharge

Put simply:

• We will have moved from reactive to proactive care and support.
• We will have prevented avoidable deterioration of people’s health and wellbeing and met their care needs at the right time and in the right place.
• Support will be holistic: looking after people’s physical, psychological and social needs.

‘Everyone has a bed – and it’s at home’.

Seven Strategic Objectives underpinned by six supporting schemes, have been designed to deliver our agreed vision and the aims of the Better Care Fund:

1. Ensuring that people have a positive experience of care and enhancing quality of life for people with care and support needs. (Integrated Single Point of Access (Gateway to Care); Weekend Single Point of Access to Intermediate Care (Gateway to Care); Self-Care Assistive Technology for Independent Living; Self-Care Hub including LD Hub)

2. Enhancing quality of life for people with care and support needs as a result of long term conditions. (Frailty; Targeted Prevention for Dementia; Carers Offer; Community Equipment (including the Loan Store); Home Improvement Agency; Handyperson Prevention Scheme; Disabled Facilities Grants for Adaptations; Preventative Home Support (CQC Registered Home Care)

3. Ensuring that people have a positive experience of care and support through improving access to primary care services and Improving people’s experience of integrated care. (Case Management: Allocated Lead Professional Worker for 75+ in General Practice; Case Management: Social Work Assessments; Demographic Growth Pressures for
Personal Budgets; Care Act (2014) new statutory duties Implementation and Review Costs)

4. Delaying and reducing the need for care and support and helping people to recover from episodes of ill health or following injury. (Residential Transitional Beds; Intermediate Care Community Beds; Intermediate Supported Care (Heatherstones Reablement Unit); Intermediate Care Social Work; Reablement & Coordinated Support at Home; Community Support for Stroke Recovery)

5. Delaying and reducing the need for care and support through reducing delayed transfers of care and reducing the number of permanent admission to residential and nursing care homes. (Out of Hours Emergency Duty Urgent Assessment; A&E Physician; Complex Discharge Coordination; Early Supported Discharge for Stroke)

6. Enhancing quality of life for people with care and support needs at end of life. And

7. Treating and caring for people in a safe environment and protecting them from avoidable harm and safeguarding adults who circumstances make them vulnerable and protecting from avoidable harm. (End of Life Social Work; Home Hospice for End of Life; Hospice; Quality In Care Homes; ASC Capital - Telecare (Quest for Quality Scheme)

(b) Work with the Third Sector

We have worked with the third sector in Calderdale to ensure they have the capacity and capability needed to deliver their critical role in implementing CC2H. The work has focused on; investment to enable them to develop into real players in the local market and ensuring an on-going dialogue with the CCG so that there is clarity on our commissioning intention. There are a number of strands to this work:

1. Voluntary Action Calderdale (VAC)
   • Provide strategic and structural support for the VCS (Voluntary and Community Sector) through Health Connections initiative – funded via a grant from the CCG.

2. Organisational Development
   • Engagement with the sector on Care Closer to Home (including a specific CC2H event on 1 April – 121 delegates, primarily third sector – see key piece of feedback relating to third sector knowledge about CC2H).
   • Support development of proposals from the sector; particular emphasis on partnerships
   • Support provided to develop approach to monitoring and evaluation
   • Bringing together the work of VAC and North Bank Forum in order to reach the maximum number of third sector providers.

3. Networks
   • CCG representation at various forums such as the Disability Partnership, Staying Well and Mental Health Matters

42 Care Closer to Home Evidence Pack
4. Safeguarding

- Provision of safeguarding training
- Increase coverage of training across the sector
- Showing the push of safeguarding is working
- Attend Safeguarding Adults Board & the communication/training sub groups of the Children’s Safeguarding Board

5. Grants and Bursaries

- Allocation of additional funding Grants (totalling £2.1m in 14/15 and £0.5m) to develop initiatives to support CC2H (see examples that follow)
- Grants were for 12, 18 and 24 months
- Grants awarded to range of providers (see overview of 14/15 investment in table below)


- GP Co Commissioning
- Introduction of Engagement Champion training for people with Learning Difficulties
- Refresher training has taken place to enable Engagement Champions to renew their certificates

Table 1 - Overview of investments made in 2014/15

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Scheme</th>
<th>Progress</th>
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<tbody>
<tr>
<td>Healthy Minds</td>
<td>Mental health support and recovery</td>
<td>Developing support groups across Calderdale</td>
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<tr>
<td></td>
<td></td>
<td>Recovery courses (Well Aware) have been completed</td>
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<td></td>
<td></td>
<td>Pilot workshops focussing on a range of themes introduced</td>
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<td></td>
<td></td>
<td>Developed monitoring and evaluation systems</td>
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<td></td>
<td></td>
<td>Developing evidence base to demonstrate impact of service on individuals and wider</td>
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<tr>
<td>Noah's Ark Centre</td>
<td>Counselling</td>
<td>Enhance counselling capacity for individuals, children and families</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Developing monitoring and evaluation system to capture the benefits on individuals, family, friends and wider system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop capability to explore new service areas across Calderdale in partnership with others and develop new revenue streams</td>
</tr>
<tr>
<td>Basement Project</td>
<td>Community Detoxification</td>
<td>Introduce client focused support and social networks to enhance recovery from substance misuse</td>
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<td></td>
<td>Reduce the dependence on out of area placements</td>
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<td></td>
<td></td>
<td>Provide greater choice for individuals and healthcare professionals</td>
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<td></td>
<td></td>
<td>Create sustainable legacy of volunteers</td>
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<tr>
<td>Basement Project</td>
<td>Mutual Aid Facilitation</td>
<td>Increase awareness to substance misuse specialists and generic workers across health and social care settings of Mutual Aid. Provide Mutual Aid Awareness to clients within the treatment system and those entering the system. Increasing the numbers of people accessing Mutual Aid Groups in Calderdale through the support of trained facilitators.</td>
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<tr>
<td>Calderdale DART</td>
<td>Personal Planning</td>
<td>Assist clients with elements of forward life planning and work towards their recovery and regaining their independence. Develop monitoring and evaluation system to demonstrate impact.</td>
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<tr>
<td>Women Centre</td>
<td>Women’s Wellbeing</td>
<td>Develop referral and signposting pathways to facilitate the integration of wellbeing provision for women and girls with complex needs. Build an evidence base of the effectiveness of the approach, impact on wider health and social care system and social return on investment e.g. social impact tracker database, Outcomes Star framework.</td>
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<tr>
<td>Home Start</td>
<td>Support for families with a disabled child</td>
<td>Enhance the capability of HomeStart to provide volunteer support for families that experience parental mental illness. Support the joining up and access to services for families (both adults and children). Enhance the impact of volunteer support on the quality of life of both the family receiving support by increasing social networks, a sense of self-efficacy and providing opportunities for personal development.</td>
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<tr>
<td>Citizens Advice Bureau - Calderdale</td>
<td>Welfare reform programme</td>
<td>Pre-screen ATOS assessment. Develop capability of health teams understanding and responsiveness to the challenges of the sick and disabled with regards to the implications of the Welfare Reform Programme. Develop integrated approach across Calderdale to respond to the welfare needs of the sick and disabled. CAB will produce a clear, accessible ‘self-help’ pack (in print and electronic format) to be offered to all individuals wishing to challenge an ATOS assessment.</td>
</tr>
<tr>
<td>Forget Me Not</td>
<td>Children’s and families support</td>
<td>24-7 family-led care at home or in Russell House; widen access to high quality palliative and end of life care and respite; provide choice where they receive their care and choice of place to die; launch of a “smart” communications campaign which targets professionals, families, and communities across Calderdale, with coherent messaging about our service, enabling choice and improving access. Care - introduction of a specialist palliative care medical team and advanced skills in our nursing team. It is envisaged that as well as service delivery, these professionals will act as a resource to the local health economy, facilitating local, multi-professional learning and development opportunities in the field of palliative and end of life care. Patient centred - pilot of a specialist mobile bereavement service which will be available to the growing number of</td>
</tr>
<tr>
<td>Community Transport</td>
<td>Transport</td>
<td>Calderdale families being served.</td>
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</tbody>
</table>
| Food For Life Partnership | FFLP in Calderdale | Independence – provide 5 day week service to support access to services  
Develop monitoring and evaluation system  
Develop evidence base to demonstrate impact  
Capability to respond to new revenue streams e.g. personalised budgets  
Provision and access to knowledge and skills to make good food choices for children and young people, their families, school staff and the wider community  
Extend programme to Early Years settings; focus on ensuring registration for Free School Meals eligibility is enabled & eligible children are taking a nutritious, balanced FFLP meals  
Sustainable - build resilience locally through embedding autonomy in the Calderdale Cook’s Network and the new Midday Supervisor Network  
Integration - introduction of our approach in care homes and work with older people in the community through schools, linked to our Age UK partnership developing intergenerational cooking skills supporting greater independence and supporting care home caterers |
| CHIBs | Later Life Planning and Bereavement Support | Work in partnership with AGE UK and other local groups including BME communities  
Introduce a holistic service to older people aged 50+ who have been recently bereaved or bereaved for longer periods but are still grieving and who have not previously sought assistance  
Use AUCKs Planning for Later Life toolkit Provide to provide advice, information and practical support  
Initiate early preventative support for those progressing normally through the initial of grief stages with more targeted support for those who have suffered additional difficulty with the normal grieving process  
Befriending for those needing additional or emotional support through open referral to AUCK and CHIBS  
Aid individuals to return to normality, relieve anxiety and stress  
Befrienders will encourage increased independence, activities and sensible eating |
| X-Pert Health | Diabetes Education in BME communities | Work in partnership with the Women's Activity Centre (WAC)  
Engage and deliver a NICE compliant diabetes self-management education programme to people (both men and women) with diabetes who have been referred to the project by local GPs  
Develop community peer educators  
Train the educators and deliver 30 single-sex programmes (5 programmes per half-term) to 500 participants. |
(c) **Dialogue with Other Organisations**

There are a number of important local forums which we have used to ensure that local transactional and transformation work is aligned to CC2H delivery. Presentations and written information has been shared to ensure the need for the alignment is clearly understood. Evidence of this can be found in the minutes of the relevant minutes for:

- Health & Well-being Board
- BCF Board
- BCF Operational Group
- Adult Overview and Scrutiny Committee
- Children’s Overview and Scrutiny Committee
- Joint Kirklees & Calderdale Overview and Scrutiny Committee
- CC2H Board
- CC2H Operational Group
- Planned Care Board
- Urgent Care Board
- System Resilience Group
- Vanguard Implementation Team
- Vanguard Upper Valley Steering Group
- CHFT Community (CC2H) Contract Meeting
- CC2H/Third Sector Steering Group

Both CHFT and CMBC have committed their organisations to delivery of CC2H, through the inclusion of the CC2H specification within their contracts for 2015/16. The original Outline Business Case produced by CHFT setting out their aspirations for community services is being used, along with national evidence and good practice, to support the development of specific elements of the CC2H model. Models developed by SWYPFT for strengthening community mental health services are also being used in a similar way. Evidence can be found in the minutes of CC2H Operational Group and CC2H Board.
The Vanguard Opportunity

Calderdale’s application to receive Vanguard status was set in the context of delivery of CC2H, and a significant number of applications from other sites across the country. Of the 300+ applications, 29 were approved – Calderdale being one. This was seen as validation of the strategic direction and model for CC2H.

The Vanguard partnership is made up of:

- Calderdale CCG (sponsoring organisation)
- Pennine GP Alliance
- CHFT
- CMBC
- SWYPFT
- Locala CIC
- SWYPFT
- VAC

Vanguard provides Calderdale with a unique opportunity to use this partnership to accelerate CC2H implementation though the testing out implementation in one part of Calderdale, before learning is quickly spread to the whole of the Calderdale. The Vanguard work is focused on the Upper Valley initially, testing our CC2H across 3 patient cohorts; those who are frail, those with one or more Long Term Conditions and children with complex needs. The slide below sets out this approach graphically.

**What does Vanguard add?**

- Opportunity to test out the 4 CC2H functions with 3 particular patient cohorts and roll-out learning to the whole of Calderdale

- Prevention and Healthy Lifestyles
- Supported Self-managed Care
- Integrated H&SC first point of access
- Integrated Community Model

- 3 Cohorts: LTCs, Frailty, Children with Complex Needs
- Start with Upper Valley, spread to all 3 localities
- Accelerant for CC2H
- Experiment and learn about organisational, contracting and financial forms
- Business case for funding full CC2H
In terms of future models, it enables the partnership to explore how we implement CC2H in terms of new provider models and ways of commissioning as described below:
7 System Metrics

The CCG has identified a number of key metrics in order to understand the need for system change and the impact CC2H is having on utilisation and quality. The following indicators have been included in this pack:

Current Issues:

- Demographic changes
- Outcomes (premature years of life lost)
- Health inequalities

Impact of CC2H on Utilisation of Healthcare:

- Emergency admissions
- Improvement in community services

(a) Demographic change

![Graph showing population growth from 2011 to 2023](source_image)

*Source: Office for National Statistics 2012 based population projections*

- Population of Calderdale is 206,400
- Increase of 14,000 since the 2001 Census
- Latest district-level population projections are based on 2012 population estimates
- Assume that recent trends in migration, fertility and mortality will continue
- Projections indicate a period of relatively rapid population growth over the coming years
- Total district population projected to grow by around 13,300 between 2012 and 2022 (a 6.5% increase)

*Data source: Calderdale JSNA*
The projected population of Calderdale is summarised in the table above:

- The largest growth is expected to occur in the older age groups
- 30% increase in those aged 85 plus by 2022
- 19% increase in those aged 65 to 74
- 34% increase in those aged 75 to 84
- There is also expected to be a substantial increase in children

Data source: Calderdale JSNA

(b) Life expectancy

- Charts above illustrate the increase in life expectancy for males and females in Calderdale compared to the average for England
- Charts illustrate the increase in life expectancy for males and females between 2000 and 2013
- Charts illustrate the gap between Calderdale and the national average for life expectancy
- Life expectancy for males in Calderdale – 78 years; England – 79.4
- Life expectancy for females in Calderdale – 82.1 years; England – 83.1

Data source: http://www.phoutcomes.info/public-health-outcomes-framework
(c) Premature Death

- Chart illustrates the plans Calderdale submitted to NHSE to reduce the rate of potential years of life lost (PYLL)
- Ambition is to reduce PYLL by 15% over 5 years
- Year 1 results positive
- Challenge – to continue to drive improvement in key disease areas such as CHD, stroke, pneumonia and amenable cancers


(d) Health Inequalities

The charts below show life expectancy for men and women in this local authority for 2011-2013. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life expectancy gap for men: 9.3 years
Life expectancy gap for women: 9.2 years
• The health of people in Calderdale is varied compared with the England average
• Deprivation in Calderdale is higher than the national average
• 20.1% (8,200) of children in Calderdale live in poverty
• Life expectancy for both men and women in Calderdale is lower than the England average
• Life expectancy is 9.3 years lower for men and 9.2 years lower for women in the most deprived areas of Calderdale than in the least deprived areas


(e) **Utilisation – Emergency Hospital Admissions**

- Weekly volume of emergency admissions during last 3 years at the local acute provider (CHFT)
- Overall 5.9% reduction at CHFT during this period
- Period – 1st April 2012 to 29th March 2015
- Data source - SITREP
• Run charts illustrates the monthly volume of emergency admissions for Calderdale patients to CHFT
• Volume of emergency admissions in 2014/15 reduced by 4.9% compared to 2013/14
• Data source - SUS

• When developing the 5 year strategy for Calderdale, benchmarking data ranked Calderdale in the upper quintile when its rate of activity for non-elective admissions was compared to all CCGs in England
• Data source: NHSE Commissioning for Value atlas

• Chart above compares the rate of admission for conditions not requiring admissions (CNRA) across all CCGs in England
• Calderdale is ranked in the upper quintile and is above the national average

• Chart above compares the rate of admission for ambulatory care conditions (ACS) across all CCGs in England
• Calderdale is ranked in the upper quintile and is above the national average
(f) Utilisation – Community Services

Data indicates:

- An increase in the utilisation of community nursing services during 14/15 compared to the year previously (2013/14)
- Increase in the number of patients with care plan over the same period
Data indicates:

- Volume of community acquired pressures ulcers in 14/15 lower than 13/14
- Data suggests a safer environment due to improvements in community acquired pressure ulcers and pressure ulcer recovery.
- The percentage of leg ulcers healed in 14/15 is higher than 13/14
- Suggests more effective in treatment

Source: CHFT Community Dashboard
8 Enablers

(a) Workforce Strategy

The Strategy is in development based on the following pieces of work:

- Support the development and delivery of a workforce model to capture baseline workforce information in relation to numbers and skills for all partners.
- Project forward activity and anticipated workforce changes under status quo and for three specific currently critical scenarios: General Practice Workforce changes; Movement of services from Hospital to Community; Social Care changes
- For each of these forward projections consider: the future patient demand for service; the capacity and capability needed in integrated teams to deliver the demand (rather than more of the same); the future opportunities offered by further integrating the workforce and; the impact of maximising the utilisation of technology.
- Define the mechanism whereby this work informs the commissioning of future transformation programmes, including CC2H, to support delivery of the new workforce.

(b) Information Technology & Digitisation Strategy

The CCG is developing an Information Technology and Digitisation Strategy to support the CC2H programme and delivery of the Vanguard bid. IT systems and information flows are key enablers to the transformation of community services. The key areas of the strategy are:

- Integrating information across health and social care.
- Unified Communications
- Mobile Working
- Self-Care and Patient owned record

In order to support the development and implementation of the strategy significant investment will be required to enable the strategy to be delivered. The CCG is currently scoping the potential cost and delivery timeline of the IT strategy for submission as part of our Vanguard value proposition.”