Delivering Care Closer to Home in Calderdale - Vanguard Value Proposition – 2016/17

Draft 5.0
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**Appendices:**

Appendix A: Bain Value Assessments: Hypothesis Tree, Prevention, Self-Care, First Point of Contact, Integrated Community Model

Appendix B: Detailed financial modelling on investment and Return on investment

Appendix C: Risk Log 2016/17

Appendix D: 2016/17 Milestones
1.0 Introduction – the context for our major transformation

The Five year Strategic Plan for Calderdale CCG set out the focus of a 5 year change programme which will centralise key services to improve outcomes for patients and continue the shift of services and resources from unplanned hospital care to integrated health and social care - delivered in community and primary care settings. Our aim is to use our Vanguard alliance to deliver this new multi-sector model of community services, and use Vanguard funding to pump-prime change

Commissioners across the acute footprint have developed proposals for future Community and Hospital services. The proposals seek to transform the organisation of care and the infrastructure by which it is delivered and constitute major change under section 244 on the NHS Act 2006.

There are two interlinked pieces of work:

- Calderdale Care Closer to Home Programme
- Hospital Services Programme with Greater Huddersfield CCG

These proposals will be implemented in three inter-related phases over the next five years:

- **Phase 1** - Strengthen existing community services in line with the Five Year Forward View
- **Phase 2** - Further enhance community services – by creating a new care model.
- **Phase 3** - Delivering the hospital changes needed to make our system safe and sustainable

In February 2016 Calderdale CCG with its commissioning partners in Greater Huddersfield CCG is likely to embark on a formal public consultation for both the Right Care Hospital Change Programme and the Calderdale Care Closer to Home proposals.

This strategic context is hugely important for our Vanguard in that is sets a clear timeline for change which will influence the work we do, the benefits we will achieve and when we will achieve them. Vanguard financial modelling sets out a case for pump-priming transformation during 2016/17 and 2017/18. We then start to generate net system savings in the first quarter of 2018/19, with a full ROI by Q2 of year 5 and a net return of £4m by the end of year 5. This context is consistent with the One-Year Operational Plan being developed by the CCG for 2016/17.

We believe we are one of a very small number of Vanguard sites nationally who are embarking on such radical change as part of a Vanguard programme. We believe there will be a high degree of replicability and learning from the innovative work done in Calderdale.

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Calderdale Vanguard – Care Closer to Home in Calderdale
Value Proposition 2016/17
2. The Calderdale Vanguard – why we are unique

The Calderdale Vanguard is underpinned by a strong ethos of integrated partnership working. Partners within Calderdale have been engaged in a system reform agenda for 3 years.

This programme sits within a backdrop of extensive public and stakeholder engagement. The system has started the change programme, but believes that its Vanguard activities provide an accelerant which will deliver benefit at greater pace and scale.

Our Vanguard Partners are:
- Calderdale Pennine GP Alliance
- Calderdale CCG
- Calderdale Metropolitan Borough Council
- Calderdale and Huddersfield Foundation Trust
- Locala CIC
- South West Yorkshire Partnership Foundation Trust
- The Third Sector (through Voluntary Action Calderdale)

Our aims are to:

- Develop a new care model care model that is; person-centred, personalised, coordinated, empowering - created in partnership with carers, citizens and communities and supported by volunteering and social action.
- Ensure that there is a high degree of replicability in our work, which provides a benefit much wider than Calderdale itself.
- Transform the way our system currently operates so there is a greater focus on the prevention of ill health (physical and mental health), resulting in reductions in premature death and dependency, and improvement in health, health inequalities and wellbeing.
- Shift the balance from avoidable hospital admissions to integrated health, social care and third sector models delivered in community and primary care settings.
- Ensure the work is aligned to the four core values of the New Care Models (NCM) Programme; clinical engagement, patient involvement, local ownership, and national support and delivers a high degree of replicability for other systems.
- Maximise learning from other Vanguard sites and other countries; both about the way in which we can transform care, but also by developing new approaches to provision, commissioning and payment

The agreements made on the back of the submission of this Value Proposition will be set within the context of the formal Partnership Agreement agreed between Calderdale CCG and NHSE and then reiterated within the Partnership agreement across the seven equal Partners of the Calderdale Vanguard and the CCG.
3. **Our Challenge – why we need to make change**

Calderdale is made up of both urban and rural areas with a number of distinct towns and communities. Understanding Calderdale and its people is an important step in designing future models of care and in developing this Value Proposition. One of these communities (the Upper Calder Valley) is the focus for initial work in Calderdale, with a view to rolling out learning at pace across the rest of Calderdale.

Our system has recognised that significant change is essential. In developing this Proposition, we recognise the pivotal role that our communities play – both in the development of the plan and its successful delivery. As a system we have made significant efforts to engage with our population and our ambition will see this dialogue continue as we work with local communities across Calderdale to generate a dynamic conversation that will ultimately drive the changes required.

Over the coming years we know that the size of the population in Calderdale (217,000) is set to increase. As well as the large increase in the number of people aged over 65 years and children. There will also be greater, and sometimes more complex’ variations in the range of needs expressed in the different communities and ethnic groups that make up Calderdale.

We believe that General Practice is at the heart of a wider system of integrated out-of-hospital care. This will see us working on a more systematic and collaborative basis with; our GP Alliance, community health and mental health services, social care, third sector organisations, community pharmacists and other partners. With plans to shift resources from acute care to out-of-hospital care, we need to understand the flows into and out of General Practice, and how Community Services ‘wrap around’ General Practice. As part of our commitment to develop General Practice we will work with local partners to develop and implement a local GP Career Start scheme for newly or recently qualified GPs.

We have worked with the NCM Team and Bain Consulting to develop a view of the ‘value’ to be generated from our Vanguard in terms of; outcomes, people’s
experience of services, quality and efficiency. A high level summary is set out in section 5.0.

Detailed value assessments for each of the four elements core elements of our model are included within this Value Proposition, and work will continue with the NCM team and Bain Consulting to further develop the work. In summary our Vanguard seeks to address the following challenges:

(a) Outcomes Challenge

- Equitable and easy access to services is challenged by geography and demographics.
- Deprivation is higher than the national average and about 20.1% (8,200) children live in poverty.
- Life expectancy for both men and women 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.
- Major improvements to be made in key disease groups such as respiratory disease, cardiovascular disease and cancer.
- In Year 6, 18.9% (457) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was worse than the average for England.
- In 2012, 26.7% of adults are classified as obese. The rate of alcohol related harm hospital stays was worse than the average for England.
- The rate of self-harm hospital stays was 222.5. This represents 459 stays per year.
- The rate of smoking related deaths was 362 worse than the average for England. This represents 390 deaths per year.
- We are seeing, and will continue to see competing pressures due to; growing numbers of children and older people with increasing needs, whilst also meeting increasing external standards,

(b) Experience Challenge

Through extensive engagement local people told us they want to see:

- As many services as possible should be close to home in local settings such as a GP practice with improved waiting and appointment times
- Services that are coordinated and wrap around all the persons needs involving a range of partners and agencies
- The right staff. With the right skills that are caring and competent and treat people with dignity and respect
- Services that are properly planned and that are appropriately staffed and resourced, have the right equipment and maintain quality
- More information available about health conditions and more communication about what is available to ensure people can make choices and have support to self-manage health care
• Services that everyone can access including clean comfortable buildings aimed at the right target audience, appropriate information and staff that represent the community they serve.
• Any barriers to; travel, transport and parking, addressed with a clear plan which takes account of diversity and locality
• Improved communication between all agencies involved in a person’s care and treatment including better communication with young people
• Services that are responsive and flexible - particularly in an urgent care situation
• Reduce delays in getting the care and treatment required and improving waiting times
• Technology that people can use to reduce travel times and unnecessary journeys – particularly for young people
• Support for mental health across all services

(c) Quality Challenge

• We have workforce issues relating to: an ageing GP workforce, shortage of middle grade doctors in A&E, and national recruitment issues across a range of specialties.
• We have issues in delivering the capacity and capability in; community beds, re-enablement, home-care and care homes that meets current and future demand.
• There are significant workforce challenges and the need to change culture and ways of working.

We know that in Calderdale too many people:

• Dying prematurely, and that this is worst in areas of Calderdale with high deprivation
• Are dying in our hospitals. The hospital Standardised Mortality Rate is higher than the England average
• Are admitted to residential or nursing home care
• Stay longer in hospital than is clinically necessary
• Are admitted to hospital with a condition which is considered nationally to be treatable or preventable within the community
• Are readmitted within 30 days of discharge from hospital
• Wait over 5 weeks for diagnostic services.
• Report they do not have a good experience when they attend A&E
• Leave A&E without having been seen.

(d) Financial Challenge

• There is a requirement to make long-term financial savings which make the system viable and sustainable.
• Our system is over-reliant on emergency unplanned hospital activity compared to the rest of the country with high levels of ‘avoidable’ admissions
• By 2021/22 the financial challenge facing the area of Calderdale and Greater Huddersfield (health sector only) amounts to £281m.

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Calderdale Vanguard – Care Closer to Home in Calderdale Value Proposition 2016/17
• There are significant social care financial challenges which impact both on the delivery of front-line care and investment in prevention & healthy lifestyle, and supported self-care interventions.

• There is a potential to maximise community estate community buildings/libraries to support better community offers and delivery a better VFM.
4.0 The New Care Model – our solution

Set within the strategic context and challenges set out above we have developed a model – Care Closer to Home. This model will deliver the aims of our Vanguard programme by fundamentally improving: outcomes, people’s experience of services, the quality of care received and deliver efficiencies at pace and scale.

Through significant engagement with our population and stakeholders we have developed the Care Closer to Home model, which is described in an animation (plus a number of individual case studies built from real Calderdale patient stories). See link: http://www.calderdaleccg.nhs.uk/your-health/care-closer-to-home/

There are four key functions/programmes within the care model, and a number of key enablers which combine to create the entirety of the model. This forms the basis for our Value Proposition. The model therefore is not just about transforming care, but also about transforming; our approach to population health, current systems of provision, commissioning and payment.

A key element of the Vanguard work will be to accelerate implementation of new care model in three specific cohorts of patients. This will provide us with the ability to measure change and replicability. The three cohorts are:

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

2. People with a Long Term Condition(s)
   - Prevention, early intervention and self-care for those at risk
   - Integrated working (MDT/care planning) for those with complex needs
3. Children with complex health and care needs and their families

A detailed overview of the scope of the work for these three cohorts is set out in our 5-Year Value Proposition submitted and agreed in 2015.

This model has been agreed with New Care Models Team as part of sign-off of the original 5-Year Value Proposition. The ‘value assessments’ for each of the four key elements of the model are described in the following section. We believe there is a high degree of replicability and learning for other systems and Vanguard.

The four key elements of the care model are at different stages of development and delivery:

(a) Prevention and Healthy Lifestyle Programme

What’s the Aim?

To ensure we have an approach to prevention that is:

- System owned, underpinned by the Marmot principle of “proportionate universalism”
- Pulls together physical and mental health prevention initiatives.
- Informs all commissioning decisions across the local health and social care economy
- Focuses on smoking, alcohol misuse, obesity and physical inactivity
- Inclusive of breadth of ill-health prevention at the population level

What has it already achieved?

The programme is currently led by the Public Health Team in Calderdale MBC and is built on work already undertaken by CMBC. The interventions undertaken to date are included below and are the result of over £3.0m of investment by CMBC over the past two years:

- Implementing ‘affordable warmth’ across Calderdale
- Increasing physical activity levels across Calderdale linked to the insight and development work undertaken with IBM in 2015 to implement the vision of – Active Borough Calderdale
- Home modifications in identified vulnerable service user
- Behaviour change and health improvement programmes linked to physical activity, weight management, alcohol harm reduction/prevention and tobacco control/smoking cessation
- Resource and expertise provided via the Council’s Better Living Team to train and support the Health Trainers recruited as part of Vanguard
- Investment in database and technology development to support data collection and monitoring of relevant interventions
- Investment in NHS Health Checks which will support the Health Trainer delivery model as part of Vanguard
- School based healthy eating and improving the school food environment programmes and Public Health in Schools Co-ordinator

From Vanguard funding of £200k allocated in Q4 2015/16 the following additional actions have taken place this quarter.

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Milestone</th>
<th>Start Date</th>
<th>Lead</th>
<th>Progress</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduce Affordable Warmth Initiatives (linked to frail elderly)</td>
<td>Starts Q4 (Year 0)</td>
<td>Dean Wallace - Public Health Consultant</td>
<td>A housing health impact assessment has nearly been completed. We would look to progress links between health workers (e.g. District Nurses and Health Visitors) to support residents in accessing support in this area from the central council service. This can be progressed initially in the Upper Valley as a pilot scheme. The mechanism for the project can be in place by 31st March 2016. The project delivery would be projected to start in pilot form by the end of Q1 year 1.</td>
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<tr>
<td>2</td>
<td>Introduce Home Modification Interventions (linked to frail elderly)</td>
<td>Starts Q4 (Year 0)</td>
<td>Dean Wallace - Public Health Consultant</td>
<td>Work is underway to align the home modification work with the affordable warmth programme to maximise potential outcomes, using the Vanguard Programme to pull the system together with a focus on the frail elderly population. Mechanism for delivery in place by 31st March 2016, pilot project in place by end of Q1 year 1.</td>
<td></td>
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<tr>
<td>3</td>
<td>Increase physical activity in the local population – developing local walking and swimming initiatives</td>
<td>Starts Q2 (Year 1)</td>
<td>Dean Wallace - Public Health Consultant</td>
<td>Developing a system wide approach to increasing physical activity across the population of Calderdale. The additional Vanguard element will support the acceleration of this work with a specific focus on Care Closer to Home priority population groups. A steering group for the project is in place which will link closely with the Vanguard Implementation team to take this work forward as planned.</td>
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<td>4</td>
<td>Targeted wellness services for children and young people</td>
<td>Starts Q4 (Year 0)</td>
<td>Dean Wallace - Public Health Consultant</td>
<td>Prevention oversight group to be established to determine most appropriate local approach given resources available. Establish delivery route and project plan by end of Q1 year 1. Implementation to begin Q2 year 1.</td>
<td></td>
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<tr>
<td>5</td>
<td>Workplace health improvement programme – including nutrition</td>
<td>Starts Q1 (Year 1)</td>
<td>Dean Wallace - Public Health Consultant</td>
<td>Progressing as part of the wider Better Living Movement in Calderdale. Steering Group established, which will link to the Vanguard Implementation Team. Pilot workplace sites to be engaged by end of Q1 year 1.</td>
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<tr>
<td>6</td>
<td>Develop comprehensive volunteering (Youth)</td>
<td>Starts Q2 (Year 1)</td>
<td>Dean Wallace - Public Health Consultant</td>
<td>Following a successful local pilot a roll-out of the Youth Health Champion volunteering model will be implemented in all secondary schools in Calderdale as part of the Vanguard, this process will be underway by Q2 year 1.</td>
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<td>7</td>
<td>Health trainers undertake initiatives with patients at high risk of developing LTC</td>
<td>Recruitment starts Q4 (Year 0)</td>
<td>Dean Wallace - Public Health Consultant</td>
<td>Beginning work on potential delivery models and recruitment processes, to support primary prevention in the community across Calderdale. Clear position on recruitment and service model and job descriptions and person specifications to be agreed by end of Q4 year 0. Recruitment to be completed by end of Q3 year 1.</td>
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**What Value does it add to the new care model?**

Full value assessments for this programme related to outcomes, experience and quality are included as Appendix A. The clinical assessment is included below as an illustration. A draft set of milestones for 16/17 is included as Appendix D. We believe there is a high degree of replicability in this work for other Vanguards and systems.
We recognise that given the nature of prevention work the major benefits associated with this programme, for example improvements in life expectancy and reductions in health inequalities would not materialise over the life of our Vanguard. However, we have developed a number of indicators and targets which show the value of the interventions for 2016/17. The value of these interventions will grow year-on-year and will continue to be described in future Value Propositions. This work provides us with starting point for a radical upgrade in prevention interventions as outlines in the FYFV.

Further savings are expected in future years based on the natural lag in returning benefits for preventative interventions. Whilst we cannot currently profile further savings across the 5 years, the national evidence base indicates that in general the return on investment for such schemes is in order of every £1 invested providing the system with a £5 saving within 3-5 years. On this basis we believe that the work has significant value.

The programme finances will be:

Five Years – 2017/18 – 2020/21: Costs £1.7m/£1.1m ROI/£0 local investment*
Two years - 2016/17-1018/19: Vanguard Request to pump-prime model £800k/£0 ROI/£0 local investment*

(*CMBC and the CCG have made substantial investment in prevention work over the last 2 years – however we are unable to confirm the recurrent investment position at this point)
(b) Supported Self-Managed Care:

**What’s the Aim?**

- Look at self-care across the life-course, with the challenge of taking a population perspective as well as a service user/patient/carer perspective.
- Ensure services are; accessible, targeted and multi-media
- Ensure all providers have a role
- Ensure approaches to self-care integrate physical and mental health and well-being.

**What has it already achieved?**

- Commissioning of a self-help website ‘My Stroke Guide’ where people can find out information about their condition provides a forum for peer support and ways of contacting therapists or others supporting their condition/
- Service commissioned for dementia includes the CRISP training for carers to provide education about dementia and how to support people, looking at coping skills as well as peer support.
- Commissioning an innovative Staying Well programme that brought together social prescribing, and neighbourhood hubs to provide support

From Vanguard funding of £50k allocated in Q4 2015/16 the following actions have taken place this quarter.

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**Project: Supported Self-Managed Care – Develop and Implement Strategy**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Milestones</th>
<th>Start Date</th>
<th>Lead</th>
<th>Progress</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop and implement an integrated strategy for new models of self-care</td>
<td>Starts Q4 (Year 0)</td>
<td>Caron Walker – Public Health Consultant</td>
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<td>2</td>
<td>Assess and identify the most effective self-management and peer support interventions</td>
<td>Starts Q4 (Year 0)</td>
<td>Caron Walker – Public Health Consultant</td>
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<td>3</td>
<td>Take a phased approach to identify which long-term conditions will be prioritised for interventions based on local epidemiological data</td>
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<td>4</td>
<td>Develop and implement training programmes for people with a range of long-term conditions</td>
<td>Starts Q1 (Year 1)</td>
<td>Caron Walker – Public Health Consultant</td>
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<td>5</td>
<td>Scope and develop a range of providers, including the VCS</td>
<td>Starts Q2 (Year 1)</td>
<td>Caron Walker – Public Health Consultant</td>
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<td>6</td>
<td>Support the development of community based peer support groups</td>
<td>Starts Q2 (Year 1)</td>
<td>Caron Walker – Public Health Consultant</td>
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<td>7</td>
<td>Identify suitable, accessible venues in the community for training programmes and peer support groups</td>
<td>Starts Q2 (Year 1)</td>
<td>Caron Walker – Public Health Consultant</td>
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<td>8</td>
<td>Select and implement technology solutions to support self-managed care</td>
<td>Starts Q2 (Year 1)</td>
<td>Caron Walker – Public Health Consultant</td>
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<td>9</td>
<td>Fully implement new model</td>
<td>Starts Q2 (Year 1)</td>
<td>Caron Walker – Public Health Consultant</td>
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(https://www.myhealthtools.uk) a digital platform developed by Calderdale’s public health team in partnership with the University of Manchester, that supports people to self-manage their long-term conditions, with links and further information on self-management, this will be ready by the end of Q4, Year 0.
What Value does it add to the new care model?

Full value assessments for this programme related to outcomes, experience and quality are included as Appendix A. The clinical assessment is included below as an illustration. A draft set of milestones for 16/17 is included as Appendix D. We believe there is a high degree of replicability in this work for other Vanguards and systems:

**Calderdale: Value generation assessment**

**Clinical –Supported Self Care(v2)**

<table>
<thead>
<tr>
<th>Primary assessment</th>
<th>Sub-assessment</th>
<th>Evidence available</th>
<th>Further evidence to be gathered</th>
<th>Medicine</th>
<th>Target (by 31.3.17)</th>
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<td>June 2014</td>
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<td>March 2017</td>
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</table>

We recognise that this programme is in the initial stages of development and that value will grow as the work progresses into 2016/17. This programme provides us with the basis for delivery of Wanless principles, particularly those associated with engaged communities, and the long-term benefits which far out-weight the delivery of short-term goals. We also recognise that given the nature of some elements of the supported self-care work, some of the major benefits associated with this programme, for example improvements in life expectancy and reductions in health in inequalities would not materialise over the life of our Vanguard. However, we have developed a number of indicators and targets which show the value of the interventions for 2016/17. The value of these interventions will grow year-on-year and will continue to be described in future Value Propositions.

The programme finances will be:

Five Years – 2017/18 – 2020/21: Costs £1.25m/2.5 ROI
Two years - 2016/17-2018/19: Vanguard Request to pump-prime model £560/£227 ROI
(c) First Point of Contact (FPOC):

What’s the Aim?

- FPOC Hubs in localities – linked to multi-professional working, joint care planning and single records.
- Quick referral, Quick screening and Quick triage
- Timely appointments/visits offered for cases assessed as urgent.
- Non urgent cases either offered an appointment or signposted to their local spoke dependent on need
- Extended hours and 7 days a week service
- Extended role for third sector providers
- Using learning from other providers by understanding best practice and evaluation of existing models in place e.g. Bolton, Kirklees, etc.
- Reductions in utilisation of other health and care services

What has it already achieved?

From Vanguard funding of £50k allocated in Q4 2015/16 the following actions have taken place this quarter

<table>
<thead>
<tr>
<th>No</th>
<th>Milestone</th>
<th>Start Date</th>
<th>Lead</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop option appraisal for H&amp;SC FPOC</td>
<td>Starts Q3 (Year 0)</td>
<td>Rhona Radley - PM CC2H</td>
<td>Mandate to proceed received by Vanguard Implementation Team to scope out to test a FPOC for Child and Adolescent Mental Health Services (CAMHS). Design principles and task and finish group established</td>
</tr>
<tr>
<td>2</td>
<td>Scope technology Scope premises/estates to deliver service requirements</td>
<td>Starts Q4 (Year 0)</td>
<td>Rhona Radley - PM CC2H</td>
<td>Company identified to scope future spatial planning Project in the Upper Calderdale Valley Health Centre. Project being delivered to CCG January 2016. Quotation process being developed to scope technology requirement</td>
</tr>
</tbody>
</table>

What Value does it add to the new care model?

Full value assessments for this programme related to outcomes, experience and quality are included as Appendix A. The clinical assessment is included below as an illustration. A draft set of milestones for 16/17 is included as Appendix D. We believe there is a high degree of replicability in this work for other Vanguards and systems:
We have developed a number of indicators and targets which show the value of the interventions for 2016/17. The main aim for 16/17 will be the creation of the hubs and the development of the underpinning ways of working.

The programme finances costs will be:

Five Years – 2017/18 – 20120/21: Costs £2.25m/£2.58m ROI/£0 local investment
Two years - 2016/17-1018/19: Vanguard Request to pump-prime programme £1.0m/£163k ROI/£0 local investment

(d) Integrated Community Services Model

What’s the Aim?

This is the critical element of our New Care Model in that it brings together the new Community Division of Calderdale and Huddersfield Foundation Trust with the new Pennine GP Alliance (which represents all but one of our 26 general practices) - working with all Vanguard Partners, this new entity provides the core of our new community model.

- Supporting people at home care and in supported housing (including care homes etc.) and their carers, identified via risk stratification.
- Integrated multi-Professional teams working in the 3-4 localities in Calderdale
- Integrated models of care that will enable delivery of co-ordinated support that will keeps people well and maintains their independence
- Providing an enhanced level of care for those with complex needs (those who are frail, children and people with long-term conditions).
- Providing time limited, health and social care rapid response, crisis and recovery supported by care co-ordinators and MDT working.
- Developing a new Super Walk-in Service using Keogh best practice to improve the urgent care offer across Calderdale. The first will be in the Upper Calder Valley.

**What has it already achieved?**

- Extending the scope of the Quest for Quality to include the remaining 14 care homes
- Established a new Palliative Care out of hours model which will be integrated within the new community model.
- Start to develop a new strategic model for building capacity and new care models in the care home sector
- Implementing a risk stratification tool for people with a Long term Conditions

From Vanguard funding of £522k allocated in Q4 2015/16 the following additional actions have taken place this quarter

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### Project: Integrated Community Services (health & social care) – Implement Agreed Model

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Start Date</th>
<th>Lead</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Implement new care offers for 3 UCV cohorts; LTC, Frailty and Children and Young People with Complex Needs (health &amp; social care)</td>
<td>Starts Q4 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
<tr>
<td>2</td>
<td>Strengthen current models of Quest for Quality in Care Homes and Out of Hours Palliative Care models (health &amp; social care)</td>
<td>Starts Q4 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
<tr>
<td>3</td>
<td>Define new transport requirements to support delivery</td>
<td>Starts Q4 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
<tr>
<td>4</td>
<td>Define Multi-Professional working to manage holistic approach across agencies (health &amp; social care)</td>
<td>Starts Q4 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
<tr>
<td>5</td>
<td>Introduce third sector Link Worker Model</td>
<td>Starts Q4 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
<tr>
<td>6</td>
<td>Define Crisis Response for avoiding admissions to long term care.</td>
<td>Starts Q4 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
<tr>
<td>7</td>
<td>Define Supported Discharge Offer</td>
<td>Starts Q4 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
<tr>
<td>8</td>
<td>Agree criteria and pathways for rapid access and diagnostics</td>
<td>Starts Q4 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
</tbody>
</table>

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### Project: Urgent Care Centre – Upper Calder Valley

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Start Date</th>
<th>Lead</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dialogue with Provider</td>
<td>Starts Q3 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
<tr>
<td>2</td>
<td>Develop design proposal</td>
<td>Starts Q3 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
<tr>
<td>3</td>
<td>Develop and agree specification and costings</td>
<td>Starts Q4 (Year 0)</td>
<td>Rhona Radley– PM CC2H</td>
</tr>
</tbody>
</table>

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**Calderdale Vanguard – Care Closer to Home in Calderdale Value Proposition 2016/17**
What Value does it add to the new care model?

Full value assessments for this programme related to outcomes, experience and quality are included as Appendix A. The clinical assessment is included below. We have developed a number of indicators and targets which show the value of the interventions for 2016/17. A draft set of milestones for 16/17 is also included as Appendix D. We believe there is a high degree of replicability in this work for other Vanguards and systems:

The programme finances costs will be:

Five Years – 2017/18 – 2020/21: Costs £26.27m/£17.1m ROI/£15.6m local investment
Two years - 2016/17-1018/19: Vanguard Request £4.1m/£2.2m ROI/£5.2m local investment

(e) National Replicability

The CC2H model is built on an evidence base developed nationally and is therefore replicable in other parts of the country. The specific work being undertaken with the three patients cohorts have also a good deal of replicability.

Development of New Care Model has been informed by the principles that underpin value assessment frameworks:

- Clarity on the cohorts of patients the new models of care are targeting
• Assessment, application and alignment of evidence to the interventions that will drive the new models of care
• Description of the interventions with clear outputs and outcomes
• Clear starting position in terms of baselines to monitor the progress with the implementation of new models of care and quantification of its impact
• Description of evidence base

Working with the NCM Team to develop and share good practice will inform our approach. We believe the following elements of our plans have a high degree of replicability nationally:

• Four discrete programme elements of CC2H (prevention, supported self-care, health and social care single point of contact and new integrated community model).
• Work to case-find and support those who are frail, using the electronic Frailty Index
• Work with partners to case-find and support children with complex needs and their families
• Work to transform a current walk-in centre into an Super Walk-in Care
• Work we have done in partnership with our third sector, particularly on building capacity and capability, and quality assurance models.
• Work we are doing to define outcomes from the CC2H model based on patient engagement

(f) Role of New GP Alliance

We know that primary care is one of the greatest strengths of the NHS and our Vanguard with its clinically led, adaptable and efficient use of resources to provide care for its registered patient population. The Pennine GP Alliance (PGPA) aims to unlock the potential of primary care at scale.

The PGPA is a newly formed organisation with 26 practices covering 100% of the population of Calderdale and its practices. We are in a unique position where the PGPA can lead with one voice for primary care, representing a single aim of putting the health and wellbeing of our patients to the forefront of planning. This clinical leadership and ability to operate at scale in Calderdale is vital for the development of a new clinical model for out of hospital care and services which can be provided in the community. Added to this public and patient engagement from CC2H has shown the desire for services to be wrapped around GP Practices and these practices to be a more central part of the community model.

In order to achieve these ambitions the 26 practices joined to form an alliance and together invested £200,000 showing their commitment for this vision. This enables PGPA to be an equal partner and ensure a clinical provider led voice to all aspects of Vanguard modelling, planning and delivery. However challenges exist with capability and capacity of this newly formed alliance and these need to be developed for the successful delivery of a new community model for CC2H.
Primary care is at the heart of wider system integrated of out of hospital care with GP practices already have key relationships with community health services, social care, third sector organisations, community pharmacists and other partners. The emerging relationship between the PGPA and CHFT; working jointly and building trust and mutual respect cannot be under-estimated. Relationships of this nature are needed between all partners to achieve success.

The PGPA represents 26 individual practices with different needs and pressures. Work will be done to address the tensions involved in preserving sufficient autonomy for practices whilst undertaking a collective endeavour to work together at scale. For this to work PGPA needs to engage with practices that they represent to explode myths and explain benefits, garnering views and feeding them into planning whilst keeping them informed and engaged. By breaking down these barriers and bias we will be building strong relationships and ensuring clinicians and front line staff along with patients have buy in and have local ownership of the new model and its delivery.
5.0 Enablers

Our 5-Year Value Proposition submitted in October 2015 sets out detail regarding our strategic aspirations for eight key enabling strategies which are critical to delivery of our CC2H model. Total funding of £1.7m has been identified to deliver a number of these enablers across the two years, and is set out in the detailed financial assessment (Appendix B)

- New Payment Mechanisms
- PMO capacity and capability inc communications and marketing
- Primary Care Strategy
- Workforce Strategy
- IT agile working
- Engagement and Equality Capacity
- Estate Strategy
- Transport Strategy

<table>
<thead>
<tr>
<th>Enabler</th>
<th>Funding</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1 (16/17)</td>
<td>Year 2 (17/18)</td>
</tr>
<tr>
<td>IT</td>
<td>160k</td>
<td>160k Agile working, single care record</td>
</tr>
<tr>
<td>Assistive Technology</td>
<td>180k</td>
<td>100k IT solutions to support patients in their own homes</td>
</tr>
<tr>
<td>Finance and contracting</td>
<td>80k</td>
<td>80k Support to develop new pricing mechanisms and contractual forms in line with NCM work-stream</td>
</tr>
<tr>
<td>PMO and Alliance Leadership</td>
<td>100k</td>
<td>300 Three posts held by Alliance and new communications and marketing post (£269k Year 0)</td>
</tr>
<tr>
<td>CHFT leadership and engagement</td>
<td>200k</td>
<td>200k One new post, plus additional to be agreed.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>100k</td>
<td>100k Joint working PGPA/CCG to engage practices in the Vanguard work and support delivery of primary care strategy outcomes</td>
</tr>
<tr>
<td>Engagement</td>
<td>80k</td>
<td>80k Capacity and capability to support dialogue with patients and stakeholders</td>
</tr>
<tr>
<td>Transport</td>
<td>20k</td>
<td>0 k Review of CC2H transport requirements</td>
</tr>
</tbody>
</table>

The engagement element of our enabling work includes the formation of a Communities Panel to ensure that patients, citizens and our communities are involved with future service developments and proposed changes. We are recruiting around 60 local people from across Calderdale to work with us in this initiative. The panel will reflect both our geographical and demographic make-up.
We believe that this initiative will accelerate our move towards real citizen involvement in Vanguard which we believe is a critical element of a programme which is underpinned by the value of social movement. We believe that there will be a high degree of replicability for other Vanguards and systems.
6.0 Outcomes and Measurement

We have adopted an approach that is in line with leading edge improvement initiatives such as the Triple Aim programme in the US. The approach advocated is built around three strategic aims and is consistent with OBA and Logic measurement models suggested by NHSE:

1. Improving Population Health (better health/outcomes)
2. Improving Patient Experience (better care)
3. Improving Quality of care (better care)
4. Improving Efficiency/PerCapita costs (better value)

A high level view of our value assessment is set out below as an illustration, and is underpinned by value assessments for each component of the model. A full set of value assessments is included as Appendix A.
7.0 Finance & Activity Modelling

The Five Year Value Proposition submitted to the NCM Team in 2015 set out:

- The context for our financial modelling
- The significant financial challenges being faced by our providers and the work being done by CHFT on their 5 Year Financial Plan
- The do-nothing scenario and underpinning activity assumptions
- The best, mid and base case assumptions and rationale for choice of the mid-case

Building on this, our 2016/17 Value proposition is based on the financial modelling set out below:

- At a strategic level our plans seek to improve the financial sustainability as a system – generating both sustainability and productivity.
- The cost of the Vanguard programme is £19.3m in the period 2015/16 to 2017/18 and £35.7m over the period 2015/16 to 2020/21
- We will invest £7.8m locally
- During this period we will realise efficiencies of £2.5m in the period 2015/16 to 2017/18 and £24.1m during the period 2015/16 to 2010/21.
- **We are seeking £8.98m (2015/16 to 2017/18) to fund the difference between the costs, local investment and savings – this will pump prime the system transformation**
- We then start to generate net system savings in the first quarter of 2018/19
  With a full ROI by Q2 of year 5 and a net return of £4m by the end of year 5.
- We have asked for a risk reserve of £2.6m as an enabling across the two years as this represents the anticipated savings for the new care model. We believe the funding is still required to pump-prime the change should the savings not materialise, to ensure that the transformation can still take place, given the financial challenges to our system as set out in section 2.0. From 2018/19 onwards it is anticipated that net savings will be delivered and the model will be self-finance.

A financial summary for the entirety of our 5 Year Care Closer to Home work is set out below.
<table>
<thead>
<tr>
<th>Care Closer to Home Activities</th>
<th>Vanguard Funding Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>£200,000</td>
</tr>
<tr>
<td>Self Managed Care</td>
<td>£50,000</td>
</tr>
<tr>
<td>First Point of Contact</td>
<td>£50,000</td>
</tr>
<tr>
<td>Community Model</td>
<td>£3,100,000</td>
</tr>
<tr>
<td>Enablers</td>
<td>£210,000</td>
</tr>
<tr>
<td>Risk Reserve</td>
<td>£0</td>
</tr>
<tr>
<td>Total Costs Per Annum</td>
<td>£3,610,000</td>
</tr>
<tr>
<td>Total Savings Per Annum</td>
<td>£0</td>
</tr>
<tr>
<td>Net Costs / (Savings)</td>
<td>£3,610,000</td>
</tr>
<tr>
<td>Commissioner Investment</td>
<td>-£2,600,000</td>
</tr>
<tr>
<td>(Surplus)/Deficit</td>
<td>£1,010,000</td>
</tr>
</tbody>
</table>

Enabling/Transformation Costs  £210,000  £1,350,460  £2,683,285  £0  £0  £0
New Model of Care Costs       £3,400,000  £5,455,000  £6,220,000  £6,220,000  £5,100,000  £5,100,000
Total Costs                   £3,610,000  £6,805,460  £8,903,285  £6,220,000  £5,100,000  £5,100,000

Total Savings                 £0  -£610,460  -£1,963,285  -£4,139,310  -£8,128,499  -£9,300,000
Commissioning Investment      -£2,600,000  -£2,600,000  -£2,600,000  -£2,600,000  -£2,600,000  -£2,600,000
(Surplus)/Deficit             £1,010,000  £3,595,000  £4,340,000  -£519,310  -£5,628,499  -£6,800,000

Recoup of full investment     Years 4 to 5
Net savings at end of 5 yrs   -£4,002,809

A detailed financial analysis is set out in Appendix B
8.0 The Programme

(a) Governance and Relationships

The Programme is overseen by a governance structure made up of 7 equal Vanguard partners:

- Pennine GP Alliance
- Calderdale CCG
- Calderdale & Huddersfield FT
- Calderdale MBC
- South West Yorkshire Partnership FT
- Locala CIC
- Third Sector (Via Voluntary Action Calderdale)

A small Programme Team, to join the existing provision from the CCG, has been established to bring the rigour and control of Programme Management methodology to the partnerships work. The team has:

- Supported the development of Partnership Agreement between NHSE and Calderdale CCG
- Begun the development of a new Community Panel which is critical in our aspirations related to citizen and community empowerment. This would involve
patients, carers and future patients undertaking a ‘critical friend’ role in reviewing our plans. This would be led by the third sector.

- Developed a Partnership Agreement between all partners and the CCG setting out commitments and expectations
- Developed a governance structure for the programme which includes a proposal for a new formal Partnership Board (made up of 2 representatives from each partner organisation (one voting and one non-voting)) which would initially sit within the CCG’s governance structures reporting to the Governing Body, but ultimately would become the potential governance structure for an alliance type new provider entity.
- Developed Terms of Reference for the new Board and the programme structures beneath it (both work-streams for the care model itself and for the enabling strategies and plans)
- Working to ensure that all Programmes, and where appropriate, enablers, are jointly-led by a commissioner and provider and that all Programme and enabler leads come together to ensure that work is interconnected and no dependencies and lost.

This work sets out to ensure that all partners are represented in every aspect of the work to ensure we deliver our aspirations. Also to ensure we have the right level of senior managerial and clinical leadership driving the change programmes.

We have already agreed the involvement of the Leadership Academy in supporting our Vanguard leadership through the development of; cultures, behaviours and values, and also design principles which would underpin decision making.

We have agreed arrangements by which the NCMs Team and the Calderdale Vanguard will work in partnership. This includes:

- Informal monthly meetings with the Programme Team Leads
- Formal quarterly monitoring meetings between representatives of the Vanguard Programme Board and the NHSE Programme Director to seek confirmation on delivery
- Development of documentation, particularly highlight reporting and financial reporting arrangements will be agreed and shared.

This relationship is underpinned by the Partnership Agreement between NHSE and the CCG which also focuses on the eight key support requirements. These requirements have been documented and are monitored through the programme office.

We have documented our key risks related to delivery of the programme and we will continue to work with the NCM Team and our partners to take mitigating actions. A copy is attached as Appendix C
END OF DOCUMENT