Calderdale HWB
A Single Plan for Calderdale

This document provides the basis for the further development of the Single Plan for Calderdale, and was submitted to West Yorkshire Healthy Futures Programmes as Calderdale’s STP submission in 2016.

This Version was signed off by the Calderdale Health & Wellbeing Board in January 2017
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Section 1
Vision, challenge and commitment
Single Plan for Calderdale

- Creates a strong narrative
- Which speaks to each part of our system
- Is an aspiration for Calderdale underpinned by a ‘golden thread’ in everything we do
- Is outcome-driven, clear metrics of success linking narrative and individual plans
- Enables HWB to test delivery plans from across the system and hold people to account for delivery
The Vision for Calderdale

Calderdale Vision for place based health

• People must be empowered to take greater control over their own lives, to influence personalised services and to take greater responsibility for their health outcomes
• All resources and assets in places must be used to support wider determinants of health and wellbeing outcomes
• A system shift towards prevention and early intervention will require services to organise and professionals to behave in very different ways.

We are reimagining a new health and wellbeing system which promotes personalisation, supports healthy decisions, enables physical activity and encourages responsibility

By integrating health, local government, housing and other services across a geographic area (which could be a city region, town or neighbourhood), we believe we can reengineer the system to secure better outcomes and become sustainable for the future

Action on
• Wider determinants of health social factors, variation & inequality)
• Health improvement: for people, communities, workforce
• Health protection: protecting health of communities and safe care
• Avoidable premature mortality: prevention is central part of health care practice

Action through
• Contributing to place based services including sustainability and transformation plans
• Taking Life course approaches to holistic prevention and care
• Responding to local population needs and wider factors affecting health and people’s ability to make health life choices
• Supporting resilience and independence

Action by
• Increasing the visibility of health and social care professionals in prevention and population health and measuring impact
• Being a vibrant force for change building a ‘culture of health’ in our society
• Working with people, families and communities to equip them to make informed choices and manage their own health
• Making every Contact Count
Calderdale: the health, care and efficiency gap.

The Health and Wellbeing Gap

Life expectancy for both men and women in Calderdale has been increasing year on year for the past decade. However, it is still lower than the England average and 9.3 years lower for men and 9.2 years lower for women in the most deprived areas. Deprivation is higher than the national average and about 20.1% (8,200) children live in poverty.

Our hypothesis - by focusing on preventative services, self-care and early intervention, and providing interventions in the community, and using community assets, we can reduce the public need to visit hospitals.

The Care and Quality Gap

• In Calderdale too many people:
  • Are 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

By pursuing our dual aim of:
  • Changes to hospital based care.
  • Changes to primary and community based care.
  • We aim to improve care and quality of services for the people of Calderdale

The Productivity and Finance Gap

In Calderdale we forecast a combined health and social care finance gap of £100m by 2021/22

Our system is over-reliant on emergency unplanned hospital activity compared to the rest of the country with high levels of ‘avoidable’ admissions - £9m avoidable admissions per annum.

By investing in services in the community, focusing on prevention and self care and ensuring people get the support they need when and where they need it we can improve the efficiency of our services.
Service user and public engagement

- Service planning is an inclusive process, including service users, carers, public, staff & partners.
- The Council use Talkback to capture the public views, a panel of residents who broadly reflect the diversity of Calderdale. It is a large group of over 1500 people.
- Calderdale CCG and Council has an ongoing programme of engagement with local people and staff. The intelligence we have has been used to shape plans. We will continue to create plans relevant to our local population through this process.
- Local engagement is key to driving the changes set out in the Care Closer to Home Programme, the Better Care Fund and the Vanguard and the recently completed public consultation on Hospital Services.

The CCG Engagement and Experience for Local People Strategy (2015/18) sets out how we have ongoing dialogue with the public.
Our Commitment to Change

Our common Purpose:

We move away from a model of care that is so dependent upon beds in hospital and in care home settings with the purpose of:

• Reducing to a minimum rates of hospital admission.

• Reducing to a minimum rates of long term care placements

• Ensuring that, when people require hospital care, we reduce to a minimum their length of stay in hospital.

Our system:

• We are famous for the strength and impact of our partnership and collaboration.

• There is a change in the nature of the relationship between people and services so that people are contributors to and owners of the services.

• The primary accountability of services is to the people that we serve. People are not just involved in their own care, they have the opportunity to be involved in making decisions about the way in which services are delivered – membership or shareholder models of ownership.

• All people working with and for health and care services in Calderdale are supported to be the best they can be.

Our Commitments:

• We work within the limits of the funding available. We balance the books every year.

• We improve value for money and manage demand by finding new and more cost effective ways of enabling care.

• We improve the experience of care

• We improve the health of the population. We keep people well.

• We keep people safe.

• We keep people independent. We support people to live safely and well at home.

• We break down the barriers between physical and mental health services.
Our Plans

What we Know

- Our system is over-reliant on emergency unplanned hospital activity compared to the rest of the country with high levels of ‘avoidable’ admissions - £9m avoidable admissions per annum.
- Local people tell us they would prefer to receive care closer to home, with good access to appointments and continuity of care.
- Our workforce is getting older and we have difficulty retaining and recruiting in some professions.
- By focusing on preventative services, self-care and early intervention, and providing interventions in the community, and using community assets, we can reduce the public need to visit hospitals and contribute to the triple aim.
- By pursuing our dual aim of changes to hospital based care and changes to primary and community based care we aim to improve care and quality of services for the people of Calderdale.

What we have already done

- We have engaged and consulted on large scale hospital change and care closer to home.
- Community & primary care with other partners are developing a fully integrated locality approach.
- Created Calderdale Vanguard new care model.
- We have a full value assessment/logic model of the Care Closer to Home model including prevention and self care management.
- Through the Better Care Fund we have an integrated Gateway to health and social care, an integrated team managing transfer of care from hospital, an agreed approach to transforming care for people with learning difficulties, use of the NHS number as a single identifier across our system, an agreed approach to integrating our monitoring and performance management.
Section 2a

Improving the health of local people
Improving the health of local people

The following slides describe the health of the population of Calderdale, reported by Public Health England in 2016

- Life expectancy for both men and women has been increasing year on year for the past decade however it is still lower than the England average and 9.3 years lower for men and 9.2 years lower for women in the most deprived areas
- Deprivation is higher than the national average and about 20.1% (8,200) children live in poverty

We have seen progress in reducing the number of premature deaths from cardiovascular disease and cancers mainly due to considerable reductions in smoking rates. However there is still work to be done to reduce the increasing rate of obesity across all generations. This work is important as this increasing rate could undo the progress seen to-date. There are emerging threats from other factors not originally considered to be significant e.g. poor air quality, increasing levels of social isolation and loneliness

Our hypothesis – by focusing on preventative services, self-care and early intervention, and providing interventions in the community, and using community assets, we can reduce the public need to visit hospitals.

We will build on strengths in an area and look at what has worked well in communities and ensure all policy and planning decisions consider impact on health and health inequality e.g. in transport, economic development, land use

by redesigning the hospital care we can provide more care in the community, reducing the need to go to hospital, and provide more expert care, reducing the length of time you need to spend in hospital.

The STP will contribute to the Health and Wellbeing objectives for the place of Calderdale:

- 10% fall in mortality from causes considered preventable by 2020
- Increase number of physically active adults by 10% by 2020 equal to over 9000 people being more active.
- Reduce the health inequalities gap by focussing action with vulnerable communities such as for people with severe and enduring mental health needs. Right Care data suggests we can save 43 lives by working together on this. National benchmarks suggest we can add 10-15 years to the lives of people with long term mental health needs. Our integrated locality model of care will support achievement (under 75 excess mortality indicator).
Calderdale - Health Summary 2016

Health in summary
The health of people in Calderdale is varied compared with the England average. About 20% (8,200) of children live in low income families. Life expectancy for both men and women is lower than the England average.

Health inequalities
Life expectancy is 9.0 years lower for men and 10.2 years lower for women in the most deprived areas of Calderdale than in the least deprived areas.

Child health
In Year 6, 18.2% (433) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 38.7*. This represents 18 stays per year. Levels of smoking at time of delivery are worse than the England average. Levels of GCSE attainment and breastfeeding initiation are better than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 596*, better than the average for England. This represents 1,196 stays per year. The rate of self-harm hospital stays is 182.2*. This represents 374 stays per year. The rate of smoking related deaths is 319*, worse than the average for England. This represents 352 deaths per year. The rate of people killed and seriously injured on roads is worse than average. Rates of sexually transmitted infections and TB are better than average.

Local priorities
Priorities in Calderdale include tackling health inequalities, obesity, physical activity, tobacco, and air quality. For more information see www.calderdaleisna.org.uk or www.calderdale.gov.uk

* rate per 100,000 population

Population: 207,000
Mid-2014 population estimate. Source: Office for National Statistics.

This profile gives a picture of people’s health in Calderdale. It is designed to help local governmen and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

Follow @PHE_uk on Twitter
Calderdale – Health Summary 2016

Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

This chart shows the percentage of the population who live in areas at each level of deprivation.

Life expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2012-2014. Each chart is divided into deciles (tenth) by deprivation (IMD2010), 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 was no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile (IMD2010) in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

Early deaths from all causes:

- MEN
- WOMEN

Early deaths from heart disease and stroke

Early deaths from cancer

Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group, 2014/15

This chart shows the percentage of hospital admissions for each ethnic group that were emergencies, rather than planned. A higher percentage of emergency admissions may be caused by higher levels of urgent need for hospital services or lower use of services in the community. Comparing percentages for each ethnic group may help identify inequalities.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>All ethnic groups</th>
<th>White</th>
<th>Mixed</th>
<th>Asian</th>
<th>Black</th>
<th>Chinese</th>
<th>Other</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>39.6%</td>
<td>39.3%</td>
<td>48.7%</td>
<td>47.6%</td>
<td>42.4%</td>
<td>42.4%</td>
<td>45.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>39.4%</td>
<td>39.9%</td>
<td>38.8%</td>
<td>44.0%</td>
<td>43.1%</td>
<td>35.9%</td>
<td>44.9%</td>
</tr>
<tr>
<td>Calderdale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local number of emergency admissions</td>
<td>22,179</td>
<td>21,607</td>
<td>124</td>
<td>1,768</td>
<td>113</td>
<td>20</td>
<td>162</td>
<td>247</td>
</tr>
<tr>
<td>Local value %</td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
What Makes us Healthy?

What Makes Us Healthy:
- Genetics 20%
- Environment 20%
- Healthy Behaviors 50%
- Access to Care 10%

What We Spend On Being Healthy:
- 88% Medical Services
- Healthy Behaviors 4%
- Other 8%
Section 2b
Improving care and the quality of services
Improving care and quality of services

This section describes the gap in care and quality of our services. It draws on a range of information sources including:

- What the public think
- NHS England Commissioning for Value information
- NHS England reports on admissions to hospital that could be avoidable. Particularly ACS (ambulatory care sensitive) conditions and CNRA (conditions not requiring admission). These are conditions people have that if the right care, support and advice was available in the community people would not need to be admitted to hospital.
- West Yorkshire Quality Surveillance Group
- CQC (Care Quality Commission) reports on providers of social care, hospital, primary care, community care and mental health in Calderdale
- Commissioner reviews of services provided in Calderdale, such as priority risk ratings of social care providers
- Provider data on the quality of services
- The workforce gap

In summary, we know that in Calderdale too many people:

- Are 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

We also know that:

- People would prefer care close to home, and good access to appointments and continuity of care
- Our workforce is getting older and we have some difficult to recruit to areas.

By pursuing our dual aim of:

- Changes to hospital based care.
- Changes to primary and community based care.

We aim to improve care and quality of services for the people of Calderdale
Improving care and quality of services

We have workforce issues relating to an ageing GP workforce, shortage of specialist doctors in hospital and national recruitment issues across a range of specialties.

The CCG have reviewed the ‘Right Care’ packs provided by NHS England. This information demonstrates variation in outcomes and spend from similar localities, and therefore the opportunities for improving care and efficiency. The review of the right care packs tells us we may have opportunities in the following areas:

Emergency admissions for acute conditions not usually requiring admission

<table>
<thead>
<tr>
<th>Number of people</th>
<th>3,603</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed days</td>
<td>19,613</td>
</tr>
<tr>
<td>Average bed days per person</td>
<td>5.4</td>
</tr>
<tr>
<td>Cost (healthcare only)</td>
<td>£6.5m</td>
</tr>
</tbody>
</table>

Emergency admissions for chronic ambulatory care sensitive conditions

<table>
<thead>
<tr>
<th>Number of people</th>
<th>2,047</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed days</td>
<td>9,899</td>
</tr>
<tr>
<td>Average bed days per person</td>
<td>4.8</td>
</tr>
<tr>
<td>Cost (healthcare only)</td>
<td>£3.3m</td>
</tr>
</tbody>
</table>

These tables describe in 2015-16 the people admitted to hospital who could have been looked after at home or in the community. In total 5,650 admissions, £9.8m.

Headline opportunity areas for your health economy

A note on the methodology used to calculate your headline opportunities is available on our website: [https://www.england.nhs.uk/comm-for-value/](https://www.england.nhs.uk/comm-for-value/)
Improving care and quality of services: Workforce Challenges

The local and national health and care system face significant workforce challenges, people are key to everything we do so the workforce challenges impact on improving care and the quality of services. These challenges are highlighted as follows:

- In primary care, 25% of our GPs say they may retire in the next 4 or 5 years. This is in line with the national picture.
- In social care difficulty recruiting the staff required to deliver support and care to people, both in their own homes and in residential and nursing homes.
- The Trust vacancy rates reported in October 2016 in key staff groups were:
  - Nursing and midwifery – 10%
  - Medical and dental staff – 12.8%
- In the Trust 5 year plan, published in January 2016 workforce challenges were noted to exacerbate the following issues:
  - Non-compliance with Royal College of Emergency Medicine’s recommendations on Children and Young People in Emergency Care settings, Critical Care workforce standards and emergency department consultant cover.
  - Intense, fragile clinical rotas where unplanned services are provided at two sites.
  - Recruitment, retention and vacancy challenges.
  - Long-term sickness absence challenges primarily relating to anxiety, stress and depression.
  - Heavy reliance on Agency staff – in the range of £2m per month.
Improving care and quality of services

Our GP practices collectively perform highly, as reported in the GP Patient Survey (GPPS) with overall patient experience reported as ‘good’ at 87% for Calderdale, compared to 85% nationally.

- We have good outcomes for overall patient care.
- The initial reports arising from CQC inspections are positive with all inspected practices (25 out of 26 to date) receiving overall judgements of ‘Good’, with 1 Practice receiving Outstanding overall and further 2 practices receiving outstanding in specific areas.
- We recognise that one size does not fit all in terms of the different communities and needs across Calderdale, so there will need to be variation in the way services are set up.
- The public tell us they want access to appointments at time they can make, they want care close to home where possible and they want good continuity of care (not to be passed from one person to another and have to keep repeating their story).
- Benchmarking data indicated the potential to save 131 lives per year through changes models of care.
- Benchmarking indicates there is the potential to save 43 lives year for those aged under 75 with severe mental illness
- There is a national shortage of GPs and Practice Nurses, making these roles difficult to recruit to
- A survey of primary care revealed 25% of GPs are planning to retire within the next 5 years
- The workforce shortage leads to high use of locums plus gaps in ability to obtain locums
- Because of these challenges across Calderdale we recognise some variation in primary care delivery, service provision and quality of care

- Delivering the capacity and capability in community beds, re-ablement, home-care and care homes that meets current and future demand is challenging
- Children’s safeguarding services in Calderdale were previously the subject of an improvement notice following inspection in 2010. The intervention notice was lifted in September 2016 and the practice continues to improve delivering better care for vulnerable children from both the health and social care perspective.
- For adult and children social care, the priorities focus on evolution not revolution as we improve and target our approach, building on three key areas:
  - encourage improvement, innovation and sustainability in care and support, reframing risk from a public health and safeguarding perspective in recognition that some of the actions we take/recommend to keep people safe are the things which ultimately contribute to health inequalities.
  - mind the gap between our strategic ambitions for integrated personalised care and support which provides a framework for people to be in control of their lives and optimises health benefits and return on investment at a system level and the reality of the care and support market.
  - bridge the fair cost of care, stabilising the care market through working towards equalisation and equity of access for people regardless of funding source.
- ensure parity of esteem between physical and mental health to ensure in Calderdale mental health is truly ‘on a par’ with physical health for our whole population.
Improveing care and quality of services; Social care providers

This table describes priority risk ratings of social care providers. These are undertaken annually by the Council’s Contacts team to determine priority for monitoring of service activity. They describe the proportion of high, moderate and low risk providers of social care.
Improving care and quality of services: CQC Summary for GP practices and Social Care in Calderdale

- Calderdale GP Practice sites:
  - 1 outstanding
  - 27 (100%) Good
  - 0 (0%) Requires Improvement
  - 0 (0%) Inadequate

- Calderdale Adult Social care services:
  - Still waiting for first Outstanding: 170 (1%)
  - 41 (63%) Good
  - 21 (32%) Requires Improvement
  - 3 (5%) Inadequate

- Adult Social Care services (National):
  - 12,502 (72%) Good
  - 4,349 (25%) Requires Improvement
  - 379 (2%) Inadequate
Improving care and quality of services: CQC Summary for providers

Calderdale and Huddersfield NHS Foundation Trust CQC summary.

<table>
<thead>
<tr>
<th>Final ratings for Trust</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

- There will be a trust wide improvement plan agreed following the Quality Summit in October 2016.
- Three core services that require improvement are Maternity, Paediatrics and Critical Care.
- Improvement plans are being developed for these services.
- A number of Requirement Notices (21) some of which related to maintaining safe staffing levels, improving patient flow, mandatory training rates and medicines management.

South West Yorkshire Partnership NHS Foundation Trust CQC summary.

<table>
<thead>
<tr>
<th>Final ratings for Trust</th>
<th>Safe</th>
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<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

The Trust’s improvement plan has been agreed with the CQC and work is progressing towards a reassessment by the CQC which may change the overall rating.
Improving care and quality of services

Our integrated transformation programme is designed to shift the provision of care from unplanned to planned care, and the location from hospital to community. The programme has 2 primary strands:

- Transforming hospital based care to provide high quality specialist care when you need it and local community based care as often as possible
- Transforming primary, community and social care (including mental health), to an integrated out of hospital care service, safe and effective outside core hours, combining the benefits of CC2H, Vanguard, BCF,, primary care strategy, shift balance from unplanned to planned

- A move to an accountable care system using innovative payment mechanisms and contract models
- All age Emotional and Mental Health and Wellbeing Strategy
- 24/7 integrated community care
- Sustainable system wide model for urgent care
- System wide model for delivery of planned care

These developments will:

- Increase the proportion of people that are satisfied with their access to care and continuity of care in the GP patient survey and Trusts Friends and family tests.
- Reduce the number of people admitted to hospital with a condition which is considered nationally to be treatable or preventable within the community by 70% to 1,695 admissions by 2021.
- We will continue to innovate, ensuring fully compliant mental health liaison services, innovative police liaison, and community based places of safety in a crisis, to improve outcomes and reduce avoidable hospital admissions for example reduce suicide in Calderdale. In 4 years we will achieve a 75% reduction in suicides, with an ambition to reach zero suicides
- Halving the number of patients who have extended LOS in hospital of between 11-100+ days (reduction from current 157 to 79 per quarter from Q1 16/17 baseline)
Section 2c

Improving productivity and closing the financial gap
Improving productivity and closing the financial gap

There is a requirement to make long-term financial savings which make the system viable and sustainable;

- Our system is over-reliant on unplanned hospital activity compared to the rest of the country with high levels of ‘avoidable’ admissions - £9m avoidable admissions per annum. This is made up of ‘ambulatory care sensitive’ and conditions not requiring admission.
- By 2021/22 the financial challenge facing the area of Calderdale (health sector only) amounts to £71m
- 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 – The social care gap at 2021 is forecast to be £29m.
- There is a potential to maximise community estate community buildings/libraries to support better community offers and delivery a better VFM
- The Calderdale STP will deliver the Calderdale STP solutions to reduce the financial gap for Calderdale in 2020/21 from £100m to £56m.
- The Council will review its medium term financial strategy to mitigate its deficit across (including BCF), then work with the system to mitigate the remaining gap for example through integrated commissioning arrangements. This reduces the financial gap currently forecast to around £29m by 2020/21, reducing the total Calderdale gap to £27m.
- Work with partners across West Yorkshire to create a balanced financial plan for West Yorkshire. This is anticipated to benefit Calderdale over 5 years by £16m. Reducing the gap to £11m after 5 years.
- The Right Care Right Place programme will further reduce the gap by £11m in 21/22.
### Modelling assumptions:
- Figures are cumulative across the 5 year period
- Inclusive of data from Calderdale CCG, CHFT, CMBC and SWYPFT
- Population shares used for CHFT (47%) and SWYPFT (20%)
- CMBC figures inclusive of full organisation gap
- Solution figures are inclusive of CCG QIPP and provider CIP
- Remaining unmitigated gap at year 5 = £64m
Section 3

The Calderdale STP and actions to close the local gaps
STPs - Alignment: Calderdale and WY STP

A Plan for Calderdale

- Environment
- Communities
- Housing
- Employment
- Education
- C&YP
- Adult Social Care
- Health
- Public Health

Calderdale STP

“Primacy at a local level”

WY STP (Healthy Futures Programme)

“Work at scale, improve local outcomes”

9 WY priorities

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The Calderdale STP

The Calderdale STP is one consolidated framework pulling together detailed plans to deliver improved primary, community and hospital based care and support. There are two main strands to the local STP:

- **Changes to hospital based care.** From March – June 2016, Calderdale CCG, in partnership with Greater Huddersfield CCG, undertook a public consultation on changes to hospital based care in Calderdale and Huddersfield. The independent report on the public consultation is now available. The CCGs are now in deliberation, and will make a decision on next steps in public on 20 October 2016. Clinical leaders designed the proposals on future hospital based care.

- **Changes to primary and community based care.** Changes in primary and community based care (including mental health care) are described in the Vanguard Programme, Care Closer to Home, Delivering the GP Forward View and the Better Care Fund. These four elements are being brought together into one operating model through the Local Transformation Board. Clinical leaders from commissioning bodies and providers, voluntary sector leaders and social care leaders are working together to deliver these proposals.
### Addressing the 3 gaps

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Description</th>
<th>Health &amp; wellbeing</th>
<th>Care &amp; Quality</th>
<th>Efficiency &amp; finance</th>
</tr>
</thead>
</table>
| New models of primary and community based care | • Prevention & Supported Self-care  
• Care navigation - Support to patients and carers in navigating through the complex health and social care systems to overcome barriers in accessing quality care and treatment  
• Community, Primary Care and third sector  
• Integrated community model & first point of contact  
• 7 partners locality model  
• Maximise BCF opportunities  
• integrated commissioning approaches that focus on service redesign that strengthens sustainability/resilience (capacity) and supported innovation and quality of outcomes | ✓                   | ✓             | ✓                     |
| Changes to primary care through the GP 5 Year Forward View | • Support and grow the primary care workforce  
• Improve access to general practice in and out of hours  
• Transform the way technology is deployed and infrastructure utilised  
• Better manage workload and redesign how care is provided  
• Maximise impact of Estates & Technology Transformation Fund | ✓                   | ✓             | ✓                     |
| 7 day services (7DS), both within the hospital and across the community. | • 7DS principle to be incorporated into future developments  
• Review of large scale proposals  
• Pilot of Frailty 7DS model  
• Focus on reduced variation in care | ✓                   | ✓             | ✓                     |
### Items of the STP that will address the 3 gaps (cont)

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Description</th>
<th>Health</th>
<th>Care &amp; Quality</th>
<th>Efficiency &amp; finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review hospital based care,</td>
<td>• To meet national standards</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Alignment with Healthy Futures priorities (WY STP)</td>
<td>• Prevention, Cancer, Mental health, Stroke, Urgent and emergency care, Specialist commissioning, Primary and community care, Standardisation of commissioning policies, Acute collaboration</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Governance and performance management</td>
<td>• Oversight of STP deliver by the HWB, • Engagement with the public, carers, voluntary sector and staff on STP • Delivery STP outcomes</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Digitisation</td>
<td>• Joint work on shared records, • Self-care platforms • PGPA &amp; CHFT joint working</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Workforce plans</td>
<td>• Joint work focused on new care models • National learning</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Changes to Social Care</td>
<td>• Meeting the Fair Cost of Care to be able to build a resilient social care system that is of high quality and avoiding inappropriate admissions and delays in discharge • Flexible contracting for support • Implementing the national vision for adult social work • Joint commissioning with the CCG • An asset based approach to community social work that focuses on preventative early intervention and wellbeing</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
The work so far: Care Closer to Home

Calderdale Multi Specialty Community Vanguard

Dr Matt Walsh
Chair

Rosemary Cowgill
Senior Responsible Officer

Debbie Graham
Vanguard Director

Amanda Jenkinson
Programme Management
Office Lead

Michael Fulton
Communications & Marketing Officer

PROGRAMMES

Prevention
Programme Lead: Caron Walker

Supported Self Management:
Caron Walker

Integrated Community Model/
First Point of Contact:
Rhona Radley/Mandy Gibbons-Phelan/Dr Fawad Azam

Projects
Develop Comprehensive Volunteering
- Youth Health Champions
Targeted wellness services for children and young people
- Mental health first aid training
- 0-5 website for families and children
Environment Improvement
Workplace Health Improvements

Projects
Supported self-management with peer supporters
Develop community pharmacy role in supporting users
Training for practitioners and consultants
Developing support plans and health MoTs

Projects
Locality Development
FPop and Navigators
GP Locom/Career Start
Mental Health Outreach into Primary Care
Care Homes Weekend Admission Interactive Platform
The work so far: Community and primary care working with other partners to develop a fully integrated locality approach
The work so far: We have a full value assessment of the CC2H model (NHSE NCM Team/Bain Consulting)

![Calderdale: Value generation assessment Clinical – Prevention and Healthy Lifestyles](image)

<table>
<thead>
<tr>
<th>Primary assertion</th>
<th>Sub-assertion</th>
<th>Evidence available</th>
<th>Further evidence to be gathered</th>
<th>Metrics</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population outcomes will be improved by introducing a new integrated prevention and healthy lifestyles programme as part of the new model of care</td>
<td>The most significant health benefits will be delivered by new interventions associated with three patient cohorts: people with one or more long-term condition, people at risk due to their frailty, children and young people with complex needs:</td>
<td>Boyce, T et al (2010) A proactive approach. Health Promotion and Ill-health prevention. The Kings Fund</td>
<td>Generate local evidence base – understanding the benefits of interventions for different population groups</td>
<td>From 2015/16 baselines:</td>
<td></td>
</tr>
<tr>
<td>1. Introduce new brief interventions training for front line-staff</td>
<td>Target the brief interventions at those who would benefit from behavioural change to prevent or manage a long-term condition</td>
<td>Buck, D and Frooni, F (2012) Clustering of unhealthy behaviours over time. Implications for policy and practice.</td>
<td>1. Number of community staff trained to provide brief interventions</td>
<td>50 staff trained</td>
<td></td>
</tr>
<tr>
<td>2. Target the brief interventions at those who would benefit from behavioural change to prevent or manage a long-term condition</td>
<td>Introduce new training for front-line staff on brief interventions to prevent or manage risk associated with their frailty</td>
<td>Buck, D and G for the Public's Health. Thomson, H. (2013) Improving the Public's Health, housing, improvements for health and associated socio-economic outcomes. The Cochrane Library.</td>
<td>2. Number of Youth Champion facilitators trained</td>
<td>10 Youth facilitators</td>
<td></td>
</tr>
<tr>
<td>3. Introduce new training for front-line staff on brief interventions to prevent or manage risk associated with their frailty</td>
<td>Introduce new health trainer service to provide practical support and help</td>
<td></td>
<td>3. Multi-media information &amp; support package</td>
<td>66% of schools</td>
<td></td>
</tr>
<tr>
<td>4. Train course facilitators and introduce and roll-out new Youth Champion Training</td>
<td>Introduce new multi-media pre-pregnancy, pre-school support package for all new mothers to support healthy start information and support.</td>
<td></td>
<td>% mothers accessing support booklet</td>
<td>95% mothers</td>
<td></td>
</tr>
<tr>
<td>5. Introduce new health trainer service to provide practical support and help</td>
<td>Introduce new Workforce Health Improvement programme to provide information and support.</td>
<td></td>
<td>% midwives with app loaded and in use</td>
<td>80% midwives</td>
<td></td>
</tr>
<tr>
<td>6. Introduce new multi-media pre-pregnancy, pre-school support package for all new mothers to support healthy start information and support.</td>
<td>Introduce new Workforce Health Improvement programme to provide information and support.</td>
<td></td>
<td>Number of hits on website</td>
<td>5,000 hits</td>
<td></td>
</tr>
<tr>
<td>7. Introduce new Workforce Health Improvement programme to provide information and support.</td>
<td>Generate local evidence base – understanding the benefits of interventions for different population groups</td>
<td></td>
<td>4. Number of client accessing new Health Trainer services</td>
<td>200 new clients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. Number of workplaces actively participating in Workforce Health Improvement Programme</td>
<td>20 workplaces</td>
<td></td>
</tr>
</tbody>
</table>

Source: Vanguard Value Proposition (Aug 2015)
The work so far: Better Care Fund

We have:
- an integrated Gateway to health and social care
- an integrated health and social care team managing transfer of care from hospital
- a model for locality working
- an agreed approach towards transforming care for people with a learning disability or mental health need
- use of the NHS Number as a single unique identifier across our system
- an agreed approach towards integrating our monitoring and performance systems
The work so far: We are engaged in a large-scale Hospital Change Programme
Our Achievements since 2013/14

The key focus of the Care Closer to Home (CC2H) work has been to shift the balance from unplanned and avoidable hospital admissions, to planned, integrated care provided in community and primary care settings - delivering prevention and self-care at scale. The work we do seeks to deliver the triple aim of; improving health, improving care and improving value.

In Calderdale, we believe that the work we have done with our partners on CC2H has had a significant impact on our growth in emergency admissions. The table below summarises this position for Calderdale compared to the national picture. It indicates that the rate of growth in Calderdale has been more than half that of the rate experienced nationally.

Volume of Emergency Admissions, 2014/15 to 2015/16:

<table>
<thead>
<tr>
<th></th>
<th>Calderdale</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014/15</strong></td>
<td>22,313</td>
<td>5,497,523</td>
</tr>
<tr>
<td><strong>2015/16</strong></td>
<td>22,563</td>
<td>5,656,112</td>
</tr>
<tr>
<td>% change</td>
<td>1.12%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

CC2H developments

**2013/14**
- Tackling the impact of loneliness in older people
- Improved Services for people with learning disabilities
- Developed a Support Independence Team (SIT)
- Developed our flagship Quest for Quality in Care Homes programme - phase 1
- Supporting people with Respiratory Conditions at home

**2014/15**
- Health Connections – supporting Third sector organisations
- New Service for people with Respiratory Conditions – a new community team
- Palliative care Pilot
- Quest for Quality in Care Homes - phase 2
- New Services for People with Mental Health Problems

**2015/16**
- Diabetes Service in the Community
- New Heart Failure pathway and COPD Services at Home
- (Quality For Health (QFH)
- Transforming care for people with learning disabilities
- Continuing Healthcare Hospital discharge Team (CHCDT)
- Mental Health - Parity of Esteem
- New Care Home Model
- Other community investments
Section 4

Leadership, governance and Engagement
Future Commissioning and Delivery Models

**Strategic direction: Single Plan for Calderdale**

**Integrating Commissioning:**
- Health & social care working jointly
- Sharing budgets
- Defining outcomes, measuring performance
- Agreeing longer-term contracts
- Capitated budgets
- Larger geographies
- Payment, procurement and statutory duties
- Encouraging and supporting providers to work in a more integrated way

**Tackling the Wider Determinants of Health:**
- Inequalities
- Economy
- Education
- Environment
- Employment
- Housing
- Prevention at Scale

**Delivering new models of primary & Community Services:**
- Collaboration and integration
- New ‘Integrated Care organisation
- Delivering integrated primary and community services, physical and mental health, in partnership with statutory and third sector
- Prevention, self-care, independence, personalisation

**Working on a West Yorkshire Footprint:**
- Oversight by Healthy Futures Programme
- Includes acute reconfiguration locally and across WY
- 9 priorities – delivery at scale (critical mass, doing things once)

**Enablers:**
- Digitisation
- Workforce
- Estate
- Data quality and analysis
- Communication
Governance and Leadership

- Calderdale, a health and social care system led by the Health and Wellbeing Board (HWB); a multi-agency commissioner/provider collaboration. HWB is committed to developing a STP for Calderdale.
- Calderdale has a track record of collaboration through opportunities such as Better Care Fund, Vanguard, the System Resilience Group, Hospital Programme Board.
- HWB reviewed the governance and further strengthened it with the introduction of the Local Transformation Board (LTB), reporting to HWB, enabling agencies to work together at pace & ensuring a coordinated approach to local plans.
- Calderdale HWB is moving from being a receiver of reports to becoming a deciding and doing body.

Calderdale STP is one consolidated framework pulling together detailed plans to deliver improved primary, social, community and hospital based care and support.
- Calderdale STP is an essential component of West Yorkshire STP, working together with the HF Programme Team.
- Calderdale reaches out to partners through WY STP, WYATT, other local STP plans and local government to address the wider determinants of health through the place based STP.
Leadership and Clinical Leadership

- Leadership for the local STP is provided by the Calderdale HWB, made up of councillors, Council officers and officers and clinical leaders from the Clinical Commissioning Group.
- Partnership working with all providers of care including the voluntary sector includes working with Calderdale Council, Calderdale and Huddersfield NHS Foundation Trust, Locala, Pennine GP Alliance, South West Yorkshire Partnership NHS Foundation Trust and Voluntary Action Calderdale.
- Clinical leadership locally is seen as vital to transformation. Clinicians from primary and secondary care come together with Local Authority and other colleagues at HWB
- Integrated Commissioning Executive and A&EDB to ensure a joint approach to planning of services.
- Primary Care is provided by 26 separate GP practices, these are individual businesses. Engagement and leadership is therefore complex and critical. Calderdale has a good history of collaboration amongst its practices and a history of close working with the wider health community.
- Within Calderdale we have seen the establishment of a GP Federation (the Pennine GP Alliance) of which all 26 practices in Calderdale are members and therefore cover 100% of the local population. The Alliance provides an important vehicle to facilitate the shift of services into primary care and community settings - delivering innovation that benefits patients and delivers value for money. We believe this is an important feature of our ability to delivery change at scale within general practice locally.
- The NHS, social care and third sector workforce are recognised as an important asset that underpin the future success and sustainability of the transformation we have planned.
- Leadership is challenging. People are worried by change and really value the services they know, often services they have known for generations. Leadership requires a clear vision and an ability to show people how we will get there.
- The STP describes 2 significant changes to service delivery. These are:
  - **Changes to hospital based care.** From March – June 2016, Calderdale CCG, in partnership with Greater Huddersfield CCG, undertook a public consultation on changes to hospital based care in Calderdale and Huddersfield. The independent report on the public consultation is now available. The CCGs are now in deliberation, and will make a decision on next steps in public on 20 October 2016. Clinical leaders designed the proposals on future hospital based care.
  - **Changes to primary and community based care.** Changes in primary and community based care (including mental health care and social care) are described in the Vanguard Programme, Care Closer to Home, Delivering the GP Forward View and the Better Care Fund. These four elements are being brought together into one operating model through the Local Transformation Board. Clinical leaders from commissioning bodies and providers, voluntary sector leaders and social care leaders are working together to deliver these proposals.
West Yorkshire footprint

- Calderdale STP is linked to the WY STP. The WY STP is being developed through existing channels as well as new and emerging relationships.
- Structured relationships across West Yorkshire including the acute hospitals group WYAAT, the 10 Clinical Commissioning Group 10CC, the West Yorkshire HWB Chairs, the combined authority, the leaders meeting create a platform to develop the STP.

West Yorkshire Context

1 STP for West Yorkshire, made up of:
- 9 West Yorkshire-wide priority areas
  - Acute collaboration
  - Cancer
  - Mental health
  - Prevention ‘at scale’
  - Primary and community care
  - Specialised commissioning
  - Standardisation of commissioning policies
  - Stroke
  - Urgent and emergency care
- 7 enabling workstreams
  - Workforce
  - Digital
  - Leadership and organisational development
  - Communications and engagement
  - Finance and business intelligence
  - Best practice
  - Commissioning

The West Yorkshire STP is being developed reflecting the primacy of local STPs. We ask 3 questions to determine if we get a benefit acting at a WY level:
- Does the need require a critical mass beyond a local level to deliver the best outcomes?
- Do we locally need to share best practice to achieve the best outcomes?
- Will working at WY level give us more leverage to achieve the best outcomes?
Meeting the Guidance on Engagement

- The STP guidance calls for us to engage local people in development of a Sustainability and Transformation Plan which builds on the Call to Action work developed nationally.
- The process we are asked to follow is to develop a case for change, engage and then formally consult with a range of key stakeholders.
- The local system can evidence that the content of spirit set out in the Call to Action is a substantive element of both the engagement and consultation undertaken as part of Right Care, Right Time, Right Place. The timeline for this is set out below:
  - Phase 1: Development stage - Engagement: March 2012 – July 2014
  - Phase 2: Engagement stage - Pre-consultation engagement: July – Dec 2015
  - Phase 3: Consultation stage - Consultation: 15 March- 21 June 2016
  - Deliberation: July – Mid October 2016
  - Decision: 20 October 2016

- The Health and Wellbeing Board will, as part of its STP oversight role, ensure that there is a continued and meaningful dialogue with the public and stakeholder in Calderdale on the STP and what it means for local people.

People have told us the following priorities:
- Giving clear information to the patient about their health conditions and the plan for their care
- Delivering more services closer to home
- Delivering flexible services that offer the right care at the right time in the right place
- Delivering health services through caring and competent staff and volunteers
- Putting the patient at the centre of their care
- Improving communication about patients both within and between primary, secondary, community and voluntary sector, and social care
- Providing seamless, holistic care that links all aspects of care together and wraps around all of a person’s needs
- Improving use of technology to communicate with patients and carers and other health services
- Increasing public awareness of health conditions and how to minimise the risk of developing them
- Working with community and voluntary sector partners to deliver health care in the community
- Enabling people to care for themselves and seek help when they have concerns
- Ensuring that hospital discharge is well planned and timely
- Making sure all changes to services are properly planned and resourced and do not lead to problems accessing services
Section 5

Next steps and reporting arrangements
Key milestones and decisions

- Engagement with the public about the future model of health and social care services - Ongoing
- Strengthening our primary care delivery plan for Calderdale in the light of development of the GP 5YFV - Ongoing
- Key decision point: Consultation on future provision hospital and community healthcare - CCG decision to move to Full Business Case - October 2016
- JOSC meeting to discuss CCG decision on hospital reconfiguration - 16 November 2016
- The first point of contact for health and social care will be delivered by - Spring 2017
- Roll out of integrated community services through the implementation of 5 localities - Spring 2017
- Full implementation of new care model in community and primary care - 2018.
- Agree acute care collaboration across West Yorkshire - April 2018
## Delivery of the 9 WY priorities (1)

<table>
<thead>
<tr>
<th>Calderdale - Placed-based</th>
<th>Priority</th>
<th>West Yorkshire @ scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement new (Keogh) model</td>
<td>Urgent &amp; Emergency Care</td>
<td>Designate new models</td>
</tr>
<tr>
<td>Implement community &amp; primary care offer</td>
<td></td>
<td>Primary care (111 &amp; prescriptions)</td>
</tr>
<tr>
<td>Liaison psychiatry</td>
<td></td>
<td>Hear, see and treat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 day services</td>
</tr>
</tbody>
</table>

- Delivery FYFV for Emotional wellbeing & MH (adults and children)
- AMHP Capacity Plan & Save Haven
- Integrated community model (part of CC2H)
- Parity of esteem

### Mental Health & Emotional Well-being

- MH Liaison
- Suicide prevention
- C&YP, CAMHs (tier 4)

<table>
<thead>
<tr>
<th>Implement new National Cancer Strategy, particularly</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention &amp; screening</td>
<td></td>
</tr>
<tr>
<td>Early diagnosis</td>
<td></td>
</tr>
<tr>
<td>Survivorship</td>
<td></td>
</tr>
<tr>
<td>Define community model</td>
<td></td>
</tr>
</tbody>
</table>

- Prevention
- Early diagnosis
- Experience & effectiveness
- Configuration
- Survivorship
Delivery of the 9 WY priorities (2)

<table>
<thead>
<tr>
<th>Calderdale - Placed-based</th>
<th>Priority</th>
<th>West Yorkshire @ scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Obesity</td>
<td>Prevention ‘at scale’</td>
<td>• Workforce health</td>
</tr>
<tr>
<td>• Food, physical activity &amp; environment</td>
<td></td>
<td>• Smoking</td>
</tr>
<tr>
<td>• Youth</td>
<td></td>
<td>• LAC (maximise health contribution)</td>
</tr>
<tr>
<td>• Health trainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diabetes prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cardiovascular programme (prevention, detection, care planning and treatment)</td>
<td>Stroke</td>
<td>• Configuration of hyper-acute stroke services</td>
</tr>
<tr>
<td>• Obesity, vascular, neuro-rehabilitation</td>
<td>Specialist Commissioning</td>
<td>• Obesity, vascular, neuro-rehabilitation</td>
</tr>
</tbody>
</table>
Delivery of the 9 WY priorities (3)

<table>
<thead>
<tr>
<th>Calderdale - Placed-based</th>
<th>Priority</th>
<th>West Yorkshire @ scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary care strategy focused on improving access</td>
<td>Primary and community care</td>
<td>• Strengthening primary care through enhanced workforce strategy</td>
</tr>
<tr>
<td>• New Pennine GP Alliance to support primary care development and resilience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Strengthening mental health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Developing evidenced based thresholds/restricted policies</td>
<td>Commissioning policies</td>
<td>• Developing consistency of approach</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sharing good practice</td>
</tr>
<tr>
<td>• Vascular Services</td>
<td>Acute collaboration</td>
<td>• Create efficiencies at scale</td>
</tr>
<tr>
<td>• Stroke Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>