# QUESTIONS

ABOUT

# CARE CLOSER TO HOME DATA

(FOI request 131FOI20.21 / 2021120)

# ANALYSIS

OF

CALDERDALE & KIRKLEES

# NHS COMMISSIONERS' RESPONSES

16.2.2021
Calderdale and Kirklees 999 Call for the NHS
c/o 19 Unity Street, Hebden Bridge, HX7 8HQ

My Freedom of Information questions aimed to elicit data that show the impact, since 2018, of Calderdale and Kirklees Care Closer to Home programmes on Calderdale and Huddersfield hospitals' emergency admissions and A&E attendance.

The Clinical Commissioning Groups must produce evidence that Care Closer to Home services are on track to cut A&E attendance and reduce emergency decisions by more than 10% over five years. The assumption that they will is the basis for the hospitals' planned capacity, which keeps 2019 bed numbers rather than provide more to absorb the forecast increase in A&E attendance and emergency admissions activity caused by demographic growth.

Despite the Independent Reconfiguration Panel's direction that NHS organisations must provide timely information for Calderdale and Kirklees Joint Health Scrutiny Committee, the Calderdale and Greater Huddersfield Clinical Commissioning Groups have persistently failed to provide these data, despite the Committee Co-Chairs' repeated requests.

The Clinical Commissioning Groups responses to these Freedom of Information questions also omit any relevant data that would show the impact of Calderdale and Kirklees Care Closer to Home programmes since 2018 on Calderdale and Huddersfield hospitals' emergency admissions and A&E attendance. They do however make it clear that such data exist.

# Contents

# Introduction

In a recent FOI response (ref: 131FOI20.21 / 2021120), Calderdale and Kirklees NHS Commissioners failed to provide requested data that would provide evidence to support their aspiration that their Care Closer To Home programmes will reduce unplanned hospital bed days at Calderdale Royal Hospital by more than 10% over 5 years, and cut A&E attendance at both Calderdale Royal Hospital and Huddersfield Royal Infirmary. *(Calderdale and Huddersfield NHS Foundation Trust Reconfiguration of Hospital Services Strategic Outline Case 2019, p13).*

Their unevidenced claim underpins the Trust's decision in their revised 2019 Strategic Outline Case (p 32), to keep overall hospital bed numbers broadly at the 2019 level - rather than increase capacity to take account of the forecast increase in hospital usage from demographic growth. (For A&E attendance, this forecast increase is 2% and for non-elective admissions, 2.7%. Presumably the forecast increases are yearly, although the SOC (p 35) does not state the time period.)

I made the FOI request because over the last 2 years Calderdale and Greater Huddersfield Clinical Commissioning Groups have consistently failed to provide this data, despite repeated requests from Calderdale and Kirklees Joint Health Scrutiny Committee.

## The Secretary of State's approval of the Trust's revised plan is only conditional

One of his conditions is that the Calderdale and Kirklees Care Closer to Home programmes provide evidence to show that planned hospital capacity is safe.

For that to be the case requires Care Closer to Home performance data that show the programme is on track to achieved its projected reduction of A&E attendance, and a more than 10% cut in unplanned hospital bed days, over five years.

The Secretary of State has directed Calderdale and Kirklees Joint Health Scrutiny Committee to let him know if and when his condition is met. Obviously the Councillors' committee can't do this as long as the Clinical Commissioning Groups fail to provide data in support of their aspiration.

This is why Calderdale and Kirklees 999 Call for the NHS is now writing to the Independent Reconfiguration Panel and Secretary of State to ask them to direct Calderdale and Kirklees Clinical Commissioning Groups to immediately provide the

required data to Calderdale and Kirklees Joint Health Scrutiny Committee - and the public.

## Independent Reconfiguration Panel direction to NHS organisations to provide timely information for Scrutiny

In rejecting the original 2016 Right Care Right Place Right Time plan and recommending a revised plan,  the Independent Reconfiguration Panel report said that NHS organisations should from now on provide timely information to the Calderdale and Kirklees Joint Health Scrutiny Committee and avoid repeats of things like their withholding of the Full Business Case until a private meeting with the Committee immediately before the its scheduled meeting in public.

Calderdale and Greater Huddersfield Clinical Commissioning Groups have ignored the Independent Reconfiguration Panel's direction to provide timely information to the Calderdale and Kirklees Joint Health Scrutiny Committee They are making a mockery of the consultation process with the Councillors' Committee.

# FREEDOM OF INFORMATION QUESTIONS

*Please note: In order to provide a clear analysis of the Clinical Commissioning Groups' FOI response, in this summary I have grouped the questions in sections 2 and 3 differently than they were in the FOI request and response. So the question numbers here are not the same as the question numbers in the FOI docs.*

1. Questions about the scope of Calderdale and KIrklees Care Closer to Home Programmes

2. Questions asking for quantitative and qualitative performance data for Care Closer to Home that the Clinical Commissioning Groups have been collecting since 2018

3. Questions about the availability of skills and resources to examine and interpret the above data

# GENERAL COMMENTS
## on the Freedom of Information response

*Digging out hard facts about relevant Care Closer to Home performance data in the FOI response has been like looking for needles in a haystack. So apologies for the haystack dimensions of this document.*

*It does beg the question of why the Clinical Commissioning Groups' responded with a haystack instead of the requested needles.*

## 1. The response to questions about the scope of Calderdale and Kirklees Care Closer to Home Programmes

The response by the Clinical Commissioning Groups provided what looks like fairly exhaustive information about **Calderdale and Kirklees Care Closer to Home programmes -** including a Greater Huddersfield and N Kirklees CCGs' March 2019 document that admitted that their "system" was:

> *"not in a position to fully articulate the proposed place based community service and delivery model...".*

The response shows that Care Closer to Home is intended as a cost-cutting range of out-of-hospital services delivered by an array of NHS, local authority, private and voluntary sector organisations, using new methods and relying heavily on patients' self management of their conditions and on unpaid care from family, friends and volunteers.

The services are for the frail elderly and other people with long term physical or mental health problems, who are most at risk of A&E attendance and emergency admission to hospital. They aim to reduce A&E attendances, emergency admissions to hospital and length of hospital stay. Key Perfomance Indicators for the various services have been identified that measure the level of achievement of these outcomes. But no data was provided about whether these intended outcomes are being achieved.

The Calderdale and Kirklees Care Closer to Home programmes aim to cut £millions of costs each year by keeping these patients out of hospital, but no data was provided about cost savings to date.

**All the information provided by the FOI response on this topic is in Appendix 1**


**The Care Closer to Home information provided in the response to question 1 is copious but very woolly.**

A lot of the services have been around for years. What about the community beds they previously cut, the rapid response teams they cut, the walk in centres they cut? Previously all of these services were branded too expensive and scrapped, there are not many community beds.

Has capacity now increased massively? Have community staff got fast access to the community beds needed, and equipment such as hospital beds, commodes etc?

It's skilled and labour intensive work. Where's the evidence unskilled staff (Primary Care Network 'alternative roles'), private and voluntary sector providers and unpaid carers can deliver any of this?

## 2. The response to Questions asking for Care Closer to Home performance data since the start of 2018

**In their response, the Clinical Commissioning Groups have failed to provide any data about Care Closer to Home reductions in A&E attendance and emergency admissions that would justify the hospital Trust's decision to keep overall hospital bed numbers at the current (2019) level, rather than increase capacity to take account of population growth and other demographic change.**

Despite many indications in their response that the Clinical Commissioning Groups DO have data that shows the impact of Care Closer to Home on A&E attendance and emergency hospital admissions, Calderdale CCG failed to provide any such data. Kirklees CCGs referred to some skimpy data that were largely irrelevant as they pre-dated 2018. The only exception was Kirklees Care Closer to Home monthly data for March 2018 and December 2018, which showed a December improvement in reductions in emergency admissions and A&E attendance, compared to March

In response to a question about cost savings from the Care Closer to Home programme, Calderdale CCG provided no data but referred us to the April 2019 SOC Economic Case.

The meagre data provided in the FOI responses to Question 2 is in Appendix 2


**The failure to provide the data we asked for is perplexing -** it's clear from the Clinical Commissioning Groups' responses to both questions 2 and 3 that they have the data we requested.

**In addition, we think implementation of the hospitals reconfiguration plan would constitute a misuse of public money and failure to provide the best-value service that is fit for purpose.**

We found the April 2019 SOC Economic Case to be biassed and misconceived. Calderdale Clinical Commissioning Group told us it provided data about savings resulting from the substitution of Care Closer Home services for hospital service. It doesn't.

By ignoring all externalities that affect patients, their families and friends and focussing on cash releasing economic benefits for the hospitals trust and Clinical Commissioning Groups, it ignores the significant economic costs of the reconfiguration plan.

As well as imposing increased costs on patients, their families and friends, some of the so-called economic benefits that are projected to accrue to the local NHS organisations will have the perverse effect of shrinking the local economy, so increasing socio/economic inequalities and increasing NHS costs as a result of the health impacts of increased deprivation.

## 3.The response to questions on the availability of skills and resources to examine and interpret the data

Calderdale and Kirklees NHS commissioners' response did not identify any lack of skills and resources to examine and interpret data.

- They know what data they need to collect in order to show the impact of the Calderdale and Kirklees Care Closer to Home programmes on A&E attendance and unplanned bed days.
- They have been collecting this data.
- They have the data analytical skills and resources needed to examine and interpret the data.

- They did not identify any problems marrying data that records innovative clinical and non-clinical activities and their outcomes, with routine data based on existing units of hospital activity

The CCGs' responses to question 3 are in Appendix 3


**Their response to Question 3 clearly shows they could produce the requested data - so why haven't they?**

Could their failure to do so be because:

- The data don't support their "aspiration" Care Closer to Home services will reduce A&E attendances and cut unplanned hospital bed days by more than 10% over 5 years?

- And this would show how unsafe is CHFT's decision to keep overall hospital bed numbers broadly at the 2019 level, rather than increase capacity to take account of the forecast increase in hospital usage from demographic growth?

# Appendix 1

## The scope of Calderdale and Kirklees Care Closer to Home Programmes

### 1a) Care Closer to Home is for "high intensity service users" - patients with chronic health problems who are most at risk of hospital admissions.

#### 3 key elements of the Care Closer to Home programme.

The 3 elements of the **Calderdale Care Closer to Home Programme** are in Table 1, below. (Confusingly, each element goes by 2 names: the names used in the McKinsey Right Care Right Time Right Place Modelling Report and the names used by Calderdale Cares.

**Table 1**
**Elements of the Calderdale Care Closer to Home Programme**

| ***McKinsey Report Name*** | ***Calderdale Cares Name*** |
|---|---|
| Prevention and proactive care | Integrated wellness services (prevention and population health |
| Swift and appropriate access to care | Care and support in a crisis |
| Support with care transition | Step down to home or new residence |

Table 2 (below) lists the **3 key elements of the Kirklees Care Closer to Home programme** *(Source: p12, Care Closer to Home Evaluation Report, Greater Huddersfield and North Kirklees Clinical Commissioning Groups March 2019 )*

They are basically the same as Calderdale's but with slightly different names.

| Table 2.<br>Three key elements to Kirklees care closer to home and Locala's integrated service model |
|---|
| Proactive care (preventative), |
| Rapid Response (for crisis and to support a planned response) |
| Early supported discharge/transfer to the most appropriate environment. |

## 1b) The processes for delivering these main elements of Care Closer To Home

**Calderdale's** response was straightforward

| Table 3.<br>Calderdale processes for delivering main elements of Care Closer To Home | |
|---|---|
| ***Main element of CC2H*** | ***Delivery processes*** |
| Prevention and proactive care / aka integrated wellness services (prevention and population health) | a) case management<br>b) Multidisciplinary teams<br>c) Care co-ordination<br>d) Individualised care plan<br>e) Frequent touchpoints<br>f) Scheduled service user follow-ups<br>g Self-empowerment and education |
| Swift and appropriate access to care/ aka care and support in a crisis | h) Rapid response<br>i) Rapid access to primary care<br>j) Access to specialist care<br>k) Appropriate referral and medication practices |
| Support with care transition / aka step down to home or new residence) | l) Discharge support<br><br>m) Intermediate care |

**The Kirklees CCGs'** responses to this question were bonkers - they listed the outcomes of their Care Closer to Home contracts instead of their delivery processes.

But they did add: “For further detail please refer to the service evaluation documentation of Kirklees CC2H contract.” (This documentation is included in the CCG’s online link https://nkgh-ccg.co.uk/wp-content/uploads/2021/01/PUBLIC-Governing-Bodies-Agenda-Papers-13.02.19-1.pdf)

From documents presented to the 13.3.2019 GH and NK CCGs’ Joint Governing Bodies meeting, I did manage to disentangle the Kirklees Care Closer to Home delivery processes.

**Key elements of Kirklees Care Closer to Home programmes**

P12 of the 88-page *Greater Huddersfield and North Kirklees Clinical Commissioning Groups March 2019 Care Closer to Home Evaluation Report* explains that the Care Closer to Home Integrated Service Model has **three key elements** (as in 1a) above):

- Proactive care (preventative),
- Rapid Response (for crisis and to support a planned response) and
- Early supported discharge/transfer to the most appropriate environment.

**Kirklees Care Closer to Home delivery processes**

On p13, an Integrated Service Model infographic shows the 3 main elements of CC2H in a row of orange boxes, and what I take to be their **delivery processes** underneath them in blue boxes:

Figure 1: Integrated Service Model

However on p56, the Greater Huddersfield and North Kirklees Clinical Commissioning Groups March 2019 Care Closer to Home Evaluation Report admits that at the time (March 2019) their "system" was

> *"not in a position to fully articulate the proposed place based community service and delivery model...*

"The CCGs need to continue work with all stakeholders to identify which elements of health: GP practice, primary, community and secondary care services, social care and wider community services that are relevant to this approach. We then need to establish new ways of working so that these will be increasingly delivered in an integrated way...

"The new Primary Care Network Contract and the seven national Network Service Specifications will be key to informing what needs to be included in the service delivery model."

Translated, the elaborate language ("not in a position to fully articulate the proposed place based community service and delivery model..." seems to mean " We don't really know how local providers will deliver the Care Closer to Home programme, or what its scope will be.")

## Failures of Locala's delivery processes 2015-18 and Locala's plan to improve them 2018-20

Greater Huddersfield and North Kirklees Clinical Commissioning Groups' March 2019 Care Closer to Home Evaluation Report lists many failings in Locala's delivery of Care Closer to Home services.

Organisations that complained about these failings included:

- CHFT, which had a LOT of problems with Locala;
- KIrklees Council, which said CCTH "still appears as a disparate set of services."
- The Huddersfield GP Federation, which said the CCTH service specification was too vague, and also asked whether the CCG had considered seeking an independent review/audit of the CCTH tender process and the contract management of CCTH to ensure lessons were learnt - and what about the future financial envelope?

Nonetheless the Clinical Commissioning Groups decided to extend Locala's Care Closer to Home contract for a further 2 years, to 2022.

The Report shows that the reason for this was uncertainty about whether the "market" is sufficiently developed for procurement of an Integrated Care Provider, as required by the national policy "direction of travel".

From 1 April 2022 Clinical Commissioning Groups will be abolished and their functions absorbed by statutory NHS Integrated Care Systems that will be operating under a new Provider Procurement Regime that is currently out to consultation.

Locala produced a 2018-20 Care Closer to Home Plan that aimed to make good their many failings in deliverying CC2H in the first 3 years of their contract. The 2018-20 Plan relied heavily on estates, digital and workforce solutions and the alignment of Locala's delivery of  Care Closer to Home services with GPs' Primary Care Networks.

The Integrated Service Model infographic (above) did not include Multidisciplinary Teams as a key Care Closer to Home delivery process. But P 25 of the Kirklees NHS Commissioners' 2019 Care Closer to Home Evaluation Report says that they are - and that in the first 3 years of Locala's contract (2013-2018), stakeholder feedback showed GPs' and practice staffs' strength of feeling that:

> "Multidisciplinary Team working has not been delivered on a consistent basis and for some practices not at all; and entire services from the original specification and bid have not been delivered consistently or at all."

Apparently acknowledgine to this criticism, the Locala Care Closer to Home Plan 2018-20 says (p12) that Locala will,

> "Deliver integrated models of care through MDTs in Primary Care Networks focusing on vulnerable patients who are high users of health and social care services. Integrated team development in adult health and social care services will enhance service delivery. Work has initially started in Holme Valley with identified Community Nurses and Social Workers aligned to groups of practices. This membership will be widened to include mental health and third sector partners and will support high risk patients to reduce avoidable admissions to hospital and reduce admissions to long term residential and nursing care through an integrated MDT."

This begs the question of whether the Multidisciplinary Teams' delivery of Care Closer to Home services has improved in the past two years, 2018-20. (See Appendix 3**,** below)

Also on p25, the Kirklees NHS commissioners'  2015-18 CC2H Evaluation Report says that from

*"soft intelligence gathered, it is clear there are concerns from stakeholders around Locala's service delivery, service performance and service staffing/skill mix."*

Locala's 2018-20 Care Closer to Home Plan includes various workforce proposals that are presumably intended to address stakeholders' concerns about staffing/skill mix.

P 52 of Locala's Care Closer to Home plan 2018-20 seems to **address concerns about service delivery with proposals to establish delivery processes** that include:

- Supporting colleagues to feel confident to identify and implement changes that result in better care and outcomes for patients.

- Use of digital technology to monitor, communicate and appraise multiple patients with less resource, supported by the patient held record, telehealth and virtual consultations; online booking systems, self-testing, 'virtual' clinical care and online access to self-care resources.

- An estates strategy that uses buildings and assets to facilitate joint working and co-operation between Locala and statutory, voluntary and private partners. (On p11, the CC2H Plan 2018-20 adds, "This is already starting to happen in some places e.g. shared premises including Eddercliffe Centre and Slaithwaite Town Hall and co-location with the Local Authority Hospital Avoidance and Reablement teams in Emergency Departments to support early discharge." There is more on ps16-17: "We will share buildings, spaces and systems with partners to provide care that is integrated; where patients are seen by the right person at the right time regardless of the organisation providing the care. Locala will:

- Further rationalise our estate.

- Ensure future readiness for Greater Huddersfield CCG Phase 2 shift of care from acute to community.

- Develop our hubs so that non-clinical services are centralised and patients have appropriate access to clinical services.

- Continue to make best use of existing estate with clinical services accommodated to support the integrated clinical model. We will continue to rationalise the use of bases for clinical and non-clinical colleagues without

compromising the relationship with community care teams and general practice.

- Work with partner organisations and look for synergies to supplement the existing estate needs.

- Address the aging nature of the estate by creating hubs which concentrate community clinical expertise together serving larger populations. We will have identified the right spokes for care delivery and be working with the Local Authority, general practice and third sector partners to ensure those spokes are fit for purpose.

- Use our technology enabled integration model to support virtual as well as physical co- location e.g. skype-based MDTs and clinical discussions. As a health and social care system with a focus on community, general practice, social care and the third sector, we have consolidated teams into health and social care hubs, which are now working to align to Primary Care Networks.

- Have fit for purpose premises that offer flexible clinical accommodation to meet the changing needs of health providers, in the correct location, that meet the needs of the population and represent long term value to the local health economy. This also involves further co-location of health and social care and will provide the opportunity for greater integration of primary care with community teams e.g. building on Eddercliffe in North Kirklees and encompassing Civic Centre, Mill Hill Health Centre and Slaithwaite Town Hall.

- Develop place based approaches to the delivery of care to patients and the public e.g. focused work with sheltered housing providers and extra care communities. )

- The new GP Primary Care Network Directed Enhanced Services contract, that explicitly requires GP practices to work in networks with neighbouring practices and other providers including community service providers, based on their network's collaboration agreements. (And p10 adds, "With primary care we will:

- Develop a clear GP activity and communications plan which is reviewed monthly.

- Deliver a matrix management approach to primary care account management to improve communication channels and develop partnership working. This will include clearly defined roles, activity and meeting plans.

- Provide colleagues with the support and skills required to work in partnership with Primary Care Networks.

- Have regular meetings and communication with Primary Care Networks.

- Deliver Integrated Models of Care Multi-Disciplinary Teams in Primary Care Network areas as they continue to emerge – there will be a pilot and phased roll out approach.

- Identify and deliver GP partnership projects focused on improving patient outcomes.

- Work with Primary Care Networks to deliver data sharing projects with the ambition of data sharing becoming the norm.

- Develop a strategy for engagement and locality development which will be shared with partners."

Locala sees **digital technology** as key here. In relation to 'Work with Primary Care Networks to deliver data sharing projects with the ambition of data sharing becoming the norm', P13 of the Locala Care Closer to Home Plan 2018-20 refers to delivery of patients data to third sector partners through

"Automate[d] referrals through SystmOne templates and practice models to capture data of patients accessing Locala and third sector services" in order to "establish a synergy between clinical and non-clinical interventions, revealing where non- clinical intervention becomes a majority intervention in a patient's care plan."

("Non-clinical intervention" is a reference to the increasing use of social prescribing for peope with long term health problems, by link workers employed by Primary Care Networks and funded through the Primary Care Networks Directed Enhanced Services contract)

Priority 2: Digital **in** Locala's Care Closer to Home Plan 2018-20( ps 14-15 says,

"Locala will **invest in health technology** that improves patient outcomes or results in more efficient use of clinical time such as; online booking systems, self-testing, 'virtual' clinical care and online access to self-care resources. With an integrated health and social care approach it can also provide a more joined-up 7 day service. We will:

- Use digital technology to support self-care and maximising independence and measure our success.

- Deploy digital-health interventions to selected patients which will be built into the SPC [think this means Single Point of Contact] processes and electronic patient record system.

- Explore videoconferencing for some follow-ups, side-effects monitoring and communications with families and carers and also with care homes and Primary Care.

- Explore patient held records as part of integrated provider and pathway developments, and work towards the use of wearable technology becoming more available.

- Continue to develop our use of SystmOne in line with how the clinical record will be used in SPC, Localities, expert teams and with partners, for example GPs. Develop new SystmOne modules with all stakeholders, including GPs.

- Involve patients and carers in the use of technology, keeping abreast of how emerging consumer technology can support patient care.

- Implement digital monitoring to support self-care for people with long term conditions and early warning scores for patients in our intermediate care beds

- Develop an offline working solution to allow clinical colleagues to complete records/visits regardless of a stable connection.

- Work with Local Authority partners to identify opportunities to remotely control environmental conditions or trigger alerts (e.g. movement sensors).

- Introduce digital monitoring of patients where data can improve patient outcomes through supporting self-care, self-monitoring or by helping to reduce clinical input or admissions to Emergency Departments or hospital e.g. self-testing for UTIs, LTC digital monitoring for COPD and Heart Failure, digital Early Warning Scores in Intermediate Care beds.

- Deliver pilots as part of Locala's Digital Journey, to incorporate the testing of wearable technology to support clinical care, as appropriate technology is identified. "

**Calderdale Clinical Commissioning Group's** annually updated report *Care Closer to Home in Calderdale – An Overview* from 2013/14 similarly said that In October 2019 the 5 PCNs Maturity Matrix's https://www.nwacademy.nhs.uk/sites/default/files/resource_files/PCN%20Maturity%20matrix%2019-20%20Final.pdf and Development plans, placed them all at Foundation level.

## 1c. A complete list of Care Closer to Home/ Integrated Community Health Provision initiatives.

Calderdale Clinical Commissioning Group referred to their report *Care Closer to Home in Calderdale – An Overview* from 2013/14. It is updated annually to share with Calderdale LMC and wider partners.

In their Care Closer to Home update to the Aug 2019 Health and Wellbeing Board this report is what Calderdale CCG referred to as the scope of CC2H (now called Integrated Community Health Provision).

They told the Health and Wellbeing Board that the updated content was to be agreed Q2 2019-20, and that it included "new community offers focussed on high intensity service users."

The latest version produced in September 2020 lists place-based community interventions that were undertaken in 2018-19, plus an update. This list follows.

### Calderdale place based community interventions 2018/19 - 2nd quarter 2019/20

#### *Cancer*

2018/19

A new 'FIT' kit was launched to improve the detection rate for suspected bowel cancer. The new kit is a single, more accurate test which will reduce referrals for unnecessary colonoscopies.

A vague symptoms services was launched for people who are displaying symptoms which may or may not be cancer. The service offers a rapid diagnostic one stop shop to arrive at a diagnosis. Previously, people would have been referred to numerous services and have had numerous tests bouncing around between services.

#### *End of Life and Palliative Care*

Commissioners and providers are working across Calderdale and Greater Huddersfield to develop an integrated model of care which enables end of life services to be coordinated, person- centred, available seven days, and with a single point of access.

The key focuses are:

- Electronic palliative care coordination systems ('EPaCCS');
- Gold Standards Framework ('GSF')
- Single point of access
- Training

*EPaCCS*
The electronic system has been updated and re-launched to all partners involved in palliative care. This enables care to be more coordinated and person-centred.
*Gold Standard Framework (GSF)*
GSF is a programme available to GP practices and hospices to enable a gold standard of care for all people in the last  years of life, supporting them to live well until they die. A pilot is underway in 5 GP practices and Overgate hospice - consequently the care of these people at the end of their lives should be more proactive, person-centred and systematic.

*Single Point of Access*

A 'single point of access' is being developed to provide people and loved ones of those at the end of life with a single phone number to contact. When rolled out, this should improve patient experience and coordination, and reduce duplication in services.

*Training*

End of life and palliative care education and training continues in care homes. An 'End of Life Care Best Practice Workbook for Support and Care Staff' has been developed and rolled out across Calderdale and Kirklees. This is an educational tool for organisations and CQC expect care homes to use it.

### *Delayed Transfers of Care*

The system is continuing to address patients with long lengths of stay; so called stranded or super-stranded patients. Multi-agency discharge events review and plan for safe and timely discharges and address barriers as they arise. Calderdale continues to respond to the 8 high impact changes annual self-assessment.

CHFT continues to deliver transformation work and efficiencies through the SAFER patient flow programme. Discharge to assess is used for some patients where a further assessment in their home environment can support discharge and ensure their needs are met.

Extensive public engagement events to consult on the CC2H model was undertaken during March 2019, followed by a market engagement event in August 2019 to consult and advise Calderdale on the possibility of moving towards a procurement process if the Alliance pilot was unsuccessful in delivering CC2H.

*Update from 2018/19*

An expansion of the frailty service will see a Same Day Discharge unit which will be a 7 day service – 8am – 8pm.

### *Diabetes*

By the end of April 2019, GP practices in Calderdale had made over 1,100 referrals to the National Diabetes Prevention Programme, delivered by Reed Momenta since 2017. After 6 months of taking part in the Programme, the mean weight loss of people taking part was 2.6%.

The CCG recognises the importance of a continued focus on preventing Type 2 diabetes, an approach which is in line with Calderdale's Wellbeing Strategy and Care Closer to Home. Calderdale CCG is a member of the newly-formed WY&H ICS Diabetes Programme Board. This aims to support delivery of the NHS Long Term Plan diabetes commitments, deliver prevention at scale and reduce health inequalities across the ICS. The Programme Board will work closely with primary care, use primary care networks/localities to continue generating referrals to the NDPP and ensure the NDPP meets the needs the groups who experience barriers to diabetes healthcare, such as people from BAME backgrounds.

### *Frailty and Falls*

An acute frailty service is located at HRI. The multi-disciplinary frailty team actively identifies and draws people with a Rockwood score of 4-9 from the ED to undertake assessment with the ambition to get them home the same day and avoid admission. An expansion of the frailty service will see a Same Day Discharge unit which will be a 7 day service – 8am – 8pm.

A frailty 'one-stop shop' is being piloted in North Halifax from November to promote early identification and care planning for those at risk of frailty, including falls.

The Staying Well team and the Fire & Rescue service continue to promote and engage with people at risk of falls, social isolation and loneliness and signpost to services as required.

*Progress update from 18/19*

The new PCN DES for Anticipatory Care may further enhance targeted work for this cohort of people through early identification and assessment to maximise and maintain independence at home for as long as possible. This will reduce the need for permanent admission to 24 hour care for our frail elderly population.

### *Integrated Living Model*

The Integrated Living Model will create a new model of care for community services aligned to Care Closer to Home. Using evidenced based interventions a review of current services, pathways and processes will remove duplication and confusion to ensure services are patient-centred and holistic. The service aims to maximise independence keeping people safe at home longer and avoiding unnecessary hospital stays or admission to long term care. The focus is on rapid services at times of crisis including appropriate short term step up to community facilities and safe, timely and effective step down following a hospital stay. The review of the community bed base will include day provision where needed for rehabilitation and OPAT as well as reviewing the provision to ensure it meets the current needs of our local population eg stroke rehabilitation, neuro rehabilitation and people with dementia.

*Progress update from 18/19 page 22.*

During early 2020 we will test and evaluate a number of areas where we can make changes to our current pathways and provision to better meet the needs of these people and further reduce reliance on lengthy and potentially harmful stays in hospital. In February we plan to engage with our stakeholders and providers to gather their views about around the potential changes.

### *Long term Condition – COPD*

NHS England have funded licences for self-management app (MyCOPD), which is [sic] empowers patients to manage their own long term conditions closer to home; and the expectation is that they will need to access specialist care less frequently. The Apps will distribute to patients from November 2019.

*Progress update from 18/19 page 22.*

### *Respiratory*

West Yorkshire and Harrogate Health and Care Partnership are currently scoping a place based Respiratory Project aimed at improving respiratory outcomes; beginning in April 2020 and completing in March 2024.

The aims of the project are to:

- Help people be in control of their long-term health issues
- Build meaningful and trusting relationships with clinical professionals
- Develop proactive routine follow-up and reviews to empower people and prevent delays/omissions in care
- Develop collaborative goal setting and timely reviews
- Build connectivity with peers for support

The Clinical Forum is currently scoping:

- The project outline
- Priority ambitions
- How to champion to clinicians
- Programme leads
- Recommendation to the JCC.

### *Pain Management*

New NICE guidance is due imminently regarding Pain management; once the guidance is published we will start to develop pathway specifications and work with providers to manage the interventions required

### *Medicine Management & Optimisation*

The Medicines Management team at the CCG plan and support the delivery of an annual medicines optimisation plan within Calderdale GP practices. This includes cost effective and evidence based changes to prescribing plus a programme to improve specific quality and safety in prescribing measures. Safety and quality in prescribing initiatives reduce the impact of and likelihood of drug induced admissions.

Implementing national and local prescribing guidance for long term conditions helps patients to receive evidence based care and optimise their disease management. Managing their long term conditions most effectively with the aim of reducing need for urgent care. Benefits:

- Self-care for minor, self-limiting conditions supports resilience in general practice
- Improved quality and safety in prescribing improves patients health and safety and reduces harm from medicines
- Cost effective prescribing allows the CCG to spend money more effectively on NHS services.

NHSE Planning Guidance published in February 2018 stated that CCGs were required to provide extended access to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. To meet this requirement, and in response to the engagement we now have extended access to GP services across Calderdale. A mixed offer of pre- bookable and on the day appointments are available in all 5 localities Monday to Friday 6:30-8:00pm and in two localities at weekends. There is also a number of appointment types available including face to face and telephone dependent on need. In addition to this and in response to the requirements of the new GP contract every primary care network now provides additional appointments outside of core opening hours. This has provided additional opportunity for patients to be seen in Calderdale. For both these extended access appointments the clinician who sees the patient has access to their full medical records and can start them on any appropriate treatment or generate any onward referral.

A national review of access to primary care is taking place to understand whether these initiatives have worked. Locally, we are also working hard to understand how effective this provision is to meet the needs of our population.

### *Medicines Optimisation plans for 19/20*

The Pharmacy Leadership Group for WY&H ICS are working to deliver a single Area Prescribing Committee for West Yorkshire from April 2020. This allows a consistent approach to the shared prescribing of specialist medicines across West Yorkshire and will bring benefits for clinicians and patients in terms of access and patient safety. There will be a single guideline in place which agrees responsibilities for specialists and GPs and what monitoring is required Eg. Patients attending consultants in any of the acute trusts in WY will be able to receive medicines classified as suitable for shared care from their GPs.

Benefits:

- Patients can access the same list of specialist medicines from their GPs across west Yorkshire regardless of which consultant or hospital they attend.
- Consistent monitoring for patients on specialist drugs ensuring safe and effective use of these medicines.

### *Medicines Optimisation plans for 20/21*

Progress update from 18/19:

***Antibiotic Prescribing*** - Calderdale is an outlier for antibiotic prescribing. We are in the worst 15% of CCG for total antibiotic items per 1000 STAR-PUs (a prescribing unit which is weighted for age and sex, which allows benchmarking between practices or organisations of different sizes). The CCG benchmarks poorly against our 10 similar CCGs in Right Care and in the ICS for antibiotic prescribing..

In terms of quality of prescribing in Calderdale this is of significant concern – if antibiotic resistance increases due to continued overuse of antibiotics there is a risk that patients may need admissions for treatment of their infection. In order to try to prevent this, the CCG has developed a local antibiotics awareness campaign:

***Get a Grip on Antibiotics*** - Calderdale CCG has launched Get a Grip on Antibiotics to raise awareness of Antibiotic Prescribing in Calderdale amongst both the clinicians in our Member Practices and the General Population. We will promote self-care as first line for minor infections and support GPs to ensure that antibiotic prescribing is appropriate.

We are planning work with partner organisations, including Calderdale Council to further the reach of this campaign.

Campaign Benefits:

- Self-care for minor, self-limiting conditions supports resilience in general practice
- Improved quality and safety in prescribing improves patients health and safety and reduces harm from medicines

Note:  COVID-19 has impacted on the delivery of this campaign as it was suspended in March, which may continue through winter 2020. However there has been a Calderdale wide reduction in antibiotic prescribing, this has been seen in other CCGs too although Calderdale has seen the biggest drop across the ICS. This just needs to be sustained post COVID.

### *Respiratory Prescribing: Excessive prescribing of rescue medication, Short-Acting B2 Agonists (SABA), in asthmatic patients.*

June 2020 data shows that over the previous 12 months, 29% of asthmatic patients in Calderdale received 6 or more SABA inhalers which is significantly above the national average of 19%.

In terms of quality of prescribing this is an issue as the overuse of SABA inhalers and under-use of preventer medications have been highlighted as key contributors to asthma-related deaths in the National Review of Asthma Deaths Report (NRAD) and in an observational UK study as part of the SABINA Global Program which found that high use of SABA inhalers was significantly associated with an increased risk of exacerbations, asthma-related primary care consultations and asthma-related hospital outpatient consultations.

One of NHS England Long Term Plan respiratory ambitions is to reduce the of rescue medication (SABAs) in asthmatics patients and the CCG has developed guidance to support practices in delivering this element of the plan. There is a national dashboard which shows the number of asthmatic patients at risk from excessive SABA use and we plan to share this information regularly with practices and PCNs. We are also due to present this information to the practice nurse forum in October 2020.

Campaign Benefits:

Aims to improve quality of prescribing , and so asthma control in individual patients, therefore may help to reduce emergency attendances and ultimately emergency admissions.

Learnings From the COVID pandemic:

Better System working and relationships - we have worked as closely as possible with other CCGs, LA, LMC, LPC, PCNs secondary care, hospices, out of hours community pharmacies and others. Many organisations have come together to ensure problems are monitored and resolved if and when possible. One example of this has been improving assurance around the availability of end of life medicines from Community Pharmacies in Calderdale.

### *Musculoskeletal (MSK)*

MSK shows examples of how this fits the RCRTRP and CC2H models about where people would prefer their care delivery:

MSK was formalized as a first point of contact (FPOC) for all orthopaedic referrals in June 2018. Primary care colleagues and FFT surveys have evidenced a positive impact as a result of these changes. For example less people needing to access the hospital in 2019.

*Progress update from 18/19 page 23.*

The new GP contract from NHS England has provided some additional funding to support first contact practitioners working within GP practices. This is intended to increase appointments in primary care and will enable care to be delivered closer to home; this may reduce the activity that moves into the MSK service.

### *Older Adults' Mental Health*

The older adult's mental health intensive support service is currently under development and will support the CC2H approach.

The CCG Governing Body has agreed to invest in commissioning an older adults mental health intensive support service from SWYPFT. This service will operate 7 days a week from 8am to 8pm, and will offer intensive home based treatment as an alternative to hospital admission, thus allowing service users and carers to be supported in the least restrictive environment with the minimum disruption to their lives.

Expected benefits:

- Reduced utilisation of hospital services: Reduced A&E attendances and unplanned admissions to hospital
- Improved health: Better management of condition
- Improved care: More people enabled to stay at home and live within the community
- Improved value: Reduced costs associated with A&E attendances and unplanned admissions

### *Outpatient Visits*

Working with CHFT to introduce more virtual outpatient appointments for patients and their families/carers to reduce unnecessary outpatients attendance. Wrapping care around the person, rather than them having to transition multiple services.
As an example:

Virtual fracture clinics - where xrays are reviewed and a treatment plan with advice is developed and communicated with the patient in real time. This may mean that they do not have to visit to see the consultant initially and can be sent directly to the service that they require.

*Progress update from 18/19*

Work continues on the development of the demand management system (Ardens). New specialties and clinicians are being introduced into GP practices patient management softaware to reduce variation in referrals into secondary care

For example:

- Fatty liver clinics
- Arrhythmia clinics

### *Outpatient Appointments*

Diabetic clinic, neuro reviews and cancer follow ups also provide patients with a video review, which prevents unnecessary and lengthy visits to hospital. In some instances e.g. cancer chemotherapy treatments, this initiative could be potentially minimising patient exposure, considering their vulnerability and complications that can be incurred when experiencing neutropenic episodes in treatment, feeling fatigued and are too unwell to travel.

### *Personalised Care*

Personalised care changes empowers people to make informed choices, shared decision making and determine their plans for treatment and ongoing care and support. We are embedding all aspects of personalised care across all areas and disciplines including physical and mental health for all ages.

Social prescribing link workers employed within the Primary Care Networks will signpost to early intervention and prevention services including those in locality areas often delivered by the voluntary sector to maintain wellbeing. They will work closely with the existing Staying Well service who are already embedded in our local communities.

New services are contracted to deliver personalised care and there is a particular drive towards spreading the take up of personal health budgets more widely. For

example our new wheelchair services is offering both PHBs and support from the social prescribing link workers.

*Progress update from 18/19*
Social prescribing link workers employed within the Primary Care Networks will signpost to early intervention and prevention services including those in locality areas often delivered by the voluntary sector to maintain wellbeing and independence and reduce social isolation and loneliness. They will work closely with the existing Staying Well service who are already embedded in our communities.

### *Quest for Quality in Care Homes*

This service provides wrap-around multi- disciplinary support to Calderdale care homes and ensures a consistent and sustainable model of care for older and vulnerable individuals.

The 'Quest' model includes the offer of Assistive Technology:

### *Telecare*

A range of innovative sensors /detectors/alarms to detect incidents and alert staff to incidents occurring. 78% of care homes have seen a reduction in falls year on year, with 60% of homes seeing a reduction in falls of at least 25%.

### *Telemonitoring*

Allows care home residents to have a virtual appointment via secure video link with a clinician. This supports wrap-around care for residents and reduces avoidable out of hours hospital attendances /admissions.

### *Telehealth*

Telehealth monitors are available for people with long-term conditions to support self-managed care.

### *'Red Bag' Scheme*

Introduced across all Calderdale and Kirklees care homes to:

- Improve interpersonal communication between care homes, hospitals and ambulance crews
- Improve the persons experience when transferred between services.
- Reduce unnecessary incidents / omissions of care occurring

### *Capacity Tracker*

An electronic system which enables care homes to upload their live/real time vacancies. This supports more efficient discharge /transfers across the system.

### *Safespace*

Calderdale Safespace is an out of hours support service for people in emotional distress, provided by Healthy Minds, the local mental health charity. It is open on Wednesday, Friday, Saturday and Sunday evenings, and offers 1-1 support by telephone, text, Facebook messenger or face to face, plus peer support and access to wellbeing activities.

Benefits:

Reduced utilisation of hospital services: Reduced A & E attendances (Safespace is not a clinical service, so it is not possible to link Safespace records with hospital records; however, self- reported outcomes from the service point to reduced usage of A&E services)

Improved health: People supported to manage and improve their own emotional health and wellbeing. In the formal evaluation report, 66% of respondents using the service felt less anxious/depressed after accessing it

Improved care: Individual support, with peer support

Improved value: Reduced costs associated with A & E attendances and unplanned hospital admissions; social return on investment provided by voluntary sector (£4.54 per £1 invested in this service)

*Progress update from 18/19*

Safespace has become well-established in Calderdale as part of the response to emotional distress and crisis. It is currently open four evenings a week, but the CCG is increasing its investment so that it can open every evening from summer 2020.

### *Older adults' mental health intensive support service*

In October 2019, the CCG made a decision to invest in an older adults' mental health intensive support service. The service is designed to provide a timely and effective response to crisis and risk of relapse, and provide intensive home based treatment where this will meet the needs of those in crisis. The service will run from 8am to 8pm seven days a week (outside these hours its function will be provided by

the adult intensive home based treatment team). The service will be provided by South West Yorkshire Partnership NHS Foundation Trust, and is expected to begin operating in spring 2020.

### *Wheelchair services*

CCGs Governing Bodies approved the outcome of the procurement process, assured that it had been robust, and strengthened by the extensive involvement of service users and other stakeholders throughout 2016-2018. The new service commenced 1st October 2019.

*Progress update from 18/19*

All three CCGs (Calderdale, Greater Huddersfield & North Kirklees) each provided £100k non-recurrent funding to the service (total £300k) in this financial year (2020/2021) to support Ross Care in reducing open episodes of care from 1 October 2019 (the new contract start date). This work prioritises people waiting longest and with the greatest need.

During the C-19 Pandemic, Ross Care completed risk assessments and introduced new processes to ensure the safety and wellbeing of staff and service users. Improvements were made to the Elland site, including reorganising the depot, painting clinic rooms and reception, and creating more child-friendly areas.

### *Independent Living Model supporting people with dementia*

As part of Care Closer to Home, partners are working together to develop an Independent Living Model (ILM) which builds on the current reablement offer in order to keep people in the community. As part of ILM, key stakeholders e.g. Council, CCG, SWYPFT are working together to review the current pathway for people with dementia and how we can build upon current services in order to support more people to remain at home and prevent escalation of crisis and potential avoidable admissions to hospital. The development of the new older adults' mental health intensive support service will form a key part of this model through the provision of specialist advice and support.

### *Individual Placement and Support*

Individual Placement and Support (IPS) has been operational since September 2019 in Calderdale for people using secondary mental health services who want paid work. The service is staffed by a Council and Trust employment specialist and an IPS team leader. The service provides an assessment or vocational profiling around

the person's interests, coaching around the practicalities of finding a job and preparing for interviews whilst providing tailored ongoing support when the person is in work. The team also search for jobs and speak to employers directly alongside the service user or on their behalf to identify well-suited roles, acting as a crucial link between the individual, their employer and their clinical team.

### *Wellness hub*

North Halifax Community Wellbeing Partnership has set up an evolving wellness hub at Beechwood Medical Practice, aimed at encouraging people from North Halifax with serious mental illness to come along and receive support/advice from a number of different services designed to help improve their health and wellbeing. The services represented cover housing, benefits, work, healthy living, physical and mental health and social activity. Once the model is established, the plan is to roll it out to other groups of people starting with people with learning disabilities.

### *Mental health rehabilitation service*

A business case is being developed for a mental health rehabilitation service. The service will incorporate the inpatient rehabilitation service (already established at Lyndhurst in Elland) but will also include a new outreach service which will work to support people to avoid hospital admission or to return to daily living after an admission. The service will help to reduce the use of out of area placements.

### *Savile Bank supported living*

Ten supported living flats for people with long term mental health needs have opened at Savile Park, and will be fully occupied by the end of March 2020. Each resident has an individual tenancy and is being supported by Union Housing Scheme to live as independently as possible. This is part of work being undertaken by the Council and the CCG to increase the range of housing options for people with long term mental health needs.

### *Assessment and Treatment Units*

As part of the West Yorkshire and Harrogate (WYH) Health and Care Partnership, the CCG has been working with partners CCGs and Local Authorities to review the current WYH Assessment and Treatment Unit (ATU) service's form and function. This is building upon the national Transforming Care Partnership programme and the ambition to reduce the number of people in hospital. A proposal for a new approach to the WYH ATU bed base is to be presented to JOSC for consideration in February.

### *Thriving in Calderdale*

In Calderdale, the mental health and wellbeing needs of children, young people, parent carers/ families are being met through implementation of the national Anna Freud Centre 'Thrive' model.

Under the old Tiered, CAMHS system, children and young people were assigned care provided by specific providers, based on their assessed complexity of need.

Thrive is based on the concept that around 80% of children and young people at any one time experience the normal ups and downs of life but do not need individualised advice or support around their mental health issues.

They are considered to be 'Thriving'. For the remaining 20%, the Thrive approach means that children and young people can receive support at any time, from the most appropriate service and resources within the system that meets their needs.

'Thrive' is a person-centred, whole system approach, where mental health and wellbeing is considered everyone's business.

Applying the 'Thrive' model will mean the people of Calderdale are more likely to live healthy and independent lives, secure in the knowledge that, if they need them, services will be there to keep them safe, supported and cared for.

### *Open Minds Partnership*

Since 2015, providers and commissioners of emotional health and wellbeing services have been working ever more closely together to transform and improve the offer for and experiences of children and young people of Calderdale. This work continues as we move into a new decade.

Statutory and third sector partners continue to maintain and develop new working relationships with each other, that enable greater collaboration and joined-up working needed to deliver 'Thrive'.

In February and November 2020, the Anna Freud Centre delivered its Mental Health Services and Schools Cascade Training to partners in Calderdale. Funded by the Department for Education, this innovative programme has brought together over 50 professionals from schools and colleges, mental health providers and other key stakeholders across Calderdale. It aims to encourage closer working by all those providing mental health and wellbeing support to children and young people as part of 'Thrive' and the Open Minds Partnership.

In parallel, the Health and Wellbeing Taskforce (responsible for the Local Transformation Plan which ended 2020) the Open Minds Steering Group, and other partners, such as Healthwatch Calderdale came together to form a wide Open Minds Partnership (OMP) in Summer 2020. This is a cooperative of local authority,

NHS and third sector organisations commissioning and providing emotional wellbeing and mental health support for children and young people in our area.

The OMP aims to foster closer links with additional providers and stakeholders, and create a stronger partnership approach to delivering improvements in emotional health and wellbeing services for children and young people in Calderdale.

The Group meets quarterly to drive forward the delivery of Thrive, the NHS Long Term Plan, plus the local priorities which are the legacy of our work on the Local Transformation Plan.

### *Children and Young People's Emotional Wellbeing and Mental Health during the C-19 Pandemic*

During the C-19 Pandemic, the Open Minds Partnership (multi agency partners working together across Calderdale - OMP) continued to support our children and young people and their families.

Open Minds (the new name for CAMHS) has continued to accept referrals throughout. These are accepted via email, online and via telephone, but no longer through the post. This is a permanent change, made to safeguard vulnerable children and young people and ensure their needs are met as quickly and appropriately as possible, particularly those at highest risk, such as those with suicidal thoughts or emerging eating disorders.

Commissioners, providers and wider partners meet regularly to identify and manage risks, ensure effective communication and provide support to children, young people, families, and professionals working with them. Partnership updates on the current service offer, and the status of neurodevelopmental assessments (including for autism) were provided regularly to partners, including colleagues in education and primary care.

The Partnership has continued to work with young people to develop and share COVID-19, and broader emotional wellbeing advice via the Calderdale Open Minds web site: http://www.openmindscalderdale.org.uk/ , including Worry Cards.

Developed by young people, these aim to help decrease stress levels about any worries or queries students might have, especially those who've not accessed formal education since March 2020.

The Partnership has also developed bespoke return-to-school guides with, and for primary and secondary school children, parents, and school staff.

Calderdale MBC, in collaboration with OMP partners, will use a small DfE grant to deliver a 'Wellbeing for Education Return' project in the Autumn 2020 term. Building on existing local initiatives and using new training resources, this will provide

additional support to staff in state-funded schools and colleges, so they can better support students returning to education during the C-19 pandemic.

### *Meeting the needs of Children and Young People with Autism Spectrum Disorder*

In January 2019, system leaders, young people, parent carers, community representatives and elected members attended Calderdale's first Children and Young People's Autism Spectrum Disorder (ASD) summit.

Here they pledged to transform the experiences and outcomes of children and young people, and take positive Action on Autism. The outcomes were used to inform the work of the Calderdale ASD Steering Group and Open Minds Partnership during 2019.

Referrals for autism and/or ADHD are now integrated within the Open Minds First Point of Contact (FPoC). Previously, cases would undergo a lengthy triage process within the FPoC and then undergo a further screening by the mental health provider South West Yorkshire Partnership Foundation Trust (SWYPFT).

The system has been adapted so that families and professionals are now sent a screening questionnaire within a few days of a referral being made. The information from the questionnaires is used to determine whether a specialist assessment is then offered. This new process gives parents/carers the opportunity to give their views and contribute to the decision- making process.

Some parent carers can experience difficulties while waiting for an autism assessment for their child or young person. They now have access to a practitioner who provides support to them while they wait.

Open Minds also provides direct interventions to young people on the waiting list for an autism assessment. This is in addition to the support provided to parent carers.

Another Summit took place in February 2020. Calderdale Young People with Autism Spectrum Disorder (ASD) designed and led a Marketplace event and stakeholder summit at North Bridge Leisure Centre, Halifax, for system partners. Here, they recommitted to continue the transformation the of ASD services for children and young people. The ideas and actions it generated are being used to inform Calderdale system working under the 'Thrive' model and next steps for ASD, to be delivered by the Calderdale ASD Steering Group, part of the Open Minds Partnership.

### *Calderdale Mental Health Support Teams (MHST)*

In 2020, Calderdale was successful in securing NHS England funding for two Mental Health Support Teams (MHST).

These teams will help young people in our schools by supporting teachers and staff to identify issues young people may have as early as possible, so they can get help and support when they need it. Their work is even more important in alleviating the impact of the C-19 Pandemic.

Recruitment of these teams will result in an increase in the number of mental health professionals working in Calderdale as part of the Open Minds Partnership. The new Teams will begin work in September 2020.

### *CC2H Alliance – Care home Directed Enhanced Service*

Update from 2018/19

COVID ECH DES - Joint collection of daily intel' from Council Quality Business Relationship Managers and CCG teams for each home to support the rapid deployment of IPC/Quest resources to homes in or near to crisis to prevent outbreaks and address associated quality issues.

Cross agency Tactical Command Group, supported by a Covid SitRep made a significant contribution to the reduction of combined symptomatic and positive cases/deaths across resident and staff groups during this period from March to July 2020.

A consensus was reached during Covid across CHFT, LA and CCG to conduct a joint operational and strategic approach to address long standing quality issues and promote market development and sustainability. With a commitment that the same offer will be provided to all homes regardless of type.

Right Skills In The right Place – Enhanced Care Home Support Team are focusing on Social, Medical and Emotional needs of all residents in all homes; including Supported Accommodation for People with Learning Disabilities

Shared skills – Shared Workforce - i.e. Combined CCG/LA Business Relationships Managers/'One Quality Team'.

Integration of Medication reviews; looking at a model where the pharmacist is part of the team rather than a single designed approach.

Third Sector and Public Health have a significant part to play with the Wellbeing Agenda for Care/Nursing Home residents and staff.

Work is being undertaken to scope out the impact of one GP practice per care home (financial, workforce). This may lead to a delivery discussion at PCN level. There is a commitment to weekly MDTs, which will include a GP.

## Services in North Kirklees CC2H contract

This is the list they sent, plus some additional N Kirklees CC2H services from Appendix A - Current services and functions for NHS Greater Huddersfield and North Kirklees CCGs Community services. This is an Appendix to the Community services Engagement and consultation mapping summary document March 2013 – August 2018

| | |
|---|---|
| Hub | Co-ordination of referral throughout the system. Both adult and children |
| Community beds – access to beds which can be used flexibly to meet holistic needs of the patient | Current provision intermediate care beds. |
| Care homes | Access to additional health service/clinical provision to ensure an integrated approach to address proactive and anticipatory approaches, rapid response to crises (including planned response) and early supported discharge (if hospital stay is necessary). |
| Nursing, adults & children | District nurse, community matron, nurse practitioner, children's community nurses as examples. |
| Specialist nursing, adults & children | Includes for example (not limited to):<br><br>Neurological Conditions<br>Tissue Viability<br>Continence,<br>Heart Failure,<br>ESD<br>COPD,<br>Dementia<br>TB. |

| | |
|---|---|
| Rehabilitation | Cardiac rehabilitation,<br>Pulmonary rehabilitation<br>Stroke early supported discharge. |
| Therapy adults | Occupational Therapy,<br>Physiotherapy,<br>Podiatry (including diabetes podiatry provision)<br>Dietetics,<br>Speech and Language Therapy<br>Co-ordination and integration with Speech and Language, Dietitians, Podiatry functions. |

| | |
|---|---|
| Children's community Service | Physiotherapy<br>Occupational Therapy,<br>Speech and Language Therapy,<br>Children's community nursing,<br>Looked After Children health nurses,<br>Youth Offending Team Nurses<br>Pupil referral Unit nurses<br>Specialist support to schools. |
| Older people's mental health | Older People's Memory Monitoring,<br>Admiral Nursing,<br>Older People's Acute Liaison Service<br>Older People's Community Mental Health Team. |

| | |
|---|---|
| Early Supported Transfer/Discharge | Case management<br>Navigator<br>Holistic assessment<br>Involvement of carers.<br>Care planning (including self-management, emergency care plan and advanced care planning)<br>Co-ordination<br>Self-care sign posting/referral<br>Access to equipment (including bariatric and specialist equipment)<br>Communication of current presentation and needs<br>Liaison<br>Communication<br>Sign posting<br>Records management<br>Infection Control<br>Safe guarding<br>Escalation<br>Referral to other services<br>Carer assessment |
| Hospital Avoidance | Proactive approach/intervention to prevent a hospital admission |
| Rapid Response; “Crisis Intervention” including a planned response | Proactive approach/intervention to prevent escalation of care needs to hospital. |
| Medicines Optimisation | Patients cared for as part of the integrated care model gain maximum benefit from prescribed medicines. |
| Care Co-ordinator | Co-ordinating patient care across care settings and over time, particularly for patients with long-term chronic and medically complex conditions, who may find it difficult to 'navigate' fragmented health care systems. |

| | |
|---|---|
| Self-Care | People with long term conditions are increasingly independent, self-sufficient and resourceful to confidently manage their needs, reducing dependency on the health and social care system and improving their wellbeing and lifestyle. |
| Frailty Model | Healthy Active ageing and supporting independence<br>Living well with simple or stable long term conditions<br>Living well with complex co-morbidities, dementia, frailty<br>Rapid support close to home in crisis<br>Good acute hospital care when (and only when) needed<br>Good discharge planning and post discharge support<br>Good rehabilitation and re-ablement after acute illness<br>High quality nursing and residential care for those who truly need it.<br>Choice, control and support towards the end of life |
| Falls | Awareness and education raising<br>Screening for future fall risk<br>Screening for future fragility fractures<br>Timely/rapid wound management and suturing response<br>Diagnosis<br>Assessment<br>Referrals<br>Investigations (to rule out cardiac and neurological causes)<br>FRAT level 1 carried out (generalists)<br>FRAT levels 2 and 3 carried out (specialists) |

| | |
|---|---|
| Community-based Cardiology | Assessment & Management<br>Care planning<br>Case management<br>Education<br>Cardiac rehab – interdependencies for educational input with respiratory provision<br>7 day availability to specialist clinical provision<br>Rotational approach across secondary care<br>E-consultation |
| Palliative and End of Life Care | Awareness and education raising<br>Integration with care co-ordinator<br>Assessment<br>Referrals<br>Palliative/end of life care (integration with specialist palliative care teams).<br>Qualified staff able to meet complex needs<br>Respite?<br>Access to generic nursing function/specialist nurses/clinician/community matron<br>Advanced care planning<br>Pain management?<br>Specialist holistic assessment, 24 hours advice and support to staff/patients/carers? |
| Dermatology - other community based services | Right dermatological care in the right place at the right time by the right people, whilst ensuring value for money<br>That overall 60% or more of activity is delivered in the community setting |

| | |
|---|---|
| Community based respiratory approach | Admissions avoidance<br>Assessment<br>Early Supported Discharge<br>Specialist Case Management<br>Access to psychological therapies<br>Palliative care<br>Provider Respiratory Training and education<br>Self-management<br>Adoption of care planning hierarchy model (personal care plan, self-management plan, emergency care plan, advanced care plan )<br>Urgent reviews (admissions and early supported discharge)<br>Community MDT - complex asthma service (children & adults)<br>Spirometry (diagnosis and post broncho-dilator ARTP accredited)<br>Home Oxygen Service (Assessment; review & contract monitoring – respiratory & non-respiratory)<br>Home assessments and investigations<br>Nebuliser Service<br>Pulmonary Rehab<br>Use of E-consultation (not currently commissioned)<br>Input into national audit<br>New TB service (community and specialist care across Kirklees)as per agreed specification |

## Services in Greater Huddersfield CC2H contract:

(From same sources as N Kirklees, please see above.)

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|---|---|
| Cardio Vascular | Cardiac Rehabilitation,<br><br>Heart Failure/ BNP<br>Stroke Early Supported Discharge (ESD). |
| Dermatology | Integrated specialist dermatology service. |
| Diabetes | DAFNE & DESMOND,<br>Safer Ramadan - diabetes-risk prevention programme,<br>Diabetic Foot Screening (new and follow up),<br>Specialist Nursing (Adult)<br>Community Diabetes Service. |

| | |
|---|---|
| End of Life | Gold Standard Framework Facilitator,<br>MacMillan Benefits Advisor, Rehab Team & Care Home Nurse Educators<br>Community End of Life (EoL) Care Facilitator.<br>Palliative Care - Adult and Child |
| MSK | Minor Hand Surgery,<br>Podiatric Surgery, including biomechanics<br>Community Musculoskeletal (MSK) Service, including Extended Scope Physio.<br>Community based Chronic Pain Management |
| Mental Health | Older People's Memory Monitoring,<br>Admiral Nursing,<br>Older People's Acute Liaison Service<br>Older People's Community Mental Health Team. |
| Respiratory | Asthma Respiratory Nurse,<br>Respiratory ESD,<br>Pulmonary Rehabilitation & Support,<br>Respiratory Nursing and<br>Respiratory EoL Breathe Better programme. |

| | |
|---|---|
| Therapies | Community Rehab,<br>Dietetics<br>Podiatry |
| Specialist Nursing | Specialist Nurses e.g. Continence, Multiple Sclerosis, Tuberculosis, Tissue Viability |

| | |
|---|---|
| Community Generic | Community Matrons including case management,<br>District Nursing,<br>Intermediate Care Services including; Falls, and Intermediate Care (IMC) Bed,<br><br>Outpatient parenteral antibiotic therapy,<br>Single Point of Access (SPA) and extended SPA for the model,<br>Involvement in some children's multi-disciplinary teams including Pupil Referral Service, Youth Offending Team Looked After Children<br>Virtual Ward / Frailty / Admission Avoidance. The Locala 2018-20 Plan adds (p12): "We will...Work with third sector and partner organisations on the **admission avoidance Local Incentive Scheme (LIS)** supporting patients with a range of non-health interventions, supporting them to reduce their reliance on traditional health services. Development of a SystmOne template and practice model will identify patients at risk of admission and prescribe non-health interventions through referral to our third sector partners..." |
| Other Generic | Continence<br>Hospital at Home,<br>Neurology (community) and<br>Day Surgery (plastics, podiatry) |
| Seamless Home from Hospital – Calderdale and Greater Huddersfield | Contribute to a reduction in avoidable hospital admissions and delayed transfers of care.<br>Avoidable admissions include admissions from A&E for non-clinical reasons and readmissions after discharge. |

**The Kirklees CCGs also responded:** For further detail please refer to the service evaluation documentation of Kirklees CC2H contract.

At the end of this 2019 Evaluation Report comes the Locala Care Closer to Home Plan 2018-2020.

**This includes the following additional CC2H services (p4)** , delivered from both of Locala's Business Units – "Integrated Community Services" and "Living Well".

- Age UK Personal Independence Workers
- Children's Expert Team
- Dietetic Outpatients
- Integrated Community Care
- Intermediate Care – IV Therapy
- Intermediate Care - START (Short Term Assessment and Rehabilitation Team)
- Diabetes Specialist Education
- Moorfield – Dermatology
- Moorfields MSK
- Moorfields – Neurology
- Specialist Nursing – Cardiac rehab
- Specialist Nursing – Diabetes
- Specialist Nursing – Respiratory (might be the same as COPD in NK list, above)
- Supporting Transfer of Care
- Older People's Mental Health Care home Liaison Service
- High Intensity User Group
- Medicines Management
- Wound care
- Long Term Care support
- Home from hospital

- Specialist Falls service
- Reablement
- End of Life Champions
- Breath Better/Heart Failure support groups (Kirkwood Hospice)

## Plus the Kirklees CCGs sent this additional info: Kirklees Community based Urgent Care Services:

NHS England and West Yorkshire and Harrogate Care Partnership Ageing Well programme have been established to support the implementation of the NHS Long Term Plan ambitions.

A key part of the National Ageing Well Programme is the establishment of seven urgent community response accelerator pilot sites to support delivery against 0-2 hour and 2 day response targets.

In November 2019, Kirklees was selected as one of the national accelerator areas for Urgent Community Response.

### More information about Urgent Community Response (UCR):

*What is Urgent Community Response?*

As part of the NHS' Long Term Plan to support England's ageing population and those with complex needs, local health service and council teams will begin the roll out of Urgent Community Response teams.

These Urgent Response teams will give those who need it fast access to a range of qualified professionals who can address both their health and social care needs.

*Why are we introducing an Urgent Community Response in Kirklees?*

The Service Aim for the Kirklees UCR is to provide a 0-2 hour response for patients diagnosed as severely frail (and moderately frail from Yorkshire Ambulance Service and Care Homes) in order to prevent avoidable admissions and readmissions by managing the patient at home with appropriate ongoing community support.

These 0-2 hour and 2 day urgent response standards are part of a range of commitments which aim to help keep older people well at home and reduce pressure on hospital services.

*Who will provide Urgent Community Response locally?*

A Kirklees Provider Alliance has come together to collaboratively deliver the Urgent Community Response locally. The Alliance is made up of Third Sector leaders, Locala, Local Care Direct, Kirklees Council, Primary Care Network Clinical Directors, Curo and My Health Huddersfield GP Federations, Kirkwood Hospice, SWYPFT, Greater Huddersfield and North Kirklees CCGs, YAS, 111, Mid York Hospital Trust and Calderdale and Huddersfield Foundation Trust.

The Kirklees Urgent Community Response team has resource to recruit an additional 37 staff to support delivery- 33 being health and care colleagues and four providing managerial and administration support.

*How will Urgent Community Response be delivered?*

In Kirklees, residents who are severely frail (and those who are moderately frail if referred from Yorkshire Ambulance Service and/or Kirklees Care Homes) will be able to access a response from a team of skilled professionals within two hours, to provide the care they need to remain independent and avoid an admission to hospital.

A central Kirklees Urgent Community Response Hub will provide clinical triage and either refer onto a face to face appointment or signposting to another service. This hub is being hosted by Local Care Direct.

If the service criteria is met and the triage process indicates that an urgent response is needed then a 0-2 hour referral will be made.

Alongside this 0-2 hour response, a two day standard will also apply for teams to put in place tailored packages of intermediate care, or reablement services, for individuals in their own homes with the aim of restoring independence and confidence after a hospital stay.

*Where and when will Urgent Community Response be delivered?*

The Kirklees Urgent Community Response service is an 18 month pilot. To that end the Kirklees Provider Alliance Network will be constantly evaluating and auditing demand, capacity and outcomes which will help us amend and improve the service as its develops.

The Kirklees Urgent Community Response services will be implemented in a phased approach – based on the learning as the service embeds.

- To begin with the service will;
  be available for Kirklees residents who are severely frail (and those who are moderately frail if referred from Yorkshire Ambulance Service (YAS) and/or Kirklees Care Homes.

Receive referrals from Kirklees Primary Care, Kirklees care home and Kirklees community services.

The intention is that once the service is up and running referrals will be accepted from Yorkshire Ambulance Service, 111 and self- referrals.

**Our impression is that these are pie in the sky plans.** The Care Closer to Home information is very woolly and has been around for years. And what about the community beds that were previously cut, the rapid response teams that were cut, the walk in centres that were cut?

Step down beds / hospital admission avoidance - great. But has capacity increased massively? Have community staff got fast access to the community beds needed, and the equipment such as hospital beds, commodes etc? And how quickly is social care going to step in so that these rapid response teams (that mostly were previously disbanded) can get the next person out of hospital fast?

Previously all of these services were branded too expensive and scrapped, there are not many community beds. It's skilled and labour intensive work. Where's the evidence unskilled staff (alternative Primary Care Network roles) and private providers can deliver any of this??

Single point of access for the dying - aka gold line, been around for years. Has it demonstrated that hospital beds are unnecessary?? FIT tests saving colonoscopy referrals? Great - what about the any number of other things that cause admission and block beds?? And diabetes omg unless they are going to plough money into public health and early years and challenge fast food and sugar ..... Please!!

As for the "self-management app (MyCOPD)" that the CCGs distributed from November 2019 - it's amazing how well all these people look in the video. Crackers. My neighbour who died in Jan this year had COPD, he had no internet and a 20 year old Mokia pay-as- you-go.

# Appendix 2

*Please note: In order to provide a clear analysis of the Clinical Commissioning Groups' FOI response, in this summary I have grouped the questions in sections 2 and 3 differently than they were in the FOI request and response. So the question numbers here are not the same as the question numbers FOI docs.*

## Questions about Quantitative and Qualitative Data collected by the Clinical Commissioning Groups since 2018

That show:

a) the impact of CC2H on unplanned hospital bed days and A&E attendance;
b) patients' and clinical and caring staff experiences of the quality of CC2H;
c) any cost savings as a result of the impact on unplanned care of improving planned and self-care;
d) what data the CCGs provide to CHFT
e) how patients' social and economic situation and general wellbeing affect their ability to manage their own health and care, and the type of care they need from health and social care services.

### *Q2a Which Care Closer to Home key performance indicators do the NHS Commissioners use to collect data about the impact of CC2H on unplanned hospital bed days and A&E attendance?*

Specifically: do Calderdale, GH and N Kirklees CCGs use the 3 Key Performance Indicators in the CC2H Prospectus that the Clinical Commissioning Group reported on to the 14.11.19 Calderdale Adult Health and Social Care Scrutiny:

- emergency admissions for urgent care sensitive conditions/100K population
- Av delayed transfers of care per day/100K population
- Use of hospital beds following emergency admission/100K population

**NHS Commissioners' response** : "Please note that the evidence base for the impact of integrated care tends to be based on whole system changes which cannot easily be disaggregated and sized."

**Calderdale CCG** added: "These KPIs are part of the developmental agenda. These may change as the programme matures and will be influenced by learning from the COVID-19 pandemic."

## *Q 2 a.i) Have the CCGs decided to use different KPIs than those recommended by the McKinsey RCRTRP Modelling Report?*

In order to be able to demonstrate the impact on performance as soon as possible, the Report suggested metrics could include:

- Non- elective (NEL) admissions and bed days
- A&E attendances
- Hospital length of stay
- GP appointments and referrals to secondary care
- Usage of intermediate care services, both bedded and non-bedded
- Number of people in long term residential care and in receipt of home care packages

Please refer to the answer given in response to question 5a.

**Calderdale CCG's response** referred me to their answer to Q 2a)

**Kirklees CCGs' response** directed me to a March 2017 "table of indicators in the service evaluation documentation of Kirklees CCTH contract, referenced in Q3, particularly in Section 7, Table 7."

Their Table 7 (not included here) shows there are scores of Care Closer to Home Key Performance Outcome Indicators indicators. These include:

- reduction in emergency admissions
- reduction in A&E attendance

The data in Table 7, Key Performance Outcome Indicators Mar-17 is irrelvant to the FOI request as it is not in the 2018- onwards timeframe that I'd asked for.

But, for the record, in 2017, Locala had not achieved its monthly Key Performance Outcome Indicator target of -2.04% reduction in emergency admissions (Reported one month behind). Instead in March 2017 there was apparently a 0.62% increase.

There were 9 months worth of data from July 2016 to March 2017 in the KPMG 2018 Well-Led Governance Report on Locala Community Partnerships, from the link to the 13.3.2019 GH and NH CCG Governing Body papers https://nkgh-ccg.co.uk/wp-content/uploads/2021/01/PUBLIC-Governing-Bodies-Agenda-Papers-13.02.19-1.pdf .

The KPMG 2018 Well-Led Governance Report included a Patient Outcomes Monthly Monitoring Table, July 2016- Mar 2017.

The table showed Reduction in emergency admissions was rated Red: the target of a -2.04% reduction had not been met in a single month.

Here is the 'change in emergency admissions' data extracted from the Patient Outcomes Monthly Monitoring Table, July 2016- Mar 2017

% Change in Locala patients' emergency admissions (Target: -2.04%)

| July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 | Jan 2017 | Feb 2017 | Mar 2017 |
|---|---|---|---|---|---|---|---|---|
| 2.16% | 2.91% | 3.05% | 4.74% | 2.12% | 1.67% | 1.72% | 1.07% | 0.62% |

Reduction in A&E attendances -the RAG rating was N/A.This seems to be because the target is to be confirmed.
The actual figure for March 2017 A&E attendances is 613.39. What does this mean? How can you have a fractional A&E attendance?

But this is just one 3 month period in 2017/18. Where are the data for all the other quarters during Locala's 5 year contract 2015-20, which has been extended for a further two years to 2022?

The Locala Care Closer to Home Plan 2018-2020 (p8) lists among its successes:
"Admission avoidance work through the Local Incentive Scheme in 2017/18:
- Reduction of 113 avoidable admissions as at the end of Q3
- Reduction of 113 A&E attendances as at the end of Q3"

## Q 2b) What data are being collected to show the main KPIs over time for all the initiatives (as listed in answers to Question 1c, above) in Calderdale and Kirklees Care Closer to Home?

Specifically, please provide all the Calderdale and Kirklees data you have been collecting since 2018 that identifies the impact of all the Calderdale and Kirklees Care Closer to Home/ Integrated Community Health Provision initiatives on:

- CHFT A&E attendances
- CHFT Non-elective/unplanned hospital admissions and bed days

- CHFT Hospital length of stay,
- GP appointments and referrals to CHFT secondary care
- Usage of intermediate care services, both bedded and non-bedded
- Number of people in long term residential care and in receipt of home care packages
- Patient satisfaction with CC2H services
- NHS, social care and VCS staff satisfaction with CC2H services

**NHS commissioners' response:** "In relation to Calderdale, as part of our CC2H programme we set 3 key measures, one of which was to sign off the KPIs. Due to the pressures of the COVID-19 pandemic this was paused and as a consequence no data has been collected. In addition, please refer to the answer given in response to Question 2a)

"For Kirklees please refer to Q2a)."


**a) With regard to the lack of data collection since the Covid-19 pandemic** - the data that's not been collected may relate to an assertion Neil Smurthwaite (at the time the Acting Chief Officer of Calderdale Clinical Commissioning Group,) made to the September 2020 Calderdale and Kirklees Joint Health Scrutiny meeting: that hospital capacity issues will be taken care of by NHS England/ Improvement investment in new roles in community care, such as social prescribing, physiotherapists and pharmacists.

In the Feb 2019 CKJHOSC meeting, the co-chair Cllr Colin Hutchinson said that at the West Yorkshire and Harrogate level there were very serious concerns about numbers of staff available to work within the system. The Joint Health Scrutiny Committee need to know the data about that.

In order to identify how many patients can be allocated to new, less-skilled "additional" practitioners instead of GPs, Calderdale Primary Care Networks are currently analysing their patient lists using a commercial digital platform that requires the unconsented sharing of patients' real-time personal GP medical records. https://calderdaleandkirklees999callforthenhs.wordpress.com/2021/02/06/calderdale-gp-patients-real-time-medical-data-is-being-shared-without-their-knowledge-or-consent/

**b) With regard to the years 2018/19 and 2019/20, Calderdale's statement that no data has been collected surely can't be true?** C19 started in March 2020. Why haven't they provided data for the 2 preceding years? (And this goes for the Kirklees CCGs too).

At some point over the last three years Matt Walsh (at the time the Calderdale NHS Commissioners' boss) told CK JHSC that the A&E Board had a lot of the data and invited the committee's Co-Chair Colin Hutchinson to have a look at the A&E Board data.

In February 2019 Matt Walsh agreed to give Calderdale and Kirklees Joint Health Scrutiny Committee vital data about the impact of the Calderdale Care Closer to Home on A&E attendance and unplanned hospital bed days. He added that,

> *"There is so much data that NHS Commissioners can't see the wood for the trees."*

He offered to identify subsets of data on outcomes for patients to 'share' with the Joint Health Scrutiny Committee. He said the NHS organisations already report this data to NHS England.

**So why haven't they provided these data in reponse to this FOI request?**

Did the NHS Commissioners get lost in the data wood? Because they did not give these subsets of data on patient outcomes to the July 2019 Calderdale and Kirklees Joint Health Scrutiny Committee meeting.

The co-chair Cllr Smaje then said that Calderdale and Kirklees Joint Health Scrutiny Committee wanted 'a specific piece of work' from the NHS organisations to show the evidence underpinning Strategic Outline Case claims that care closer to home services demonstrate a reduction in hospital care.

Cllr Hutchinson added that the Scrutiny Committee would assess which data they need to test that the local NHS is on a trajectory that makes the hospitals planning assumptions valid. An informal workshop with the Clinical Commissioning Groups and the Trust about the data dashboard would be useful, particularly in relation to the 1st 2 requirements of the Secretary of State - the need for further work on out-of-hospital care and the capacity within the hospitals.

Matt Walsh said they fully accepted that. They needed to do that work themselves. (Presumably so they could see their way out of the data wood.)

But by the 18th October 2019 Calderdale and Kirklees Joint Health Scrutiny Committee meeting, no data dashboard information was forthcoming.

Cllr Hutchinson reminded the Clinical Commissioning Groups that the Scrutiny Committee needed to know about the increase in 'care in community settings'.

They still needed to be assured that the rest of the integrated system is delivering the background on which the hospital reconfigurations can take place.

Matt Walsh disputed that it was the job of Calderdale and Kirklees Joint Health Scrutiny Committee to scrutinise this data. But it is. The Secretary of State has made that plain.

At the 25th September 2020 ckjhsc meeting, Cllr Smaje said work was needed on how the capacity of community service will work.

The NHS Commissioners seem rather desperate to avoid the issue of the Care Closer to Home care model and its performance.

It was not on the agenda at the Autumn 2019 Brighouse stakeholders engagement event on the hospitals reconfiguration, despite:

- a written request from Hebden Bridge Town Council to include it,
- and me then standing up at the start of the meeting and asking why the opening presentation on the scope of the engagement event had omitted this vital question.

Surely it can't be because either they don't have the data, or it's hidden like a needle in a data haystack?

c) **Calderdale's Care Closer to Home Overview from 2013/4** (sent in response to this FOI) says in 2018/19 they were "Aligning work stream measures to the Outcomes Framework – Proposed Indicators:

- Emergency admissions for urgent care conditions per 100,000 population
- Average delayed transfers of care (delayed days) per day for all reasons per 100,000 population
- Population use of hospital beds following emergency admission per 1,000 population
- Consider and agree your key measures for 2020/21 by June 2020."

So where's the 2018/19-2019/20 data on these indicators?

**In the Kirklees CCGs' response,** the **data they referred to were largely irrelevant, as they pre-dated 2018**.

The KPMG 2018 Well Led Review of Locala gave an amber red rating to the question of whether appropriate and accurate information was being effectively processed, challenged and acted on. They said improvements were required to improve and receive assurances on the quality of data. (para 6.4, p 33)

Within the relevant 2018-onwards timeframe, I could only see Kirklees monthly data for March 2018 and December 2018. This was in the KPMG 2018 Well-Led Governance Report on Locala Community Partnerships.

There was a December improvement in reductions in emergency admissions and A&E attendance, compared to March. (Unlike other patient outcomes, there were no targets. Why? In March 2017 the emergency admissions target was -2.04% reduction. )

| Data | March 2018 | December 2018 |
|---|---|---|
| Reduction in emergency admissions | 4.05% (ie increase) | -1.42% |
| Reduction in A&E attendance | -2.48% | -3.67% |

However a performance report is produced on a monthly basis demonstrating performance against both the CC2H contract's agreed outcomes and any applicable national standards such as 18 weeks Incomplete Standard, 52 Weeks standard, MRSA and C.Difficile. A dashboard summary gives an overall view of the number of indicators which have been achieved.

Since we know from the KPMG 2018 Well Led Review of Locala that this monthly performance report includes data on reduction in emergency admissions and reduction in A&E attendance, why did GH and NK CCGs not provide these data?

Plus, (para 8.2, Care Closer to Home Evaluation Report,Greater Huddersfield and North Kirklees Clinical Commissioning Groups March 2019 ) The CCGs will monitor delivery of the Locala Care Closer to Home plan 2018-2020. via active review of Locala implementation action plan at Contract Management Board meetings.

## Q 2c) What metrics are being used to monitor the experience of patients, and clinical and caring staff, in order to identify the quality of care that is received and given?

**CCGs' response**

"As part of the CCGs' legal duty, we (Calderdale, Greater Huddersfield and North Kirklees CCGs) monitor our providers' patient experience and feedback through a number of channels including contract monitoring meetings, clinical quality boards, service specifications and our engagement activities.
We capture feedback from service users about providers through compliments, complaints, patient experience feedback reports and the results from surveys. We also visit providers and this allows us to use a range of measures to assess the quality of front line services. The visits include conversations with staff and service users about their views and experiences."


**1. The first para of this response relates to question 3h, below,** which asked about any problems the CCGs were encountering with translating clinical data into measures for analysis of the effects of service transformation - problems such as: recording units of activity and outcomes in a way that distinguishes between information captured during a face-to-face appointment, a telephone call with the patient, a clinical-clinical call about the patient, or information added by administrative staff.

In their response to Q 3h, the CCGs said they'd already answered this in their response to Q 2c, but I can't see that they have.

2. Based on my own and others' experiences that they have directly told me about, I doubt the validity of much of the feedback the CCGs "monitor" from their engagement activities.

The CCG uses "appreciative inquiry" https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2020/08/Appendix-7.2-AI-training.pdf as an "engagement" method. This invites selected groups of people to identify the good qualities of health care that they've experienced and then to "dream" about how this could be extended to the whole local NHS and social care system. It doesn't explain to people what changes the CCG is proposing - but the CCGs then take responses to their appreciative inquiry as endorsements of their proposals.
The CCGs also carry out engagement using "community assets" who are employees of voluntary and community organisations which are designated as "community anchors".

These organisations may be the CCGs' clients, contracted to provide various community services.

CK999 protested about this practice in our response to the 2016 Right Care Right Time Right Place consultation. During that consultation an online maternity services engagement survey was filled in by all kinds of people without the remotest interest in maternity services, because they wished to support a cash-strapped community group that was promoting the survey in exchange for a £5 payment from the CCGs for each completed survey. At the time, we asked the CCGs to explain this and they admitted paying these groups. We protested to the CCGs that this seemed entirely unethical

The CCGs' payments for engagement compromise the validity of the process. Some if not all of these groups are the Clinical Commissioning Groups' "community assets" aka "community engagement champions" or "community voices". In 2016, their role was to encourage their members and the public to respond positively to the consultation. This practice continues.

NHS Greater Huddersfield CCG's 'Community Voices' scheme currently uses around 60 voluntary and community sector organisations, that they train to engage with the local population on the CCG's behalf. The CCG describes these people as "community assets".

Their employers require them to attend the training. By report, the 4 X 2 hour training sessions the CCG puts them through are based on biased, highly leading training materials.

As a result of this manipulative "training", a community asset required to attend this training told us,

> *"They are all oblivious in our meetings, but all lovely people that want to engage with local community they support."*

Like the 'Community Voices' training, the surveys the trained community assets have to send out to other community groups are often biased and leading to the CCGs' desired responses. But community assets are under pressure to get the surveys completed and returned, because each one earns £5 for the cash-strapped organisation that employs them. Some voluntary and community organisations then share some of the money they earn from pushing the surveys with the organisations whose members completed and returned the surveys.

This sounds like cash for questions - a practice deemed reprehensible when MPs are involved.

What's the difference when Clinical Commissioning Groups pay voluntary and community sector groups, that are known and trusted by their community, to to do their highly biased engagement work for them?

What kind of position does this put the community assets in? One of them told me that when colleague asked for responses to the survey it took ages to engage as no one knew what a Clinical Commissioning Group was, and it started arguments about the NHS.

3. There was highly selective presentation of information at a **2019 CHFT public engagement event with the architects and others.**

There was no information about the size of the proposed A&Es - just an assortment of more or less pretty pictures about the design of the waiting areas. Of course design matters, but if the A&Es going to be overcrowded, it doesn't matter how pretty they are.

I asked the architect whether the CRH A&E capacity was going to be big enough for the numbers of people - or was it going to be another Cramlington, which became overcrowded with people in beds in the corridors soon after it opened? The architect hadn't heard of Cramlington.

How could CHFT not have told the A&E architect about Cramlington? The public were led to believe during the 2016 Right Care Right Time Right Place public consultation that the hospitals' reconfiguration was based on Cramlington Specialist Emergency Hospital https://www.northumbria.nhs.uk/our-locations/northumbria-specialist-emergency-care-hospital/, and its satellite hospitals that send all their A&E patients straight to Cramlington.

4. There was a highly leading presentation at **a 2019 Brighouse public engagement event on the hospitals reconfiguration,** which omitted any consideration of Care Closer to Home despite:

- a written request from Hebden Royd Town Council to include in the agenda for the event
- me standing up in the meeting, reminding them of this, and asking for them to present information on Care Closer to Home and its relation to the hospitals' reconfiguration plans.

## Q 2d) Are there any cost savings as a result of the impact on unplanned care of improving planned and self-care?

Specifically, have the cost savings identified in the Calderdale CC2H 2018 Prospectus been realised since 2018? The Prospectus said improving Care Closer to Home planned and self-care would cut hospital costs of unplanned care by between £5.5m/ year (using RightCare benchmarking data) and £6.4m/year (using national data on avoidable admissions) - although to date these outcomes had not yet been achieved.

**NHS Commissioners' response**

The CC2H 2018 prospectus relates to Calderdale only. In Calderdale the benefits of changes are in published SOC (strategic outline case), referenced in JHOSC (The Joint Health Overview and Scrutiny Committee) papers Oct 19 and the link to the CHFT website is: https://www.cht.nhs.uk/fileadmin/site_setup/contentUploads/About_us/Publications/BoardPapers/BOD_2017/FINAL_SOC_18_April_20 19.pdf


**1. The response doesn't say** if the the cost savings identified in the Calderdale CC2H 2018 Prospectus been realised since 2018

2. The 2019 revised Strategic Outline Case is unconvincing about the cost benefits of the proposals, although it says the **Economic benefits** (as assessed with the Economic Adviser from the Department of Health) are both cash releasing benefits and societal. They include:

- Pay savings, efficiency and productivity;
- New roles and models of care;
- Reduction in estate costs;
- Reduction in length of stay through efficiency;
- Societal benefits delivered through reduced length of stay.

These economic benefits are questionable. And they don't put a figure on the cash releasing savings, as far as I can see.

Then there's the question about what economic societal benefits are. The 2019 revised SOC Economic Case section seems to define this as

"[T]he net value to society (the social value) of the intervention compared to continuing with Business As Usual. What are the risks and their costs, and how are they best managed? Which option reflects the optimal net value to society?"

Where is the data to show that there will be societal benefits from **pay savings, efficency and productivity**? This looks like a societal disbenefit to me. Such processes hit the workforce in terms of redundancies and working harder for the same pay - worsening the reality of working life. This creates health problems and so increases costs to the NHS and to society. It also goes against all rational economic understanding that pay cuts and redundancies are likely to shrink the local economy. There will be fewer staff with money to spend and this will have a local inverse multiplier effect - ie a shrinkage effect.

Where is the data to show **new roles and models of care** will have either cash releasing or societal benefit?

There may be cash releasing benefits for the hospitals from **reduction in length of stay through efficiency** - and there is a claim that there are **societal benefits too** from quick discharge from hospital, once immediate medical needs have been met.

But what about the costs to the patient and their family, friends and neighbours of being quickly kicked out of hospital and having to self care/ rely on unpaid care provided by family, friends, neighbours and voluntary organisations?

Such costs are called an externality. The Strategic Outline Case Para 8.4.5 'Externalities' says:

"The impact on other organisations has been considered and modelled within the economic assessment"

But it doesn't seem to have crossed the economic assessors' minds that there are negative externalities in terms of the impact on patients and their family/friends/ neighbours of reduction in length of stay through efficiency.

Why should patients and their family/friends/nieghbours have to bear these costs? The NHS Constitution starts,

***"The NHS belongs to the people."***

All members of the public pay for it. So why should those least able to afford it pay twice - through taxation AND through externalisation of NHS costs onto them?

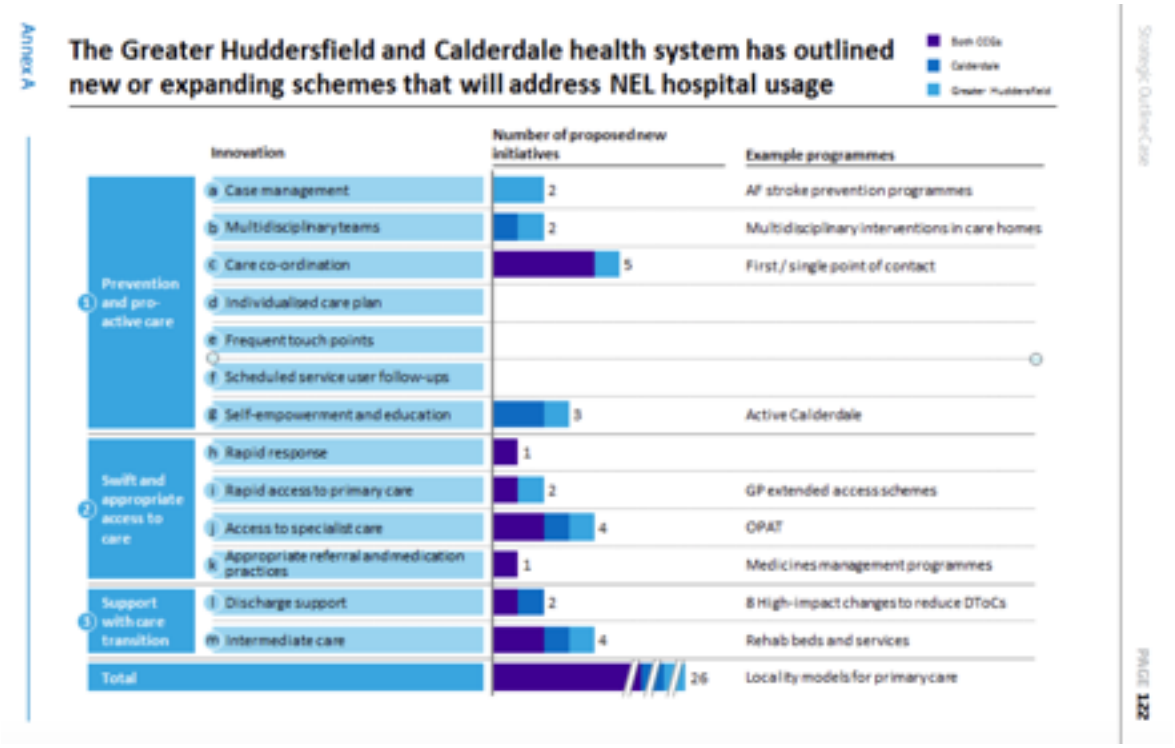
The same goes for the cash releasing benefits (to the hospitals) of reduced patient travel between sites.

They're talking about inpatient ambulance transfers - not about patients and their families and friends having to schlepp from one end of Calderdale to HRI for planned

care and step down/rehab beds,  and from the other end of  Greater Huddersfield to Halifax for acute and emergency care. This is an active societal disbenefit that will disproportionately affect the poor and elderly.

It seems that they've not considered or modelled externalities as they affect patients, families, friends and neighbours -nor the way in which these externalities will worsen social, economic and health inequalities and so INCREASE the cost to the NHS and other public organisations.

3.  The Strategic Outline Case says (p16) **future CCG investment decisions** in primary and community services "to address demand pressures, enable workforce expansion, and develop new services to meet the needs of the population" are based on their "aspiration" to reduce unplanned hospital bed days by 30% over 5 years, through the "new or expanding" Care Closer to Home Services listed below.




The CCGs' 'aspiration' is based on McKInsey's contentious RIght Care Right Time Right Place modelling report - NOT on the basis of data about the impact of these Care Closer to Home services on unplanned/ emergency  hospital bed days, for which it seems no reliable evidence exists.

Regardless, the Strategic Outline Case (p16) asserts,

"This improved care means people do not have to go to hospital so frequently and once there can leave it more quickly." Data?

**4. The revised 2019 SOC Capacity Impact of the Proposed Model is confusing about the required capacity of both HRI and CRH A&Es and urgent care centres.**

On p 34, the SOC says

The Trust has previously been supported by a Senior Economist and an Intelligence Analyst at NHSI to undertake very detailed long-term activity capacity modelling work... For this SOC a high level review and refresh of the previous work has been undertaken. The Trust and commissioners are aligned on the modelling of activity.

p 35: Activity Growth Assumptions, based on review of 3-year activity trends, include an assumed 2% growth for A&E. Is this 2% growth assumption being fed into CHFT's modelling of the volume of A&E and urgent care activity on each hospital site?

The full range of activity growth assumptions (excluding Obstetric and Midwifery non-elective admissions, which has been reviewed separately based on birth rates and known booking rates) is:

- Flat growth for day case, elective and outpatient activity;
- 2% growth for A&E;
- A 4% growth in non-elective short-stay admissions and a 1% growth in non-elective long- stay admissions (net growth of 2.7% across all non-elective admissions);
- 2% growth in community.

The SOC says these activity growth assumptions have been modelled within the financial plan for future years.

But elsewhere, the SOC says that because all blue light ambulance attendances and acute admissions will be diverted from HRI to CRH, CHFT needs to model the volume of A&E and urgent care activity on each hospital site. This modelling will be informed by discussion with Yorkshire Ambulance Service regarding clinical protocols for ambulance diverts

5. GH and NK CCGs did not reply to this question but Informal Governing Body – Committees in Common 14/11/18 said that

"Future community services offers an opportunity to meet financial needs...Opportunity to review funding envelope for future model." (source: Care Closer to Home Evaluation Report, Greater Huddersfield and North Kirklees Clinical Commissioning Groups March 2019)

**What do the cost savings translate to, in terms of any reduction in A&E attendances and Non-Elective Bed Days to date**

**NHS Commissioners' response**
Please refer to the answers given in response to previous Questions (2a and 2b)

Comment Those answers don't give the requested information.

## Q2e) What Calderdale and Kirklees Care Closer to Home performance data do the CCGs provide to CHFT, when this data sharing started, how often it takes place and by what means.

**Response:**

The Calderdale Collaborative Community Programme Board (CCCPB) is developing a framework which will be the basis of a platform for the collaborative to develop as it matures. In addition, please refer to the response given to question 2a.

The Kirklees CC2H service is provided by Locala, not CHFT.


**Doesn't CHFT need to know how Care Closer to Home programmes in BOTH areas are working?**

The Greater Huddersfield and North Kirklees Clinical Commissioning Groups March 2019 Care Closer to Home Evaluation Report identifies the CC2H programme as co-dependent with the Right Care Right Time Right Place hospitals reconfiguration strategy. It says this has been developed to work in conjunction with CCTH, building capacity and capability to support out of hospital services.

"In line with... the work on capacity and capability from the Right Care, Right Time, Right Place programme we will be able to identify what additional opportunities there are for developing more and expanded services in local communities."

Surely this requires sharing key CC2H performance data with CHFT?

**Also it would seem from the CC2H Evaluation Report that Kirklees CCGs DO share data with CHFT,** since on p72, there is a note, dated 19/12/2018 headed Secondary Care Provider, that refers to community services data issues:

“Trust Board discussions have noted they have serious concerns around safety, quality and governance of services provided from a community provider [Locala] that is rated inadequate, for its Community services.

Moreover, there are differentials in performance, outcomes and consistency due to different providers of community services in different parts of Kirklees. Examples of these differences include;

- Delayed transfers of care
- Diabetes
- Dietetics
- In-reach nursing (cardiac, orthopaedics, Home from Hospital, Intermediate Care, Respiratory)”

The Trust Board discussions also criticised the outcomes-based specification, which

> “has left providers debating about who should be providing what and could have left patients at risk. It was noted that the Trust have continued to deliver services where funding has been removed for in the best interest of the system.”

The Trust Board also noted that the multiplicity of Care Closer to Home provider organisations caused problems including duplication of back office costs, ensuring there is enough expertise and

> “Provider to Provider relationships and working [that] were at times difficult, which had resulted in occasions where the process/pathway/responsibility took precedent over the patient.
>
> Lessons needed to be learnt ...specifically around how the service specification was drafted (i.e. clarity and difficulties around contract being outcomes based) and ensuring there was common understanding of what services entailed (prior to bids and following transfer). The Trust continues to deliver services that funding has been removed for in the best interest of the system.”

On 27.01.2019 CHFT added that they,

> “felt that operationally Locala’s community services often focused on the minimum service level set out in the contract, rather than focussing on providing good quality care that is patient centred. This has impacted on the seamless provision of services across the patient pathway to the detriment of the patient.”

## Q2f) What data if any are being collected to identify how patients' social and economic situation and general wellbeing affect their ability to manage their own health and care, and the type of care they need from health and social care services?

**A 2f)** The CCGs continue to engage and identify views as part of our engagement. See also the response provided to question

In addition, Calderdale CC2H Prospectus https://www.calderdaleccg.nhs.uk/download/a-prospectus-for-commissioning-an-alliance-for-care-closer-to-home/?wpdmdl=12746&refresh=604e89b9bd6021615759801 sets out the Case for Change and the 3 dimensions used by Calderdale CCG as part of our triple aim (page 2, section 1.3). Further work has continued on these areas including:

a. High level indicators

b. Nuffield and other international leading research to inform our framework (which will be developed further over time)

c. Developmental areas built collaboratively with partners


1. **This doesn't answer the question.** Probably because it's poorly worded. What I meant was, are the NHS Commissioners collecting any quantitative data on:

   - the costs/benefits of patients' and their family/friends/neighbours' assumption of caring responsibilities, as part of the so-called "left shift" of NHS services exemplified by Care Closer to Home
   - the clinical outcomes of CC2H self care, compared to care provided by NHS clinicians and therapists
   - need for NHS hospital, community health and primary care by different socio-economic groups

2. P2 section 1.3 of the Calderdale CC2H Prospectus is about the savings the Clinical Commissioning Group reckons it can make from a focus on CC2H services that reduce unplanned and episodic admissions to hospital. My question 2d identified those projected savings and asked whether they'd been realised since 2018. They didn't answer this question.

3. What high level indicators have been worked on? What developmental areas?

# Appendix 3

*Please note: In order to provide a clear analysis of the Clinical Commissioning Groups' FOI response, in this summary I have grouped the questions in sections 2 and 3 differently than they were in the FOI request and response. So the question numbers here are not the same as the question numbers FOI docs.*

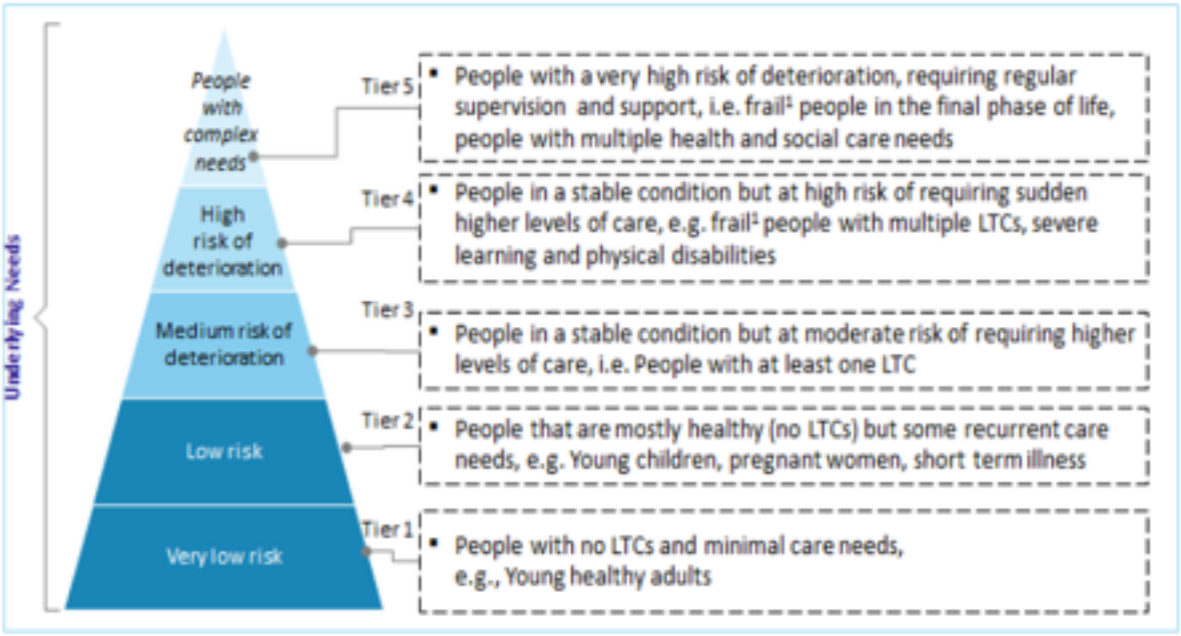
## Questions about access to data analytical skills and digital resources

### Q3 a) Which Calderdale and Kirklees Care Closer to Home initiatives rely on risk stratification of patients,

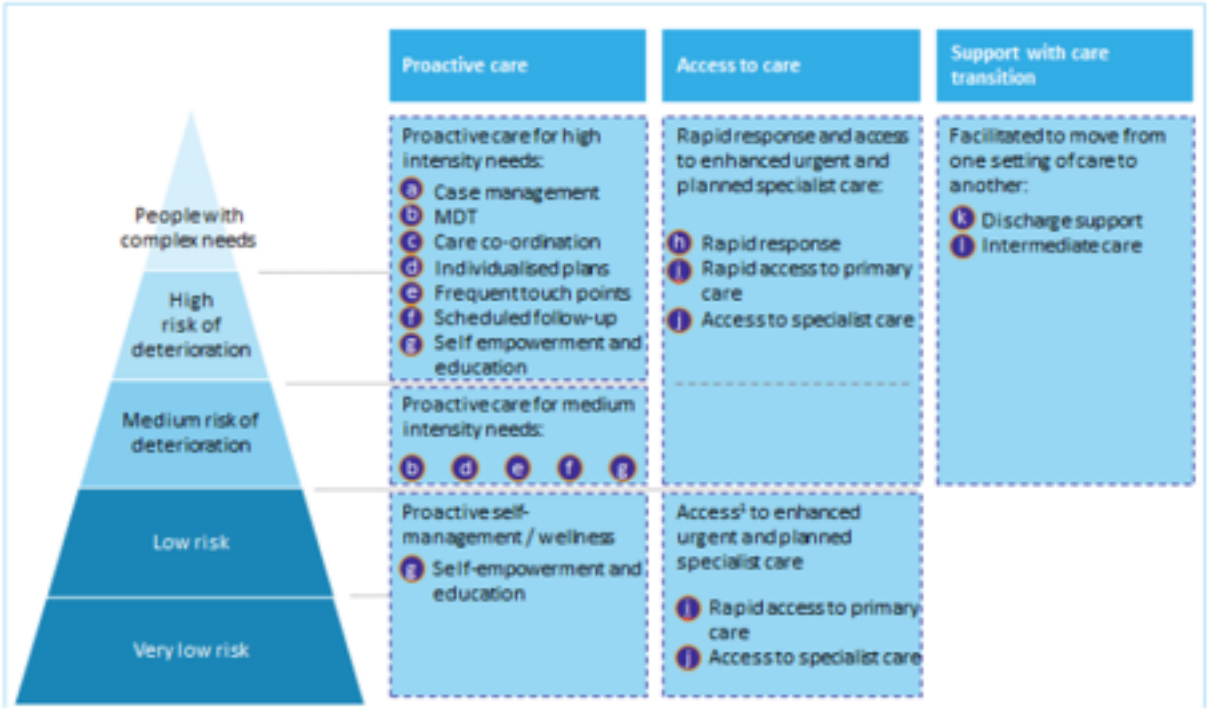
**A3a)**

- The Calderdale CC2H prospectus is based on the principles of risk stratification using the top performing integrated systems (described in the McKinsey report and included in Appendix C of the CC2H Prospectus).

**Top systems specifically design care packages around segments of the population with differing needs**



**Bundles of these integrated care interventions can then be designed for each population need group**




- No response from GH and NK CCGs

Q 3b) How is this risk stratification being carried out, given that it seems there are no Calderdale or Kirklees organisations that are approved for risk stratification? https://www.england.nhs.uk/publication/list-of-risk-stratification-approved-organisations/

Calderdale 999 CALL FOR THE NHS Kirklees COMMENT

**A 3b)** Risk stratification has not yet been implemented across Calderdale or Kirklees. We are however, embracing the principles of Population Health Management and looking to pursue a model and methodology. As described in the CC2H prospectus, Integration and Collaboration are essential to this approach and therefore any models will be co-produced and agreed with partners through the Collaborative Community Partnership Board.

Kirklees are working with NECS (North of England Commissioning Support) regarding the Risk stratification tool that they provide and is already established across some other areas of West Yorkshire. Work is ongoing regarding piloting the tool across Primary Care Networks and partners and formalising the Information Governance arrangements

## Q 3c) What access to data analytical skills do Calderdale and Kirklees HWBs, CCGs, LAs, providers and others have? (Including Calderdale and Kirklees Joint Health Scrutiny Committee).

Given that the Adult Social Care Outcomes Framework, England, 2015-2020 says that for -

> "Transformation of local health, care and support systems...The intention ... is that commissioners, providers and HWBs will use both population- and provider-based data collectively to monitor and assess how effectively their local care economies are delivering integrated care...Listing relevant indicators...is just the start. **Much will depend on the ability of local organisations to work individually and collectively to understand the data and the relationships within them, and to have the appropriate forums and arrangements locally for doing so.**

**A 3c** The CCGs are only able to answer this question in relation to their own organisation. CCGs have core Business Intelligence Units who collaborate with partners to support the CC2H and Integration Agenda.

**Response**

1. What data do the CCGs core Business Intelligence Units work on, in relation to Care Closer to Home and CHFT's planned hospital capacity?

2. What is the nature of the core Business Intelligence Units' collaboration with partners, since the CCGs total failure to provide data based on relevant indicators to CKJHOSC would suggest an unwillingness or inability to collaborate?

3.

## Q 3d) What forums and and other arrangements are there for these organisations to individually and collectively scrutinise and discuss the Care Closer to Home data and the relationships within them?

**A 3d**

- Calderdale Integrated Commissioning Executive
  Kirklees Integrated Health and Care Leadership Board

**Q 3e) In particular, what use, if any, are Calderdale Cares and the Kirklees equivalent making of the Yorkshire and Humber Local Health and Care Records Exemplar integrated clinical records,**

in order to support CC2H and identify its impact on unplanned hospital admissions, A&E attendance and other key performance indicators? (https://www.wyhpartnership.co.uk/our-priorities/digital/local-health-and-care-record-exemplars-lhcre

**A 3e)** Kirklees and Calderdale do not currently have access to the LHCRE Integrated Care record but are fully engaged in the ongoing project.

**Q 3f) How is that data is being intelligently monitored over time, eg through the use of statistical process control methods that help identify when a change has occurred?**

**A 3f)** The Calderdale and Kirklees systems have the capability to use SPC. The KPIs as identified in the CC2H prospectus https://www.calderdaleccg.nhs.uk/download/a-prospectus-for-commissioning-an-alliance-for-care-closer-to-home/?wpdmdl=12746&refresh=604f51467e7401615810886 and the Kirklees CC2H contract are framed in a way that all KPIs can be monitored over time.


**So if all KPIs** identified in the CC2H prospectus and the Kirklees CC2H contract can be monitored over time, why haven't they provided this data in response to the FOI request?

The KPIs in listed in the CC2H prospectus (p9) are (next page):

| Domain | Short term indicators |
|---|---|
| Population health | •Avoidable Admissions –composite of: Admissions for ambulatory care sensitive conditions per 100,000 (IAF)<br>•Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHSOF)<br>•Admissions for conditions that do not require hospital admission per 100,000 (IAF)<br>•Emergency admissions for children with lower respiratory tract infections (LRTIs) (NHSOF)<br>•Mental Health indicators to be determined |
| Proactive Prevention & Patient Centred Approach | *Rate of emergency admissions per 100,000 (BCF)<br>*Rate of delayed transfers of care per 100,000 population (BCF)<br>*Emergency readmissions within 30 days of discharge from hospital (NHSOF)<br>*Out of area placements (local trajectory)<br>*Patient experience of care/ quality of life (national surveys v local survey) |
| System, Staff & Sustainability | *Total bed days associated with emergency admissions (Vanguard/ New Care Models)<br>*Staff turnover<br>*Staff experience (local survey)<br>*Carer reported quality of life (ASCOF) |

**Q 3g What problems, if any, are being encountered with data quality?** - eg the Nuffield Trust toolkit explains there are particular problems with how new patient pathways and care models are captured using routine data. (Apparently the standard units of acute activity do not capture such innovations as specialist 'advice and guidance' services as a substitute for outpatient referrals, one-stop clinics combining diagnostics and assessment, and new urgent care pathways in a consistent way across the country.)

A 3g) Please refer to the response provided for question 3f.

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**The response to Q 3f doesn't in any way answer Q3g.**

## Q 3h) How are Calderdale and Kirklees clinical data being translated into measures for analysis of the effects of Care Closer to Home on the key performance indicators?

**A 3h)** Please refer to the response provided for question [3c].


**3c simply refers to the existence of the CCGs' core Business Intelligence Units.**

## Q 3h) What problems, if any, are the CCGs encountering with translating clinical data into measures for analysis of the effects of service transformation?

The Nuffield Trust toolkit 'Trusted measures: analytical resources for integrated care' says these can include:

- Difficulty identifying events and standard units of activity, such as to distinguish between information captured during a face-to-face appointment, a telephone call with the patient, a clinical-clinical call about the patient, or information added by administrative staff.
- Inconsistency between and within practices in how clinical terms are used to capture information,
- A large part of the valuable information is held within free-text parts of the notes, which presents both analytical and governance issues.)

**So how are Calderdale and Kirklees clinical data being translated into measures for analysis of the effects of Care Closer to Home on the key performance indicators?**

**A3h)** This question has been answered in the above responses provided, including the answer to question [2a]


**Actually, it hasn't.** But the CCGs' response to Q 1c), regarding the benefits of the mental health service Safespace in reducing A&E attendances, said that as Safespace is not a clinical service, it is not possible to link Safespace records with hospital records; however, self- reported outcomes from the service point to reduced usage of A&E services)

This seems to imply that they *can* generally link other (clinical) CC2H services to hospital records to identify effects on unplanned A&E attendance/ hospital admission.