Transforming Community Services

Introduction – Calderdale Cares

Calderdale Cares is our integrated model of health, care and wellbeing in Calderdale, a network of organisations and people coming together to improve the health and wellbeing of the Calderdale population, focusing on enabling people to stay well, and live independent and fulfilled lives. We are doing this is by putting people and patients at the centre of their care, building on their strengths and resilience, and enabling people to take control of their own health, care, and wellbeing wherever possible. This approach fully recognises the inter-relatedness of physical and mental health and wellbeing and the need for parity between them. Prevention and early intervention are at the heart of all we do.

Residents of Calderdale and employees of organisations that make-up the Calderdale Cares network have told us what differences they want to see, and we have used this to be clear about the high-level outcomes that we will achieve together.

a) *Better wellbeing for all*
    - Healthier people – Increase the length of time people live in good health (both physical and mental wellbeing)
    - Narrowing the gap in health – narrow the gap in the length of time people live in good health between the most deprived and least deprived areas and between groups of people in the borough
    - Improved physical and mental wellbeing in children and young people
b) *Harness the strengths of Calderdale's people and communities*
    - A thriving voluntary and community sector
    - People are connected to support in their local community to help them stay independent and well
    - People in Calderdale are empowered to care for their own health and wellbeing
c) *Seamless services for those that need help*
    - Health, wellbeing, care, cultural and art services can be easily accessed as close to home as possible

- People with long-term care needs receive continuity of care and only tell their story once
- People with complex health and care needs receive co-ordinated care from across the Calderdale Cares network, with a named care co-ordinator

d) Partners working together to make this change happen through the Calderdale Cares Network

- Staff work across organisational boundaries, in teams without walls, with the person or patient at the centre
- Information is shared across the network and more people get support with their health, wellbeing, and care digitally
- Buildings are shared across the Calderdale Cares network of organisations and create space for people and communities to look after their own health and wellbeing
- The importance of the new Calderdale Community Collaboration as a vehicle for change is recognised

Over the last 16 months Covid-19 has presented us with arguably one of the greatest challenges of our lives. Yet despite the enormous challenge, collaborative working throughout our response to the pandemic has shown us just how successful we can be when we work closely together with a clear purpose.

Community Health, Care and Wellbeing Services

Community services are central to delivering our Calderdale Cares outcomes, and to enabling the sustainability of the local health and care system. The Care Closer to Home Programme (CC2H) was developed in 2018. CC2H was Calderdale's local model reflecting the evolution of Primary Care Networks (PCNs) and wider development of integrated locality hubs, moving towards a single point of contact (one single point to handle all requests and/or inquiries addressed by the appropriate person).

The CC2H prospectus was produced to strengthen and co-ordinate care outside hospital and deliver a wide range of services from those with complex health and care needs, to health promotion and prevention (keeping people well, treating and managing acute illness and

long-term conditions and supporting people to live independently in their own homes). We have been building on our ambition to deliver more and better support and services across community and primary care.

Our Story So Far

- In July 2020, following the first wave of the COVID-19 pandemic, Calderdale Partners came together to take stock and review/reset the existing Care Closer to Home Programme (CC2H). The rationale for this was to help stabilise the system and show how our communities and services came together to address challenges and adapt. It also enabled us to learn from doing things differently, understand what has worked well and allowed us to work differently. The aim of the review was to capture that learning for the benefit of all.

- By working together, the aim is to transform the experience of people who use services as well as the experience of those who deliver them. The outcome from the review has helped us to understand and:
    - learn from our mistakes and restore services,
    - create a place-based system that promotes health and wellbeing
    - work together to develop a workforce that is adaptable to new care needs /demands and challenges as they arise across the whole community (locality and/or place based)

- In line with our transformation plans and Calderdale Cares principles, Providers renamed the Calderdale CC2H programme. This is now known as **'Calderdale Collaborative Community Partnership Board'** (3CPB).

- At the end of 2020, all 8 partners (Calderdale and Huddersfield Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust, 5 Primary Care Trusts, Calderdale Metropolitan Council, Voluntary and Community (VAC) Calderdale, Calderdale Clinical Commissioning Group, Locala, West Yorkshire Pharmacy)) signed up to working collaboratively, developing a co-produced comprehensive model, and becoming more integrated i.e. sharing resources such as capacity

- By working together, we can help everybody to reach their potential. This will be achieved by having one clear set of collaborative priorities across all partners.

- This work builds on strong existing working relationships between Calderdale Cares partners, and is in line with the vision and ambition articulated in our strategic intent
- We use a needs-based stratification of the population as the basis for designing packages of care to serve high-need, medium-need and low-need populations. For each cohort we develop integrated care interventions that we describe as broadly covering:
    - Proactive management of population health and preventing admission,
    - Providing rapid access to primary care and specialist advice in community settings,
    - Facilitating discharge and transfers between care settings.
- Our integrated care model works across our system: Community health services, Voluntary sector, Hospices, Social Care, Out of Hours primary care, Community Pharmacy, General Practice, Hospital services, Education, Housing, Police, Community Safety, Fire and Rescue
- It is supported by a set of "enablers": Workforce; Data Sharing; Population Health Management; Personalised Care; Primary Care Networks; Workforce; Estates; Digital.
- The integrated model is also based on 6 core principles: -
    - Person Centred
    - Place Based Integration, Investment and Provision
    - Culture Shift in Operating Model
    - Sustainable and Future Ready Place Based Workforce
    - Place Based Digital Maturity
    - Place Based and Integrated Pathways

Below are the key factors developed in creating the conditions to achieve Calderdale Cares outcomes

1. **Person Centred** - The vision will only be delivered if citizens and service users recognise that the services are designed around their needs (as opposed to specialty,

organisation) and it can be evidenced through embedding quality into our culture and operationalising key quality metrics/indicators (safety, outcomes, experience and sustainability) into everything we do from data capture (clinical assessments,

2. **1**.outcome measure use, citizen captured data) through to operational dashboards for service improvement. The individual needs to be able to easily seamlessly and safely navigate the system.

3. **Place Based Integration, Investment and Provision** – The vision will need to be supported through looking at the totality of investment and resources available to public bodies across the place to meet community needs, manage risk, improve outcomes and effectively address increasing demands for services. Provision will be Informed by good evidence-based practice, population level data insights (see place based digital maturity), co-design and building services to meet the needs and improve the health and well-being outcomes of all communities

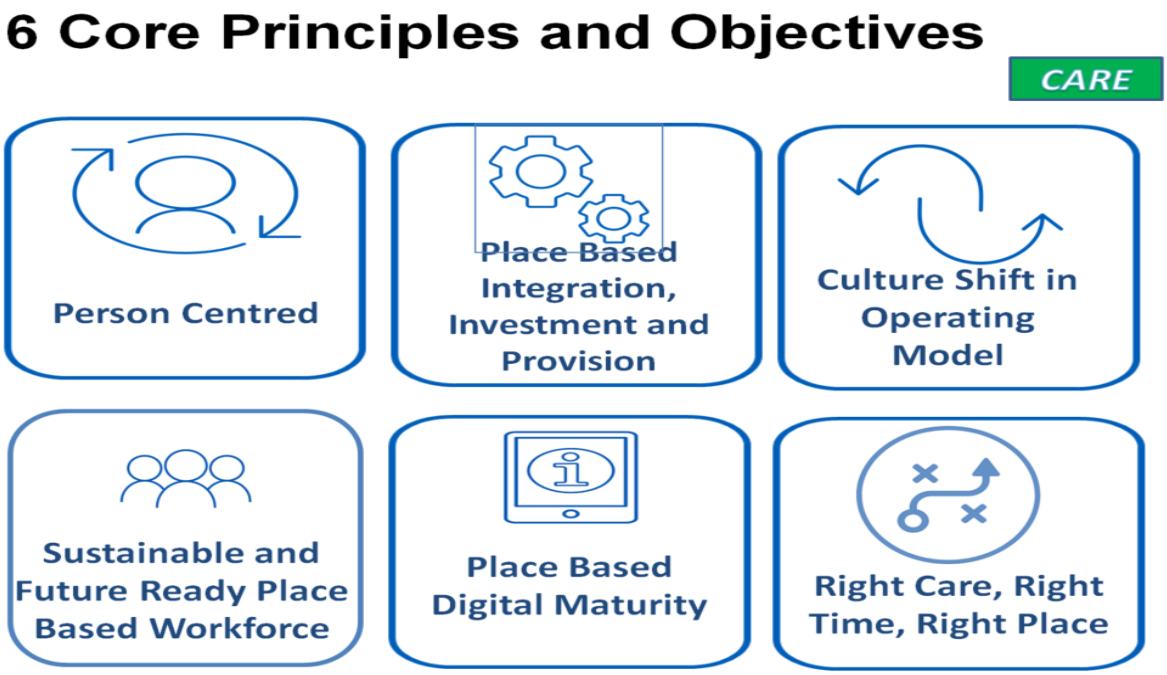
4. **Channel Shift** – We will implement across services in the new operating model enablers and processes to support a shorter- and longer-term channel shift in health and care provision at a Calderdale place level. Focussing on opportunities for early intervention and prevention that moves from reactive to proactive support across communities, reducing health inequalities and unnecessary conveyancies/admission and improving longer terms health and care outcomes

5. **Sustainable Place Based Workforce** – One single workforce across all community/primary care – which needs to be working at scale and working together to create an 'us' culture across place but reflect the importance of collaboration at footprint and system level

   We will need a workforce that is fit for purpose now and in the future (right competencies, right cultures, right skill mix for identified need), sustainable (clear development pathways, excellent recruitment and retention, excellent people managers) and evidence based in its decision making (from recruitment and retention through to care delivery)

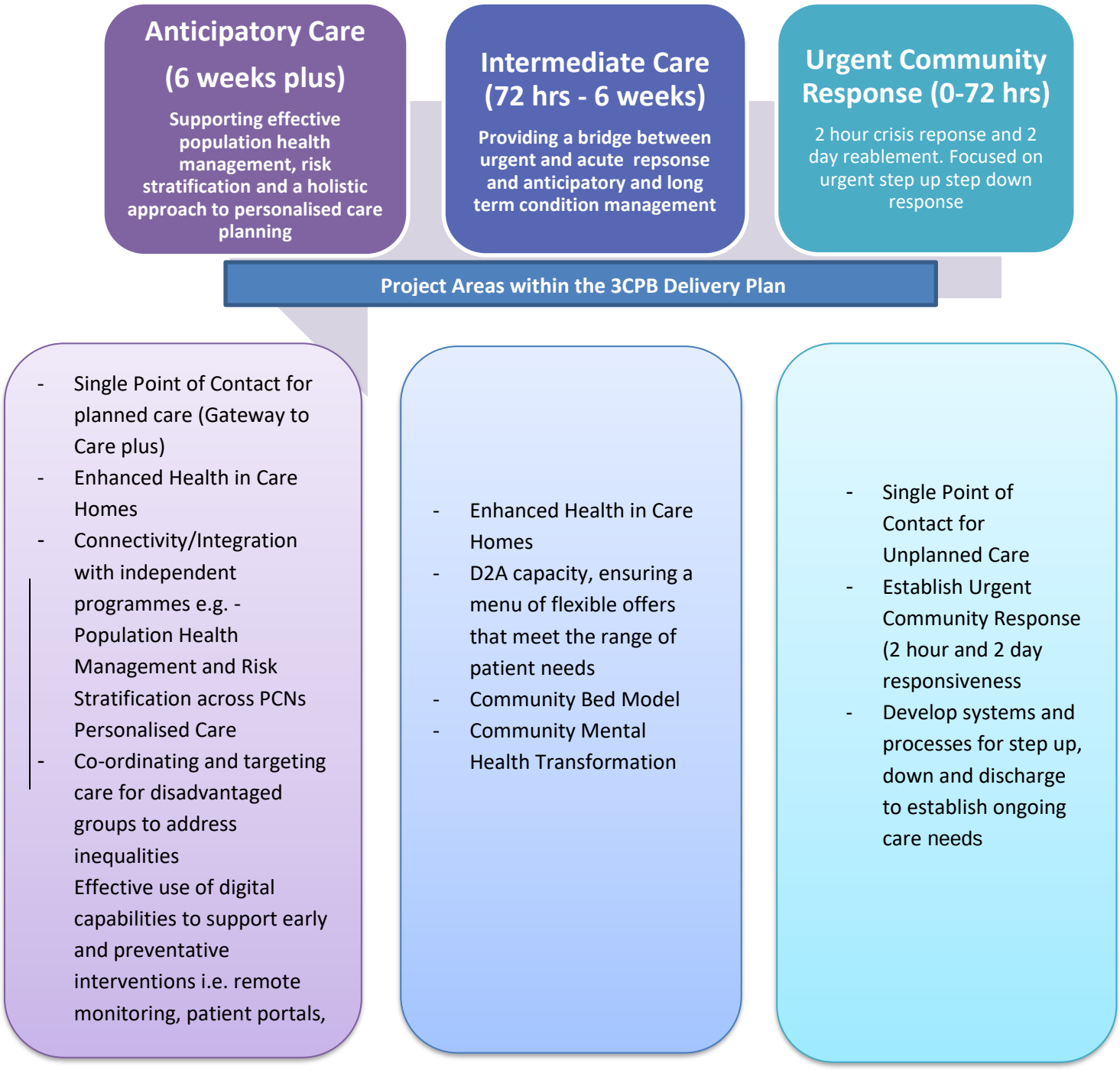
6. **Place Based Digital Maturity** - We will need place based digital maturity incorporating but not exclusive to integrated systems, population health level analytic capability and effective decision support capabilities for citizens/service users and the workforce.

7. **Right Care, Right Time, Right Place** – We will need to ensure health, care and public health We will need to be ruthlessly focussed on quality improvement through embedding quality into our culture and operationalising key quality metrics/indicators (safety, outcomes, experience and sustainability) into everything we do from clinical data capture (clinical assessments, outcome measure use, patient captured data) through to clinical and operational dashboards for service improvement and governance.



Calderdale Collaborative Community Partnership Board (3CPB) – Programme/Plan

We have developed a delivery plan to improve care and wellbeing outcomes, reducing the need for escalation to enable people to live healthier independent lives for our population



Highlight reports to provide further detail on the project areas are under development and implementation as part of the 3CPB programme

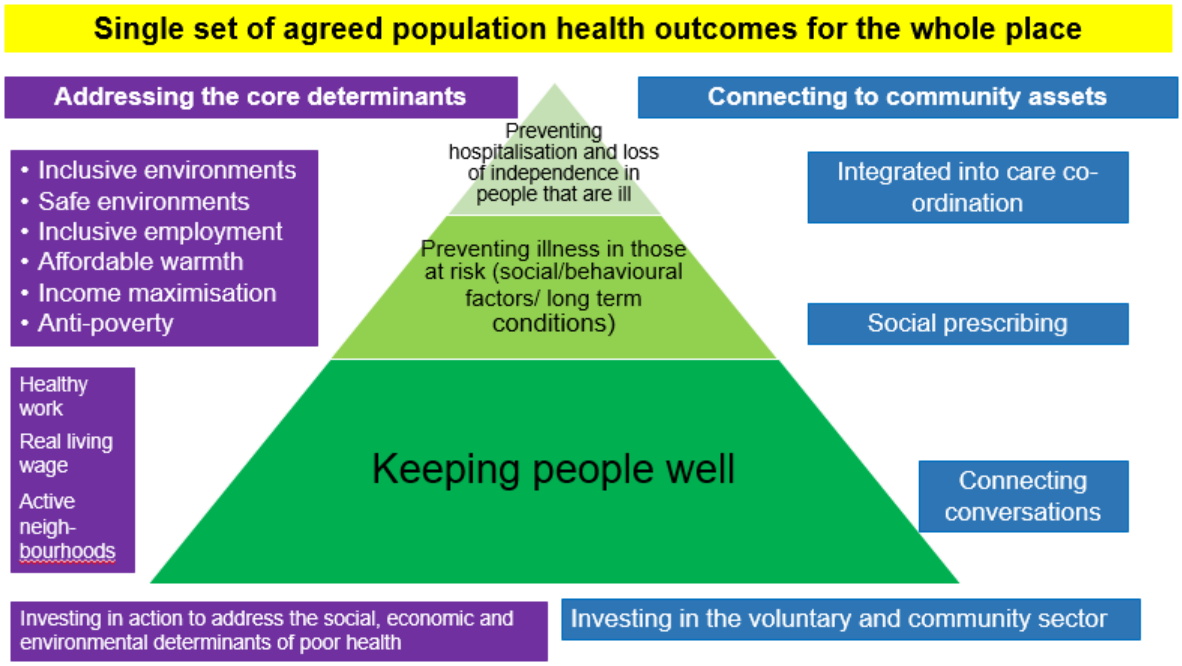
Keeping people well and preventing ill health

In 2021, building on lessons learned from tackling Covid-19, 3CPB explored expanding the integration of preventative services and programmes with other community services to achieve Calderdale Cares Outcomes. This is important if we are to maximise the impact of integration on the sustainability of Calderdale's health and care system. Enabling people to be independent and well costs less than providing hospital and social care and enables

specialist resources to be preserved for thigh quality acute and intensive services for those that need them.

The model below has been developed to apply a population health management approach to the achievement of the Calderdale Cares outcomes.

It aims to keep as many people as possible healthy and independent for as long as possible by joining up services and programmes, investing in action to address the root causes of poor health and investing in voluntary and community activity to enable those with health and wellbeing challenges to be connected to assets in their local community.



3CPB has identified 3 population groups to work with to test the integration model to achieve specific outcomes. This will involve 'co-production' of the model with service users and front-line workers from across sectors to identify the specific outcomes and how services can best be integrated.

The 3 areas where we are going to adopt a population health management approach are:

1. Starting Well – lost child development as a result of Covid, self-harm and suicide
2. Working Age Adult – multi-disadvantage groups
3. Older Age People – frailty and respiratory