NHS
Calderdale

improving health, improving lives

NHS CALDERDALE

IMPROVING HEALTH, IMPROVING LIVES

Commissioning Strategy for Calderdale 2008/9 – 2014/15

1. INTRODUCTION

Calderdale Primary Care Trust purchases services to meet the needs of the Calderdale population, but is also responsible for providing many of these services itself. The purpose of this Strategy is to provide a clear strategic direction for the next five years to ensure that the PCT and our Practice Based Commissioning (PBC) colleagues commission high quality, clinically sound and cost effective services. It provides a model for the future that takes into account national and local policy drivers and the needs of the people of Calderdale. Practice based commissioning will give general practice more freedom to determine the services that should be made available for the local population. The PCT will bring to this, a wider view of the overall needs of people living in their communities, and identify inequalities. The PCT will work in partnership with practice based commissioning to facilitate local services that address inequalities and fit with the overall strategic direction to improve heath and well being.

The Strategy sets out an exciting and challenging agenda for the next five years which places a particular emphasis on promoting and improving health, reducing inequalities, empowering individuals to take greater control over their health and commissioning and delivery services within a partnership approach. One of our most important partnerships is with Calderdale MBC, with whom we jointly commission and also provide a range of local services. Building on our good relationships and opportunities for creative service models, we aspire, as part of our ambition, to have even greater synergy with our colleagues in the local authority.

The Commissioning Strategy represents the key planning document for the PCT and its partners for the next five years. It sets out the broad vision for how services for the people of Calderdale will change and develop over this period. It provides an overview of the current and future needs of the population, what people want, analyses the current patterns of services and provides an oversight of how we expect to see such services change and develop.

1.1 What is Commissioning?

Commissioning is the process of securing and managing appropriate healthcare services for the population at value for money. In essence it is composed of three phases:

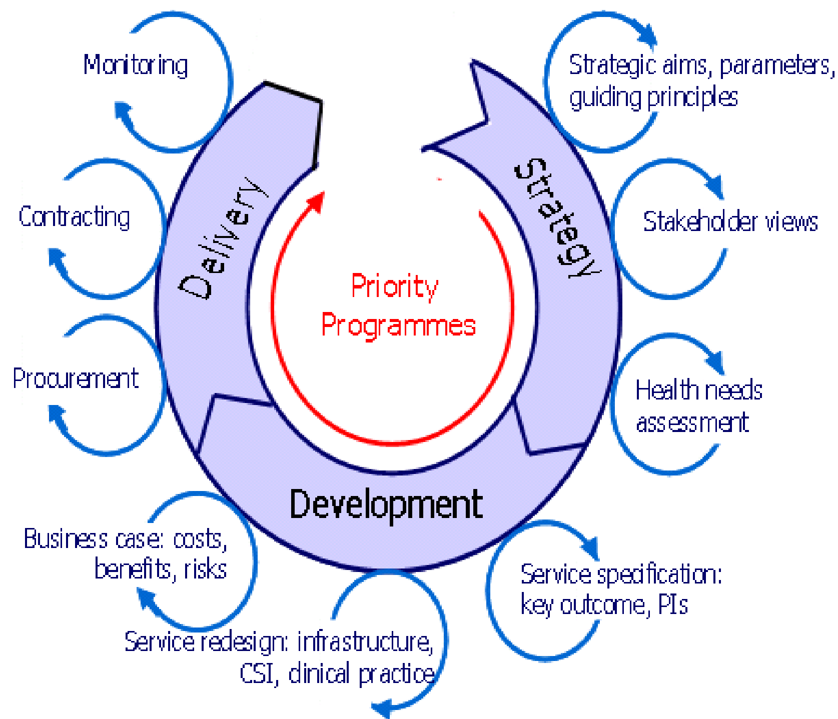
- Understanding, segmenting and anticipating the needs of local communities and individual patients and planning and prioritising accordingly.
- Defining services to meet these needs and contracting for them from the most appropriate providers.
- Monitoring provision and managing contracts, to continuously improve outcomes for patients and local communities.

All of these processes are interlinked and dependent on each other to ensure the best outcome for patients.

The PCT has adopted a commissioning cycle which articulates the key steps to World Class Commissioning and places patients and the public at its centre. The cycle underpins the work undertaken to develop the programmes which are at the heart of delivery of the PCT's business, and builds upon our previous successes in

jointly commissioning services with the local authority and Local Strategic Partnership.

Fig 1: PCT Commissioning Cycle



Commissioning will play a crucial role in the success of system reform. It is pivotal to managing overall system affordability and high quality care. Commissioners will determine the practical availability of choice and will play an ever increasing role in quality management of service, through detailed service specifications and legally binding service contracts.

Commissioning also brings a requirement to secure the best value in the use of resources. Challenging how we spend our money locally and ensuring that the best outcomes are achieved are at the core of the commissioning role.

As established above, commissioning is not the sole responsibility of the PCT and the Calderdale Commissioning Group (CCG). In order to be effective we need to work in partnership with General Practice, local authority and Local Strategic Partnership (LSP). General Practice is closest to individual patients and is best placed to advise them on their choices. The Local Authority is responsible for services, including education, environmental health, social care and economic regeneration. Effective partnership working between the PCT and the local authority is essential to provide local people with effective public health, prevention and support for those who are most vulnerable. There is a history of successful joint working with the Local Authority which includes a range of jointly commissioned and jointly delivered services in the fields of; mental health, children's and older people's services for example. This includes joint approaches to both procurement and contract management. In addition, the PCT and local authority are working closely with a wider range of partners in effectively delivering our Local Area Agreement ambitions.

Our Local Strategic Partnerships (LSP) is also seen as crucial to delivery of our ambition. The Calderdale LSP has a successful history and was recently awarded the Local Government Chronicle Award for best LSP nationally

1.2 Purpose of the Commissioning Strategy

The Commissioning Strategy represents a key planning document for the PCT and its partners for the next five years. It sets out the broad vision for how health and well being services for the people of Calderdale will change and develop over this period. It provides an overview of the current and future needs of the population, what people want, analyses the current patterns of services, together with an oversight of how we expect to see such services change and develop.

In a rapidly changing world any document which tries to cover a period of five years can become dated within a short time after its publication. For this reason this document offers a long-term, wide ranging overview of commissioning intentions rather than detailed plans for changes in services. Both service users and potential providers of new and existing services require much more information to comment upon proposals or to plan how they might provide services respectively. Consequently, this Strategy will be supported by the Annual Operating Plan, which provides more detail on the implementation of the Strategy in the year ahead. This will also be supplemented by strategies and delivery plans for each of the Programmes and Critical Components. Each of these is currently at varying levels of development and implementation.

The strategy therefore has three key purposes:

- To outline proposed developments to enable service users to give informed comment on proposed changes and developments.
- To assist the PCT and partners to put in place arrangements to delivery mutually agreed objectives.
- To give existing and potential providers of changed or developed services an early opportunity to understand the proposed changes and to review and develop their own services to meet the requirements of the commissioner(s).

3. PROGRAMME MANAGEMENT

3.1 Background

Given the complex environment surrounding the NHS, and the increasing demands and expectations being placed upon the system, the organisation has developed a corporate programme management approach to deliver it's business. This approach provides the vehicle to deliver large-scale transformational change and the ambition of the organisation and its partners by aligning current and future capability with the vision, values and objectives of the organisation.

The approach is built upon the Managing Successful Programmes (MSP) methodology developed by the Office of Government Commerce, and focuses on delivery of clearly defined benefits and outcomes. The approach builds on learning from successful delivery of the Medical & Elderly Programme during 2006/7. Given the range of partners involved in this first Programme, there is a broad understanding locally of

what the PCT is striving to achieve. Our Local Authority colleagues are closely engaged in Programme development with the PCT in a number of key areas, and are seen as crucial partners in delivery of the majority of Programmes.

3.2 Programme Suite and Critical Strategic Components

The aspirations and key deliverables of the organisation have been mapped back to a suite of 10 key programmes and 10 critical strategic components. In creating this framework, the PCT is able to deliver both its ambition and key local and national deliverables, for example: Local Area Agreement, Darzi Review, Operating Framework and recommendations from Director of Public Health's Annual Reports.

Programme Suite:

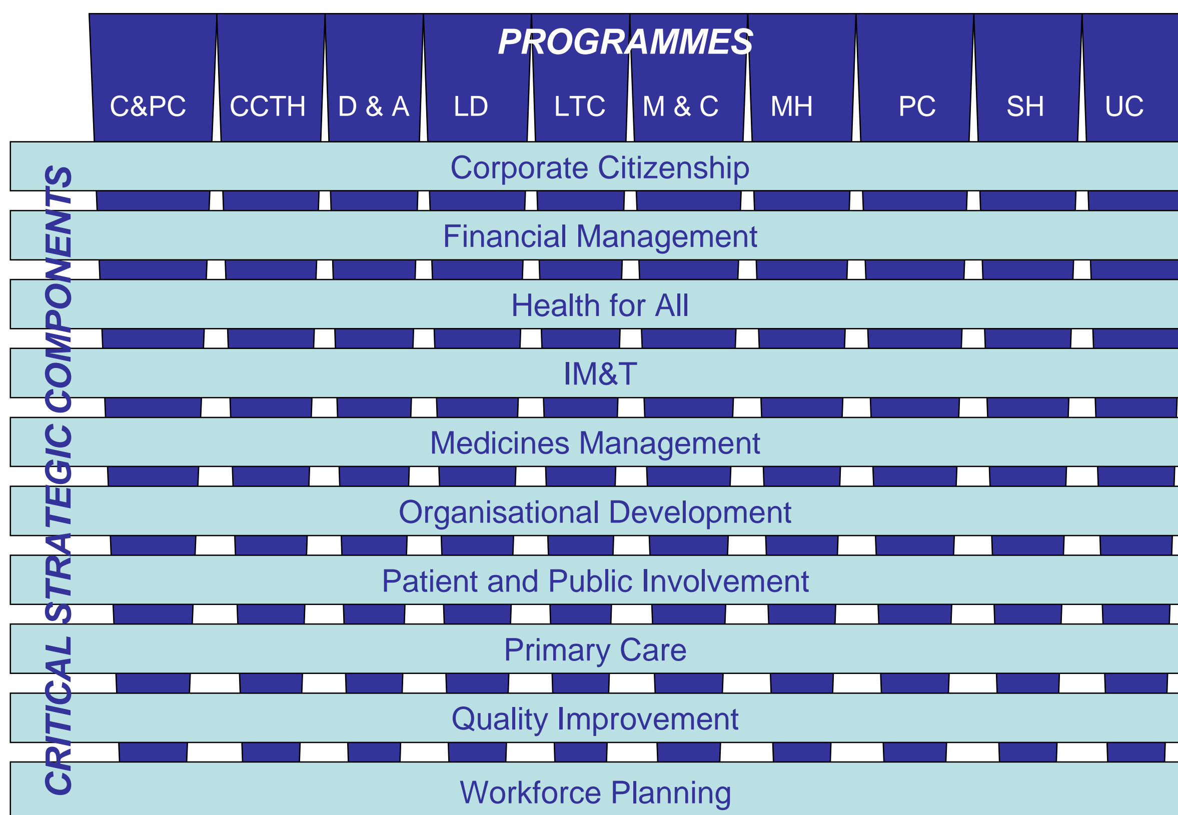
- Cancer & Palliative Care (C&PC)
- Care Closer to Home (CCTH)
- Drug & Alcohol Services (D&A)
- Learning Disabilities (LD)
- Long-Term Conditions (LTC)
- Maternity & Children (M&C)
- Mental Health (MH)
- Planned Care (PC)
- Sexual Health (SH)
- Urgent Care (UC)

Critical Strategic Components:

- Corporate Citizenship
- Financial Management
- Health for All
- Information Management & Technology
- Medicines Management
- Organisational Development
- Patient and Public Involvement
- Primary Care
- Quality Improvement
- Workforce Planning

The model overleaf shows alignment of the 'ten by ten' approach.

Fig 2: Ten by Ten Approach



Each of the 10 Programmes has been described within the next section. For each programme this includes:

- Introduction to the work area
- An overview of needs and the views of the public and patients
- Key issues related to the work
- Outcomes/benefits from the work (these outcomes are undergoing further refinement through the development of individual strategy maps and balanced score cards)
- Deliverables for the 5 year period.

Each of the 10 critical strategic components has been described within this section. For each component this includes:

- Component definition
- Strategic direction
- Outcomes and deliverables
- Fit with programme delivery

An impact analysis has been undertaken to identify, for each programme, which includes:

- Quantifiable health impact
- Impact on activity, particularly acute activity
- Financial impact

The financial narrative contained within the Strategic Plan explains our approach to investment in the programmes and critical components to ensure delivery of outcomes.

3. PROGRAMME SUITE

The following section contains Programme descriptions for the 10 PCT Programmes:

Programme 1	Cancer and Palliative Care
Programme 2	Care Closer to Home
Programme 3	Drug and Alcohol (Substance Misuse)
Programme 4	Learning Disabilities
Programme 5	Long Term Conditions
Programme 6	Maternity & Children
Programme 7	Mental Health
Programme 8	Planned Care
Programme 9	Sexual Health
Programme 10	Urgent Care

Programme 1 - Cancer and Palliative Care

1. Introduction

This programme covers three areas of work – Cancer, Palliative Care/End of Life Care (this section uses both headings and interchanges between the two) and Children and Young People with Cancer. Each of the areas are at different stages of development and link with other programme areas, so for example end of life care cuts across long term conditions, urgent care, mental health, care closer to home to name just a few. This means that whilst this overall programme will have responsibility in making sure improvements are made the actual delivery of the actions may take place within another programme.

There are three key documents which relate and influence each of these areas of work – The Cancer Reform Strategy which was published in December 2007, the End of Life Care Strategy published in July 2008 and Improving Outcomes Guidance for Children and Young People published in 2005. Locally we are responding to these national documents, developing local action plans taking into account local health needs.

2. Cancer Needs Assessment

Around one-quarter (23% female; 28% male) of all deaths (under 75s) in Calderdale in 2005 were due to cancer, making it the second leading cause of deaths after circulatory diseases. During 2004-06, there were 1467 deaths from cancer in Calderdale.

In Calderdale thirty six per sent of all premature deaths (under the age of 75) in 2005 were from cancer. There has been a 10 percent decrease in "all cancer" mortality during the period 1995-2005, which is lower than the national decline (16%) over the same period, and the gap between best and worst quintiles has widened. Calderdale is at risk of not achieving the PSA target of a reduction in under-75 cancer deaths of 20% by 2010, and a reduction in the inequalities gap by at least 6 percent.

The PCT-commissioned Cancer Health Equity Audit to investigate trends in inequalities in cancer mortality in Calderdale. The audit report was finalised in July 2008 and showed that:

- Women under 75 years as a whole across the Calderdale area do not appear to have shown the same falling trends in death rates as men have in the last decade.
- Lung and colorectal cancer are specific cancer sites in which women are not making as good progress as men in Calderdale.
- Furthermore, women in the most deprived quintile of the population seem to be fairing particularly worse especially in progress on reducing the inequality gap in lung and colorectal cancer death rates

Further analysis is underway and will report in October 2008.

In 2004, there were 928 registrations for cancer in Calderdale. Overall there are no major differences to be seen in incidence rates for all cancers in Calderdale compared to other areas, nevertheless there is a trend towards increasing incidence of cancer in women under-75 years, who are now more likely to be diagnosed with cancer than men in this age group.

The top 5 cancers in Calderdale in 2004, by registration rate, were breast cancer (146 per 100,000), prostate cancer (100 per 100,000), skin cancer (96 per 100,000), lung cancer

(56 per 100,000) and colorectal cancer (42 per 100,000). The general trend for breast cancer seems to be that registration rate is increasing. The registration rate for skin cancer has increased by approximately 50% during 1993-2004. There is a slow but steady increase in the incidence of lung and colorectal cancer in women with those for colorectal cancer being focused (but not exclusive to) the most deprived quintile of the population.

Trends for cancer registrations largely reflect ageing of the population and changes in patterns of risk factors. By 2016, there is expected to be a rapid growth (increase of 36%) in the number of people aged 65-74 years (a rise of 5,600). The numbers aged over-75 years are also expected to climb, leading to a rise of 28% in this age group (4,200) by 2021. Both will have implications for cancer incidence.

Over half of all cancers could be prevented by changes to lifestyle. There is not good trend data for risk factor prevalence in Calderdale but where it, or proxy indicators, does exist, these do not augur well:

- Smoking is the single largest preventable risk factor for cancer, responsible for 30% of all cancers in developed countries and up to 90% lung cancer deaths. An estimated 21% of the population of Calderdale are smokers but deprived areas have smoking rates twice the level of the least disadvantaged areas. Trend data is not available.
- Excessive alcohol use is strongly linked to an increased risk of cancers of the mouth, larynx, oesophagus, liver and breast and accounts for 20-30% of liver and oesophageal cancer. Trend data on alcohol consumption is not available but a proxy indicator, alcohol-related admissions to hospital shows a steady increase of more than 50% between 1998-2005.
- 30% of all cancers in developed countries are related to diet. Only an estimated 21% of the adult population in Calderdale consume the recommended levels of fruit and vegetables which is significantly lower than in England.
- Being obese increases the risks of many cancers including uterus, kidney, colon, gallbladder, oesophagus and breast. There is an estimated rate of 21.8% of adults obese in Calderdale (8,000 people) with a further 30,000 overweight. Assuming current trends, by 2025 42% of men and 39% of women will be obese.

The cancer programme will address all these issues to ensure our ambition, which is to reduce cancer morbidity and mortality and reduce the gap in mortality between the most deprived and least deprived areas in Calderdale is achieved.

3. End of life Care

End of Life Care is care that helps all those with advanced, progressive, incurable illness (irrespective of their diagnosis) to live as well as possible until they die. It enables supportive and palliative care needs of both the patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support. The ambition of this programme is to ensure local end of life care matches the best in the country.

From the PCT's End of Life Care Baseline Review, which was completed this year, we know that the majority (57%) of people still die in hospital. The Department of Health's End of Life Care Strategy published in July 2008 highlighted that most people would prefer to die at home as long as high quality care can be assured. In Calderdale we need to reverse the trend of people dying in hospital (unless it is the patient's choice) and increase the

number of people who can die at home. To do this we will be working collaboratively with all our key partners in Calderdale.

4. Children and Young People with Cancer

The Improving Outcomes Guidance (IOG) recognises that the needs of children and young people with cancer are different from those of older adults with cancer so the ambition of this programme area is to ensure that they get the best possible care and the care is most appropriate for their age.

The key recommendations from the IOG are:

- Care should be coordinated across the whole of the NHS and be available as close to the patient's home as possible
- Cancer networks should ensure that they meet the needs of children and young people with cancer
- Multidisciplinary teams should provide cancer care
- Each child or young person with cancer should have a key worker
- Care should be appropriate to the child's or young person's age and type of cancer
- Time in the operating theatre and a children's anaesthetist should be available when needed
- Children and young people with cancer should be offered the chance to take part in research trials
- Treatment should be based on agreed protocols
- A register of all cancers in people aged 15–24 should be urgently considered
- Cancer networks should ensure there are sufficient specialist staff

There has been a Yorkshire Care Network wide group meeting since the publication of the guidance to implement these recommendations. Specialist care is provided at Leeds but it is important that shared care arrangements are in place with each locality across the network to ensure there is sufficient support and care provided closer to home.

5. Cancer Reform Strategy

Since the Cancer Plan was published in 2000 waiting times for patients with suspected cancer have reduced significantly and clinical outcomes against our European neighbours have improved as a result of the implementation of challenging targets, Improving Outcomes Guidance (IOGs) including the development of care pathways.

The Cancer Reform Strategy which was published in December 2007 builds on the progress made since the 2000 Cancer Plan and sets a clear direction of travel for cancer services over the next 5 years. Its aim is to have the best cancer services in the world by 2012.

The strategy sets out six areas of action to improve cancer outcomes. Locally we are finalising our local action plan in response to this strategy taking into account local health needs. The six areas are:

<u>Preventing Cancer</u>

- We will do more to raise awareness of the risk factors associated with cancer with health promotion activities to reduce smoking, excessive alcohol consumption, increase healthy eating and exercise and increase sun awareness and reduce the

use of sun beds. We will target awareness and health promotional activity aimed at women especially those living in the more deprived areas of Calderdale.

- We will roll out the national HPV Vaccination programme for young girls. This will protect against the strains of the virus which causes around seven out of ten cases of cervical cancer.

Diagnosing Cancer Earlier

- We will tackle the falling participation of women aged 25-35 in the Cervical Cancer Screening Programme and inform women of the results of their smear within 2 weeks as announced in the Cancer Reform Strategy.

- The Breast Screening Programme is being extended to nine screening rounds between 47-73 years and digital mammography is being rolled out. These changes mean that we are reviewing the current service model and discussing what changes need to be made to implement the extension of the programme.

- We will implement the new NHS Bowel Cancer Screening Programme locally from February 2009. Our Bowel Cancer Screening Centre will operate across Calderdale, Kirklees and Wakefield. Nurse assessment clinics will be based within the community following the philosophy of Care Close to Home. The colonoscopy clinics will take place at Calderdale Royal Hospital.

- There are opportunities to commission risk factor screening and referrals services (e.g. alcohol) through community pharmacists. The recently published Pharmacy in England white paper identifies the important role pharmacy has in early detection and prevention of some cancers.

- We will be working closely with primary care colleagues to agree how best to provide more support to them in identifying cancers earlier, reducing the variation of fast track referrals and ensuring the delivery of the extended waiting time targets for cancer.

Ensuring Better Treatment

- Waiting times are being extended to increase the number of patients who benefit from the current standards. We are working with Calderdale and Huddersfield NHS Foundation Trust (CHFT) to implement the extension of the targets within the national timescales.

- Work will continue to fully implement Improvement Outcomes Guidance (IOGs) for specific cancer sites. The Skin IOG is an area which needs focus in order to ensure full compliance before Peer Review which is planned for 2009.

- We will work with CHFT to develop community chemotherapy services wherever appropriate.

- We will improve access to specialist therapy and rehabilitation support in areas such as speech therapy, specialist OT and dietetics.

Living with and beyond cancer

- We are currently planning to develop a new approach to follow up care after breast surgery. The aim is to test the feasibility and acceptability of the new supportive care model of follow up as apposed to follow up based on traditional out patient visits.

- We need to review the range of services and support which is available for cancers survivors.

Reducing cancer inequalities

- As already explained, one of our ambitions with the cancer programme is to reduce inequalities. Our local action plan will target areas where improvements can be made to reduce the gap between the most and least deprived areas in Calderdale and improve the trend in death rates for women, particularly in lung and colorectal cancers.

Delivering care in the appropriate setting

- Discussions with our key partners need to take place on how we can deliver new models of care. There are opportunities to shift some services from inpatient to ambulatory care and improvements can be made in how primary care colleagues access diagnostic tests. We need to work with primary and secondary care clinicians to agree how further improvements can be made in how we deliver local cancer services.

6. End of Life Care

The PCTs end of life care baseline review identified much good practice but also highlighted the need to have an integrated approach to palliative care, supporting people to be cared for in their preferred place of care. The review also highlighted the need to improve the quality and consistency of data available so that services can be commissioned more effectively.

In July 2008 the Department of Health (DH) published their End of Life Care Strategy – promoting high quality care for all adults at the end of life.

The PCT now needs to respond to this national strategy and the findings from the baseline review by producing a local action plan in partnership with all key stakeholders setting out how we will implement local improvements and deliver our ambition to provide end of life care that matches the best in the country.

Two actions have already been agreed for 2008:

- To appoint a Macmillan Clinical Nurse Specialist for Care Homes to improve end of life care across all care homes in Calderdale and reduce the number of unplanned admissions and deaths in hospital

- To appoint an End of Life Care Facilitator to build on the work already started on implementing end of life care tools ensuring complete roll out and embedding these into clinical practice.

Our action plan will focus on the areas identified in the End of Life Care Strategy, namely:

- Strategic Commissioning
- Identifying people approaching the end of life
- Care planning
- Co-ordination of care
- Rapid access to care
- Delivery of high quality services in all locations
- Last days of life and care after death
- Involving and supporting carers
- Education and training and continuing professional development
- Measurement and Research
- Funding

We will be working closely with other programme areas, particularly long term conditions, to ensure end of life care pathways are developed for all conditions irrespective of their diagnosis.

We will also be developing a programme of support for children and young people and their families with end of life care needs.

7. Children and Young People with Cancer

We will work with local providers to develop the support for children and young people with cancer and their families as part of the shared care arrangements with the Leeds Hospital Trust.

8. Outcomes

Specific outcomes for the Cancer and Palliative Care Programme for the next five years will be:

- A reduction in the cancer mortality rate by 20% for people under 75 by 2010, with a reduction in the inequalities gap of at least 6% between areas with the best and worst heath and deprivation indicators.
- Achievement of the extended cancer waiting times targets in 95% of cases
- Implementation of a local bowel cancer screening programme delivering at least a 60% uptake.
- Achievement of the expanded breast cancer screening programme and implementation of digital mammography
- Implementation of the HPV vaccination programme
- Increased uptake of cervical cancer screening of women aged 25-35
- 100% uptake of end of life care tools by 2012 (current baseline to be agreed)
- Increase the uptake of palliative care education by key staff – community matrons, District Nurses, Out of Hours Doctors, Social Care and Care Home staff. (current baseline to be agreed)
- A reduction in the number of people dying in hospital by 20% by 2012.
- An agreed service specification for a new integrated palliative care model. This will specify the level of skills and competencies required within the community.
- A reduction in the delays in the transfer of palliative patients by ambulance

9 Link to World Class Commissioning Outcomes

This Programme is contributing to the achievement of the WCC Outcome on:

- Reduction of cancer mortality rate in the under-75s

This Programme is working with the Health for All Critical Component in achievement of the WCC Outcomes on:

- Smoking quitters

This Programme is working with the Quality Improvement Critical Component in achievement of the WCC Outcome on:

- Self-reported experience of patients and users

Programme 2 - Care Closer to Home

1. Introduction

The Chief Executive of the NHS has stated that "The shift of care from secondary care settings will be a significant challenge for local health communities. Clinicians and managers have seen the potential benefit to patients of redesigned, community-based services." Therefore the ambition for programme is to rise to this challenge and to develop a wide-range of locally-based services that deliver care for patients as close to home as possible. For patients, this will include - ensuring their assessment is undertaken at the right time, by the right person in the right place, ensuring their services are delivered by skilled, well-qualified staff, who work within integrated services. The shift of services from centralised points into localities will be underpinned by an effective analysis to maximise our ability to delivery of seamless, patient centred high quality care.

The definition of care closer to home used for this programme is – the provision of more convenient and accessible care for patients through; substituting high tech clinical environments for community based settings, enhancing the skills of staff to undertake roles previously undertaken by those higher in the NHS skills escalator, maximising the use of new technologies in maintaining the individual's independence, moving from a medical care model to self-care being supported by a broader range of care providers and looking at a wider-range of providers to those who have traditionally delivered NHS care, particularly commercial and voluntary sectors.

The scope of the programme at this point covers adults within Calderdale and is focussed primarily on the shift of unplanned care into community settings – thus preventing unnecessary and inappropriate hospital admission. The shift of planned care is covered by the Planned Care Programme, and there will be synergy between the two programmes to maximise the benefits to patients. It also aimed at the use of transformational change to develop patient focused pathways and protocols to ensure patients receive care in the right setting.

Calderdale Council are seen as crucial partner in delivery of this Programme, building on good joint working which has been undertaken in relation to both jcommissioning (jointly commissioned services and joint contracts), and the development of more integrated health and social care delivery models, for example mental health and intermediate care services.

2. Needs Assessment

Needs assessment work provides the following picture:

- During 2008/7 it is estimated that the PCT will commission 91,230 emergency occupied bed days, and this is to be reduced to 89,983 by 2009/10.
- Every week in Calderdale there are approximately 6 people whose discharge was delayed (approximately 338 people per year). This equates to nearly 2,000 bed days per year utilised for those who did not need to be in hospital.
- Tribal report indicated that on any one day only 32% of people in medical & elderly beds were receiving medical treatment, the remainder (66%) were, for a number of reasons, awaiting discharge home or into other services.
- BCBV indicators for emergency admissions (Q4 07/08) shows the PCT has a productivity opportunity of £1.6M, and are ranked 57th out of 152 PCTs nationally.

- The numbers of patients being admitted to nursing and residential homes in Calderdale is currently declining in line with national trends (approx 300 per year).
- During Q1 08/09, 1212 people, who were considered to be very high users of services, were provided with a service by a Community Matron.

The recent Joint Strategic Needs Assessment (August 2008) gave the following additional information of relevance to shifting care to community settings:

- The population of Calderdale is set to increase, particularly amongst the older population with a rapid rise (36%) of those aged 64-74 years by 2016 and a 28% increase in the over-75 years population by 2021
- Overall, 18% of people in Calderdale are recorded as having a limiting long-term illness: this is almost 1 in 7 of the working age population and half of Calderdale's older people
- The main reasons for admission to hospital in Calderdale are related to reproduction, followed by cataracts, chest pains and breast cancer.
- The top diagnoses by length of stay are urinary tract infection closely followed by fractured neck of femur; heart diseases and respiratory diseases also have along length of stay
- Around 10% of Calderdale residents provide unpaid care on a regular basis, an increasing proportion of whom will be elderly themselves: understanding the social, economic and health situation of carers, as a basis for effective support, is likely to be an increasingly important element of planning and providing for older people
- 30% of households in Calderdale consist of a single person; this is projected to rise to 34% (or 32,000 households) by 2016 of which a growing number will be single pensioner
- 31% of households do not have access to a car or van and there are likely to be increasingly pressing issues concerning access to services across the District, particularly for older people and non-car owners
- Those living in Calderdale's most disadvantaged communities experience significantly greater ill-health than elsewhere in the district

The views of the public/patients have been sought in a number of ways, and these include:

- There should be a strong emphasis on the rights of people to have choice and their ability to control what happens to them
- Services should be provided as close to home as possible, particularly those currently provided within a hospital setting. Wherever possible, services should be provided on a locality basis
- Any plans to move services should include an assessment of transportation issues.
- Hospital admission and discharge processes should be designed to reduce anxiety and improve patient experience. This will shift the emphasis away from increasing dependence to promoting independence and empowerment of people to 'be themselves'.
- Long-term care in care home settings should be provided to the highest standards, retaining the dignity and respect of residents
- There should be joint working at the broadest level, so that there is engagement of those who deliver, for example; housing, learning, leisure and creative opportunities

3. Issues

There are a number of issues related to delivery of care closer to home services locally.

- Benchmarking clearly identifies significant opportunities to move away for traditional models of delivering healthcare in Calderdale.
- There is a need to reduce; emergency bed days, excess bed days and delayed discharges and delays in assessing people for social care packages – particularly for conditions which could be treated in the community.
- An integrated estates strategy is needed - building upon the Community Hospitals Project to ensure local estate is fit for purpose for major shift initiatives.
- A workforce planning strategy is needed to delivery extended roles and enhanced skills development.
- The telecare/telehealth agenda yet to be fully developed in Calderdale.

4. Outcomes

Over the next 5 years the Care Closer to Home Programme will deliver:

- A 1% reduction in emergency bed days usage by 2010
- A 10% reduction in delayed discharges by 2012
- A reduction of 5% in the number of people with ambulatory conditions who receive care within a hospitals setting.
- Reduce the number of people admitted into long-term care directly from hospital by 20% by 2012.
- The development of a new 15-bedded, community-based, nurse-led sub-acute unit to deliver step-up and step-down nursing care outside a hospital setting by Autumn 2009
- Increase the number of Community Matrons to 20 by 2012

5. Link to World Class Commissioning Outcomes

This Programme is working with the Quality Improvement Critical Component in achievement of the WCC Outcome on:

- Self-reported experience of patients and users

5. Deliverables

This will be delivered by:

Creating New Services

- Ensure delivery of the Community Hospitals Project – with an initial focus on the Brighouse, Todmorden and central Halifax developments. There are a number of key capacity issues which will be addressed by the delivery of the Community Hospitals agenda locally, these contribute to the delivery of the NHS next stage review planned care recommendations (to improve access to diagnostics, care provided outside of hospital and home monitoring of conditions). This will also be supported through the ongoing procurement for the local extended primary care services, Practice Plus. This work will also aim to maximise the potential for creative partnerships with Calderdale Council, particularly around the establishment of 'one-stop' shop approaches to healthcare and innovative fitness and leisure-time activities

- Commission a nurse-led sub-acute unit outside an acute hospital setting, and community service to provide specialist rehab and nursing support and provide a more effective setting in which to assess patients prior to a decision being made regarding admission to long-term care.
- Commission additional clinical and psychological capacity to support patients going through the specialist rehab pathway
- Commission an integrated telecare and telehealth service to provide remote diagnostics and support self-care.

<u>Expanding Current Services</u>

- Commission extra-care housing capacity to provide additional choice for patients requiring intermediate care.
- Further develop the Home from Hospital supported discharge scheme to reduce delays in discharge.
- Continue to work closely with CHFT and Calderdale Social Services to ensure effective discharge and patient flow.
- Develop a transfer of care specification which will support effective flow of patients within the system.
- Commission a new integrated falls service and continue to develop the falls prevention element of the service.
- Working closely to the LTC Programme to expand the current number of Community Matrons providing a service locally.
- Commission specialist Pharmacist for Epilepsy to support epilepsy review in primary care
- Undertake work to complete the Care Outside Hospitals Pilot to facilitate shift of activity into community settings and share learning.
- Further develop the Partnerships for Older People Projects (POPPS) which aim to reduce the number of emergency unscheduled bed days for the over 65's and increase the proportion of older people supported to live in their own homes. Existing projects consist of Neighbourhood schemes, Locality Integration, Home from Hospital, Improve the health and well-being of carers and Falls Prevention

Programme 3 – Drug and Alcohol (Substance Misuse)

1. Introduction

Our ambition - abuse of drugs and alcohol can cause significant and enduring harm to the lives of young people, adults, families and communities across Calderdale. The aim of the Substance Misuse Programme is to commission services and interventions that will mitigate the harm, support the rehabilitation and social re-integration of affected individuals and seek to enhance the health and well-being of substance misusers, their families and the communities in which they reside.

The term Substance Misuse refers both to Drugs and Alcohol. The definitions underpinning this programme are;

Drug abuse; the term drugs used in this document refers to psycho-active drugs including illicit drugs and non-prescribed pharmaceutical preparations.

Alcohol abuse; the term misuse in this document refers to the illegal or illicit drug taking or alcohol consumption which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. Drug misuse is therefore drug taking which causes harm to the individual, their significant others or the wider community. By definition those requiring drug treatment are drug misusers.

In terms of scope, this programme has direct responsibility for commissioning health and social care provision for substance misuse across health, housing, employment and training and criminal justice settings. Thematically the programme covers prevention, early interventions and specialist interventions (clinical and non clinical) to adults and young people in Calderdale.

This programme is implemented within a joint commissioning structure with partner agencies including the police, probation, adult services, housing, children's and young people and the 3rd sector. User involvement is well developed within this programme and is represented in the joint commissioning process.

This programme seeks to develop and commission integrated treatment systems for adults and young people that address the main thematic areas referred to above.

2. Needs Assessment

Key finding from the Partnership needs assessment;

- Needs assessment work carried for the period April 2005 to March 2007 identified 2128 adult problematic drug users of whom 1351 were users of heroin and/or crack cocaine. A further 220 young people (under18's) were recorded as being problematic drug users.
- A recent needs assessment carried in the Yorkshire & Humber region by the DoH as part of the ANARP (Alcohol Needs Assessment Research Project) programme suggests a 5.2% prevalence figure for problematic drinkers aged between 16 – 64 years old. This equates to 6219 individuals in Calderdale.

- Alcohol related admissions to hospital have increased steadily from 2.5 per 1000 during 1998-2000 to 3.89 per 1000 in 2003-2005 (a 55.6% rise). The gap between the most and least deprived areas of Calderdale widened by over 30% in the same period.
- Calderdale is significantly worse than England on male alcohol-attributable hospital admissions, alcohol-related recorded crimes, hazardous drinking and harmful drinking
- Around 54% of Year 10s (14-15 year olds) told us they were drinking occasionally, with about 25% out of control. Data from a recent talkback survey identified that the vast majority of people in Calderdale saw young people under 18 buying or consuming alcohol; 40% of respondents thought that adults buying alcohol for people under 18 was a problem in alcohol, and there was support for tougher measures to control alcohol sales
- Substance misuse harms directly affect approximately 7% of the 16 – 64 population who are problematic substance misusers. This equates to 8567 individuals in Calderdale.
- The developing Joint Strategic Needs Assessment is indicating a need to address alcohol related harm in order to improve life expectancy and reducing health inequalities.

In terms of public and patient views, the following represents the key messages:

- Service user surveys carried out independently (by the National Treatment Agency) demonstrate that service provision is being carried out at a level that is above the average national and regional standard
- Surveys carried out annually as part of CMBC Talkback and the baseline survey carried out in 2007 for Calderdale Local Area Agreement by IPSOS (formerly MORI) indicate that drug and alcohol use and drug dealing remain significant issues of concern for Calderdale residents
- That public awareness of how to access drug treatment provision has increased in the last 2 years.

In terms of benchmarks:

- That we have been very successful at engaging with a high proportion (87%) of the priority cohort of drug users in Calderdale i.e. heroin and/or crack
- That we are successful at retaining a high proportion of drug users in effective treatment (currently 86%)
- That our commissioned services have contributed significantly to a reduction in drug related harms across health, criminal justice and social care e.g. decrease in drug related offending
- That we have been successful at engaging a significant proportion of the most chaotic groups of drug users into our treatment system (evidenced in most recent needs assessment)
- That we have successfully developed “niche” specialist clinical provision e.g. specialist dual diagnosis for substance dependent individuals on CPA and ante and post natal provision for substance misusers who are pregnant and/or have young children
- We have been successful at developing a joint commissioning process with partner agencies
- We have developed significant joint commissioning relationships with other Calderdale partnerships e.g. Supporting People and Children’s & Young People
- That we have consistently been scored as Green by our main external performance management agencies i.e. NTA (DH) and DIP (Home Office)

- That we have been scored as excellent by the Healthcare Commission regarding our commissioning process and our harm reduction provision
- That we have brief interventions to target harmful and hazardous drinking across a range of settings

3. Outcomes

- To maintain the quality of drug provision and to ensure that we retain the required capacity to meet need - as the main budgets that underpin this programme are no longer ring-fenced.

- To develop a better alignment between ring fenced drug allocations and mainstream funding both in terms of NHS and partner funding streams

- To ensure that all current and future service provision is securely commissioned and contracted on the basis of evidenced based service specifications emphasising quality and contracts that are clearly defined in terms of performance

- To place greater emphasis on the effectiveness of drug provision and seek further improvements in outcomes notably in terms of individuals in treatment programmes who are able to become fully functioning citizens e.g. re-entering the job market and/or who successfully achieve sustained abstinence.

- To meet the challenge posed by the new Public Service Agreement for drugs and specifically the 3% increase in heroin/crack users in effective treatment set as a minimum by the DH for the next 3 years (Vital Sign 14). This is a challenge because of the high levels of engagement already achieved in Calderdale regarding this cohort.

- To reduce the harms caused by alcohol within the local health economy and across our communities by developing more effective prevention initiatives and a more coherent treatment system for alcohol interventions that effectively address the health and social care needs of those who are using alcohol hazardously, harmfully or dependently as part of the wider partnership approach to reducing alcohol related harms in Calderdale

- To improve our communication and engagement with the general public and influence public perceptions regarding the quality of services we offer where those services have been evidenced as being of high quality

4. Link to World Class Commissioning Outcomes

This Programme is contributing to the achievement of the WCC Outcome on:

- Reduction of hospital admissions for alcohol-related harm

5. Deliverables

- To implement a commissioning strategy where all commissioned services will be aligned to the following client pathways from April 2009:
    - Voluntary access drugs interventions
    - Criminal justice drug interventions
    - Alcohol interventions
    - Social care substance misuse interventions

- Substance misuse interventions for young people
- Self Help Provision

- To commission the following new services:
  - Tier 3/4 Alcohol Interventions Service for adults by end of 2008
  - Tier 3/4 substance misuse services for young people by March 2009
  - Tier 2/3 service for the Social Needs of Priority Drug and Alcohol Users by March 2009
  - A Self Help organisation for drug and alcohol users by April 2008

- This programme, as lead commissioner for substance misuse in Calderdale, will implement a robust procurement process for all commissioned activity in this programme from April 2008 and will ensure that all commissioned services go through that procurement process and are working to new contracts by April 2009

Programme 4 - Learning Disabilities

1. Introduction

The ambition for the 5-year programme for learning disabilities is reflective of the recent work done to develop a new Joint Strategy for Adults with Learning Disabilities which aspires to empower people with learning disabilities, improve their access to healthcare and provide effective support for their families and carers through their involvement in all that we do. We aim to create opportunities to maximise their independence by; developing individualised budgets and increase direct payments, access to all forms of advocacy, learning, employment as well as day and evening support. To impact on the life experience of people with learning disabilities we will focus on improving all forms of accommodation, access to leisure services and support to enable them to be active members of the communities they live in. There is also an ambition to ensure delivery of high quality, effective services for those with challenging behaviour and autism.

In the context of eligibility to benefits and care services an individual with an IQ score of 70 or less is defined as an adult with learning disabilities. In Calderdale there are 767 adults with learning disabilities known to the council and they range from people with a mild learning disability to moderate or severe or profound. It is possible that there are as many as 800 adults with learning disabilities in Calderdale but because some people are able to live independently, or with families they are not known to the council.

The scope of the programme relates to; successful delivery of the aims of the strategy and the action plans supporting the outcome of the Yorkshire and Humber Performance and Self Assessment Framework. It includes those living within Calderdale and those placed outside the Calderdale area. The programme is based on involvement and a broad partnership approach to delivery of the strategic ambition.

2. Needs Assessment

- The proportion of people with a learning disability who are known to Calderdale Council has remained fairly constant over the past few years. In total, at present, there are 447 people over 18 years known to Calderdale Adult Services who have a learning disability. It is anticipated that the overall numbers of people living with learning disabilities in Calderdale will increase by 26.9% by 2025; however, there is an actual and projected rise in the number of children surviving childhood with severe disabilities. Projections suggest a 0.7% increase in the prevalence of severe and complex disabilities by 2011 and a 1% increase by 2021.

- People with learning disabilities are also living longer than previously putting pressure on existing services. It is anticipated that by 2025, the numbers of people over-70 with learning disabilities will almost double. In addition there are 82 adults with learning disabilities living with older carers who will need to access services in the near future.

- Only 6.3% of adults known to the council are from the Black and Minority ethnic (BME) community. They are currently low users of services but that may change as new generations of families from the BME communities decide to take on less of the caring role. In addition we are experiencing a growth in numbers of children from BME communities with profound and multiple disabilities that growth is projected to continue.

- There are over 50 adults with learning disabilities placed out of area. Many of these have challenging behaviour or autism and whilst they are well managed through children's services there is a lack of local provision to meet their needs as adults.

- Social Care only supports around 10% of the estimated people currently living with a learning disability in Calderdale.

Through a successful engagement event people with learning disabilities, their families and carers in Calderdale have told us what is important to them:

- Being Healthy
- Having a fulfilling life
- Having more choice and control over their own lives
- Felling respected and feeling good about themselves
- Having appropriate access to education, training and employment

Across the local health and social care economy we spend over £19m. However both the PCT and the council demonstrate lower than average spending on learning disabilities both in their comparator groups and nationally. The council spend on average £80 per head on adults (18-64) with learning disabilities and PCTs programme budget for learning disabilities (including children and adults) shows an average spend of £30 per head. However both commissioners continue to spend increasing amounts each year in this area.

3. Key issues

There are a number key service issues related to delivery of the aims of the learning disabilities strategy that need to be managed in the context of the current level of expenditure across health and social services :

- The need to engage primary care in Health Action Planning
- The need to review of services for challenging behaviour and autism
- The need to bring back adults with learning disabilities placed out of area
- The need to develop an agreed pathway for transition from adult to children's services
- The need to introduce individual budgets and growth in direct payments
- The need to increase opportunities for learning and employment

Underpinning the Strategy will be a year on year Joint Commissioning Plan – the delivery arm of the aims of the strategy. A Joint Commissioning Plan is currently being developed by the PCT and the Council to deliver the strategy. Successful delivery will enable local people with learning disabilities to:

- Live the lives they want
- Exercise Choice and Control (personalisation)
- Improve what they do during the day and evenings
- Have improved access to healthcare to reduce health inequalities for people with learning disabilities
- To access care closer to home and reduce the numbers of people placed out of area
- See improvements in people's housing situation – Increasing the range and quality of housing and support options for people with learning disabilities
- Access the widest range of personalised services by better use of resources and value for money through the application of the principles of World Class Commissioning

4. Priorities

In line with the ‘Big Priorities’ and the ‘Wider Agenda’ in ‘Valuing People Now’ the priorities for the programme are:

- The introduction of Individual Budgets – a multidisciplinary working group will develop a scheme and initiate pilots
- Helping more people to have a direct payment – increasing the numbers of people having a direct payment
- A renewed focus on Person Centred planning – building on current good practice to ensure everyone has a person centred plan and that delivery of outcomes is monitored
- Increasing opportunities for learning and paid and unpaid work – supporting people to live the lives they want and improving the way we manage the transition from children’s to adult services including a work-stream looking at ways to improve and increase paid and other forms of work supported by meaningful education opportunities that prepare people for work
- Working through the Primary Care Health Subgroup secure the involvement of Primary Care in Health Action Plans to achieve level 3 performance by providing prevention services and better management of long term conditions for people with learning disabilities
- A review of how acute services meets the needs of adults with the most complex health issues such as challenging behaviour and autism
- Promoting the inclusion of people with learning disabilities in mainstream housing initiatives and increasing the focus on access to home ownership and housing with assured tenancies to ensure people are able to live in the communities they want to closer to their families and friends.

5. Link to World Class Commissioning Outcomes

This Programme is working with the Quality Improvement Critical Component in achievement of the WCC Outcome on:

- Self-reported experience of patients and users

Programme 5 – Long Term Conditions (LTCs)

1. Introduction

Approximately 50,000 people in Calderdale are registered as having a long-term condition (LTC). Nearly a third will have three or more health conditions and are more likely to suffer from mental health problems. Another 26,000 people are registered as having hypertension, a key risk factor to developing vascular disease. Having a LTC, particularly one which is not well-managed, has a huge effect on the quality of life and well-being of not just the person concerned, but also their families and carers.

The LTC programme has two ambitions – to improve the health of those at risk of developing LTCs, by commissioning quality services aimed at prevention and early diagnosis, and to reduce mortality and morbidity for those who already have LTCs, by commissioning services that will provide better access to treatment and high quality care.

Also, the LTC agenda, particularly in relation to addressing the needs of the 'fail elderly', as described by Lord Darzi, is one in which Calderdale Council is a vital partner. There is a strong history of successful jointly commissioned and jointly delivered services for older people which provides a strong basis for successful delivery of this programme as a whole.

2. Long Term Conditions

LTCs can be defined as those conditions that cannot, at present be cured, but can be controlled by medication and other therapies. There are currently 127 conditions defined as long-term conditions. However, the programme will initially focus on conditions within the following over-arching disease groups, which are:

- **Vascular Conditions** - Diabetes, Stroke, Renal Disease, Peripheral Arterial Disease and Coronary Heart Disease (CHD), including Heart Failure.

- **Respiratory Conditions** - COPD and Asthma

- **Neurological Conditions** - Multiple Sclerosis (MS), Parkinson's, Alzhiemers, Dementia and Epilepsy

- **Other Conditions** - Rheumatology

3. Needs Assessment

The following information provides an overview of key messages from needs assessment work:

- People with long-term conditions are the most intensive users of health care services, and they account for 80% of GP consultations.
- People with long-term conditions who are frequently admitted to hospital account for 36.5 of overall bed day usage
- 26% of people with long term conditions have three or more other conditions (poly-morbidities). The number of co-morbidities increases progressively with age, with

higher levels among women. A significant proportion of people with long-term conditions also suffer from mental health problems.

- Stroke is the single largest cause of adult disability in England.
- 11% of those claiming Incapacity Benefit/Severe Disablement Allowance in Calderdale do so because of diseases of the respiratory or circulatory system, and 7% because of diseases of the nervous system
- The 2008 JSNA states that 35.9% of all adult female deaths in Calderdale were as a result of circulatory diseases (34% of men).
- YHPHO estimates that Calderdale's obesity rate in adults is 21.8% equating to some 8000 obese people.
- From QMAS April 2008, there were 8184 people registered with diabetes in Calderdale, with around 70 new diagnoses every month. Adults with diabetes are twice as likely to die before the age of 80 as those without the condition
- In Calderdale 21% of the adult population smoke and round 250 premature deaths a year are attributed to smoking. Smoking is a significant risk factor in relation to deaths for both vascular and respiratory conditions.
- Half of Calderdale's older people are living with a limiting long-term illness. 10-15% are estimated to have depression, 3-5% severe depression and 7% with dementia.
- The population of Calderdale is set to increase, particularly amongst the older population with a rapid rise (36%) of those aged 64-74 years by 2016 and a 28% increase in the over-75 years population by 2021
- Those living in Calderdale's most disadvantaged communities experience significantly greater ill-health than elsewhere in the district

The public and patients have views on the work we can do to more effectively support their needs, this includes;

- Ensuring care is planned with patients to take account of their needs and lifestyle
- Ensuring patients are supported to manage their own condition and maintain their independence
- Providing services where patients can rapidly access appropriate tests and treatment, which means a diagnosis can be made sooner and symptoms controlled or reduced
- Providing the right information to help people to recognise and detect symptoms early
- Ensuring patients have timely, ongoing access to appropriate rehabilitation services which meet their continuing and changing needs
- Ensuring support for patients in later stages of their life, to receive a broad range of services which meet their personal, social, psychological and spiritual needs
- Enabling carers and families to access support and services in their own right

There are a number of issues related to the delivery of the long term conditions programmes locally:

- There is a need to reduce CHD and stroke related mortality and disability - hospital services will need to be redesigned, extended and expanded in line with national targets.
- There is need to deliver on a number of Vital Signs agreed for local action relating to LTCs. These include: increasing the proportion of people with long-term conditions supported to be independent and in control of their condition; reducing the number of emergency bed days per head of weighted; reducing rates of hospital admissions for ambulatory care sensitive conditions; improvements in our vascular risk score and a reduction in the number of patients with diabetes in whom the last HbA1c is 7.5 or more.

- LTC is also a key work-stream within the Lord Darzi 'NHS Next Stage Review', which emphasises improvements in diabetes and stroke care, and focuses on care standards, care planning and self management.
- Delivery of efficiency opportunities related to; COPD, asthma, diabetes and hypertension which have been identified as some of nineteen 'Ambulatory Care Sensitive' conditions, where patients could be better managed in the community to avoid unnecessary admission to hospital.
- The need to commission services to provide supported self management and self care which are currently under-developed services, and will be a key focus of roll-out of the rehabilitation programme within the Care Closer to Home Programme

4. Outcomes

- Reduce the number of Occupied Bed Days utilised by those with LTCs who have frequent admissions to hospital.
- Continue to reduce the death rate for CHD in line with national indicators, with a particular focus on reductions within electoral wards with the highest levels of deprivation.
- Continue to reduce the death rate for vascular diseases, particularly premature deaths.
- Increase in the number of diabetics being diagnosed every month to address the estimated current 1800 undiagnosed diabetes patients within Calderdale.
- A feature of high quality stroke services is that 80% of patients who have had a stroke need to spend 90% of their time in hospital on a specialist stroke unit, and this will be a target we will deliver locally.
- 60% of high risk TIA cases will be assessed and treated within 24 hours by a stroke physician to provide the best opportunity to reduce the risk of full onset of stroke.
- Maximise the benefits to patients by the development of a self-care programme and provide greater knowledge, improve quality of life and reduce exacerbations.
- For approximately 100 COPD patients per annum to receive pulmonary rehabilitation to increase their ability to exercise, reduce exacerbations and improve their quality of life.

5. Link to World Class Commissioning Outcomes

This Programme is working with the Health for All, Medicines Management and Primary Care Critical Components in achievement of the WCC Outcome on:

- Improvement in CHD controlled blood pressure

This Programme is working with the Health for All Critical Component in achievement of the WCC Outcomes on:

- Smoking quitters

This Programme is working with the Quality Improvement Critical Component in achievement of the WCC Outcome on:

- Self-reported experience of patients and users

6. Deliverables

Generic services to support patients with LTCs:

- Commission a patient stratification/risk prediction service to accurately identify patients with LTCs and ensure they are receiving the most appropriate and effective services.

- Develop one-stop clinics to provide multi-agency, multi-disciplinary services under one roof to maximise support to patients (long term development)
- Establish screening services and assessment (including oxygen assessments) for housebound and hard to reach patients with LTCs to ensure they receive regular reviews of their support needs.
- Establish specialist pharmacy services and pharmacy reviews to ensure concordance and for those who need support to manage pain.
- In partnership with the Cancer and Palliative Care Programme, commission new end-of life and palliative care services to support those with LTCs who are at the end stage of their disease.
- Provide better access to psychological support for people with LTCs
- Address any issues arising on waiting times for outpatient appointments for people with LTCs, including reducing waiting times for therapy, social services, community rehabilitation etc
- Develop strong links with CCTH programme on self care agenda and rehabilitation
- Ensure the programme has strong input into developments of early supported discharge service – to ensure patient safety and well-being when they return home
- Evaluate and explore opportunities of voluntary and commercial sector role as providers
- Commission services from community pharmacy to increase its contribution to the management of LTCs in line with the White Paper ‘Pharmacy in England’.
- Commission services to develop and implement the new ‘Patient Prospectus’ offering a menu of options to support self care
- Implementing the Lord Darzi NHS Next Stage Review recommendations for the LTC pathway

Services to support patients with vascular conditions:

- Developing an overarching vascular programme to identify areas where a broad approach can be taken to help reduce mortality and morbidity from vascular disease and provide a range of services from prevention to palliative care services.
- Recruiting a CHD business change manager to implement and further develop CHD redesign programme and CHD GP representative to act as advocate on local and regional cardiac networks
- Roll-out specialist cardiac rehabilitation, to include people with Heart Failure, to prevent further exacerbations and support recovery
- Development of an Annual Screening Service to housebound CVD patients
- Pilot Year of Care for Diabetes project in 3 practices and roll-out the learning across all practices in Calderdale
- Implement structured patient education for people with diabetes (newly diagnosed, foundation and BME for type 2 and as appropriate for type 1)
- Develop and implement a new service model for Diabetes with appropriate levels of care
- Develop primary care specialist services to enable care closer to home
- Recruitment of programme manager for stroke services to implement the recommendations of the National Stroke Strategy and delivery of the vital signs indicators
- Development of a new pathway for people with Arrythmia and sudden cardiac death (Chapter 8 CHD NSF)
- Develop and implement new services for people with Renal/Chronic Kidney Disease

Services to support patients with respiratory conditions:

- Roll-out specialist pulmonary rehabilitation to prevent further exacerbations and support recovery
- Establishing new respiratory services/clinics in the community run by specialist nurses
- Expanding community nurses role for people with COPD – oxygen assessments & nebuliser usage
- Develop a hospital at home service for people with COPD
- Develop new model of care for COPD patients with Rapid Response Team and Hospital Discharge
- Scoping of a future holistic management of care and services for COPD patients
- Scoping of future Asthma support and service requirements in Calderdale
- Further development of smoking cessation services

Services to support patients with neurological conditions:

- Recruit an LTC Programme Manager for Neurological Conditions
- Develop a Neurological Programme which will support people with debilitating neurological conditions and ensure there is a clear pathway of high quality services in place.
- Expand specialist pharmacy services for those with epilepsy

Services to support other Long Term Conditions:

- Implement the Rheumatology 'Co-Creating Health' initiative

Programme 6 - Maternity & Children

1. Introduction

There are approximately 2,600 babies born in Calderdale every year. There are approximately 37,300 children aged 0–14 in Calderdale at any one time. From projections, based on recent migration, fertility and mortality trends, this figure is set to rise over the following years. This rise will take place in 2014 and again in 2019, and will impact on demand for pre and post natal care and children's services. Our ambition is to ensure that all maternity and children's services are of high quality, integrated with other agencies, and focussed on the individual needs of each and every child and family. We will work in partnership with children and their parents/carers to develop future services and make decisions that affect their lives. We will deliver services as close to home as possible, delivered by skilled health professionals. We will provide services that are flexible, patient and family-centred, provide high quality care and contribute to children being healthy, being safe/staying safe and enabling them to make a positive contribution.

The programme definition for maternity and children programme is to commission services in partnership that; deliver the best possible care available for all pregnant women, their babies and their families, especially those children who remain vulnerable to inequalities in society as a result of poverty, social disadvantage, chronic illness or disability.

The scope of the programme is the delivery maternity and children's services for all Calderdale residents. This also covers those children that are in care who are moving into Calderdale on a temporary or permanent basis or are being moved out of the Calderdale area.

2. Needs Assessment

Maternity

- The infant mortality rate in Calderdale for the years 2003 to 2005 is 6.7 per 1000, which is higher than the rate for England and Wales (5.20 per 1000). The infant mortality rate is much higher in the most deprived areas (9.35 per 1000) than the least deprived areas (3.60)
- The fertility rate for Calderdale has remained fairly static since 2004, at around 63% per 1000, which is slightly higher than the national figure; Halifax Central has the highest fertility rate of the 4 localities
- In Calderdale there are around 7 stillbirths for every 1000 babies born, higher than for England & Wales, and the rate is increasing.
- Children from Asian, Mixed, Black and Other Ethnic groups make up an increasing proportion of births (The Black Minority Ethnic population is growing, with a very young age profile with 33% under 16 years, compared to less than 20% for other groups.)
- Around 9% of all births are to women aged under 19.
- The rate of babies born with a low birth weight is slightly higher in Calderdale than for England and Wales. Halifax North &East has a significantly higher percentage of low birth weight babies than Calderdale (9.35% compare to 8.20%)
- Halifax North & East has the lowest percentage of women breast feeding at 10 days at 43.5% and this is significantly lower than for Calderdale as a whole (54.1%)
- Over the period 2001-2006, approximately 18% of women resident in Calderdale who gave birth at Calderdale Royal Hospital were smokers at the time of delivery. Halifax North & East mothers have much higher smoking at delivery percentages than Calderdale.

- Around 43% of women aged under 18 years are smokers at delivery compared to around 15% of women aged 18 and over.

Children: Social circumstances

- 16% of the population in Calderdale live in areas of deprivation and 23.5% of children under the age of 16 reside in these areas. Maternity & children's services need to be integrated with other relevant services with appropriate care pathways developed to ensure inequalities are reduced and improve access to services, especially in deprived areas, where access to mainstream services is low.
- Around 30% of households in Calderdale have dependent children; 6.6% of these households are lone parents and the proportion is expected to rise to 9% by 2016.
- Nearly 8,000 of children (17%) in Calderdale live in households with no one in employment and 22.5% of children aged under 16 are living in income deprived households. This is significantly higher in both Halifax Central (31.5%) and Halifax North and East (27.1%)
- Around 27 out of every 10,000 children in Calderdale are allocated a child protection plan (neglect is the main reason). This is twice as likely in Halifax North and East at around 56 per 10,000.
- About 118 families a year in Calderdale, including women or children, are made unintentionally homeless (in line with national figures)
- In 2007, 3,199 incidents of domestic violence were reported to the police. Of these, children were present in approximately 1,000 cases.
- There are approximately 250 looked after children living in Calderdale at this time. About 200 children and young people are in foster homes within Calderdale.
- There are over 1,200 families (5.6%) with parents aged under 25.

Children: Lifestyle and health factors

- 25.3% of boys and 22.8% of girls are overweight or obese in Calderdale
- Around 1.7% of Year 7s (11 and 12 year olds) said they were smoking regularly, as did 17% in year 10 (14 and 15 years olds)
- About 54% of year 10 (14 and 15 years olds) report drinking occasionally.
- 50% of young people in year 7 (12 years olds) and Year 10 (15 years olds) said they sometimes felt depressed.
- The average number of decayed, missing or filled (DMFT) teeth is higher in Calderdale than in England or Yorkshire and Humber. Halifax North & East and Halifax Central both have a high average DMFT (2.69 and 2.66 respectively).
- First doses of MMR coverage is 89% which drops to 73% for first and second dose.
- There are 275 children registered as living with a disability within Calderdale. This figure is an under representation and work is currently ongoing to achieve a more accurate figure. These services available need to be evaluated, to determine accessibility and reduce inequalities.

The public and patient views associated with delivery of the programme indicate:

- Families required better access to services, especially out of hours, more consultation when developing services, a seamless service and available information about the services available.
- The need for Botox treatment for cerebral palsy to be made available at CHFT to address issues around current access and waiting times.

3. Issues

There are a number of issues related to delivery of maternity and children's services:

- There is a high level of A& E attendance by children. (April 2007 to January 2008, 13,490 attended A&E, 24% of the whole of A&E attendances) – this is due to unclear lines of referral or availability of services, specifically out of hours.
- For persons aged under 19, there is an A & E attendance rate of 364 per 1000 in Calderdale. Halifax Central has the highest attendance rate (471) followed by Halifax North & East (405)
- Services for children moving into adult services need to be reviewed, so that children are prepared for the change in service.
- Access to Midwifery Services needs to be assessed to ensure that all professionals are working together to deliver the best possible care to women.
- Primary Care professionals need to work together to enable delivery of children's services in the correct setting by the most appropriate professional.
- Prescribing Directives may need to be developed within the care pathways and clinical requirements.
- Need clinical input and training for staff to ensure that the needs can be delivered.
- Requirement of Project Managers to be in place to deliver projects identified within the Programme, particularly those requiring clinical expertise.
- All the reviews and redesign work needs to ensure that patients/parents/carers are involved. Satisfaction questionnaires need to be developed to monitor performance and expectations.
- Care pathways and clinical input required to ensure governance issues are addressed.
- Need to ensure that our successes are advertised to the areas where they are being delivered to encourage public/patient engagement, use of services and development of services.

4. Outcomes

- A reduction in the number of children attendances to hospital inappropriately via A&E by 5% by 2012.
- Improved access to children and families for assessment and treatment, by the development of a children's primary care assessment & treatment service by 2012 and by a holistic children's outreach service by 2010.
- A more streamlined service for children living with a disability by 2009.
- A more streamlined service for looked after children by the end of 2009.
- Improved equity and more accessible care available for families who are living in deprived areas by the development of the Family Nurse Partnership by 2009.

5. Link to World Class Commissioning Outcomes

This Programme is working with the Health for All Critical Component in achievement of the WCC Outcomes on:

- Childhood obesity
- Infant breastfeeding
- Reducing the level of decayed, missing and filled teeth in childeren

This Programme is working with the Sexual Health Programme in achievement of the WCC Outcome on:

- Under-18 conception rate

This Programme is working with the Quality Improvement Critical Component in achievement of the WCC Outcome on:

- Self-reported experience of patients and users

6. Deliverables

Maternity services

- Undertaking a baseline review of maternity services which will indicate developments for the future.
- Consult service users and carers on the recommendations outlined within the Darzi report on Maternity and Newborn and implement where appropriate.
- Develop pathways and protocols for midwifery services to ensure they are working effectively and efficiently with other professionals and appoint specialist midwives to support the most vulnerable families

Children's Services

- Produce a workforce planning strategy, which ensure a professional workforce is in place with the capabilities and competencies to deliver the services of the future.
- Develop health prevention and promotion strategies to prevent ill health and promote well-being.
- Further development of enuretic clinics within primary care for children, to increase mental well-being and prevent further health issues occurring.
- Commission a service to ensure that children with cerebral palsy requiring Botox injections are treated close to home without unnecessary delay.
- Commission community based nursing teams to provide support to vulnerable families to reduce inequalities and improve child health and development.
- Review paediatric outreach services to ensure integration of primary and secondary care providers and social care.
- Commission a paediatric assessment team to reduce the number of inappropriate referrals to A& E and outpatients.
- Promote the use of the community pharmacy minor ailment scheme to improve access to medicines and reduce A&E attendances.
- Ensure pathways are in place to ensure that the looked after children receive the most appropriate care and support
- Develop Child Death Panel to share lessons and learning and support a reduction in child death rates.
- Commission a matron to work with Youth Offending Team to identify health needs and provide support to families in need.
- Develop a Nurse family Partnership Team to support vulnerable families to reduce inequalities and improve health
- Produce a strategic implementation plan, in partnership with the local authority to deliver services for children with a disability, in line with the needs of children and families within Calderdale.

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Programme 7 - Mental Health

1. Introduction

Approximately one in a hundred people will be in need of specialist mental health services at any one time and without proper support a significant majority of these people will end up with poor prospects of employment, discriminated against and isolated from family and community supports. One in ten of us will have a less traumatising mental health problem in the next year which will affect confidence, raise stress levels and result in reduced work efficiency and will also have profound impacts on family including emotional distress for children.

The definition for mental health used within this programme is; mental health is a state of emotional and psychological well-being. Without sustaining a sense of emotional well-being, we are more likely to experience feelings such as isolation, loneliness, low self esteem and fear which in turn are often debilitating and have a direct effect on health, both physically and mentally.

Mental health service users are likely to have high levels of violence, abuse and discrimination directed at them compared with other groups within society and they are three times more likely to die prematurely from heart, stroke or respiratory disease than the average person on the street. Mental health problems result in greater loss of economic potential to England than any other health condition with lost output and high benefits payments. Yet people suffering from mental health problems desire work, often retain the skills necessary to complete complex work tasks. When they do gain employment they are usually denied all but the most menial and poorly paid jobs. Their reduced economic status means they drift down the social ladder so that those with profound mental health problems end up representing disproportionately high numbers in poor neighbourhoods with reduced access to other forms of social and community support.

The scope of the programme is: the delivery of an integrated service strategy which covers child and adolescent mental health, adult mental health and mental health services for older people. The range of this service includes Primary/Prevention, Early Diagnosis and Treatment, Crisis Response and Specialist Services

2. Needs Assessment

- During the period 2001-2005, there were 116 suicides in Calderdale.
- The suicide rate per 100,000 for Calderdale is 11.64. The rate varies widely by ward - 20.89 in Todmorden, 19.91 in Illingworth and Mixenden and 17.10 in Rastrick, being highest. In comparison the national rate is 9.66 per 100,000 population
- Deaths from suicide and undetermined injury in Calderdale vary greatly from year to year. In 1993 the rate per 100,000 population was 12.82, 13.04 in 2005 and 6.87 in 2006. There is no evidence to indicate that there is an overall trend reduction.
- Data from QMAS on the percentage of people with schizophrenia, bipolar disorder and other psychoses suggests that Calderdale has a similar rate of mental illness to the national figure (about 0.7%). It is estimated that mental health problems account for about one-third of general practice time with patients.
- Using estimates from the Office of National Statistics (ONS), the rate of children and young people between the ages of 5-15 that are likely to have some form of mental health problem including e.g. bereavement and loss and the effects of domestic

violence is 9.5%. 50% of young people in year 7 (12 year olds) and year 10 (15 year olds) in Calderdale said in a survey that they sometimes felt depressed

- A recent needs assessment for older people's mental health services, indicated that the current prevalence of dementia within Calderdale is 1,500, but there is national evidence relating to a level of under-diagnosis, which could take the true figure to over 4,000. It also identified that there are 500 new cases of dementia diagnosed every year in Calderdale
- In relation to compulsory admissions to mental health beds in Calderdale, the breakdown of patient ethnicity, 24% of admissions are from BME communities – the national target being 8.5%.
- In Yorkshire and Humber 38% of the people claiming incapacity or severe disability allowance have a mental health disorder. 40% of all persons in Calderdale claiming Incapacity Benefit or Severe Disablement Allowance do so because of mental illness, equating to 2.8% of all working age persons; mental illness is a secondary factor for at least another 10%.

Public and patient views have identified the need to:

- Improve access to psychological therapies by providing shorter waiting times, greater flexibility, weekend and evening access for some services
- Improve communication with those who use services and their carers
- Reduced reliance on medication, and more emphasis on therapeutic choices
- Provide training and education for primary and secondary care staff/professionals around:
    - the safety and experience of reducing/coming off mental health
    - medication
    - language, cultures and stigma
    - specialist training around different cultures e.g. asylum seekers

3. Issues

- Services should be commissioned on needs basis rather than an age related basis
- The PCT is currently failing to deliver its crisis resolution target
- Historical under-funding of CAMHS, as demonstrated by programme budgeting data is reflected in current service provision models.
- Current services are not culturally competent to meet the needs of BME and 'other' communities
- There is currently no currency or tariff to support the commissioning and benchmarking of mental health services
- There is a need to further develop appropriate services for 16 & 17 year olds in a mental health crisis.
- There is a need to develop joint commissioning and co-ordinated provision for children and young people
- Integration with primary care should be developed to improve access and choice of services that are evidence based where possible
- Further development of the mental health programme should be based on level needs assessment which is not currently available.

4. Outcomes

- Reduce the level of suicide rates by 20% by 2010 from the 2000 baseline figure

- Improve health outcomes and health inequalities in mental health by commissioning 2.0 wte BME workers in the community.
- Improve rapid and responsive access to waiting times for specialist psychological therapies to under 18 weeks
- Reduce the number of ‘unexplained’ medical conditions (somatisation) prescribing rates for antidepressants by improving access to psychological therapies for people with common mental health problems
- Reduce the number of people accessing inpatient facilities out of area by commissioning services closer to home

5. Link to World Class Commissioning Outcomes

This Programme is working with the Quality Improvement Critical Component in achievement of the WCC Outcome on:
- Self-reported experience of patients and users

6. Deliverables

Specialist Services

- Commission a low secure rehabilitation pathway which provides high quality services that are delivered closer to home.
- Commission a Psychiatric Intensive Care Unit (PICU) pathway which includes the provision of a ‘place of safety’ suite in compliance with Section 136 of the MHA.

Psychological Therapies

- Commission immediate access to psychological therapies for all people with common mental health problems
- Commission appropriate specialist psychological therapies for people with mental health problems

Adult Mental Health Services

- Commission a fully compliant and integrated crisis resolution service for those in need of urgent access to care
- Commission an integrated dual diagnosis service that is client based and addresses the mental health, substance misuse and social needs as identified
- Commission services that are needs led not age related to avoid discrimination in relation to access to care.
- Deliver the mental health promotion strategy to reduce the overall burden of mental health distress, tackle stigma and enhance the mental well-being of individuals, families, organisations and communities
- Support the development of a ‘one stop shop’ to provide support and for service users and their families
- Establish quality improvement standards for measuring mental health service outcomes.
- Implement care pathways and packages as a currency for piloting a local tariff during 08/09 with potential full implementation in 09/10.
- Consult with service users and carers on the recommendations outlined within the Darzi report and implement where appropriate
- Establish processes and procedure for implementation of the Mental Health Act 2008.

- Commission an interface pharmacist to address problems with complex medication issues for patients treated under shared-care arrangements with primary care.

Child & Adolescent Mental Health Services

- Commission Attention Deficit Hyperactive Disorder services across both children and adult mental health services
- Commission a full range of CAMHS services for children and young people with learning disabilities

Older People's Mental Health Services

- Continue to implement a new joint model of services being jointly commissioned by the PCT and Calderdale Social Services, particularly for those people with dementia.

Programme 8 - Planned Care

1. Introduction

The ambition of the programme is to commission clinically effective services from a range of providers and closer to the patient's home. These services will be commissioned with the aim of improving health and wellbeing of the population, reducing disability and reducing health inequalities. This will be achieved by working collaboratively with public health, health promotion, practice based commissioners and clinical colleagues in the generalist and specialist settings to develop evidence based integrated care pathways. The introduction of these pathways will have the effect of reducing unnecessary referrals into specialist care; reduce the number of outpatient follow up attendances where appropriate, contribute to the achievement of 18 week targets; reduce variation in length of stay; increase the proportion of day surgery in line with international best practice and will provide access to diagnosis, assessment, treatment and follow up or rehabilitation in a community setting where appropriate.

The programme covers planned investigation, diagnosis and treatment of health problems for adults, irrespective of where and by whom these services are delivered. The individual sub programmes include musculo-skeletal services; eye care; skin care and urology, general surgery and medicine and link closely with health improvement activities to reduce the causes of ill health in each of the programme areas.

2. Needs Assessment

Calderdale has an ageing population with population projections predicting a 36% increase in the numbers of people aged 64-75 years by 2016 and a 28% increase in the over-75 years population by 2021. This has implications for demand on health and social care services due to the increase in age-related conditions such as glaucoma and age related macular degeneration and musculo-skeletal conditions such as osteoporosis or arthritis. Already, 18% of people in Calderdale are recorded as having a limiting long-term illness: this is almost 1 in 7 of the working age population and half of Calderdale's older people.

The recent Joint Strategic Needs Assessment (August 2008) gave the following additional information of relevance, some of which have implications for planned shifts in delivery of care:

- The main reasons for admission to hospital in Calderdale are related to reproduction, followed by cataracts, chest pains and breast cancer.
- The top diagnoses by length of stay are urinary tract infection closely followed by fractured neck of femur; heart diseases and respiratory diseases also have along length of stay
- Skin cancer is the third most common cancer in Calderdale (by registration rate) with increasing trend, rising from 71 to 96 per 100,000 from 1993 to 2004
- The prevalence of musculoskeletal conditions is not known locally nor is there a comprehensive measure of disability, however, 7.4% of the working age population (8,925) is known to be claiming Incapacity or Severe Disablement Benefit with musculoskeletal diseases the 2nd most common known reason
- Those living in Calderdale's most disadvantaged communities experience significantly greater ill-health than elsewhere in the district
- 31% of households do not have access to a car or van and there are likely to be increasingly pressing issues concerning access to services across the District, particularly for older people and non-car owners

- 30% of households in Calderdale consist of a single person; this is projected to rise to 34% (or 32,000 households) by 2016 of which a growing number will be single pensioner
- A third of Calderdale's older people (the majority over 75) are unable to manage one of more domestic tasks, with a similar proportion unable to carry out one or more self-care tasks
- Around 10% of Calderdale residents provide unpaid care on a regular basis, an increasing proportion of whom will be elderly themselves

Public and patient views on the delivery of planned care were sought as part of the integrated service strategy for Calderdale and Kirklees.

- Local people felt that they would like to see a wider range of services provided within the primary care or community setting if it meant that they no longer needed to attend hospital. However, services would need to be provided from premises within their locality, be easily accessible, be safe and be clinically effective.

- These views were reiterated during the 'Healthy Ambitions' events held with the public and patients where patients spoke about the need to reduce waiting times, and the need to provide easy access to effective treatments that were locally provided when clinically appropriate. They also felt that more could be done to support people in preventing illness.

3. Issues

- Actions are needed to keep the ageing population as healthy and independent as possible, with interventions aimed at promoting the health of the 50+ population needed to forestall problems in later life. This is being picked up in Critical Component 3 – *Health For All*
- The local health economy has been successful in its bid for community hospital funding. Calderdale PCT is also expanding the number of new purpose built primary care premises in different locations in Calderdale. This represents an ideal opportunity to develop planned care in a strategic way, closer to the patient's home as part of the development of integrated pathways for different health conditions and procedures.
- This shift in direction is supported by the productivity metrics for Calderdale (Better Care, Better Value, Opportunity Locator), which have identified significant opportunities for delivering services differently. In particular, reducing the demand on outpatient services by delivering care closer to home, reducing the need for pre-operative bed days and reducing length of stay where appropriate.
- The Healthy Ambitions work that has been conducted across the region has also highlighted the fact that a considerable number of current OP referrals could be avoided with better access to a range of diagnostics and therapy services. Equally it was recognised that the number of outpatient follow ups could be reduced.
- A reduction in the number of OP appointments will have the effect of reducing waiting times for those patients where a specialist appointment is clinically indicated and as such will contribute to the achievement of the 18 week target.
- Developments in these areas are supported by the publication of commissioning toolkits by NICE and the department of health as well as 'no delay achiever toolkits' published by the Institute of Improvement and Innovation.

4. Outcomes

The Planned Care Programme would be considered a success in five years if it had delivered an integrated and clinically effective planned care service, provided from a range of settings, closer to the patients home where appropriate - contributing to the prevention of ill health, a reduction in the variation of access to services and an improvement of health in the local population, specifically:

- In 2012 - productivity metrics will indicate that Calderdale PCT is in the top quartile nationally for outpatient activity, pre-operative bed days and length of stay.
- Delivery of a range of planned care service in all the high volume specialties - which are assessed as cost effective, are clinically effective, are meeting patient needs and are delivered in a timely way as determined within the service specifications by 2012
- An increase in direct and timely access for specific diagnostic tests for all practices to facilitate early diagnosis.

5. Link to World Class Commissioning Outcomes

This Programme is working with the Quality Improvement Critical Component in achievement of the WCC Outcome on:

- Self-reported experience of patients and users

6. Deliverables

Hospital Activity

- Develop a suite of outcome measures to assess the impact of redesigned services and individual interventions/procedures (for example; patient reported outcome measures).
- Conducting a review of outpatient referrals and activity to identify ways of providing services more efficiently and effectively.
- Conducting a review of general surgery, in the light of the benchmark data indicating higher OP activity than expected for the population and greater lengths of stay than expected within Calderdale.
- Action taken as a result will include the expansion of minor surgery provision within primary care
- A review of pre-operative bed days will also be conducted leading to the development of pathways to ensure clinical effectiveness and appropriateness in these areas.

Community based services

- Review the follow-up activity currently taking place in a hospital setting, that can be provided from a primary care setting, such as wound dressing and suture removal, and develop new service models. This will be developed as through a part of 'Treatment Room Local Enhanced Service for primary care.
- Expand the provision of intermediate minor surgery within a primary care setting to include hand surgery.
- Develop a Musculo-Skeletal See and Treat service, using pathways developed for hips, knees and backs.
- Development of a community based minor eye ailment scheme
- Expansion of the glaucoma referral refinement scheme delivered by optometrists
- Introduction of a cataract referral refinement scheme to be delivered by optometrists

- Development of an integrated dermatology service, the majority of which can be delivered by multidisciplinary teams including dermatology GPs with a Special Interest (GPwSI) in a primary care setting.
- Develop a urology GPwSI service for the north Halifax locality
- Developing a podiatry service for care homes
- Develop an anticoagulation local enhanced service.

<u>Diagnostics</u>

- Review direct access to diagnostics in order to expand services and facilitate diagnosis by GPs. – reducing the need for patients to attend hospital outpatients
- Develop a local enhanced service for phlebotomy in order to reduce the current inequalities in access for patients and reduce the need for patients to attend the hospital.
- Develop a locally enhanced service for H. Pylori breath testing.

<u>Ophthalmology</u>

- Work closely with health promotion to address the wide-range of life-style factors that impact on eye health, including smoking and diet
- Undertake a review of low vision services
- Development of a community based minor eye ailment scheme

Programme 9 - Sexual Health

1. Introduction

The incidence of Sexually Transmitted Infections (STIs) and HIV has increased nationally as well as in Calderdale. Consequently there has been a significant increase in demand for sexual health services. The ambition of the programme is to deliver high quality, accessible, integrated* sexual health promotion and provision, which will be person centred to meet the sexual health needs of all local people in Calderdale. By working together we can ensure that sexual health, Human Immuno-deficiency Virus (HIV) and contraception promotion and provision is responsive to everyone, irrespective of age, gender, ethnicity or sexuality. Integration will help to ensure provision is coordinated, communicated and rationalised to work more effectively for everyone.

*(where integration is defined as support, information, services and community development, provide where people live).

A sexual health workshop was held in April 2008 to begin the process of refreshing the local strategy and identify actions to be taken over the next few years. The Sexual Health Programme is now fully establish with key stakeholders, who have agreed the scope of the programme, which will cover sexual health promotion and provision, including the education and prevention of teenage pregnancies, contraception promotion, the early detection and treatment of Sexually Transmitted Infections (STIs) including the Chlamydia Screening Programme and more complex viruses such as HIV/AIDS and ongoing support for people with HIV/ AIDS and Hepatitis B and C and the provision of a equitable, high quality and sensitive termination of pregnancy service; The reduction in teenage conception for 15-17 year olds has been selected as an outcome from the World Class Commissioning indicators, which reflects the commitment of the PCT to this work.

The development of the new integrated model will ensure that basic and enhance sexual health services are of the highest quality and accessible to everyone in a variety of settings, to meet the needs of young people and vulnerable; that there is one simple and coordinated mechanism for contacting the service; that any workforce development needs associated with the new model are met; that premises are suitable for delivering the new model and that the consultant –led service is able to focus on clients with specialist sexual health needs.

2. Needs

- The year end forecast for 2007/8 indicates that 3,716 people will be in contact with local GUM services, and 8,000 will have contact with local CASH services.
- The main sexually transmitted disease in Calderdale is Chlamydia where the rate of infection increased sharply from 29.8 per 100,000 in 1997 to 204.5 per 100,000 in 2006.
- The infection rate for gonorrhoea in Calderdale peaked during 2003-04 but has shown some recent decrease, with current rate lower than that found regionally or nationally. Epidemiological treatment of both Chlamydia and Gonorrhoea contacts have increased significantly since 2003.
- The rate of infection for anogenital warts in Calderdale has increased steadily since 1997.
- The prevalence of HIV has increased by 84% between 2002-2006 from 19.19 per 100,000 to 34.25. The dominant make up of local patient profile is male "men-who

have-sex-with-men" (MSM), followed by black heterosexual males and females from hyper-endemic countries. Local uptake of antenatal HIV screening is lower than the Yorkshire average and the quarterly uptake of HIV and sexual health screening is lower in Calderdale than neighbouring PCTs

- Teenage conception rates have fallen by approximately 15% since 1998 but current trend data indicates that Calderdale will not hit its 2010 target for teenage conceptions. Particularly priority should be given to supporting teenagers in the vulnerable group including looked after children and children leaving care; mental health service users, children born to teenage parents, teenagers with a history of alcohol or substance misuse or from families with a history of alcohol or substance misuse. Halifax North & East (6.2 per 1000) has a significantly higher teenage conception rate than Calderdale.
- In 2005, around 18% of all pregnancies ended in abortion in Calderdale, compared to 20% in Yorkshire & Humber and 23% in England: abortion rates are highest in the under-20s and 20-24 year old age groups.
- Currently 42% of all terminations (and 48% of those in under-18 year olds) carried out in Calderdale are at more than 9 weeks gestation. This represents a better position than that regionally, however the PCT is aiming to reduce this by a further 22%.
- 246 asylum seekers are resident in Calderdale, almost all in the age groups 19-50 years. A qualitative survey involving asylum seekers and primary care professionals is required to ascertain the needs of this vulnerable group for sexual health services.
- 98 referrals for child sexual exploitation (CSE) are being dealt with by the CSE unit in Calderdale; 96% of cases are female and the average age of these children is decreasing dramatically, with more children being abused. Children in, or leaving, care need special attention as a vulnerable target group.

Public and patient engagement activity has highlighted a number of issues that need to be addressed:

- Responsive services need to be developed within primary care and in the community which provide equitable access for everyone
- Services are sensitive and are supportive of the needs of vulnerable adults and young people.
- In particular, services need to be accessible to those worse off, with particular emphasis on vulnerable groups, which include; people in social care, substance misusers, under 16's, looked after children, offenders, people sexually exploited, Lesbian, Gay, Bisexual and Transgender (LGBT), victims of domestic violence, people with insecure accommodation and residency, victims of rape and sexual assault, sex workers, people with mental health problems and people with learning disabilities

The Sexual Health Programme Board will ensure mechanisms are in place to proactively engage patients and the public, listening to what local people want and understanding what they need. Supporting users and carers to make the right choice, not just in their choice of service, but in making healthy choices around their sexual health. This will be achieved as the board will work in partnership with patients, public and partners to strengthen local sexual health services, which is essential to provide for needs and diversity that will benefit every patient.

3. Issues

- Sexual health is a significant public health priority in the UK and there is a strong national drive to improve services. This is reflected in the operating framework and in the 'vital signs' indicators for sexual health.

- The current GUM and CASH service is well used by local people, which is a reflection of the accessibility and responsiveness of the service being offered. However, in the light of the significant increase in demand for its service, GUM has found the 48 hour access targets to be challenging.
- Calderdale PCT and Calderdale and Huddersfield Foundation Trust have worked collaboratively to improve the position and are now meeting the 100% target for appointments offered and see 84% patients within 48 hours. The challenge now is to sustain this performance.
- Chlamydia screening was introduced in Calderdale in June 2007 and continues to have a slow uptake. The Sexual Health Programme will contain a revised action plan with the aim of significantly improving the uptake of this service.
- There are a number of gaps in the approach to sexual health services locally and this is also reflected in teenage pregnancy work where there are examples of good practice including teenage pregnancy clinics which have piloted well. The CHOICES SRE pack is also being used well and effectively in some schools but not all. Services will be delivered in more consistent way across Calderdale.
- There also needs to be more systematic mechanisms for assessing the quality of support being provided to young people and vulnerable adults.
- Whilst a range of contraceptive methods and services are available in Calderdale in a range of settings, there needs to be a consistent approach offering equity of access.

4. Outcomes

- Consistently high quality, appropriate, equitable and timely sexual health promotion and provision that is accessible to everyone, in particular to vulnerable groups.
- Access to GUM is sustained into 2008/9 and beyond.
- A Chlamydia Screening service that is screening 17% of people aged 15 – 24 years by 2012[vital sign indicator]
- The prevalence of teenage conception is to be reduced by 50 % by 2010 and in particular in those areas with highest teenage conception rates. Although a vital signs indicator this has been an issue identified in the JSHNA, which has consequently been selected by the PCT as a World Class Commissioning Outcome.
- 95% of general practice has achieved the '*Your welcome'* kitemark for providing good quality and responsive sexual health services for young people by 2012.

5. Link to World Class Commissioning Outcomes

This Programme is working with the Maternity and Children Programme in achievement of the WCC Outcome on:

- Under-18 Conception Rate

6. Deliverables

Prevention and Promotion

- The implementation of a health promotion plan and establish a training programme, which will include the 'you're welcome' kitemark, Delay, Chlamydia screening, C Card and good Sex Relationships Education (SRE) to help reduce unwanted STIs and teenage pregnancy, focusing on equalities.
- Continue the development of community pharmacy within sexual health services in line with the White Paper 'Pharmacy in England'.

- Expand the current locally enhanced service with pharmacists to include Chlamydia screening and the provision of emergency hormone contraceptives (EHC)

Screening

- The delivery of a Chlamydia screening programme within a variety of accessible settings to significantly increase the uptake of screening.

Responsive treatment service, which responds to the needs of vulnerable groups:

- An integrated contraceptive and sexual health model for Calderdale, which has one easy access point. The integrated system will include the development of care pathways for contraception, STIs, sexual dysfunction, and the Termination of Pregnancy.
- The development of general practice to provide all basic and some enhanced sexual health services, in particular to increase access to Long Acting Reversible Contraceptives for young people, in the 6 identified priority areas.
- The development of services to support vulnerable adults and supporting practices with the highest population of such vulnerable groups.
- The development of services commissioned by the PCT and Local Authority which achieve the minimum 'Your Welcome' kitemark for services for young people.

Programme 10 - Urgent Care

1. Introduction

In Calderdale patients rely on the NHS if they need urgent or emergency healthcare. On a typical day in Calderdale 180 people will go to A&E, 55 people will require an ambulance, and 60 people will contact the GP OOH service. Whether patients have a life threatening illness such as a stroke, or a minor injury, patients have access to a wide range of clinicians including GPs, hospital doctors, nurses, pharmacists, dentists and mental health teams. Everybody can call on the NHS at any time to provide the urgent or emergency healthcare they need. The ambition for this programme is to make urgent care easily accessible to all residents of Calderdale, to ensure that patients are directed into the most appropriate service for their need, and to ensure that patients are treated quickly, as close to home as is possible. This is clearly a Programme where a joint commissioning approach with Calderdale Council, based on integrated services models and pathways, will maximise the benefits to people locally.

The definition of urgent care used for the programme is: the advice or treatment given in response to a medical emergency or an urgent or unexpected health problem, where help is required immediately or within the next few hours. The types of service provision include; ambulance services, accident and emergency services, GP out of hours, emergency dental services, pharmacy advice, community-based drop-in and response service and NHS Direct.

The scope of the Programme is delivering urgent care service to all Calderdale residents. It also covers visitors to Calderdale and those who need access to urgent care whilst within the PCT boundaries. The Programme is aimed at delivery of services at 2 levels;

West Yorkshire phone-based access and triage and the development a Calderdale-based local treatment model.

2. Needs

- Urgent Care should be delivered through an integrated system with seamless connections between each part of the care pathway; co-location (e.g. of UCCs and A&E) is necessary but is not in itself sufficient to deliver the required level of integration
- Common standards should apply 24 hours a day, 7 days a week. The ways in which services are provided could vary across 24 hour periods, but the common standards should apply
- The majority of care should be community based; services should be delivered as close to home as is safe and effective. Self-care, access to community services, alternatives to hospital admission and out of hours care all require further development
- Robust technology and information must underpin each part of the care pathway. This will enable more care to be delivered closer to home and will ensure sharing of information across all parts of the integrated system
- Consistent signposting is essential to help patients and professionals navigate through the care system – a single access telephone number is desirable

The recent Joint Strategic Needs Assessment (August 2008) gave the following additional information of relevance:

- The main reasons for admission to hospital in Calderdale are related to reproduction, followed by cataracts, chest pains and breast cancer.
- The top diagnoses by length of stay are urinary tract infection closely followed by fractured neck of femur; heart diseases and respiratory diseases also have along length of stay
- The overall rate of hospital admission for ischaemic heart disease has been decreasing – down from 7.4 per 1000 in 2001-2003 to 5.9 in 2004-2006; admission rates for cerebrovascular disease and myocardial infarction show no clear discernible trend
- Road traffic accidents in total in Calderdale showed a decline between 2001 and 2007, with those involving injury decreasing by 30%More than 6% of over-65s attend hospital A & E departments as a result of falls; the vast majority of admissions to hospital as a result of falls are among people aged 75 years and over
- 31% of households do not have access to a car or van, which could impact on use of ambulance for access to care
- Those living in Calderdale's most disadvantaged communities experience significantly greater ill-health than elsewhere in the district

The public and patients have extensive views on the work we can do to improve urgent care services, and these were captured during patient engagement in summer 2007. The public stated that they need the following;

- More information in a variety of formats and media on what services are available and how to contact them. People were not aware of how or who to contact in certain situations
- One point of contact to help people get the right services at the right time.
- More access to primary care services that they use regularly at evenings and weekends. There was a particular request for people to see their own GP

- Information is available at all stages of the patient pathway to avoid individuals repeating the same information to different clinicians. People were particularly concerned that professionals out of hours do not have access to their patient records.
- Personal contact where possible, rather then phone contact. Call centres were seen as useful but very impersonal. There was a request that music is not played while people wait for a response.

3. Issues

- There are currently no streamlined urgent care pathways either regionally or locally. However, this will be delivered via the ongoing procurement process and the delivery of the Community Hospitals Project.
- The Yorkshire Ambulance Service is currently unable to meet Category A targets, and work is ongoing to identify mitigating actions.
- High numbers of inappropriate Category C ambulance responses – 3,000 per annum – which has a direct impact on ambulance service ability to delivery Category A targets.
- Reducing ambulance response times to 3 minutes could almost double survival rates for cardiac arrest
- High levels of inappropriate A&E attendances – 2,000 attendances per annum are currently diverted from A&E into a service provided by primary care practitioners
- Benchmarking of current GP out of hours services shows lower than average usage
- The current GP out of hour's services does not meet quality standards for next day information and triage times.
- The lack of a local emergency dental service. The service is currently situated in Huddersfield and patients in pain need to travel too far for emergency treatment

4. Outcomes

- A reduction in inappropriate A&E attendances at Calderdale Royal Hospital by 7% on the 07/08 baseline
- A streamlined regional/local urgent care treatment model will be in place by April 2009
- An improvement in ambulance response times to 75% of category A calls responded to within 8 minutes, thus meeting the call connect target, with further targeted work to improve ambulance response times beyond 75% in future years

5. Link to World Class Commissioning Outcomes

This Programme is working with the Quality Improvement Critical Component in achievement of the WCC Outcome on:

- Self-reported experience of patients and users

6. Deliverables

- Completion of the large-scale West Yorkshire urgent care procurement to ensure that contracts are in place for the provision of integrated urgent care pathways, both within the region (phone based access and assessment), and as part of development of local treatment models.
- The outcomes of Lord Darzi's recommendations on urgent care
- A joint approach with the "Practice Plus" programme to align commissioning intentions and ensure provision of walk in services easily accessible to all the population to benefit those people without the ability to travel to central locations for treatment

- A joint YAS redesign manager for 12 months to develop a plan to; improve ambulance response times, reduce Cat C activity and improve performance in outlying areas via introduction of a Community Paramedic Service
- Work jointly with the Care Closer to Home Programme to ensure delivery of local treatment models through extending primary care access and the community hospitals project.
- An effective and efficient 24/7 model for community based services, focused on; community hospital estate, district nursing, rapid response and GP out of hours services.
- A mobile response service jointly with Social Services and Pennine 2000 to provide a service for older people, particularly those who experience a fall out of hours.
- Continued promotion of community pharmacy minor ailment scheme to improve access to health advice and medication to reduce GP attendance and A&E attendance.

3. CRITICAL STRATEGIC COMPONENTS

The following section contains a description of the 10 Critical Strategic Components that underpin delivery of the business of the PCT:

Critical Component 1	Corporate Citizenship
Critical Component 2	Financial Awareness & Investment
Critical Component 3	Health for All
Critical Component 4	Information Management and Technology (IM&T)
Critical Component 5	Medicines Management
Critical Component 6	Organisational Development
Critical Component 7	Involving People and Communication
Critical Component 8	Primary Care
Critical Component 9	Quality Improvement
Critical Component 10	Workforce Planning

Critical Component 1 - Corporate Citizenship

Corporate citizenship can be defined as: the ability of NHS organisations to embrace sustainable development and tackle inequalities through its day-to-day corporate activities, by deploying their powers and resources – as employers, purchasers of goods and services, landholder and commissioners of new buildings and refurbishments in ways that benefit, rather than damage, the social, economic and environmental conditions in which we live.

The strategic direction for this component is outlined in the NHS 'Choosing Health; making healthy choices easier' – which has been identified as one of the five new priorities for the next 10 years. This model of work will be supported by development of a Sustainable Development Commission to enable NHS organisations to self-assess progress. The model has six key areas:

- Transport
- Procurement
- Facilities management
- Employment and skills
- Community engagement
- New buildings

The outcomes of this model nationally are supported by real-life examples and include:

- Contributing to improving health
- Clear contributions from the NHS to regeneration
- Promote healthy and sustainable food procurement
- Increasing staff morale
- Faster patient recovery rates
- Support mitigation of climate change (This work is also support by the Faculty of Public Health's (FPH) 'Action Checklist' for tackling climate change identified in 'Sustaining a Healthy Future'.)

Key deliverables for this period include:

- Registering with the web-based tool in order to complete an initial self-assessment and provide a benchmark for the organisation.
- Use the wide-range of resources, case studies, workshop and presentation models to generate awareness and ideas locally.
- Use the FPH's action checklists to identify further action to mitigate climate change
- Develop a strategic direction for the organisation which identifies action and timescales.

There is a clear linkage between this component and a wide range of other components (particularly; workforce planning, PPI, and health for all). Development of this component will be undertaken with a view to its inclusion within every programme.

Critical Component 2 - Financial Awareness & Investment

Financial awareness and investment can be defined as: the ability of an organisation to make sustainable commissioning decisions and provide sound investments to secure improved health outcomes both now and in the future. Excellent financial skills and clinical resource management will enable PCTs to manage the financial risks involved in commissioning, and take a proactive rather than reactive approach to financial management.

Within the context of this document; the key strategic aim of the PCT is to:
Ensure that the commissioning strategy of the organisation is affordable and set within the organisation's overall risk and assurance framework.

The underpinning strategic objectives include:

- Routine use of programme budgeting to understand investment against outcomes and shifts/opportunities that will optimise health gains and increase quality.
- Effective analysis of costs and identification of areas for improvement, eg prescribing.
- Ensuring there is a clear understanding of the links between financial and non-financial elements of commissioning strategies.
- Develop short, medium and long-term strategic service and financial plans, highlighting areas suitable for local service redesign, innovation and development.
- Working effectively with all service providers to achieve the most clinically-effective and cost-effective approaches.
- Having strong financial and ethical values which are publically expressed and underpin the work of all staff, the PCT Board, and those with whom the PCT has a contract.
- Ensuring staff have a clear understanding of their delegated commissioning budgets, and have access to timely activity and performance data.
- Ensuring the availability of prioritisation and decision-making skills; key input summary; predictive modelling, process mapping, ratio analysis, risk assessment, market segmentation, 'what if' scenarios, simulation tools, spreadsheets, statistical analysis and variance analysis.
- Ensuring complete comprehensive risk assessments to feed into wider decision making process and investment plans.
- Using financial resources in a planned and sustainable manner and invest for the future, including through innovative service design and delivery

Key deliverables for the period include;

- Robust annual, medium and longer term service and financial plans that complement strategic plans and underpin delivery of the PCT's Business Plans and Commissioning Strategy.
- Evidence of regular tracking of performance against programmes and plans - accounting for variation and implementing effective rectification where necessary.
- Alignment of programme budgeting and financial management processes with the PCT's Programmes.

The Finance Directorate provides a critical component to the development and delivery of all Programmes. Work will be undertaken to align current contractual and financial management processes into Programmes, and will begin with a deep-dive into one specific programme to establish future principles.

Critical Component 3 – Health For All

In terms of a definition of health for all: poor health is strongly linked to deprivation and inequality. As a consequence, improving the health of the population requires the joint efforts of society as a whole. The NHS plays a key leadership role in this effort along with partner agencies, communities and individuals. Calderdale Council and our Local Strategic Partnership are seen as critical partners in delivery of this work.

Within the context of this document, the strategic direction can be described by the work being undertaken by the PCT, in conjunction with the Darzi review and the Yorkshire and Humber Staying Healthy Group. This is based on the use of a life course pathway model which both describes the complex interaction between society and the individual, and allows clear and tangible actions to be recommended. The pathway provides a powerful picture of how different stages of life are influenced by internal and external factors which impact on health outcomes for the individual. It also clearly points to where the opportunities are for the NHS and its partners to intervene and to make the healthy choices the easier choice. In addition, the PCT's strategic direction is also based on complementary work to embrace the Choosing Health principles of;

- Informed choice
- Personalisation: supporting people to make healthy choices, especially deprived groups and communities
- Working together through effective partnership

Outcomes of the health improvement work in Calderdale over the next 5 years include:

- Reducing the number of people who smoke
- Reducing obesity
- Increasing physical activity
- Improving diet and food choices (including breastfeeding)
- Encouraging and supporting sensible drinking
- Improving sexual health and promoting safer sex
- Improving mental health and well being
- Reducing health inequalities
- Increasing dental/oral health
- Minimising the health affects of climate change through supporting organisations to become Good Corporate Citizen (links with 1)
- Improving immunisation rates

This will be measured through the following indicators:

- Increasing the number of smoking quitters to 851 per 1000 population by 2009
- Improvement in health inequalities
- Improving life expectancy for males and females
- Reducing all age all cause mortality rates in males from 775 to 709 and in females, 486 to 477 by 2010
- Increasing adult participation in sport/recreation to 26% by 2011
- Reducing the number killed or seriously injured due to Road Traffic Accidents to 79 by 2011

Health for all is a critical component of each of the 10 Programmes and has clear links to other components, particularly Quality Improvement. Through its work on embedding programme management and related governance arrangements the PCT will put in place systematic approaches to ensure that health improvement activities undertaken by the Public Health Directorate underpin Programme development and delivery.

Critical Component 4 - Information Management and Technology (IM&T)

Information Management is important, because the way in which the organisation uses information underpins all the activities we undertake; the decisions we make, both individually and corporately. The focus of the PCT Information Strategy is to deliver:

- The Right Information at the Right time in the Right format to the Right person
- To support the Right decision
- To achieve better use of resources and
- Better health outcomes for our population

This is also seen as an area of work which will benefit from a joint developmental approach with Calderdale Council in relation to integrated information management and assessment systems.

In the context of this document, the strategic direction for IM&T is set out in the PCT's IM&T Strategy. The three key work-streams to achieve our strategic objectives are:

- Implementing integrated clinical systems between primary and secondary care(including community services);
- Best use of information to support World Class Commissioning;
- Ensuring data quality and system infrastructure is fit for purpose.

The key benefits will be:

Integrated Clinical Systems:

- Reduce risk and improve patient safety by increasing availability of clinical information for other sources at the point of clinical interventions
- Improve patient experience by supporting choice of provider
- Improve patient experience by increasing convenience and access to services , using technology to support provision of services in multiple locations including "care closer to home" and urgent care
- Improving clinical effectiveness and quality of outcomes through timely sharing of information
- Improve operational effectiveness by reducing duplication of data input and minimizing delays in accessing information to support clinical interventions.

Best use of Information to support Commissioning:

- Increase operation efficiency within commissioning and support functions by using technology to improve access to information and reduce duplication.
- Increase access and use of benchmarking data to evidence the effectiveness and quality of commissioned services. This support the PCT objective to obtain best use of resources for its population.
- Improve triangulation of information from different sources to support evidence of effectiveness and clinical outcomes.
- Provide user friendly and accessible technology for all users to allow access to timely and accurate information to support PCT business activities and decision making.

Data quality and Infrastructure:

- Minimise system down time by supporting robust network and infrastructure so that patient care and safety is not compromised;
- Ensure that applications run at optimum level in terms of access and performance;
- Ensures the organisation handles sensitive information appropriately for the protection of patients and the public;
- Process in place to provide evidence that data quality is assured and improved;
- Support innovation and use of technology to deliver operation effectiveness both in the frontline and in support services eg remote help desk.

The key deliverables for this 5 year period are reflected in the medium term financial and operating plan are:

- Implementation and roll out of systems to support clinical integration including Community Nursing, Child Health, Electronic prescribing and Chose and Book.
- Continued implementation of the Fitness for Purpose Plan for information Management. This defines the information requirements to support the commissioning cycle and optimise the use of technology to make access user friendly;
- A skills audit to identify the skills and training requirements to support use of information and provide a training programme;
- Investment of resources to upgrade hardware network infrastructure to support new systems and improve system performance;
- Implementation of the Information Governance Plan;
- Develop a VFM process to review supplier services and procure best value.

The PCT Director accountable for IM&T will ensure that Programme development is underpinned by a clear knowledge of the IM&T agenda and its impact on individual Programme areas.

Critical Component 5 – Medicines Management

Medicines management is about enabling patients to make the best possible use of medicines. It needs to be in place for the patient wherever they go across all care interfaces. Medicines management encompasses the entire process by which medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to produce informed and desired outcomes of care.

The principles of good medicines management should apply in all settings where patients access and use medicines, and it should travel along patient pathways, for example; from community pharmacy, to GP practice, to acute hospital admission, to intermediate care and back into the community.

Poor medicines management within and across organisations can lead to low public confidence in health provision, unaddressed health needs and unsatisfactory patient outcomes, for example, unscheduled emergency admissions or failure to maintain independence leading to re-admission to hospital/care homes. It can also lead to organisational issues such as unmet targets, inappropriate allocation of resources and inefficient services.

The strategic ambition for the medicines management agenda is to ensure its principles become firmly embedded within PCT programmes and partner organisations. This will ensure the PCT is able to meet its medicines management challenges, including those posed by Darzi and the Pharmacy White Paper.

It is recognised that medication is only part of a whole package of care, however, comprehensive strategies, as set out in the PCT's draft Medicines Management Strategy 2008-2011, will enable the PCT to deliver good medicines management which will assist in the delivery of better care, better value for patients.

Strategic objectives for this agenda are:

- Embed the prescribing of cost-effective evidence based medicines by all providers.

- Ensure patient safety in all medication processes in Calderdale including the implementation of National Patient Safety Agency alerts

- To embed Medicines Management as a core component of all PCT programmes.

- Lead the organisation in the development and quality assurance of non-medical prescribing

- Fully integrate community pharmacy into the planning and commissioning processes of the PCT to maximise the potential of community pharmacy as a primary care service provider.

- To make full use of pharmacists unique skills to deliver better care closer to patients.

- Strengthen links with other healthcare providers including GP's, pharmacists, nurses, dentists, opticians, etc.

Key deliverables will include:

- To improve use of NHS resources by the implementation of cost effective evidence based prescribing by
  - Continuing to provide prescribing support and advice to all GP practices.
  - Embed Medicines Management as a key component in the delivery of NICE guidance.
  - Integrating Medicines Management into all patient care pathways.
  - Reducing medicines waste.
  - Improving patient safety.

- Safe medicines processes are developed in all clinical areas:
  - All clinical guidelines are reviewed to ensure patient safety is accounted for.
  - Development and updating of medicines guidelines including the Calderdale PCT Medicines Code.
  - NPSA and other national guidelines are incorporated into local policy and practice.
  - Working across interfaces to ensure safe medication processes.

- Medicines Management will contribute to the PCT's Programmes by:
  - Appointing a designated Medicines Management Pharmacist to all programmes.
  - The provision of expert medicines advice to programme boards.
  - Advising where community pharmacy could contribute to the programmes achieving their goals in line with the Pharmacy White Paper for England 2008.

- Undertake a comprehensive Pharmaceutical Needs Assessment (PNA) taking into account the views of service users to assist and inform the development of services which meet the needs of the population, are effective, high quality and value for money. This will inform the future commissioning of pharmaceutical services.

- To develop a robust governance process around non-medical prescribing.

- Pharmacists' unique skills will be used to deliver better healthcare outcomes for the population of Calderdale by:
  - The development and implementation of a clinical pharmacy support service to all Care Homes.
  - The development of Pharmacist-led Clinical services, including those for long term conditions (e.g. coronary heart disease, diabetes, chronic pain, epilepsy), mental health and medication review services.
  - The development and integration of pharmacists with a special interest (PhwsI) in mental health and epilepsy to improve patient outcomes and experience.
  - Develop and implement a multi-disciplinary community based patient education programme for pain.

- To provide education and training to staff involved in the prescribing, dispensing and administration of medicines.

The PCT's Head of Medicines Management will ensure that the medicines management team works closely with individual programmes and critical components to ensure that the strategic direction and deliverables identified are delivered.

Critical Component 6 – Organisational Development

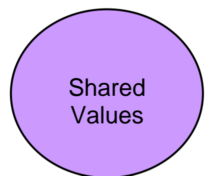
In terms of a definition: organisational development (OD) is a term used to describe a planned holistic approach to improving organisational effectiveness – one that aligns strategy, people and process

The PCT has been proactive in considering OD, and an approach was signed off by Board in September 2007.
To underpin this approach, the PCT has reviewed, with its staff, its Vision and Values, and has established a set of values by which OD work will be undertaken:

- Involve people, diversity, listen and learn
- Act with honesty
- Be fair
- Achieve continuous improvement through innovation
- Be committed to partnership

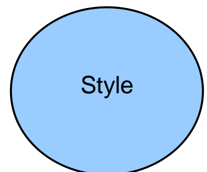
With our revised OD Plan in the light of World Class Commissioning, we are adopting the McKinsey 7S model. The following are our strategic objectives for the plan:

1) **Shared Vision and Values**
We have a shared vision for the organisation and all staff have a clear line of sight between what they do and how their work contributes to the delivery of that vision. We intend to enhance our profile with stakeholders and the public by ensuring we deliver our vision and that we live our values.

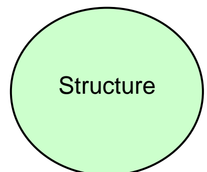


2) **Strategy**
We will embed our strategy, ensuring staff and stakeholders have a natural inclination towards quality of care, through greater clinical leadership and full engagement with local people.

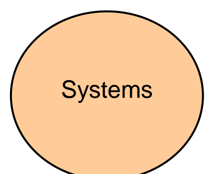
3) **Style**
Our leadership will be recognised by staff and partners as being based on engagement. Staff feel supported and that they can lead from every seat. We will consolidate our leadership capacity and role as leader of the NHS in our local health system whilst leading as a peer within the wider economy.



4) **Structure**
We will continue to development as an effective commissioning organisation, with an agile structure of line management and accountability sitting alongside a matrix based approach to virtual teams driving programmes.



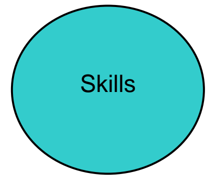
5) **Systems/Infrastructure**
We will embed our strong governance and programme approach. The commissioning cycle will drive prioritisation and financial commitments through programmes that deliver meaningful outcomes. Quality, safety and value for money will underpin all of our work.



6) **Staff**
We will sustain our reputation as employer of choice. We have set targets through the workforce scorecard and demonstrate ongoing commitment

through IWLS work streams.

7) **Skills**
Individual appraisal, personal development and measuring skills against the Knowledge and skills framework (KSF) is integral to how we operate. This is embedded in teams. Through our World Class Commissioning self assessment and diagnostic process we will identify and remedy any further skills gaps.



Our action plan encompasses the detail of response to these objectives – for example further developing the Clinical Executives – and alignment of the Calderdale Commissioning Group (PBC) and the PCT.

Critical Component 7 - Involvement and Communication

Involvement can be defined as: the active participation of patients, including children, service users, carers, community representatives and the wider public in the development of health services, and as partners in their own health care.

In the context of this document, the strategic direction for this component is set out in the PCT's documents 'Involving People Strategy – Patient and Public Involvement, 2008-2011' and Communications Plan 2008.

Its strategic aims are to

- Improve and increase early and ongoing involvement in the commissioning process and the provision of services across the PCT.
- Develop a consistent and strategic approach to involving people to ensure wider community involvement through a wide range of mechanisms
- Utilise public engagement as a means of improving health, as outlined in the Wanless Report.
- To empower patients through improving the availability of patient information across the PCT that is relevant to patients and consistent in content and quality.
- To embed involving people across the PCT through identification and development of a variety of support tools for staff and contractors and by developing an involvement culture across the PCT.
- To ensure that the PCT communicates with its providers in the right way at the right time.
- To ensure patient and public involvement is valued and demonstrable through feedback and evaluation.
- Development of an effective communication strategy to ensure that, through high quality, relevant, timely and consistent information, stakeholders and partners are informed about the PCT and the business it undertakes.

The outcomes of the Strategy will be:

- Increased public/patient choice
- Increased public/patient voice
- Changing hearts and minds (changing working practices and lifestyle choices)

The PCT's PPI and Communications Team will ensure that Programmes developed by the PCT clearly articulate the public and patient involvement and communication agenda.

Critical Component 8 - Primary Care

Primary Care and Community Health Services are central to the provision of world-class health services. The services provided by independent contractors including GPs, dentists, opticians and pharmacist are both highly regarded and highly valued by patients. Primary care acts both as a first point of contact and as a ‘gateway’ to other services both within primary care and other parts of the wider health and social services system. It is therefore essential that the PCT builds on these “out of hospital services” in order to commission health rather than illness services based on health promotion, disease prevention and early intervention.

Background

The Department of Health published its vision for Primary and Community Health Services in July 2008. The focus of its strategy provides an important reference point for the local work in Calderdale.

- Informed and empowered patients as partners in care
- Personalised services with real patient choice
- Stronger focus on health promotion and prevention
- World class commissioning underpinned by joint working between health and local authority
- Integrated care through reinvigorated PBC and new approaches to integrated care delivery
- New models, more productive and more dynamic community health services
- Higher quality through combination of registration, accreditation, choice and stronger incentives for high-performing practices
- Reduced health inequalities through fairer funding and new providers in under-served areas.

In the context of this document, the strategic aims of the PCT are reflective of emerging work from the Darzi review:

- Improving quality and safety;
- Extending access to services so as to identify unmet need, manage future demand and reduce pressure within the system;
- Tackling inequalities by closing health inequality gaps;
- Improving local partnerships, reaching and engaging communities;
- Investing in innovative services;
- Improving commissioning effectiveness and value for money;
- Ensuring best practice in contract management;
- Building capacity and capability to deliver high quality information management and analytical skills to support primary care development;
- Developing incentives and educational packages for leading-edge and trailing-edge practices;
- Ensuring effective utilisation of the local estate to meet the needs of the overall strategic direction;
- Developing local goals for improving disease management, e.g. diabetes, COPD etc.

Dentistry

Calderdale PCT has worked with local dentists to increase the number of residents receiving NHS dental care following the introduction of the new dental contract in April 2006. A total of 30 practices deliver general dental care together with two specialist orthodontic practices. A number of practices and the PCT have agreed to provide domiciliary services, emergency services and participate in a Fluoride Varnish pilot scheme for children in the areas with the highest number of decayed, missing or filled teeth. This and other initiatives will be reviewed and may be extended in future years.

Pharmacy

The PCT will work to develop community pharmacy in line with the White Paper 'Pharmacy in England' so that pharmacies can expand further their role in health promotion, reducing health inequalities, supporting healthy choices and promoting wellbeing for patients and public alike.

To help achieve this aim the PCT has commissioned a comprehensive pharmaceutical needs assessment to assist the development of community pharmacy services. The PCT currently commissions the following locally enhanced services from community pharmacy: a minor ailments service, smoking cessation service, Nicotine Replacement therapy voucher scheme, emergency hormonal contraception, head lice service, On-demand palliative care medicines service, Chlamydia screening service, care home support service, Effective intervention scheme. Not all pharmacies provide all these services and the PCT will work to ensure that provision of the services matches the needs of the population.

There are 40 pharmacies in Calderdale which provide a network of health care professionals who are easily accessible and available at times which suit patients and consumers. Many of these pharmacies now have dedicated consultation areas which facilitate the provision of current and future enhanced services to patients.

Ophthalmic Services

The PCT works with Optical providers across Calderdale through new contracts for General Ophthalmic Services introduced in August 2008. In addition, the PCT is developing a number of enhanced services, including the rollout of the glaucoma referral refinement scheme.

Health Needs

- Analysis shows that there is significant deprivation in five areas if Calderdale;
- A lack of female GPs in Central Halifax;
- A reduced range of services in Park ward (Town Centre locality) and North Halifax;
- North Halifax is our most under-doctored area with significantly lower numbers of GP per head of population;
- A lack of choice of GP practice in some areas;
- Potential retirements of a number of single handed GPs;
- Areas of increased growth in house developments in some areas.

- The average number or decayed or missing or filled (DMFT) teeth are higher in Calderdale than in England or Yorkshire and Humber. Within Calderdale it is worst within the deprived areas and in Asian children.
- Population forecasts predict growth in the under 15 population

Key Deliverables for 2012

The key deliverable identified will be confirmed through the development of the Primary Care Strategy.

- Procure additional Primary Care services for up to 18,000 people;
- Procure GP-led walk-in services
- Develop an Estate that is Fit for Purpose
- Increase the number of training practices;
- Develop and increase the range of services provided closer to home in Primary Care;
- Procure a new Out of Hours Primary Care service (this is part of the Urgent Care Tender);
- A new pharmacy needs assessment will be signed off in October 2008;
- Commission more services from Pharmacists for the management of self care following the needs assessment;
- Implement the new Optical services contract;
- Improve access to primary care services
- Commission a range of clinical enhanced services in 2008/9
- Improve patient satisfaction with access to GP services
- Increased access to NHS dentistry in care homes
- Improve quality of services ensuring consistency and reduce variation
- Maintain and improve access to NHS Dentistry with a focus in the deprived areas

Delivery of this critical component has clear links to all of the PCT programmes and many of the other critical components. This is particularly clear in terms of delivery of the Care Closer to Home Programme (which encompasses the Community Hospitals Project) and delivery of the Urgent Care Programme (extending access and the provision of walk-in centre services). This key relationship will be delivered by the Head of Primary Care and relevant Programme Managers who will provide an overview progress and ensure performance through programme governance structures.

Critical Component 9 - Quality Improvement

Quality improvement is tangible and measurable and can be defined as

" the extent to which health services commissioned and directly provided by Calderdale PCT increase the likelihood of achieving desired health outcomes and are consistent with current professional knowledge (evidence based)".

Quality means different things to different people and underpins the delivery of services across all providers. The Vision for High Quality Care for all is for an NHS that gives patients and the public more information and choice, works in partnership and has quality care at its heart – quality defined as clinically effective, personal and safe. The following are keys strands to this work:

- Patient Safety
- Patient Experience
- Effectiveness of Care

In the context of this document, the key strategic objectives for delivery of the quality improvement agenda are to ensure:

- There is a clear strategic direction for clinical engagement and leadership which underpins the breadth of the quality agenda. This work impacts on the ways the PCT's Clinical Executive delivers clinical input into commissioning and support the further development of clinical networks
- That there is a clear process for ensuring patient safety via; clinical risk assessment, incident reporting, clinical accreditation and proactive learning lessons culture which assures the quality of service provision
- An evidence base exists to underpin the commissioning, development and delivery of local services.
- Quality indicators (including clinical outcomes, patient reported experience measures and patient reported outcomes measures) are developed which provide overarching indicators of quality as well as indicators for individual services to support performance monitoring
- There is a 'governance-loop' which provides assurance around commissioning and delivery, underpinned by effective audit and monitoring processes.
- The relationship with contracting is developed to ensure quality is embedded into existing contracts, forms a part of the procurement and systems and processes are developed to support monitoring of quality based contracts
- There is a process for assuring that within the commissioning processes the training and education of the current and potential workforce is considered taken into account. Development of the workforce, through a range of mediums is vital to delivery of services. The development of quality indicators for performance related to learning and development will also be necessary

The PCT is currently developing a Quality Improvement Strategy for the PCT Board, which will identify key deliverables for 2008 – 2012. This work will have key linkages to delivery of critical components for; Public & Patient Involvement and Workforce Planning. The Quality and Engagement Directorate will work within current governance structures and evolving Programme Management governance structures to ensure that programmes are underpinned by knowledge of quality improvement principles and process, and the competence of staff to ensure quality improvement is implicit within programme development and delivery.

Critical Component 10 - Workforce Planning

Workforce planning can be defined as: “getting the right people with the right skills and competences in the right place at the right time”. Effective workforce planning requires organisations to design, develop and deliver their future workforce, making sure the resulting workforce plans are aligned with financial and business plans.

In the context of this document, the strategic direction for workforce planning is set out within the 2008/2009 Operating Framework (section 3.32). The PCT has a responsibility to make sure that it has a coherent workforce plan with clear clinical vision. This includes planning for its own workforce as well as ensuring that the workforce plans of providers are appropriate and linked to finance and service delivery plans. The PCT also has to ensure that it has assessed and mitigated any risks to service delivery arising from lack of capability in the workforce. This strategy has key links to delivery of the Staff Involvement Strategy (currently under development).

The PCT has developed a detailed framework for workforce planning, which was approved by the Board in April 2008. Key milestones have been identified to accompany the framework, and consultation has begun with the PCT’s main providers and partners to establish a constructive workforce planning network. In developing its approach to workforce planning, the PCT recognises the need to be flexible in order to accommodate the evolving nature of workforce planning in the wider NHS.

The Assistant Director for Workforce, Commissioning and Policy, working across both Calderdale and Kirklees PCTs will assist Programme Managers and operational managers in identifying and addressing workforce planning opportunities, threats and priorities within their programme or area of work. This should result in a series of workforce assessments and plans, which can be combined to form the PCT’s overarching workforce plan. It is anticipated that an initial workforce risk assessment will be completed by Autumn 2008.

7. ACKNOWLEDGEMENTS

The PCT are grateful to a wide range of people for their involvement in developing this Strategy. Particular thanks go to:

- All those organisations and individuals who took part in our Commissioning Strategy engagement process in April 2008
- The Calderdale Commissioning Group
- Our partners and stakeholders , particularly Calderdale Local Authority
- Our staff, and hose who lead on individual Programmes and Critical Components
- The PCT's Board, Clinical Executive