



NHS

**Greater Huddersfield
Clinical Commissioning Group**

Care Closer to Home

Summary of engagement

Purpose of this report

This report aims to provide a summary of the various engagement activities that have taken place in respect of local services as identified within our strategic plan and those supporting care within the community.

Our approach to engagement

Our approach to public engagement and consultation is to make sure that we use a variety of different mechanisms, methods and approaches to engage with people. We need to understand how we can best involve people, when they need to be engaged or indeed want to be engaged. We have a 'Patient and Public Engagement and Experience Strategy' which sets out our plans for the next three years and underpins our 'whole system approach' to supporting this work. Our strategy enables us to meet our responsibilities under the Health and Social Care Act 2012:

- putting patients at the heart of everything we do
- focusing on improving those things that really matter to our patients
- empowering and liberating clinicians to innovate, with the freedom to focus on improving healthcare services and,
- the recommendations of the Francis Report

The strategy shows that we are committed to ensuring that we actively engage with patients, the public and other key stakeholders to ensure that the commissioning, design, development, delivery and monitoring of healthcare in Greater Huddersfield meets the needs of our population. By listening to patients, and learning from their experience of health care we can understand what really matters to people.

We want to make sure we hear from all the people and communities in Greater Huddersfield - everyone's opinions matter. We understand that the way we ask for people to share their views can make a big difference to who responds so we will ensure we design our patient experience and engagement processes with this in mind. We also use equality monitoring to assess the representativeness of the views we have gathered and where there are gaps or we identify trends in opinion these will be looked into and plans made to address them.

Engagement so far

Throughout the year we actively promote any activities for people to become involved. In addition, we ask if people would like to have their name stored on a 'people bank' so we can contact individuals directly about healthcare services.

At a strategic or population level we have engaged through:

- Call to Action
- Right Care, Right Time, Right Place
- Commissioning intentions

Engagement as part of the development of our commissioning intentions will feed into the overall themes arising locally and support our decision making in respect of future actions. We will continuously cross reference the themes which arise from patient and public engagement to update and reflect on the intelligence we have to date.

The information we have from strategic, or population, level engagement, commissioning intentions development and engagement on specific programmes and projects form an assessment to date. What we need to do now is take stock:

- Have we got any gaps?
- Is there anything else we should consider?
- What else do we need to do to fill the gaps?
- Undertake further engagement + /or test with at stakeholder event
- Are we then ready to present a compelling case that we've met our statutory duties to engage?

The following diagram shows the areas of strategic level and service level engagement. Below these, are the service areas we have prioritised as part of our strategic plan for 14/15 and beyond, and the work carried out to date to inform these. More information on each project and how this informed the commissioning decisions can be found later in the document. Included is also a review of the communications and engagement plans that support the various areas of work.

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Call to Action

Right Care, Right Time, Right Place Commissioning Intentions

MSK	Respiratory	Diabetes	Dermatology	Cancer	Care Closer to Home	Children and Young People	Maternity	Primary care	Mental health	Urgent and emergency care
Wheelchair Services	Equality Delivery System	Anti-coagulation	Planned Care	Long Term Care	Child Development Service	Children	Princess Royal Community Health Centre	Patient Reference Group Network	Single Care Plan	Unplanned Care

Overarching themes

Staff Training including changing the culture of the NHS, communication and transparency.

- Improve communication with patients and ensure they understand their condition and treatment options and are able to make informed choices about their own care
- Make the NHS transparent at all levels
- Train specialist staff (or have a matron lead) who understand different disabilities and mental health

Education and information. All information from the NHS should be available in easy to understand formats and use a variety of different methods to reach the appropriate audience.

- There needs to be more information about how to maintain health and wellbeing and how to avoid preventable conditions
- More information on the services available and how to access them
- Education courses should be available for specific conditions and general health and wellbeing, preferably delivered by people with the condition themselves to provide peer support
- More education and information for young people – start at school, use Sure Start centres

Self Care, including prevention, was a theme arising from strategic as well as project specific engagement and included the following:

- Care that is personalised with the support of specialist staff; patients being able to access the right services at the right time
- Getting support in being healthy and to be encouraged to self care by providing access to information, advice and support with regards to diet, exercise, support groups/networks and contacts for ongoing support
- Ensuring patients are involved in the development of their care plan and informed so they know what to expect, who to contact and provision of ongoing care and support
- Involvement of wider networks such as carers and families and considering their needs
- 'Self Care' to support those who are well to ensure prevention – well-being courses for the community, particularly for young people
- Care navigators and co-ordinators to support individuals

Regular check-ups including annual check-ups or possibly more frequent depending on the age and condition for everybody.

- To be offered a wide variety of health and wellbeing checks, many people described this as an MOT or health review
- Also a call for more targeted check-ups for those groups at particular risk
- More routine scans and screening
- Early diagnosis can ensure early intervention including self help

Working together, all agencies, not just health, should work together to improve health and wellbeing.

- Joint teams that are managed centrally, not just teams that work together
- Sharing of information and the ability to access a shared, patient owned record for those that need to
- Working with the third sector, as partners to improve health and wellbeing

Improve access to health services. This included opening times and appointment availability, particularly aimed at GP practices and primary care.

- Awareness of building access issues to all staff, especially around disabilities
- One point of access for people with a long term condition
- Longer appointment times for some people, spend more time with the patient and listen
- Improve home visits and bring GP services to community settings
- Reduce waiting times for appointments and change the booking system
- Have appointments at evenings and weekends, ring fence appointments for people who work
- Have specialist staff in GP practices

Discharge planning and better hospitals. The public told us some of the things we should consider for improving our hospitals and discharge planning was part of this.

- Ensure that when people are discharged they have a robust plan that is backed up with a health and social care services 24/7.
- Ensure patients are fully recovered before they are discharged
- Assign a professional to keep regular daily contact in the first week, fund and use local VCS organisations to support the individual
- Train and support carers in their duties so they can manage
- Improve staffing levels in hospitals and care homes
- Hospitals need to be clean and serving nutritional food to support recovery
- Bring hospital services into community settings and greater integration of care across pathways

Invest in technology. Use technology better and invest in future technology, especially for monitoring and sharing information between services and patients. This was raised during our strategic level engagement but also as part of our care closer to home work.

Call to Action

Nationally, the NHS launched its 'Call to Action' - a national debate to:

- Build a common understanding about the need to renew our vision of the health care service, particularly to meet the challenges of the future;
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures;
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plan; and
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives for the next 5 – 10 years.

Every CCG was expected to play an active role in encouraging local people to participate in the 'Call to Action'.

The engagement took place during October – November 2013.

Who did we consult and what did we ask?

The National Call to Action asked the public to give their views on four broad but fundamental questions, these questions were:

- How can we improve the quality of NHS care?
- How can we meet everyone's healthcare needs?
- How can we maintain financial sustainability?
- What must we do to build an excellent NHS now and for future generations?

As these general questions had a very broad scope, they were broken down into fourteen, more specific questions. The detailed questions were used to engage with local people so they could respond to questions that were more relevant to individual experiences to ensure people could engage fully. An online and paper survey was produced with these questions.

Information about Call to Action was sent to all voluntary and community groups held on the Relationship Matrix with a link to the online survey and a printable copy of the survey. An invitation for members of the CCG to attend a group's meeting to discuss Call to Action further was also made.

The Patient Reference Group network was made aware of the Call to Action work at their October meeting and members were asked to complete the survey to share their ideas and thoughts.

Information about Call to Action was included on the NHS Greater Huddersfield Clinical Commissioning Group website, including a background to the project with a link to national information from NHS England, links to the online survey and the printable copy along with alternative contact details for further information.

Social media was used to reach those members of the public following NHS Greater Huddersfield Clinical Commissioning Group. This amounts to 2,663 followers on Twitter and 695 likes on Facebook. Each individual question from the survey was tweeted and posted several times during the period 30th October – 30th November 2013 always containing a link to the online survey.

'It's My Health Day' is a West Yorkshire wide event held for people with a Learning Disability. Staff from the Engagement team at NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit attended the event with an adapted, easy read version of the 'Call to Action' survey. Seventeen responses were received from the event. Postcode and equality monitoring information was not captured using this survey

What did they tell us?

We received contributions from 195 people. The responses were analysed and 10 key themes emerged:

Invest in the community. Invest in community and primary care, as well as local community and voluntary groups that provide support for local people with health conditions.

Staff Training including changing the culture of the NHS, communication and transparency.

Education and information. All information from the NHS should be available in easy to understand formats and use a variety of different methods to reach the appropriate audience.

National solutions and campaigns are needed; there were calls for changes to be made on a national scale.

Self Care the term used by respondents was not 'Self Care' but self-help, self-management (manage) or 'helping people cope'. Self-management (care) was a strong theme.

Regular check-ups including annual check-ups or possibly more frequent depending on the age and condition for everybody.

Working together, all agencies, not just health, should work together to improve health and wellbeing.

Improve access to health services. This included opening times and appointment availability, particularly aimed at GP practices and primary care.

Discharge planning and better hospitals. The public told us some of the things we should consider improving our hospitals there was a lot of focus on discharge.

Invest in technology. Use technology better and invest in future technology, especially for monitoring and sharing information between services and patients.

What did we do?

The findings were reported to Greater Huddersfield CCG to ensure that the findings inform future business plans. The information was also used to further inform the Calderdale and Huddersfield Strategic Review on the transformation plans which will have an impact on the population of Greater Huddersfield.

The findings were also shared with:

- NHS England as the local response to the National Call to action.
- Calderdale and Huddersfield Strategic Review Executive steering group in the format of a presentation combined with the findings from Calderdale.
- Calderdale and Huddersfield Strategic Review Programme Board, again combined with the findings from Calderdale.
- The public on the Greater Huddersfield CCG website.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in December 2013, which includes a copy of the engagement plan.

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Right Care, Right Time, Right Place

Engagement report to be produced by Dawn and Jill. Communications and Engagement plan in place.

Who did we consult and what did we ask?

What did they tell us?

What did we do?

Where can you find more information about this work?

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Strategic Priorities

A review of the Communications and Engagement plans that are in place for the following areas has taken place. Where necessary, plans have been developed and/or action in respect of these noted.

Cancer, CVD, Dermatology, Children and Young People, Maternity, Urgent and Emergency Care, Mental health

A draft Communications and Engagement plan will be developed for each of the areas. These are based around 6 week engagement to gain the views of current users of the service, with regards to what works, what doesn't and what they would like to see improved. It should be noted that engagement with local groups is already planned in respect of CVD, including an event due to take place in August 2014.

It should be noted that specialist services, such as cancer, urgent and emergency care, and paediatrics are being considered on a West Yorkshire wide basis and we will continue to reflect developments and engagement from this at a local level.

MSK

A Communications and Engagement plan has been developed in conjunction with Calderdale and North Kirklees CCGs. Engagement commenced on 16th June, for 6 weeks. The aim of the engagement is gain the views of current users of the service, with regards to what works, what doesn't and what they would like to see improved. A final report from this engagement will be available w/c 11th August 2014.

Integrated Care

Engagement has taken place throughout the project to support and shape the development of service models. Further events are planned for August 2014 to continue in this work and ensure that our plans are developed with the input of local people.

Diabetes

A Communications and Engagement plan has been developed and some initial engagement took place in January 2014 with another event planned for October 2014. The Communications and Engagement plan will be refreshed for the next stage of engagement, but will include the ongoing discussions we are already having with local groups.

Who did we consult and what did we ask?

Representatives from the voluntary and community sector, providers, commissioners, local authority and Healthwatch, were invited to attend an event in January 2014. At the event, participants were divided up into eight groups, with around eight people in each. Three groups focused on planned care, three on unplanned care and two on foot care. Each group was asked the following questions in relation to current diabetes services/support at each level of the model (prevention, self-care/pharmacy, generalist care, community specialist care, hospital specialist care):

- What is good?
- What is good but needs tweaking?
- What are the problems that need sorting out?

What did they tell us?

65 people from the voluntary and community sector, providers, commissioners, local authority and Healthwatch attended the event. The outputs were recorded on flipcharts, written up in themes, and shared with participants. The key areas for improvement were:

Prevention

- Preventative services, such as weight management
- Screening through NHS health check and other avenues

Self-care

- More education and education in different formats to meet the needs of the population with diabetes
- Accessibility of information about services/support available
- Emergency care plans so patients/carers know what to do if problems arise
- Resource community groups to work with people with diabetes
- Addressing isolated communities

Primary care

- Reducing variation in primary care/skilling all practices up to a specific level of care
- Development of care standards

Training and education (workforce)

- Consistency in training
- Mentoring

Foot care

- Ensuring that everyone gets regular high quality foot checks, with advice and signposting/referral where indicated
- Training of a wide range of health and social care professionals to recognise diabetic foot problems and signpost/refer accordingly

Specialist services

- Reviewing and increasing Diabetes Specialist Nurse provision
- Support for people with diabetes in hospital (around 1 in 5 patients in hospital at any one time have diabetes), including identifying people admitted for other conditions who have diabetes
- More accessible specialist expertise/advice
- Availability of psychological support
- Out of hours services, particularly in relation to foot problems
- Expansion of outreach

What did we do?

The themes in italics have been developed into priorities in the Calderdale and Greater Huddersfield Diabetes Strategy¹ and improvement plans have been developed for the first year of the strategy, covering all priority areas.

There were several general areas which emerged, as follows:

- Sharing of records to ensure people receive the best possible care
- More personalised services
- IT/Technology for monitoring

These will be picked up through the improvement plans.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in January 2014

¹ Calderdale and Greater Huddersfield Clinical Commissioning Groups Action on Diabetes: Five Year Strategy 2014/15 – 2018/19 (June 2014)

Respiratory

Some initial engagement took place in January 2014 with the Calderdale Breathe Easy Group. A revised project brief was drafted as a result and included engagement as one aspect of the aims and objectives of the project. A Communications and Engagement plan is being developed and the intention is to work with the Innovation Hub (i-hub) at Calderdale and Huddersfield Foundation NHS Trust to undertake the next stage of the engagement.

Who did we consult and what did we ask?

Seven people were involved in the Breathe Easy² meeting on 14th January 2014 – a mixture of men and women, middle-aged and older, some patients and some carers, all from Calderdale, although the group actually covers Huddersfield and Dewsbury as well.

They were asked about what worked well with current services and what needed improving.

What did they tell us?

Key themes which emerged were:

- Lack of information available about support available
- Peer support is critical in helping motivating people to look after themselves
- All clinics should be like Dr Thomas's - organised and keeping to time
- The respiratory nurses are excellent, but there aren't enough of them
- Smaller practices are better – in a big practice you can hardly get past the receptionist
- People with respiratory problems should be fast tracked by receptionists when they ring in so they can get help quickly
- Pulmonary rehabilitation is brilliant, but it can be difficult to get to it – transport can be available but information about it is not sent in the information about the course
- The problem is there is little following on from pulmonary rehabilitation – there is an exercise class at Halifax Fire Station for people with respiratory problems but it costs £5 per session, which is too expensive for some people
- COPD does not get as much money through fundraising as other areas such as cancer, despite the large number of people suffering with lung disease.

What did we do?

The information from the session was provided to the Respiratory Project Steering Group for them to feed into the development of the model and specification for respiratory services in Calderdale and Greater Huddersfield. A copy of the write-up from the session was sent to Breathe Easy with a note letting them know how it was being used.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in January 2014.

² Breathe Easy is a local patient/carer support group under the umbrella of the British Lung Foundation covering Calderdale and Huddersfield

Care Closer to Home

Care services across the Kirklees footprint are currently commissioned and delivered in a very fragmented way. Greater Huddersfield Clinical Commissioning Group (CCG) believes that delivery of effective services requires an integrated approach involving health, social care, voluntary sector and third sector organisations.

Through work on our transformation programme, we have identified significant patient and financial benefits from the integration of care services in Kirklees. We aim to commission innovative integrated care services for adults, which deliver improved quality and value for money. We want this to be consistent across the whole of Kirklees, whilst making sure that the needs of people in Greater Huddersfield area are met.

Who did we consult and what did we ask?

In January 2014, we engaged with the public, key stakeholders, providers and voluntary and community sector organisations in Kirklees to gain their views and ideas on our intentions to deliver care in the right place, at the right time, by the right people, doing the right things in the right way. We also wanted to capture the views and ideas from all the current service providers to ensure that any best practice and learning would be included.

In May 2014, we held follow up events focussed on the development of an integrated community-based service model (Care closer to home), developed using the feedback from the engagement undertaken in January 2014. We did this via two events – one for members of the public, voluntary and community sector, providers and key stakeholders; the other for primary care clinicians and staff.

What did the tell us?

January 2014

60 people attended the stakeholder event and 30 people attended the Primary Care events held in January and February 2014. In addition to the two events, a survey was developed to enable those people that were unable to attend the events to share their views. The questions for the survey mirrored the questions from the events. This was done to ensure that all respondents whether by event or survey were asked the same questions, this in turn would enable the data collated to be pulled together and analysed for any common themes. One hundred and twelve surveys were completed.

The main themes taken from the January engagement were:

Overarching themes that emerged across more than one area

- Regular reviews, follow ups and ongoing support and for this to be provided at home or closer to home.
- Ongoing involvement of patients and their families / carers throughout their care. Enabling them to make informed choices and ensuring that they are provided with information that they are able to understand. Patients need to know about their

diagnosis, what to expect, how to manage their condition, what their treatment options are, what ongoing support or care is available and who to contact for further support.

- Doing the right thing for patients and their families
- Provision of care navigators
- To be able to access the right services at the right time and for more services to be available in the evening and at the weekend.
- Ability for services and patients to access their patient record
- Provision of a seamless / integrated service staffed by a skilled and flexible workforce that wraps around the needs of the patient.
- Improve and increase the use of technology, such as telemedicine, self care hub, assistive technology

Self care and prevention specific themes

- To be supported in being healthy and to be encouraged to self care by providing access to information, advice and support with regards to diet, exercise, support groups / networks and who to contact for ongoing support
- Individuals supported to take responsibility for their own health and wellbeing
- Provision of local, affordable gym and exercise / sport
- Early intervention through better identification of patients at risk and targeted support

Diagnosis and care planning specific themes

- Individualised care plan held electronically that can be accessed by patient and professionals – plan needs to be outcome focused not just based on medical needs, refreshed regularly and with a holistic approach to care while improving safety and quality

Preventing admission to hospital specific themes

- Ensuring patients are fully involved in the development of their care plan and informed, so they know what to expect, who to contact, provision of ongoing care / support and regular reviews to help reduce the chance of a crisis occurring.
- Improve staffing at Care homes – increase staffing, ensure staff receive appropriate training and support to improve care and prevent high turnover of staff. Consider an increase in bed provision.
- Greater innovation and use of technology to improve outcomes and transformation

Discharge planning specific themes

- To involve patients and their families throughout the planning of their discharge. To enable them to make an informed choice, they should be advised on what services are available and what their options are. The approach needs to be holistic and flexible to meet the individual needs of the patient. This should be done early enough, to ensure that the appropriate services can be put in place. Upon discharge, patients need to know what to expect and who to contact should they require any further advice or support.

- Greater integration of care across pathways which break down traditional barriers in primary, community, secondary and social care
- Terminology needs to change from discharge to transfer of care. It was felt that discharge implies that no longer receiving care; however, in most cases the care transfers to another provider, this transfer needs to be seamless.

May 2014

Two events were held, one for members of the public, voluntary and community sector, providers and key stakeholders from across Kirklees and one for NHS Greater Huddersfield CCG primary care clinicians and staff.

Stakeholder event

32 people attended the stakeholder event; the purpose of which was to:

- Review progress to date (findings poster to reflect on feedback received and ensure this has been fully and correctly used in the development of draft plans)
- Confirm if the CCG were on the right lines (Basic model posters to outline what has been done to date in terms of developing the plans); and
- Identify if there was anything the CCG had missed and gather feedback for the way forward, including where services could be delivered in the future (Locality posters)

Findings poster

When I need care and support that is co-ordinated and planned

- Role of person advocating on behalf of person being cared for if they are unable to say/express their desires/wishes
- For British sign language user. It will be better to use a BSL advocate to work with deaf patients or clients. For example IMCA or IMHA
- How is info shared for carer/family members getting involved halfway/partway through care journey

'When I need to regain my independence

- Use of 3rd sector with specialism in sensory impairment for 1-1 support in the home or in the community
- Visually impaired rehabilitation e.g. kitchen skills, managing meds refer to sensory services

Core Community Team Functions

- Yes – speciality OK large footprint – however, the need patient needs to re-addressed locally – specialist function
- Rapid response – does this include calls to 111?
- Specialist teams available across 'clusters' with knowledge of what's available & education on specialist services provided to practitioners in the 'cluster'

1,2,3

- Will the Single Access Contact number be something easy to remember like 111/999 etc.?
- Single Point of access accessible for people with a hearing impairment? Either hard of hearing or sign language user

Basic Model posters

Ongoing Care

- Where does 3rd sector fit?
- Is there an intervention / prevention stage?
- Inclusion of private carers / agencies alongside social services commissioning. Integration of home carers is important to be part of the overall picture, linking in with others as needed.
- Deaf awareness training for all front-line staff
- Central intelligence system for clinicians to access for support services available in localities for patients – particularly to meet low level needs and reduce social isolation
- Health trainer and/or Care Navigation support crucial here
- Care Plan discussions / regular reviews need to include the whole integrated care team and the patient.
- How do expert patients programme ensure we are part of the integrated care plan. Once we are recognised as part of that care plan how do we ensure consistent use of/referral to our programme?
- I could be my own care co-ordinator

Specialist in-reach / Out-reach

- Co-ordinating with those who have most contact with patients or patients co-ordinating care if able / wanting to. Equality, community teams would have the necessary knowledge of all contacts
- Include post-natal/perinatal care.
- The system needs to be responsive to bring in the correct specialist services at the right time.
- Care-coordinators need to have the skills and experience appropriate to individual needs at a certain time – this could mean a change in coordinator dependant on circumstances.

Rapid response

- Mobile Response Team to be included and contact details available within Emergency Care Plans. Mobile response seen as positive. Skilled and could with information refer to other contacts. From here, the appropriate intervention can be initiated; this could be supported via access to e.g. clinical expertise so that this is done at the time of seeing the patients

- Acknowledgement that although the Mobile Response Team is important, emergency response can be provided by a family member/carer and details need to be recorded on an individual basis. Example provided around equipment – patient unable to access upstairs bedroom so contact details to be available for community equipment team who can respond in a timely manner to hopefully avoid hospital admission.

Supporting discharge

- Communication between GPs/hospital/Social Care is essential at the point of discharge to ensure patients have the correct services in place for when they get home and there is no delay in support.
- Package in place – or not in place – has impact on discharge, It's speed and smoothness
- After discharge, people will go to ongoing care – need skilled assessment with all that need to be there e.g. family to be present
- Instances where people discharged without carers & GPs being aware of this – results in care not being in place, negative for patients especially when living alone
- referral to sensory services where patient has visual impairment or hearing impairment that is or may impact on their health status or affect daily living activities
- Equipment for hospital discharge – multi-disc assessment & ordering equipment easily available from hospital.

General comments

- Where is prevention and self-care in the model?
- Care co-ordinator needs skills and experience to direct patients – anti natal, post natal, children, and older patients – when they need it
- A Single point of access needs to have access to a wide range of information (using integrated systems) to ensure appropriate next steps/onward referral.
- Specialist functions should be part of this. For example, a lot of antenatal care should lead to higher need around postnatal depression – need access to specialist services
- Need to take into account the needs of the population and the localities – it may differ between areas as there will be pockets of various needs
- Referral to be changed to access.
- Role of pharmacy in prevention. How do they interact with social services care needs based on patient feedback
- Concerns – follow up appointments for procedures need to be adhered to as sometimes they are lost in the system and forgotten about e.g. bone density scans, MRI scans
- How are services going to join and be accessible 24/7 across health & social care? There are gaps at the moment
- Sharing information across agencies is key to ensuring the care navigator and anyone else involved in the care/support of an individual
- Concerns: how will Joe Public without up to date technology know where to go for help in the first place? And get through the maze of info available?
- Concerns: timetable for e.g. Occupational therapies, Physio appointments, pain management – at present this is inadequate

- ALL services should be available via Choose & Book / NHS E-referral
- Need to speak to deaf people/hard of hearing people/blind & visually impaired people who all have different needs and will have some suggestions

List of Services/Locality posters

- Group of practices is positive, especially for carers as closer to visit the patient as opposed to a wider area
- District nursing – Ideally at GP practice level but certainly within a group of practices but need resilience
- Single Point of Access should be Kirklees wide however if systems are not integrated, may not be aware of all that is available, the bigger it is, the less chance to be aware of all. If they are integrated and it's working then could go wider than Kirklees
- Where things are linked to hospital discharge, link to hospital footprint
- Need to include carers in this, give carers information to equip them in their role, new Carers Act – needs consideration as part of this
- Specialist services should be Kirklees wide
- Community Rehabilitation – Group of practices/Greater Huddersfield.

Primary Care Event

Over 28 people attended the Greater Huddersfield Primary Care event held on Thursday 15th May 2014. The purpose of the event was to work together to discuss:

- Do the functions look right?
- Do any of the specialty functions need to move to be core functions?
- Do any of the core functions need to move to be specialty functions?
- What is the footprint for the locality team to deliver the core functions?
- What is the footprint for the locality team to deliver the speciality functions?

The key themes raised were:

Do the functions look right?

Majority felt that the functions did look right, although suggestions were made around:

- Children's nursing
- Midwives
- Home care
- Domiciliary care
- Social care
- Phlebotomy

Do any of the specialty functions need to move to be core functions?

All specialist services should be accessible through referral and have easy access to advice and support. The following were suggested as being part of core:

- Continuing care
- Low level IAPT, COPD, Diabetes and MSK
- End of Life Care
- Possibly memory monitoring depending on capacity of skills available

Do any of the core functions need to move to be specialty functions?

A suggestion was made that something similar to a JSNA was undertaken to establish areas of need to understand what needs to be core, and to consider more being done in Primary Care to reduce the speciality part. The following were suggested as being specialty functions:

- Paediatric nurses
- Older people's care
- Lower levels of specialisms need to be in primary care e.g. End of Life, memory monitoring

What is the footprint for the locality team to deliver the core functions?

There was some debate around the pros and cons of differing footprints, with smaller seen as more personable and able to understand the individual needs of patients. It was felt that some services would be suitable to be over a large footprint whilst others would be better suited to a smaller footprint. The number of localities / clusters varied from three to five, with the following as suggested areas:

- Central Huddersfield
- Colne Valley
- Holme Valley
- Dearne Valley
- Fartown and Friends

A suggestion of a 'wedge' shaped footprint running from the south of Greater Huddersfield to the town centre was made.

What is the footprint for the locality team to deliver the speciality functions?

It was felt that this should be based on population need and could be considered on a disease pathway. Some services could be across Greater Huddersfield, whilst others would be delivered by locality.

What did we do?

Following the engagement undertaken in January and May a further event is planned for August 2014.

Where can you find more information about this work?

Reports from the January and May engagement are available together with information on integrated care work and this can be found at

<http://www.greaterhuddersfieldccg.nhs.uk/get-involved/integrated-care/>

DRAFT

Wheelchair services

The NHS Clinical Commissioning Groups (CCGs) of Calderdale, Greater Huddersfield and North Kirklees had concerns about the wheelchair services provided to their populations. The current services were overstretched and overspent each year, with the reasons for overspend being unclear. Non recurrent resources had been identified to support the service over the last few years as demand exceeded the current capacity.

NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU) Communications and Engagement team, embarked on engagement with the public and key stakeholders over a six week period, from 4th November to 13th December 2013.

Who did we consult with and what did we ask?

The purpose of the engagement was to build on the data that had already been collated, by gaining the views of the public, key stakeholders and voluntary and community sector organisations on their experiences of wheelchair services in Calderdale and Kirklees and their suggestions on how the services could be improved.

Two events were held, one in Calderdale and one in Kirklees. Attendees included wheelchair users, carers, Healthwatch and staff who support wheelchair users in the community e.g. Locala, social workers and learning disability support workers.

The events consisted of a brief presentation which provided an overview of the current review of wheelchair services and the proposals for a new model. The event asked participants to discuss in their groups their views on the following questions:

- What is working well?
- What is working not so well?
- Are there any gaps in the service?
- Is there anything else the CCGs need to change?

Initially, the proposal had been to just undertake the two events; however, the engagement team received feedback from some members of the public advising that they were unable to attend either of the events but still wanted to share their views. To ensure everyone had an opportunity to be involved, the engagement team developed a survey. The survey was based on the questions to be used at the events and this was circulated via the engagement team's existing communication mechanisms.

Existing data held by WSYBCSU on behalf of the three CCGs was collated and analysed to form part of the engagement process. The information considered as part of this exercise was any patient feedback received in relation to wheelchair services, equipment or aids via the Patient Advice and Liaison Service (PALS) and complaints.

In addition to data from PALS and Complaints, data from previous engagement exercises and patient experience reports were also analysed for any issues relating to wheelchair services, equipment or aids.

What did they tell us?

Twenty-seven people attended the events, with thirteen people at the Kirklees event and fourteen at the Calderdale event and twenty-one surveys were completed.

The main themes taken from the existing data and the engagement were:

For some, the service was described as being quick and responsive with knowledgeable and professional staff. However, concern was expressed by many with regards to the waiting times for assessments and the provision and repair of wheelchairs.
The need for staff to receive training on: <ul style="list-style-type: none">• Disabilities /conditions to ensure that they understand the progressive nature of disabilities / conditions and how patient needs may change.• Customer service training to ensure staff actively listen and respond to service users.• Assessment and referral process to ensure that there is consistency in the application of the eligibility criteria.
It was felt that the current service does not cater for the needs of those that work or have other commitments during office hours. Respondents wanted a service that would meet the needs of everyone, including those that work. Suggestions were made to have a one-stop shop that was accessible seven days a week.
The need for additional staffing and budget, including the provision of wheelchair therapists and an increase in technical support to meet demand and reduce waiting times.
Poor communication between services and with service users which impacted negatively on the service that they received. Service users wanted to be kept up to date on the progress of their case, receive information on types of wheelchairs available and to have an easy read guide and or Charter.
People wanted the ability to have a wheelchair that meets their needs. Concerns were raised that they were unable to access a powered wheelchair for outside use, choice of equipment being limited by cost rather than suitability and the difficulties in obtaining a non standard wheelchair and adaptations.

What did we do?

Service specifications were developed around the views collated through the engagement. This led to a procurement process. Those people that had been invited to participate in the engagement were also given the opportunity to be part of the procurement process. Two lay representatives were recruited to be part of the procurement panel and were involved throughout the process.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in December 2013, which includes a copy of the engagement plan.

Equality Delivery System (EDS)

The Equality Delivery System (EDS) has been designed by the Department of Health to help NHS organisations measure their equality performance, and understand how driving equality improvements can strengthen the accountability of services to patients and the public.

It was used to support NHS Calderdale Clinical Commissioning Group (CCG) to identify local needs and priorities, particularly any unmet needs of populations, and allow them to assist in the commissioning of services to deliver better health outcomes. It also helped to demonstrate compliance with the Equality Act 2010. At the heart of the EDS is a set of eighteen outcomes grouped into four goals;

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and well-supported staff
4. Inclusive leadership at all levels

The engagement took place in September 2013.

Who did we consult with and what did we ask?

One of the features of the EDS is that it relies on organisations working with local interests to assess organisational performance. This engagement strengthened existing relationships and built new ones, ensuring that patients and the public have a voice in the grading and setting of objectives for the organisation.

The engagement focused on the following goals with local interests;

1. Better health outcomes for all
2. Improved patient access and experience

An interactive event using electronic voting and discussions was devised and delivered. To ensure effective engagement with local interests the Equality team worked closely with the Engagement team to recruit representatives from local organisations and local people to attend the local events. Invites were sent to local community and voluntary organisations and local people through the following methods.

- Relationship Matrix – E-mail, letter and telephone
- People database - E-mail, letter and telephone
- Community newsletters and bulletins

Within the invite, respondents were asked what their area of interest was, or the client group they worked with, linked to the nine protected characteristics.

- Age
- Disability
- Sexual Orientation

- Religion & Belief
- Race
- Pregnancy & Maternity
- Marriage & Civil Partnership
- Sex (gender)
- Transgender

The event was developed to use people's own knowledge and experience of the NHS as well as the groups they represented.

Interactive event

An interactive voting system was used throughout the event for participants to anonymously give their rating of the CCGs performance. The results from the room were then anonymously shown back to the group instantly. Facilitated discussion on each goal was also held prior to each voting session.

Participants were introduced to the background of the EDS and how their information would feed into the scoring of the CCG. They were involved in two discussion groups, one on each of the two goals that related to the public. Following each discussion group, participants were then asked to use the interactive voting system to rate how they felt about statements regarding the CCG's performance based on the outcomes of the overall goal. Throughout the event, participants were asked to take into account their own, or their service users', experiences of NHS services commissioned by the CCG; in respect of their interest areas around the nine protected characteristics.

To be able to understand in more detail the potential impact of membership of a protected group could have on perceptions of the audience they were asked to vote on their own personal demographics at the start of the event.

What did they tell us?

An analysis of the results of Goals 1 and 2 would suggest the following areas for further consideration;

- Meeting the needs of local communities
- Reducing local health inequalities
- Patients' needs assessed and services provided in appropriate ways
- Transitions
- Bullying harassment and abuse
- Easy access to services
- Explanations of conditions/treatments
- Complaint handling

As described it was possible to tentatively identify some trends in responses based on the equality monitoring of participants. The sample size does not allow for statistically significant issues to be discovered. However the trends described below have been used to support the development of the equality objectives.

1.1 Local NHS services meet the needs of local communities - Women and Asian/Asian British disagreed with this more

1.1 NHS promotes well being and healthy lifestyles - Disabled people disagreed more

1.3 Patients are involved in discussions about transfers - Women disagreed more

1.4 The safety of patients is a priority - Asian/Asian British disagreed more

2.1 Patients can easily access the NHS services they need - Disabled people disagreed

2.2 After being diagnosed with a condition everything is explained in a way patients understand - Men disagreed

2.3 Health professionals listen to and respect patients' views - Asian/Asian British, Black and other ethnicities disagreed

2.3 Patients' dignity and privacy are respected - Asian/Asian British disagreed

What did we do?

The feedback was used to develop the following equality objectives:

- Improve the access, experience and outcomes for South Asian patients with diabetes
- Improve patient experience equality monitoring measures

Action plans supporting these objectives have been produced.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in February 2014.

Unplanned care – Strategic Review

As part of the engagement of the Calderdale and Huddersfield Health and Social Care Strategic Review, engagement was undertaken with public, patients and carers. The engagement findings enabled the care stream to:

- Consider the views of patients as part of the strategic review; and
- Ensure that public, patient and voluntary community sector feedback is considered in the development of any future options to change the way a current service is provided or delivered.
- Highlight patient and public priorities and ensure these priorities are in line with current thinking.

The engagement took place November 2012 – January 2013

Who did we consult with and what did we ask?

An action plan for the engagement process was drafted and agreed by the Unplanned Care, Care Stream. The action plan identified three stages for the engagement process, the three stages were:

- Stage 1: To source existing intelligence which could be used to evidence patient, carer and public views.
- Stage 2: To further engage with patients, public and carers; and
- Stage 3: To conclude the engagement process by providing a report of findings.

The method of involvement to engage further with public, patients and carers was to deliver a questionnaire. The survey aimed to gather the views of the general public in respect of the services they had used the last time they had an unexpected health problem. This work looked at capturing experiences that had occurred in the last 12 months from the date of the engagement activity.

Two surveys were produced; firstly, a “general survey” to be used both in hard copies and on line. Secondly, a “location survey”, which was used by the engagement team to capture the views of people in locations across Calderdale and Huddersfield, including GP practices and Accident and Emergency departments.

The general survey was distributed in paper form to individuals via a wide range of participating organisation across Calderdale and Greater Huddersfield. These included local community groups, organisations and their distribution networks, local venues (e.g. a primary school, toddler group, women’s activity centre).

In addition, the survey was also made available to the public in web form, accessible through the external websites of the partnership programme organisations.

The location survey was used as an assisted survey in settings across Calderdale and Huddersfield, reaching a geographical spread of the venues and consisting of GP practices in Skelmanthorpe, Fartown, Slaithwaite, Hebden Bridge, Rastrick, Boothtown,

Southowram and Todmorden. In addition, the two A&E departments were also used as locations and these particular surveys were conducted from mid December 2012 to mid January 2013.

What did the tell us?

Engagement evidence was gathered from three main sources:

- Unplanned Care survey conducted over the period November 2012 to January 2013. The survey was conducted over a two month period from mid-November 2012, with the final surveys completed on 16 January 2013. In total, 1,339 general surveys were gained during the engagement process.
- Patient feedback and enquiries over the last three years, gathered from Complaints and Patient and Advice Liaison Service information, together with a review of local patients’ posts on the Patient Opinion website
- Evidence from other engagement activities undertaken in the last three years

This broad, inclusive approach was designed to maximise the use of all feedback and views provided by public, patients, carers and local voluntary and community groups, and ensure good representation from all sections of the community, including a wide range of minority groups.

There were a number of underpinning themes which were evident across the whole range of engagement evidence gathered. These are described below, and are evidenced in detail in the sub-sections of the report, as appropriate:

Patients did not always feel that they knew where best to go to access the care they needed.
GPs and community-based health care elements were often closed when the patients needed to access them, forcing them to go elsewhere, despite their preferences to use these services. Other access issues, most commonly related to availability/choice of appointments, were also commonly raised by patients.
Patients found the system fragmented with poor continuity of care – passed round from pillar to post, sometimes returning to A&E and other services on multiple occasions**. There was a need identified to build a more patient-centred approach and particularly to improve discharge and “hand-on” processes.
Delayed diagnosis and/or mis-diagnosis.
Some concerns that staff not sufficiently caring and did not take patients’ concerns about their health seriously enough, or consider their individual circumstances and needs.
Inconsistencies in standards/quality of care received - patients consistently cited high standard/quality of care as important, but quite often report big inconsistencies in services or along different stages of their pathway.

A number of examples of poor communication/ information provided to patient on their condition and subsequent management, and sometimes between different areas within the wider healthcare system at various stages of the patient pathway.
Several cases where patients felt they were inappropriately discharged from A&E and were subsequently readmitted to hospital shortly afterwards.
Patients placed high value on rehabilitation services/ being supported to self-manage/ manage their condition at home.
Several groups of patients, most notably those with long term conditions, regularly used and reported poor experiences of a number of aspects of emergency and urgent care services. This further highlighted the importance of effective management of long-term conditions within the urgent care and wider local healthcare system. This review also highlighted the need to put in place better plans to cater for disadvantaged groups such as elderly people and/or those with cognitive impairment, and families with young children, who all featured heavily as users of urgent care systems, across the evidence base.
Issues were raised about making better use of supporting technology, for instance telecare facilities and problems related to health professionals having limited (and variable) access to patient information available at point of contact.
Other problems, mentioned predominantly in relation to A&E attendance, were patients' concerns about long waits and not being told how long they would have to wait/ reasons why, and some patients were concerned that they received no, or inadequate pain relief.

** Note that this theme was also highlighted in the Planned Care engagement event.

What did we do?

The findings of the consultation exercise were considered by the 'Unplanned Care' working group. The findings have been used to help shape business cases for the work stream and ensured that the public have a voice in the future of service reconfigurations.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in February 2013, which includes a copy of the engagement plan. This can be found at

<http://www.rightcarerighttimerightplace.nhs.uk>

Planned care – Strategic Review

As part of the engagement of the Calderdale and Huddersfield Health and Social Care Strategic Review, engagement was undertaken with public, patients and carers. The engagement findings enabled the care stream to:

- Consider the views of patients as part of the strategic review; and
- Ensure that public, patient and voluntary community sector feedback is considered in the development of any future options to change the way a current service is provided or delivered.
- Highlight patient and public priorities and ensure these priorities are in line with current thinking.

The engagement took place November 2012 – January 2013.

Who did we consult with and what did we ask?

An action plan for the engagement process was drafted and agreed by the Planned Care, Care Stream. The action plan identified three stages for the engagement process, the three stages were:

- Stage 1: To source existing intelligence which could be used to evidence patient, carer and public views.
- Stage 2: To further engage with patients, public and carers; and
- Stage 3: To conclude the engagement process by providing a report of findings.

The method of involvement to engage further with public, patients and carers was to deliver an event on Planned Care. This event was hosted in a community setting and invitations were sent to partner organisations whom were best placed to identify public representatives to attend the meeting. By using the relationship matrix for both Calderdale and Greater Huddersfield, the engagement team were able to ensure that they invited representatives from various protected characteristics. In addition, the event was publicised to Patient Reference Groups representatives in the area and individuals already involved in the work of shadow CCGs.

The Planned Care engagement event was organised to give the care stream an opportunity to engage with the public as part of the pre-consultation process. The event created a platform to share information on the wider work and purpose of the strategic review; engage around planned care, sharing and receiving feedback from the public as well as testing and building on the information already identified as part of intelligence gathering.

The structure included presentations from the care stream members, audience participation and table discussions. In addition to the discussions, all questions and answers during the event were recorded and included within the analysis of this report. Furthermore, the event introduced a “pyramid of care”, based on the Kaiser Permanente

model, as a generic model to support early thinking. A dedicated area to capture any comments relating to the model were also captured and included in the report.

Following the introductory presentations, participants were split into five break-out groups to promote discussions on what they felt makes a good service. People were encouraged to think broadly, with basic structure provided to the discussion through the focus on the questions:

1. What matters to you?
2. What do you want to keep?
3. What could be done differently?

What did they tell us?

Engagement evidence was gathered from three main sources:

- Planned Care engagement event held in January 2013. Although not all organisations took up the opportunity to attend the event, we had 44 people in attendance from a wide range of local areas, disability organisations and condition related support groups representing various characteristics.
- Patient feedback and enquiries over the last three years, gathered from Complaints and Patient and Advice Liaison Service information, together with a review of local patients' posts on the Patient Opinion website
- Evidence from other engagement activities undertaken in the last three years

This broad, inclusive approach was designed to maximise the use of all feedback and views provided by Public, Patients, Carers and Local Voluntary and Community Groups, and ensure good representation from all sections of the community, including a wide range of minority groups.

There were a number underpinning themes which were evident across the whole range of engagement evidence gathered.

Focus on moving more services to be community based – more care in or close to the home, with consideration for ease of location and adequate parking/public transport access.
Timely and consistent access/ referrals to services available round the clock – choice of appointments, with minimum changes/cancellations, and on time.
Early and effective diagnosis and intervention.
Collaborative care planning (treat the person as a whole), supported by regular reviews and patients engaged in decisions about their care.
Co-ordinated/integrated care, underpinned by effective communication between services

and staff-patient.
Single point of contact/ co-ordinator role.
Consistently high quality of care provided by friendly, helpful and pro-active staff.
Provision of Information on patients' condition and treatment, the care pathway process, and available local support services (directory of services).
Supported self-management, including Assistive Technology.
Emotional, psychological and practical support, including support for carers and adequate social care funding.
Commissioning needs to involve local patient and wider public representatives, and focus funding on all aspects of patient support, including voluntary sector services and self-management support.

What did we do?

The findings of the consultation exercise were considered by the 'Planned Care' working group. The findings have been used to help shape business cases for the care stream and ensured that the public have a voice in the future of service reconfigurations.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in January 2013, which includes a copy of the engagement plan. This can be found at <http://www.rightcarerighttimerightplace.nhs.uk>

Children – Strategic Review

As part of the engagement of the Calderdale and Huddersfield Health and Social Care Strategic Review, engagement was undertaken with children and young people. The engagement findings enabled the care stream to:

- Consider the views of patients as part of the strategic review; and
- Ensure that public and patient feedback is considered in the development of any future options to change the way a current service is provided or delivered.
- Highlight patient and public priorities and ensure these priorities were in line with current thinking.

The engagement took place between November and December 2012.

Who did we consult with and what did we ask?

An action plan for the engagement process was drafted and agreed by the Children's Care Stream. The action plan identified three stages for the engagement process, the three stages were:

- Stage 1: To source existing intelligence which could be used to evidence patient, carer and public views.
- Stage 2: To further engage with patients, public and carers; and
- Stage 3: To conclude the engagement process by providing a report of findings.

The methods of involvement used to engage with children and young people were a survey and one to one interviews, to ask what children and young people do when they require unplanned care. Questionnaires were made available to children and young people through the following methods:

- Handed to clients using the Information Shop for Young People, Kirklees Integrated Youth Support Service.
- In groups with students from Calderdale College Brooksbank School, Sowerby Bridge High and Identity.
- Worked with the voluntary sector to distribute questionnaires through existing networks.
- Worked alongside the Youth Workers network to generate interest in the survey and to encourage completion.
- Promoted the survey through IYCE and CYP PP networks.

What did they tell us?

Engagement evidence was gathered from three main sources:

- An 'Unplanned Care' survey which was circulated throughout children and young people's networks and completed through one to one interviews. We received 254 views including 12 from parents.
- Evidence from other engagement activities undertaken in the last three years.

- Patient feedback and enquiries over the last three years, gathered from Complaints and Patient and Advice Liaison Service information.

This broad, inclusive approach was designed to maximise the use of all feedback and views provided by children and young people, and ensure good representation from all sections of the community, including a wide range of views from the protected groups as set out in the Equality Act 2010.

There were a number underpinning themes which were evident across the whole range of engagement evidence gathered. These are described below,

Young people say:

Involvement in planning and delivering services/activities, for example as peer mentors and educators and in decisions about our care.
Have the right adults working with us (people we can trust, who we can talk to in confidence, who are not judgemental, who like young people). Use the people who we have contact with the most to provide health messages.
Support our parents, carers, siblings and friends so they can support us.
Provide young people friendly venues in our local area, on line or through youth centres/workers and the places we go to.
Because of transport issues, we need local venues, close to home and available at the times we would like such as straight after school in our lunch break or Saturday mornings. For specialist services we are happy to travel up to 30 minutes.
We want to know what we can expect from a service (clear information, use a variety of ways to get the information through, use young people). We want information on the things we want to know about such as sexual health, drugs and alcohol, diet, lifestyle and emotional issues.

What did we do?

The findings of the consultation exercise were considered by the 'Children's' working group. The findings have been used to help shape business cases for the work stream and ensured that young people have a voice in the future of service reconfigurations that will continue throughout the coming year.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in February 2013, which includes a copy of the engagement plan. This can be found at

<http://www.rightcarerighttimerightplace.nhs.uk>

Long term care – Strategic Review

As part of the engagement of the Calderdale and Huddersfield Health and Social Care Strategic Review, engagement was undertaken with public, patients and carers. The engagement findings enabled the care stream to:

- Consider the views of patients as part of the strategic review; and
- Ensure that public, patient and voluntary community sector feedback is considered in the development of any future options to change the way a current service is provided or delivered.
- Highlight patient and public priorities and ensure these priorities are in line with current thinking.

The engagement took place November 2012 – January 2013.

Who did we consult with and what did we ask?

An action plan for the engagement process was drafted and agreed by the Long Term Care stream. The action plan identified three stages for the engagement process, the three stages were;

- Stage 1: To source existing intelligence which could be used to evidence patient, carer and public views.
- Stage 2: To further engage with patients, public and carers; and
- Stage 3: To conclude the engagement process by providing a report of findings.

The method of involvement to engage further with public, patients and carers was to deliver an event on Long Term Care. This event was hosted in a community setting and invitations were sent to partner organisations that were best placed to identify public representatives to attend the meeting. By using the relationship matrix for both Calderdale and greater Huddersfield the engagement team were able to ensure that they invited representatives from various protected characteristics.

The purpose of the Long Term Care event was to ensure that the care stream had an opportunity to engage with the public as part of the pre consultation process. The event provided an opportunity for care stream members to share the areas they wanted to look at as part of the review and present the messages already given by the public to check they were still relevant.

The event included presentations from the care stream members, with the afternoon organised as themed workshop discussions using case studies on:

- Assistive technology
- Self-care, and;
- Integrated Care

In addition there was a 'general theme' table which was used to discuss any other issues the attendees wanted considered as part of the review.

What did they tell us?

Engagement evidence was gathered from three main sources:

- Long Term Care engagement event held in December 2012. Although not all organisations took up the opportunity to attend the event, we had 50 people in attendance from a wide range of local areas, disability organisations and condition related support groups. The event had representatives from carers and whilst we did not attract the Asian population we covered a number of characteristics.
- Patient feedback and enquiries over the last three years, gathered from Complaints and Patient and Advice Liaison Service information, together with a review of local patients' posts on the Patient Opinion website
- Evidence from other engagement activities undertaken in the last three years

This broad, inclusive approach was designed to maximise the use of all feedback and views provided by Public, Patients, Carers and Local Voluntary and Community Groups, and ensure good representation from all sections of the community, including a wide range of minority groups.

There were a number underpinning themes which were evident across the whole range of engagement evidence gathered.

- Have to assess people's needs and personal objectives holistically up-front – no one size fits all.
- Effective care planning and ongoing collaborative decision making (i.e. keep involving the patient) – this will aid common vision of service user, carer, family healthcare professionals etc, and make integration more achievable.
- Training and ongoing education provided to patients, and their carers and families, to better understand their condition and support elements such as self care, assistive technology etc.
- Need to improve access to services and appointment systems, with greater availability outside normal working hours.
- Information on services provided needs to be made more accessible (touched on above, e.g. independent brokerage for DP etc).
- Single point of contact for patient is widely covered and, where, available, model is generally highly praised (e.g. Cancer, Respiratory) – again this works on several level (single point of contact for assessing needs, planning, and co-ordinating day-

to-day care, single point of access to information on available services, activities, choice etc).

- Integration of care is so important to ensure high standards of care, efficiency and good patient experience (e.g. lots of good ones – hospital discharge, integration of self care elements with other elements, intermediate care facilities etc).
- Continuity of care/service is a recurring theme, on several levels (on personal level, helps user to have contact with the same staff each time, build relationship and understanding, on wider level, continuity of service – avoid lots of short-term contracts, delays, gaps in service provision etc).
- Put greater emphasis on quality of services and the care they provide. Balance out quality vs cost – get value for money, but don't just go for cheapest option.
- People consistently advocate the need to have services close to home and embedded within their community.
- People generally happy to embrace elements of self care/management supported with by appropriate assistive technology, provided this is tailored to their needs and adequately supported within the wider health care system on an ongoing basis, i.e. not just as a direct placement for some other care element, and left to get on with it.
- It is also important to support carers, providing them with respite and practical advice and support.
- Provide and encourage support groups and link patients with like-minded individuals with knowledge and experience of their condition – important for emotional, psychological and practical support. Also include transport considerations within range of practical support.
- Commissioning needs to involve local patient and wider public representatives, and focus funding on all aspects of patient support, including voluntary sector services and self-management support.

What did we do?

The findings of the consultation exercise were considered by the 'Long Term Care' working group. The findings have been used to help shape business cases for the work stream and ensured that the public has a voice in the future of service reconfigurations.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in February 2013, which includes a copy of the engagement plan. This can be found at

<http://www.rightcarerighttimerightplace.nhs.uk>

Single care plan

The development and implementation of a Single Care Plan for children and young people was one of the projects identified by the Children's Working Group within the Calderdale & Huddersfield Health and Social Care Strategic Review. All children, 0-18yrs, with ill health or conditions (e.g. Asthma) now require a single care plan which they need to hold and take to school, youth club, scout group. Ofsted now expect schools to have regularly updated plans for children with long-term conditions. It would contain medical information, be paper based and include "must do" information such as name, age, address, any allergy details, GP and consultant details, information about their treatment plan. The plan was to be piloted once this was developed with children and young people who have Asthma.

The CCG wanted to involve children, young people and their parent/carers in order to determine how it would look and ensure it was something the "patient" wanted to use/carry.

The engagement took place in Spring 2014.

Who did we consult with and what did we ask?

Over 50 young people were involved in discussions on the Asthma Single Care Plan. The young people were aged 12 to 20 and were a mix of gender, ethnicity, socio-economic group. Some of these young people are ones who have ongoing involvement with IYCE projects, whilst others were as young people who access Youth clubs, schools, colleges and those in part time employment. Almost half of the young people involved in the discussions have experienced symptoms on more than one occasion or are recognised as having asthma.

What did they tell us?

The majority of young people stated that, if the only format was a paper based one, they would not bother carrying it with them – they did not see this as a priority. Some young people seemed interested in the idea of carrying something, which would support them in explaining to others what their condition was and help with managing it. Worries about the paper based SCP being washed or getting lost was another concern.

When discussing what would encourage young people to carry a SCP, they said

- If the only option was a paper-based version, then it would need to be discreet - credit card size was suggested on a number of occasions within a plastic pocket.
- If it looked interesting, with the use of colour and design appropriate to age.
- If there was an incentive to carry it! (for example discount for activities/shops)
- That it needed to be water and weather proof!

Despite the information that has been gathered in London, young people living and using services within Kirklees, suggested an app on their phones that can be accessed from anywhere and will not intrude with their personal belongings and 'things to remember'. The other suggestion was having a double sided plastic/vinyl type credit card with information on regarding their medical condition. This can be slipped in a wallet, bag, purse discreetly.

Some suggested that a coloured bracelet/band could be used on similar lines to a SOS, with information on. This could be linked with information that professionals could access on-line if needed.

Parent / Carers reactions:

Parents/carers were also involved in discussions on a paper-based SCP. Some of these parent/carers had children that had asthma or breathing related conditions (COPD). There were mixed views on the introduction of a Single Care Plan and some interesting suggestions.

This would be useful as there was often a lot of paperwork to complete or update if your child has a medical condition – school, out of school/holiday provision, uniformed groups, sports activities, dance activities, swimming lessons, outward bound activities, basically any other activity outside of school.

That if things changed with their child's condition, they would only have to update/amend one set of records and not have to do this for up to half a dozen different provisions.

They had concerns that their child would lose this information, which had confidential details on and were worried about data protection and identity theft for the future.

Some expressed their doubts that their child would forget to carry this with them when playing out with friends and asked how this SCP would differ with what is happening now when children play out with no SCP?

Suggestions:

A colour band is issued with a number on it for professionals to contact in order to access information on the medical condition, but were doubtful that this would actually happen. Parents/carers thought that the use of an app on a mobile device would be more useful, robust and accessible than a paper based version for children aged 10-11 years of age.

There were a few suggestions on having a plastic card like the national insurance number card or debit card with this information, which could withstand the test of time on being sat on (in jeans), being washed, dried, left in damp clothes. They also recommended that more than one card be issued, as children and teens did lose things / were forgetful.

Parents shared frustrations on the practicalities of having something that was made of paper/card and how resilient and practical this would be. Some went on to share experiences of washing and tumble drying their teens credit cards, money, bits of paper, make-up and other items left in pockets of clothes

What did we do?

Where can you find more information about this work?

A report of the findings from the engagement process was produced in May 2014.

Princess Royal Community Health Centre

Princess Royal Community Health Centre (PRCHC) has a long history of providing health services for the people of Huddersfield and has various developments on its site.

Calderdale and Huddersfield Foundation Trust (CHFT) need to invest in services for the future to support the needs of modern healthcare provide care closer to home and support the use of new and existing technology.

The site was of an age and condition that required major investment to the buildings and the infrastructure and had been identified as a building requiring extensive modernisation. Due to the extensive modernisation required CHFT made the decision to close Princess Royal Community Hospital and relocate services.

Who did we consult and what did we ask?

4 drop in sessions were held to advise the public of the intention to close Princess Royal Community Hospital, the reasons for this and to answer any queries.

An invite was sent to stakeholders and the voluntary and community sector by using the relationship matrix, which enabled representation from various protected groups to attend. In addition the drop in sessions were publicised to Patient Reference Groups (PRGS) representatives, comments cards were developed and where placed within all services at PRCHC, engagement team members also took the comments cards out whilst hosting other events within Greater Huddersfield such as a the Equality Delivery System (EDS) event and the Annual General Meeting (AGM) for CHFT.

Information about the 4 drop in sessions and how people could have their say was also tweeted on CHFT, Locala and GHCCG twitter sites and also publicised on their internal and external websites and internal and external bulletins/newsletters. A press release was also written and published within the local paper.

In addition to the drop-in sessions a pro-forma was sent to all services within PRCHC to find out from each service if there was any existing feedback from their patients about their service and/or the PRCHC as a building, within the last 2 years. This intelligence was analysed and considered as part of the whole review for PRCHC.

What did the tell us?

The feedback from the drop-in sessions and existing data collated by services at PRCHC were analysed and the following themes emerged:

- Focus on moving services to be central to the town centre with consideration for ease of location for public transport access.
- Accessibility considering the needs of people with disabilities'/wheelchair access.
- The need for a better environment and comfortable waiting areas with consideration for privacy and dignity.
- The need for adequate parking facilities'.

- Consistently high quality of care provided by friendly and helpful staff.

What did we do?

The feedback is being used by Calderdale and Huddersfield NHS Trust to help inform the next stage of the process, the relocation of services.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in October 2013.

DRAFT

Child Development Service

In Autumn 2013, the Engagement team at West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU) worked with Calderdale and Huddersfield Foundation Trust (CHFT) and Locala on behalf of NHS Greater Huddersfield Clinical Commissioning Group (GHCCCG) to engage with patients and the public around the closure of Princess Royal Community Health Centre (PRCHC) and the relocation of the services that were currently provided at PRCHC. The Princess Royal Community Hospital currently hosts the Child Development Service (Eilerslie Centre) in the Huddersfield area.

It was agreed that the building would close and as such consultation on moving the Child Development Service based at PRCHC took place over a six week period, from 19th May to 30th June 2014.

Who did we consult and what did we ask?

The purpose of the consultation was to build on the data that had already been collated, by gaining the views of the public, key stakeholders, providers and voluntary and community sector organisations on their views and their suggestions on how these services could be improved.

Existing data held by WSYBCSU on behalf of Greater Huddersfield CCG was collated and analysed to form part of the consultation process. The information considered as part of this exercise was any patient feedback received in relation to paediatrics and the Child Development Service via the Patient Advice and Liaison Service (PALS) and complaints. In addition to data from PALS and Complaints, data from previous engagement exercises and patient experience reports produced by the WSYBCSU Engagement Team were also analysed for any issues relating to paediatrics and the Child Development Service.

As part of the plan, a consultation document was produced which included a survey asking respondents to comment on the proposal. This was circulated to all parents of children that were currently using the Child Development Service and via the engagement teams existing communication mechanisms.

What did the tell us?

The consultation closed this week and feedback is subject to analysis.

What did we do?

Where can you find more information about this work?

A report of the findings from the engagement process will be produced in July 2014.

Anti-coagulation

More than 2,500 people across Greater Huddersfield are taking Warfarin. Each patient has their blood clotting monitored by an anticoagulation service (Warfarin clinic). Some will go to the hospital or their GP surgery and have a finger prick blood test and are given a result straightaway; others attend phlebotomy clinics where a blood sample is taken from your arm. The sample is sent to a testing laboratory and you are given your results by letter or telephone.

NHS Greater Huddersfield Clinical Commissioning Group (CCG) reviewed how anticoagulation (Warfarin) services were provided for patients. NHS Greater Huddersfield CCG wanted to improve access to these services by providing them closer to home; making sure every patient could have a finger prick blood test with immediate results so that any changes to their treatment could be made there and then. And would like to set up at least six clinics across Huddersfield and the surrounding valleys, so that everybody would have a clinic near to where they live and choose which of the clinics go to.

Engagement with patients took place over a six week period, from 9th December 2013 to 20th January 2014.

Who did we consult and what did we ask?

The purpose of the engagement was to build on the data that had already been collated by the transformation team, by gaining the views of patients, on their experiences of anticoagulation services in Greater Huddersfield and their suggestions on how the service could be improved.

Existing data was collated and analysed to form part of the engagement process. The information considered as part of this exercise was any patient feedback received in relation to anticoagulation services, via the Patient Advice and Liaison Service (PALS) and complaints. In addition to data from PALS and Complaints, data from previous engagement and patient experience reports were also analysed for any issues relating to anticoagulation services.

A survey was designed to gain feedback from patients about their views and experiences of the anticoagulation service and how they would prefer to receive this service from their local GP practice, health centre or hospital. The survey with a covering letter was posted directly to patients who were currently using the anticoagulation services at Calderdale and Huddersfield Foundation Trust (CHFT) and four GP practices across Greater Huddersfield. The survey was a paper based copy with a freepost return address and was also made available to complete on line.

In addition to the survey being sent direct to patients, background information on the anticoagulation service and an engagement proforma was sent to members of the Patient Reference Group Network (PRGN). Members were given details of the current anticoagulation service currently offered to patients who are on Warfarin and were asked for their help in re-designing this service. They were given the information to read and were asked to speak to at least one person that they know who uses this service.

The proforma was provided as a guide to help gain people's views. The information brought back from members was then discussed at that next PRGN meeting.

What did the tell us?

1752 surveys were completed. The key themes that emerged from the surveys, PRG Network and analysis of existing data were:

A significant amount of respondents feel that the service provided is excellent and that staff are kind, friendly and provide an efficient and professional service. Of those respondents those that access the different clinics/GPs would like for the service to continue as it is. <i>Quote "why fix wasn't isn't broken"</i>
Some respondents would like the option of being able to access the service closer to their home. Of those respondents some were concerned that the clinics needed to be close to a bus route.
The majority of respondents said that all GPs should prescribe Warfarin. Some respondents also commented on, that they would like instant prescribing by the service along with their results and being able to attend a local chemist and receive their medication.
Respondents commented on the need for the service to be flexible in order for people to be able to choose to attend a drop in clinic or book an appointment for convenience.
Some respondents expressed the need for more information, advice and support in taking their medication.

What did we do?

The findings of the engagement exercise were used to develop the service specification for the new service.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in February 2013.

Patient Reference Group Network (PRGN)

PRGN has been set up by the CCG as a forum to gather together representatives from each of the member practices' patient reference groups (PRGs). Within each PRGN meeting an engagement topic is included on the agenda. This gives the group an opportunity to discuss in detail some of the main pieces of work and priorities of the CCG and provide feedback on these. We engage with the network as part of our decision making.

October 2013

What we asked

The CCGs prospectus describes a shift in resources, money and services from hospital and specialist care to prevention, primary and community based care.

We believe that the use of technology is essential for this to succeed.

- What are your ideas about using technology?
- What would you need to make it work for you?
- How do you feel about this?

What they told us

People are wary of the accessibility of technology, mostly assuming that older people will be adversely affected. Many people called for 24/7/365 support for anybody using health technology.

Technology is seen as good for low level interactions such as test results, appointment booking and reminders, repeat prescriptions and information giving about health advice and available services. These automated interactions then release resources for those that can't use technology.

Consultations can be given using different methods such as telephone, e-mail and video conferencing. This can mean less waiting and travel for both patients and health professionals. There was a note of caution that these should be a choice and not the default.

Privacy concerns were raised about the sharing of patient information and who should have access to this. The benefits of transparency and information being available to health professionals so that people don't have to repeat their story were also noted.

Peer support and the support of self-care were seen as areas where technology can be effective.

The need for a culture change for health professionals and patients was seen as essential to integrating technology into healthcare. Cost barriers were also seen as a barrier to introducing technology.

What we asked

We wanted to know what services the group thought could be delivered in the community and what else could be delivered differently.

The group were also asked to discuss the options being put forward for a new anticoagulation service. They received an overview of the challenges that are faced by the service and potential solutions.

What they told us

Community services

The group thought that the following services could be provided in the community.

- Diagnostics such as phlebotomy, ultrasound, X-rays, doppler testing.
- Minor surgery such as sinus, cataract, hand and the removal of skin tags and cysts.
- More of a community presence for services like physiotherapy, dermatology, podiatry, weight-management service/dietician, ophthalmology, eye clinics and hearing aids. It was recognised that parts of these services were already provided outside hospital, but that there may be a possibility to include the entire pathway in the community.
- Follow up hospital care like outpatients, general check-ups and dressings with consultants working in the community.
- Other services suggested included acupuncture clinic and a 24/7 oxygen support.

Benefits

The perceived benefits of moving these services into the community were to reduce the stress of people having to travel to the hospital and quicker results that could be sent straight to their GP.

Risks

There were potential risks that the group raised about moving services into the community. These included:

- Making sure the right skills were present in primary care with access to a specialist opinion, even if this was virtual.
- Capacity of GP practices to provide extra services.
- If suitable accommodation was available or if existing estates could be used better.
- The costs of moving services.
- The effect of moving staff into the community.
- Public transport was seen as being a particular issue as it is often easier to get to hospital than some community venues.

Other comments

- Group practices together so they can offer more services on specific days.
- Increase the use of technology.
- Holme Valley was raised as a good example of services being offered closer to the community.

Anticoagulation service

The discussions focussed on the service being provided from more community locations which was seen as being more convenient for patients. It was recognised that it was not realistic for each practice to provide their own service, but that practices could cluster with their neighbours to run services in different areas. There were also suggestions for testing at home or pharmacies and using Health Care Assistants to reduce costs.

The results of the anticoagulation service engagement were fed back to the group at the next meeting.

March 2014

What we asked

We asked the group which aspects of current General Practice were most important to them to keep and what they would like to change. We also focused on four specific areas.

- Development of care out of hospital and integrated care
- Patient Experience
- Quality and Clinical variation
- Patient access to primary care services

What they told us

Most important

- The quality and continuity of care.
- Different types of appointments and ways of booking systems and repeat prescriptions.
- The variety of services available such as blood tests and appointments and also the access to different health professionals depending on need.
- Closer to home and avoiding having to go to hospital.
- Listening to patients for the improvement of their services.

Would like to change

- The attitude and privacy concerns of receptionists.
- Access to appointments, but especially at evenings, weekends and lunchtimes and also the variety of types of appointments.
- Reduce the number of do not attends.

- Access to buildings, premium telephone numbers and systems.
- Better triage.
- Sharing information and records with the hospital.
- More services available.

Development of care out of hospital and integrated care

The group concluded that they felt there should be more dialogue between patient and GP to agree the pathway that is needed for the individual.

Patient Experience

The group recommended that information should be readily available on how to feedback experiences as people don't actively seek out this information until they have had a bad experience. It was also suggested that displaying more patient experience feedback would help to raise the profile and get people to feedback their experiences. This could be done by screens and posters in waiting rooms, PRGs, website, newsletters and e-mails.

Quality and clinical variation

The discussion focussed on how campaigns for immunisations and health checks are advertised and how they should be targeted at the right audience. It was suggested that there is so much information available that is not kept up to date and is not relevant to individuals that people ignore it until they are told they need it. The group recommended looking at the audience that they need to get the message to and targeting places where they are likely to be, such as universities and schools for young people and sports clubs for men.

Patient access to primary care services

The group thought that there was a lot of appetite for new systems for booking appointments, having different types of appointments and ordering repeat prescriptions and highlighted various bits of evidence where this was backed up, including GP practice surveys and experience of using in their own practice.

They highlighted that people with long term conditions would want to have the continuity of seeing their own GP, but did not see that this should be needed for one off appointments.

It was also raised that although people had experience of goal setting with their GP, there was very little follow up to these which made them ineffective.

June 2014

What we asked

NHS national guidance says we have to focus on care for vulnerable and older people in the next 5 years. CCGs need to decide which services will help people feel supported and able to enjoy independence for longer.

This is what we want to achieve.

- They must improve the health and social care system and be measurable (so we know it has improved)
- Where possible care should be closer to home
- Schemes should save money ideally from reducing hospital attendances/admissions
- Avoid duplication with other services
- Increase people's ability to look after themselves

We wanted to know if the list of what we want achieve was correct and if there was anything missing that should be included.

We also had six options that we asked for feedback on.

- Practice based discharge coordinator service (not hospital based)
- Care co-ordination
- Targeted social care services
- Practice attached district nursing
- Dementia care workers
- Review of poly pharmacy for over 75s

What they told us

The list was seen as correct, but it was recommended that the benefits should include carers and families. The group also suggested that we should look at more support for carers. It was recommended that we consider whether the proposals contribute to crisis avoidance as this has a negative impact on patients and is costly. The link between crisis, urgent care and signposting to services when GP practices are closed was highlighted and that there was a need to support vulnerable patients who live alone. The group also felt that the use of technology should be reviewed and embraced.

Practice based discharge co-ordinator service (not hospital based)

This proposal was seen as a good idea that met all the aims. There were questions over the level of support that would be required for different individuals. The service should have the patient at the centre, acting as a central contact for a wider multidisciplinary team.

Care co-ordination

It was recognised that regular meetings must take place and that this has worked well where it already exists. There was a call for more social care involvement if this was to work as this has been missing in current similar meetings. There was concern that this could duplicate on work already being done, but was seen as the most beneficial proposal if this could be avoided.

Targeted social care services

The group felt that this proposal did not meet all the aims and was unrealistic, but they could see the improvements that it could bring. They did not understand whether the role was about signposting or care coordination, and felt that a Care Coordinator may be better placed to do this kind of role.

Practice attached district nursing

The current district nursing service was considered to be good. They suggested that consistency and a familiar face was important to this particular client group, but that this might just be a 'nice to have' and that an efficient service was more of a priority. It was felt that this proposal may bring better communication between district nursing and general practice, but that it did not meet all the aims.

Dementia care workers

The group recommended that this proposal should be considered as it met all the aims. Discussions centred around crisis avoidance which would have a positive impact on patients and families as well as being cost effective to the NHS. It was also seen as a way to promote independence and provide joined up care for patients.

Review of poly pharmacy for over 75s

Medication reviews were seen as an easy way to save money through preventing unnecessary prescriptions. It was suggested that this would benefit other groups, not just over 75s, especially people on numerous medications. The group discussed the current inconsistency in medication review dates across the area and the need for patients to have more information and understanding of what medication they were taking. More involvement from pharmacies was seen as a way of improving this. The group felt that this proposal met all the aims.